Witness Name: Fiona Catherine McQueen

Statement No.: 2

Exhibits: FMQ2

Dated: 17 June 2024

UK COVID-19 INQUIRY MODULE 3

WITNESS STATEMENT BY THE CHIEF NURSING OFFICER

This statement is one of a suite provided for Module 3 of the UK Covid Inquiry and these should be considered collectively. In relation to the issues raised by the Rule 9 requests served on the Scottish Government, in connection with Module 3, I, Fiona C McQueen will say as follows: -

1. I am Fiona McQueen, I worked for the Scottish Government (SG) as the Chief Nursing Officer (CNO) between November 2014 and February 2021.

2. I have prepared this statement with assistance from others and by reference to records and material provided to me by the SG. I have received assistance from the SG Covid Inquiries Information Governance Division and the Chief Nursing Officer Directorate (CNOD).

3. This statement is to be read in conjunction with the respective personal statements produced by Professors Amanda Croft and Alexander McMahon, UKIDM3CNO053 and UKIDM3CNO052 respectively.

4. Unless stated otherwise, the facts stated in this witness statement are within my own knowledge and are true. Where they are not within my own knowledge, they are derived from sources to which I refer and are true to the best of my knowledge and belief.

5. References to exhibits in this statement are in the form [FMQ2/number - INQ000000].

Biography

6. Three individuals held the post of Chief Nursing Officer (CNO) for Scotland during the period 1 March 2020 to 28 June 2022 ("the relevant period"):
    - Professor Fiona McQueen: November 2014 to February 2021 (interim from November 2014, then substantive from April 2015)
    - Professor Amanda Croft: February 2021 to August 2021
    - Professor Alex McMahon: October 2021 to April 2024 (interim from October 2021, then substantive from January 2022).

7. I have been an executive director of nursing in various organisations within NHS Scotland, including the health boards NHS Lanarkshire and NHS Ayrshire and Arran. I am a Registered Nurse and hold a Masters in Business Administration (MBA), a BA in Nursing, and a Diploma in Management Studies (DMS).

CNO and CNOD within DG Health and Social Care

8. The CNO is supported in delivery of their duties by a Deputy Chief Nursing Officer (DCNO), Chief Midwifery Officer (CMidO), Chief Allied Health Professions Officer (CAHPO) and Chief Scientific Officer (CSO), all of whom report directly to CNO. The CNO also has their own Chief Nursing Officer Directorate (CNOD), which comprises policy officials and clinical and educational professional advisers. CNOD sits within DG Health and Social Care (HSC).

9. As part of the DG HSC, I worked collaboratively with clinical colleagues across the DG including the Office of the CMO and the National Clinical Director. I also regularly attended meetings with non-clinical colleagues including DG HSC Policy Directors, the Cabinet Secretary for Health and Sport, other relevant SG Directors, and policy civil servants. I also attended a few meetings where the First Minister and other Cabinet Secretaries were present, and met with the First Minister, other Cabinet Secretaries and Special Advisers in preparation and delivery of the media briefings that were carried out. The list of groups I attended in discharging my duties as CNO is provided at paragraph 13.

10. In the same way as other Health Directors, I was directly line managed by DG HSC. The DG HSC delegates financial responsibility for budgets and expenditure incurred against directorate budgets to individual Directors through the Scheme of Delegation.

11. A full description of the DG HSC structure is provided in the Module 3 DG Health and Social Care corporate statement FMQ2/091-INQ000485979 submitted to the Inquiry on 18 June 2024

Role of the CNO

12. As the CNO, I held the following responsibilities during the specified period:

- Providing policy and professional advice to Ministers on matters relating to the education and workforce development of the professions for which CNOD have leadership, Healthcare Associated Infection / Antimicrobial Resistance, Professional Healthcare Regulation and wider strategic and policy aims for the various professions within its remit. The CNO was also responsible for leading on all professional and policy aspects of healthcare-associated infection policy and antimicrobial resistance
- Overseeing the student nurse, midwife and paramedic intake into universities on an annual basis. During the specified period, this work included assisting with the entry of student nurses, midwives and allied health professionals into the workforce
- Leading on Professional Healthcare Regulation including matters relating to Scotland's interests in overarching UK-wide reform of Professional Healthcare Regulation. This included regulations around students entering the workforce as part of their undergraduate programme
- Chairing the Louisa Jordan Oversight Board which oversaw the creation and ongoing use of the Scottish temporary medical facility
- Appearing, when requested, at the First Minister's daily Covid-19 briefings to the media. I supported the First Minister at a number of these briefings in 2020 and 2021
- Maintaining visible professional leadership and providing quality advice within Government and within the wider health and social care system in Scotland and the UK on issues relating to nursing, midwifery, allied health professions and healthcare science.

13. During the specified period, I exercised my responsibilities as CNO by providing professional advice and briefings. Advice was provided particularly through attendance at meetings. The groups attended by or associated with the CNO are as follows:

- **The Health and Social Care Management Board (HSCMB)**. This was essentially the main decision-making body for health and social care delivery during the pandemic
- **The Health and Social Care Planning and Assurance Group (PAG)**. This was reconstituted from the HSCMB following a decision taken on 24 March 2020. It commissioned and received relevant information, data and intelligence from the Military Planning Team and the Covid-19 Division (acting as Operations Teams). PAG met on 11 occasions in total. On 13 May 2020, the Group agreed to revert to HSCMB by the end of the month and held its last meeting on 20 May 2020
- **The Four Harms Group.** This was developed as a means to enhance existing arrangements through the already-established lines of accountability to provide advice for Scottish Ministers on the broader pandemic response. This process facilitated debate around critical decisions in the context of the SG's Framework for Decision Making, culminating in advice to Cabinet
- **The Care Home Professional Advisory Group.** The group reported to the CNO and Director of Adult Social Care and provided enhanced assurance around healthcare delivery and protection for the care home sector. The Terms of Reference and a paper outlining the role and remit of the Group are provided: [FMQ2/001- INQ000323461], [FMQ2/002- INQ000343806]
- **The Adult Social Care Oversight Board** (Chair). This group convened senior officials to take stock of arrangements that were in place to oversee care in care homes and other social care settings
- **The Four Country Clinical Group**. This was a group that evolved from meetings of the four country senior doctors. Discussion would take place about new information on the pandemic or new evidence for treatment, with the aim of seeking consensus on the clinical view for approaches to pandemic response. At times, each of the four countries' clinicians may have taken a slightly different view on application of evidence and how they advised their respective Ministers
- **Four country CNOs** would meet to share knowledge and information as well as seek consensus on relevant matters (such as staffing levels for Intensive Care Nursing where existing protocols and norms would be breached). An example is the *Joint statement on developing immediate critical care nursing capacity*, which set out the principles for increasing the nursing workforce in

critical care, including, but not limited to, flexible and staged approaches to securing additional capacity, supporting staff in working outside of their normal practice are and additional training, provided: [FMQ2/003a - INQ000228362]. This was circulated along with *Principles for increasing the nursing workforce in response to exceptional increased demand in Adult Critical Care*, a document that was produced to assist critical care staff dealing with a surge in Covid-19 patient, including guidance on non-critical care staff that could be asked to deliver nursing care under the supervision of critical nurses, provided: [FMQ2/003c - INQ000228364]. Both of these documents were circulated in an email titled *COVID19 – Guidance on critical care nursing for issue*, provided: [FMQ2/003b - INQ000227427]

- **The Scottish Executive Nurse Director Group (SEND)** meeting was a forum where the CNO met with the SEND to discuss professional matters and to share information.
- **The Louisa Jordan Oversight Board**. I chaired this board, which oversaw the creation and ongoing use of the Scottish temporary medical facility. This was a contingency arrangement to provide additional beds to care for people who had Covid-19 should the NHS run out of capacity. The submission to the First Minister from DG Health to establish the temporary medical facility Louisa Jordan at SEC is provided along with costing and modelling advice: [FMQ2/004-INQ000228365, FMQ2/004a - INQ000228366, FMQ2/004b - INQ000228367, FMQ2/004c - INQ000228368, FMQ2/004d - INQ000228369, FMQ2/004e - INQ000228370, FMQ2/004f - INQ000228371, FMQ2/004g - INQ000261872]. This submission included a requested approval to populate the temporary medical facility with up to 300 lower dependency beds, well under the site's total potential capacity of 1,211 beds, in order to minimise costs and disruption if the additional capacity was not needed, as turned out to be the case.
- **The Covid-19 Nosocomial Review Group (CNRG)**. This was a time limited expert group set up by the CMO and myself, in consultation with SG officials and Antimicrobial Resistance and Healthcare Associated Infections (ARHAI) within NHS National Services Scotland (NSS). The CNRG was established as a result of the identification of a need to better understand healthcare-associated Covid-19 epidemiology and emerging evidence in order to identify any additional Infection Prevention Control (IPC) measures that could be considered for implementation in health and social care settings, to reduce the

risk of hospital-associated Covid-19 infection in Scotland. The group was accountable to the SG through the CNO, to whom it provided advice. The CNRG first met and agreed its Terms of Reference on 7 May 2020.

14. Advice given by me throughout the pandemic was largely on nursing and midwifery professional practice and workforce numbers, Professional Healthcare Regulation, and in particular healthcare-associated infections (HCAI) in relation to protective and interventional measures such as those that happen when infection outbreaks occur within a hospital setting. This included guidance on what Personal Protective Equipment (PPE) should be worn. There were wider issues upon which I would give advice, given the CNO's role within the HSCMB and the requirements of the pandemic response, which will be detailed below. My role during the pandemic did not change.

Role of Deputy Chief Nursing Officer

15. During the pandemic, the DCNO provided professional leadership and clinical input on provision of support and development by:
    - Supporting and deputising for the CNO in their professional function to meet the SG's long-term strategic plan for NHS Scotland through change and innovation
    - Deputising for the CNO in a range of SG and external senior meetings, including NHS Chairs, Chief Executives, SENDs and HSCMB
    - Providing strategic leadership within the CNOD as well as working effectively across boundaries within the Health Directorates and the wider SG, the NHS and local government
    - Leading and co-ordinating strategic policy development reflecting the strategic vision, leadership and direction for the nursing profession and ensuring it is progressed and translated into practice within the NHS and beyond
    - Taking an overview of policy across the Directorate and identifying and influencing the contribution of, and implications for, the nursing profession
    - Leading and co-ordinating strategic policy development that maximises the contribution of NMAHPs to the implementation of the Quality Strategy
    - Providing high quality advice to Ministers and officials both personally and by advising professional officers as necessary within the Directorate and wider Health Directorates

- Providing professional, policy and organisational advice on nursing matters to health boards, local authorities and the public to ensure delivery of NMAHP and Health Directorates' policy direction
- Establishing and sustaining multi-professional working with the other clinical professions and the Chief Professional Officers to promote integrated approaches to clinical policy development and service delivery particularly in the areas of care quality
- Providing strategic professional leadership to NHS Scotland and other key stakeholders including NHS Education (NES) and Health Improvement Scotland (HIS)
- Leading and managing the professional adult nursing portfolio and associated national programmes of work.

16. DCNO (Diane Murray and subsequently Anne Armstrong) co-chaired the Clinical and Professional Advisory Group (CPAG), along with Professor Graham Ellis, Deputy Chief Medical Officer.

Role of Chief Midwifery Officer

17. The CNO is responsible at national level for all matters that relate to the professional leadership of nurses and midwives across Scotland. In order to carry out this function, the professional leadership of the midwifery profession is led by a Chief Midwifery Officer (CMidO). In doing so they report professionally and managerially to the CNO, and work across other policy areas giving advice to Ministers on all matters related to women and children's policy.

18. The CMidO's remit before and throughout the specified period included:
    - Provide professional advice across the portfolio to support implementation of Manifesto, Programme for Government and Health and Social Care Delivery Plan commitments related to pregnant women, children and families
    - Provide professional leadership for implementation of The Best Start: a five year plan for maternity and neonatal services in Scotland, including Vice Chair role and supporting the external chair with all aspects of the programme
    - Provide professional leadership input to the creation and delivery of a range of perinatal, children and families and associated policies
    - Ensure that pre-registration midwifery education is sustainable and able to flex to meet population and workforce requirements across Scotland's geography

- Develop a nationally consistent midwifery and Healthcare Support Worker (HCSW) career framework, supported by postgraduate education for band 2-9 maternity staff to underpin policy delivery
- Ensure midwifery workforce planning is supported by a workload planning tool that reflects contemporary midwifery practice and maternity services, and supports boards to apply the common staffing methodology to meet their responsibilities outlined in the Health and Care Staffing Act
- Drive midwifery leadership and succession planning supported by appropriate national initiatives
- Ensure evaluation of the newly introduced employer-led model of midwifery clinical supervision informs future direction and that this is embedded in practice
- Undertake a range of work to ensure that the contribution of the children's community nursing workforce to Covid-19 recovery is clear in an integrated context, supported by nationally consistent titles, roles and educational underpinning
- Work with others to build sustainable research capacity across midwifery and children's nursing.

Role of the CNO in advising the Scottish Government and other stakeholders

19. As CNO, I was not involved in the strategy for managing the pandemic; this was, to the best of my knowledge, principally led by the CMO along with the First Minister and the then Cabinet Secretary for Health and Sport, though HSCMB members received briefings on key decisions.

20. In general, I had limited involvement in advising Scottish Ministers on how we should respond to the pandemic between January and March 2020. I was not involved in the decision to discharge people into care homes; however I did, along with the CMO and Chief Social Work Advisor (CSWA), issue guidance to social care, provided: [FMQ2/005-INQ000376204]. In partnership with other colleagues, I advised HSCMB that cancellation of routine NHS cases should take place in order to create capacity for people with Covid-19 to be treated, in line with observing other countries, such as Italy and also England, who were ahead of us with regard to numbers of infections. My advice was based on the need to free up physical capacity within the NHS and also nursing staff to ensure there was a sufficiency of staff within the NHS. This was announced on 17 March 2020. As a consequence of my limited involvement in advising Scottish Ministers on how to respond to the pandemic

between January and March 2020, I had no involvement in the advice on working from home, reducing person to person transmission with social distancing, self-isolation, or school closures. As the pandemic progressed, I had a greater involvement in such matters, including regional and local restrictions, as a more inclusive approach was created and developed to providing advice to Scottish Ministers on the management of the pandemic.

21. As part of the CNO role, I also acted in a professional leadership role for Executive Nursing Directors. The Cabinet Secretary for Health and Sport wrote to this group on 17 May 2020 to alter their roles and responsibilities to include accountability for the provision of nursing leadership and for support and guidance within the care home and care at home sector, provided: [FMQ2/006-INQ000228376]. This followed a request from the then Cabinet Secretary for Health and Sport for multi-disciplinary teams, comprising key clinical and care leads from NHS boards and local authorities, to provide additional whole-system support to protect residents and staff, including advice on additional staffing where required.

22. Although Nurse Directors were not accountable for the care being provided by external providers to those receiving packages of care in their own home, I expected to see that where clinical and professional nursing leadership and input was required, the Executive Nurse Director would have a professional advisory role. I wrote to Nurse Directors on this on 15 June 2020, provided: [FMQ2/007-INQ000429267].

23. Further guidance for multi-agency scrutiny assurance partners was issued on 1 October 2020, provided: [FMQ2/008-INQ000429273], setting out the Executive Nursing Director role in care homes as follows:
    - Direct responsibility with Medical Director for the clinical support required for each care home in their health board area in collaboration with Directors of Public Health.
    - Professional nursing leadership, support and guidance
    - Infection control, PPE, workforce requirements, provision of mutual aid, education and training
    - Standards of Care through undertaking supportive reviews and visits with each care home.

24. I continued to provide professional leadership to Executive Nursing Directors in this sphere during my tenure.

25. As CNO, I was responsible for the reporting of and advising on nosocomial (hospital associated) infection and transmission, which informed IPC measures and assisted with the placement of patients into the appropriate Covid-19 clinical pathways.

26. As mentioned above, the CNRG was a dedicated group set up to identify any additional IPC measures which could be considered for implementation in health and social care settings to reduce the risk of hospital associated Covid-19 infection in Scotland. CNRG made recommendations throughout the time it was active. These recommendations were not published they were communicated via email to the CNO.

27. CNRG had a good understanding of the evolving Covid-19 situation within different hospital sites and stimulated further interrogation of the data and nosocomial infections-related issues faced across NHS Scotland estate. This intelligence on the situation in hospital sites was critical for CNOD to review and/or propose recommendations to Scottish Ministers in relation to a number of IPC measures. CNRG had access, via ARHAI to the number of Covid-19 outbreaks or clusters within each hospital setting. An example of this is Healthcare Worker (HCW) testing. CNRG recommendations in May 2020 (an updated in June 2020) were as follows:
    - All HCWs in wards where there is an unexpected cluster or outbreak should be tested as part of the investigation and management contact tracing; implementation of this should include early evaluation as part of the plan
    - Consideration by local Infection Prevention and Control Teams (IPCTs) should be given to HCW testing when a single unexpected case of Covid-19 is identified in a ward, with the purpose of early detection of risk of a potential outbreak; implementation of this should include early evaluation at part of the plan and on-going assessment of the local epidemiology
    - Consideration should be given in the guidance to the testing needs of HCWs working in Covid-19 (RED) wards / pathways by workforce policy colleagues
    - Research on wider universal testing of hospital HCWs to inform future policy and preparedness – Scotland should participate in the PHE SIREN study to this end which needs hospital sites confirmed within the next 10 days or CSO should consider a call for a Scotland specific study.
    - Connection of HCW testing policy and practice to the Test and Protect (TTIS) strategy at planning and implementation is important so that if a HCW is identified through that process there is a way to connect this to the enhanced outbreak response testing and management suggested here in hospital settings.

28. Advice from the CNRG to CNOD on 28 May 2020 was for additional targeted HCW testing to protect highly vulnerable patients in hospital at risk of poor outcomes from acquiring Covid-19. As a result, CNOD prepared a briefing with recommendations for the Cabinet Secretary for Health and Sport on this on 3 June 2020, the submission recommended that, as a priority, national guidance should be developed, including direction that all HCWs in wards where there was an unexpected cluster or outbreak in a non-Covid-19 ward should be tested and that local IPC teams should consider HCW testing a single unexpected case of Covid-19 was identified in a ward. [FMQ2/090 - INQ000250381, FMQ2/090a – INQ000250382, FMQ2/090b – INQ000323884 and FMQ2/090c – INQ000323885] Asymptomatic HCW PCR testing was introduced in June 2020 in the following high risk specialties: long term care of the elderly and long stay mental health facilities (as these were predominantly where clusters of Covid-19 outbreaks were reported) and cancer and blood disorder units (due to the highly vulnerable patient profile).

29. The CNRG supported SG and senior clinical advisers to:

- Interpret the SAGE outputs and other emerging scientific evidence in relation to nosocomial infection in the context of Scotland
- Provide expert advice spanning the disciplines of IPC, nosocomial infection, epidemiology, virology, statistical modelling and clinical advice more generally
- Make recommendations to CNO and CMO to reduce and mitigate against Covid-19 nosocomial infection, including but not limited to national surveillance, testing, screening, research, guidance and policy
- Support the SG Covid-19 Corporate Analytical Hub, overseen by the Chief Statistician, through analysis of nosocomial infection data in Scotland
- Advise the SG Health and Social Care Directorates, and Covid-19 Corporate Analytical Hub on strategic approach to identifying, accessing and using data to support our understanding and response to nosocomial transmission of Covid-19 in Scotland
- Develop links with other SG Covid-19 Advisory Groups, including co-opting members to the group as appropriate and taking early decisions on whether any supporting groups should be established
- Maintain close engagement with SAGE and their nosocomial sub-group, as well as the UK-wide IPC guidance cells
- Act as a mechanism for approving Covid-19 related ARHAI Scotland guidance.

30. The focus of this group was on nosocomial infection and transmission. However, it maintained close engagement with colleagues in the SG, ARHAI Scotland and PHS to ensure findings were shared and that policy recommendations were developed collaboratively with system considerations.

31. Members of the CNRG were IPC experts, clinicians and academics spanning the disciplines of epidemiology, virology, public health and statistical modelling. Ministers were not involved in the membership ToR sign-off for CNRG, as it was an independent group, but were provided with a link to the ToR when they were informed that minutes of CNRG meetings had been published on the SG website, or when the ToR were updated by the group. The ToR are provided: [FMQ2/009-INQ000323489], and the minutes have been provided and should all be considered relevant to this statement in showing the progress of discussions relating to a variety of issues that I had an interest in across my time as CNO: [FMQ2/055 - INQ000323509, FMQ2/056 - INQ000323510, FMQ2/057 - INQ000323511, FMQ2/058 - INQ000323512, FMQ2/059 - INQ000323785, FMQ2/060 - INQ000323514, FMQ2/061 - INQ000323515, FMQ2/062 - INQ000323516, FMQ2/063 - INQ000323517, FMQ2/064 - INQ000323518, FMQ2/065 - INQ000323519, FMQ2/066 - INQ000323520, FMQ2/067 - INQ000323521, FMQ2/068 - INQ000323522, FMQ2/069 - INQ000323523, FMQ2/070 - INQ000323524, FMQ2/071 - INQ000323525, FMQ2/072 - INQ000323526, FMQ2/073 - INQ000323527].

32. Clinical advisors from within SG, including the DCNO, National Clinical Lead for Quality and Safety, Interim Deputy Chief Medical Officer (DCMO) and/or Senior Medical Officers, and CNO Professional Advisors were core members of the CNRG. ARHAI Scotland, who are responsible for the delivery of the National ARHAI and IPC guidance in Scotland, were represented in the membership of CNRG and had the role of providing regular scientific critiques of available published literature. This included SAGE, Centre for Disease Control and Prevention (CDC), World Health Organization (WHO), Public Health England (PHE), UK Health Security Agency (UKHSA), PHS and UK IPC cell outputs.

33. The chair of CNRG was also a member of a sub-group of SAGE called the Hospital Onset Covid-19 Working Group (HOCWG). This group was formed under instruction from SAGE to provide an overview of possible nosocomial transmission of Covid-19 and evaluate evidence from which to recommend actions and interventions to reduce nosocomial infection and risk of transmission. The chair attended the HOCWG for the month before it

was stood down. Following the standing down of this group, the chair was invited to be an observer at the Hospital Onset Covid-19 Infection Working Group (HOCI).

34. As noted, the CNRG provided advice to the CNO and CMO. Thereafter, officials in the Healthcare Associated Infections and Antimicrobial Resistance (HCAI/AMR) Policy Unit and I considered the advice and used it to inform policy development. Submissions containing CNRG advice were provided by CNOD and CMOD to Ministers for consideration and decision. Advice was offered by the CNRG on the following topics:
    - The evolving understanding of the nature of Covid-19, infection routes, potential consequences of infection, at-risk groups, the risk of re-infection and death
    - The impact of the Covid-19 pandemic and the countermeasures taken by the SG on those at risk or vulnerable, whether as a result of underlying medical conditions or protected characteristics in Scotland
    - Testing strategy and rollout
    - NHS capacity, including the availability of staff, equipment, PPE and infrastructure and the management and significance of nosocomial infection
    - Non-pharmaceutical interventions (NPIs)
    - Face coverings.

35. One example of this was when CNRG provided advice on the use of face masks and face coverings in health and social care settings, which was used by CNO and CNOD to formulate and update the guidance on extended use of face masks in health and social care settings. The view of CNRG as noted in a briefing to Cabinet Secretary on 5 June 2020 was that current evidence from NHS Scotland cluster analysis on the number of staff testing positive, supported the SAGE view that face coverings / masks should be used by all healthcare staff who are unable to physically distance as well as members of the public who are attending healthcare settings. An article in the Lancet publication on 1 June 2020 supported the policy view. The extended use of face mask and face covering guidance was then developed and implemented as above.

Face Masks and Face Coverings Timeline

Date of Change	**Change**	**Description of change**	**Reason for change**

June 2020	Introduction of the 'Interim guidance on the wider use of facemasks'	Decision to introduce the wider use of face masks in adult hospitals and care homes for the elderly	Extended face masks/ face coverings use to reduce risk of nosocomial transmission of Covid-19 in hospitals and care homes.
September 2020	SG updated facemask guidance to cover primary and wider social care bringing these settings into line with acute and community hospitals	Updated to cover primary care (GP practices, dentists, opticians and pharmacies) and wider community care (including adult social or community care and adult residential settings, care home settings and domiciliary care), in addition to acute hospitals (including mental health, maternity, neonatal and paediatrics) and community hospitals in areas where individuals are directly cared for and areas where they are not.	Expanding the scope of the guidance to reduce risk of nosocomial transmission of Covid-19 in those settings.
February 2021			CNRG advice following commission from CNO
June 2021	9/6 - Updated version of face mask guidance and frequently asked questions (FAQ) section. 23/6 - The use of face masks and face coverings in social care settings was published.	Updated to include the wider wearing of Fluid Resistant Surgical Masks (FRSMs) by clinical and non-clinical hospital staff, the importance of FRSMs used by in-patients in hospitals and residents receiving direct care, or in communal areas in adult care homes as well as long stay/overnight	Expanding the scope of the guidance to reduce risk of nosocomial transmission of Covid-19 in those settings. Separation of guidance to support sector understanding and awareness

		visitors; and clarification around the need for outpatients, to wear face coverings, as well as encouraging individuals being cared for at home and their household to wear face coverings. A new guidance published to separate the use of face masks from healthcare settings and social care settings	
July 2021	Guidance for hospital staff to support visitors.	Questions and answers added to - guidance on the extended use of face masks and face coverings	Guidance for hospital staff and how to support visitors.
October 2021	Guidance sections updated to reflect latest position on the extended use of face masks and face coverings.	Change to physical distance requirements, waste disposal of face masks, update to the Health Protection (Coronavirus) (Requirements) (Scotland) Regulations 2021.	The Scottish Covid-19 Addendums have been updated
April 2022	Face mask guidance updated to reflect latest position.		Guidance was updated to reflect the change from legislation to guidance.
August 2022	Updates to Covid-19 asymptomatic testing guidance for patient testing; adult care home staff testing; extended use of face mask guidance and launch of Covid and Flu Vaccination Autumn/Winter 2022 [FMQ2/082 - INQ000468170]		

January 2023	Extant guidance on infection prevention and control, face mask and face covering use and patient testing for Covid-19 infection [Exhibit – FMQ2/083 - INQ000477443]		
June 2023	Guidance was withdrawn and recommended to revert to pre-pandemic and the NIPCM. [Exhibit – FMQ2/084 - INQ000469959]		Based on the evidence provided by ARHAI Scotland's rapid review of literature.

36. A Future Preparedness Paper, which was endorsed by the CNRG, captured outputs in the lifetime of the group, including the items listed above, provided: [FMQ2/010-INQ000322605].

37. CNOD also shared the views and recommendations from the CNRG with relevant SG policy teams who were responsible for the specific policy. An example of this was at the CNRG meeting of 25 September 2020, where the CNRG provided a paper on 22 September 2020 with the following recommendations for SG colleagues to consider on the Testing strategy, provided: [FMQ2/074-INQ000240789]:
    - Testing of asymptomatic emergency admissions should be rolled out to all in-patient admissions to reduce nosocomial risk, and data collected to describe the prevalence of asymptomatic carriage of SARS-CoV-2 on admission to hospital (subject to available testing capacity following prioritisation)
    - Consider the role of wider serial testing informed by local epidemiology (in addition to testing in the context of incidents / outbreaks) should there be a continued rise of cases in the community or increase in nosocomial transmission in hospitals
    - Wider weekly HCW testing should be considered if the number of cases in hospitals increases. The system should be prepared to mobilise into wider testing quickly.

38. The CNO considered any cross-cutting policy impacts and consulted with the CMO, National Clinical Director and other Health and Social Care Directors where necessary, for example the impacts on clinical pathways with changing IPC guidance. There was also further consideration of COVID-19 mitigations on population health including access to

physical activity and discussion amongst clinical leads with regards to key engagement with public and key stakeholders beyond the healthcare settings.

39. Though not a formal sub-group of the Covid-19 Advisory Group (C19AG), the CNRG provided regular updates on the work of the group at main C19AG meetings. This ensured two-way information and evidence sharing within Scotland and with wider UK groups, such as HOCI, the UK SAGE Nosocomial Group (via the CMO) and the UK IPC guidance cell. These connections and acts of information sharing enabled Ministerial updates to be made to the Cabinet Secretary for Health and Sport, the First Minister and other Ministers with a portfolio interest.

40. Recommendations from the CNRG were taken forward by ARHAI Scotland within NSS. The HCAI/AMR Policy Unit worked closely with the group to progress policy development and implementation, as well as providing secretariat support.

41. There was no official arrangement for SAGE to share any outputs with CNRG. As such, the outputs available to CNRG were those publicly available on the UK Government website. However, the CNRG Chair was also a member of the SAGE HOCI and reported back key points shared at the HOCI, as a standing CNRG meeting item.

Working relationships with other offices and organisations

Public Health Scotland

42. Direct interactions with PHS were generally limited, but CNOD did occasionally jointly commission them (as well as ARHAI Scotland) to undertake work related to IPC. An example is provided: [FMQ2/075- INQ000477446].

Nursing and Midwifery Council (NMC)

43. As set out in further detail below, my team and I liaised and worked with the NMC on emergency legislation to give the NMC, upon the declaration of a public health emergency by the Secretary of State, broad powers to temporarily register anyone it considered "fit, proper and suitably experienced".

Royal College of Nursing Scotland (RCN), Royal College of Midwives Scotland (RCM), Health and Social Care Professions Council (HCPC) and NHS Scotland bodies and organisations

44. I was represented by both clinical and policy colleagues on the Workforce Senior Leadership Group (WSLG), established in March 2020, which allowed NHS Scotland boards, trade unions / professional bodies and health and social care partners to work in partnership with SG through WSLG forum meetings. This Forum was hosted by the SG Health Workforce Directorate (HWD).

45. During the pandemic, the HWD's process regarding IPC guidance and protocols or standards consisted of engaging and communicating with stakeholders and supporting the implementation of relevant clinical guidance, including through the WSLG. The secretariat of the WSLG also ensured that any communication outside of the regular formal meetings were actioned promptly. The stated aims of the WSLG were to:

- Inform, engage and take collective action on key issues identified that required national senior strategic leadership in the Health and Adult social care workforce response to Covid-19
- Work in partnership to ensure that the healthcare system was as prepared as could be to respond to the peak of the virus, during and post response
- Ensure timely feedback from NHS boards and trade unions / professional organisations for the WSLG to address key issues.

46. Staff-side representatives and NHS employers were able to work in partnership with SG through WSLG forum meetings. Draft guidance would be shared with members from the WSLG and then following engagement, SG submissions were made to the Cabinet Secretary for Health (CSH) with recommendations. With consent from the CSH, officials would action the guidance with HWD ensuring it was shared with members of the WSLG at pace. This allowed the most up to date information to be available without delay. Key

issues and topics that were raised and discussed at regular WSLG meetings included but were not limited to: PPE (supply, FFP3 masks, WHO guidance), self-isolation, staff testing (including twice weekly testing, FAQ guide, care at home testing) and other guidance. A full list of all the topics discussed is provided: [FMQ2/076- INQ000477444].

47. CNOD also works closely with NHS NSS via their ARHAI Scotland Team on IPC matters, as they hold and maintain the National Infection Prevention Control Manual (NIPCM). It was originally intended that the ARHAI Scotland function, which was part of Health Protection Scotland, would transfer into PHS. However, when the SG and the Convention of Scottish Local Authorities (COSLA) consulted on the establishment of PHS in summer 2019, it was agreed that ARHAI Scotland would remain within NHS NSS considering the ongoing Independent Review of the Queen Elizabeth University Hospital. An independent external review has now been commissioned, which will consider where ARHAI Scotland should be sited in future, provided: [FMQ2/011-INQ000339584].

48. Policy officials and clinical advisors from CNOD attended Infection Control Manager meetings hosted by ARHAI Scotland, where the practical application of IPC measures and current challenges were discussed. This is covered in paragraphs 60-63.

49. I engaged with NHS Scotland by chairing meetings with SEND which included all territorial and national health boards as well as attending meetings with NHS board Chief Executives chaired by DG Health and Social Care. SEND meetings discussed professional matters and allowed for senior nurses within territorial and national boards could feedback on the impact of guidance or policy. During the timescale of the request, SEND discussed a number of issues with CNO including the increased oversight of Nurse Directors with care homes where SEND took opportunity to highlight the impact of IPC oversight on outcomes within care homes, and allowed the group to feed into policy making. NHS Boards had various opportunities to feed into policy across Health and Social Care Directorate.

Engagement with CNOs for England, Wales and Northern Ireland

50. My main forum of engagement with the other UK CNOs was through the CNO Forum. Building upon existing established relationships, the CNO forum includes the CNOs for Scotland, Wales, Northern Ireland and England and serves as a space to share legislative actions and changes and how this has impacted nursing workforce. This is not a decision-making forum and is purely to share best practice and shared knowledge. The meeting does not have to be quorate and does not produce minutes.

51. During my time as CNO, the forum would meet for around 45 minutes on a fortnightly basis. An example of points of discussion would be the NMC Temporary Register and impact on workforce. as demonstrated in the exhibit provided in paragraph 13 [FMQ2/003a-INQ000228362].

CNO involvement in national and local guidance

52. CNOD and I worked with NHS boards to manage and reduce the number of hospital onset cases of Covid-19 through the implementation of robust IPC measures. These measures were aligned with the guidance set out in the Covid-19 addendum, then the *Scottish Winter 2021–22 Respiratory Infections in Health and Care settings: IPC Addendum*, provided: [FMQ2/012 - INQ000322611] which was replaced by the *National IPC Manual*, provided: [FMQ2/013–INQ000339585]. This included measures such as the appropriate use of PPE, the extended use of face masks and face coverings, physical / social distancing, ensuring optimal ventilation, enhanced cleaning measures in high-risk pathways, systematic outbreak management, healthcare worker (HCW) testing and patient admission testing to ensure patients were placed in the appropriate pathway.

53. Covid-19 UK IPC guidance was in place from April 2020. It was developed in light of emerging evidence and reviews of evidence by public health and health protection organisations across the UK. It was then superseded by the updated UK IPC Guidance in August 2020. The Covid-19 Acute Addendum was published on 26 October 2020. The purpose of the addendum was to provide Covid-19 specific IPC guidance for NHS Scotland on a single platform improving accessibility for users. The guidance within the addendum was in line with the UK IPC remobilisation guidance, however some deviations for NHS Scotland existed. The addendum included guidance on:
    - Covid-19 case definitions and triage questions
    - Definition of a confirmed case
    - Definition of a suspected case
    - Triaging patients
    - Patient placement / assessment of risk
    - Critical care units
    - Split pathways
    - Staff cohorting
    - Moving patients between pathways
    - Single side room prioritisation

- Stepdown of IPC measures
- Local and national prevalence data
- Hand hygiene
- Respiratory and cough hygiene
- Personal protective equipment
- Extended use of masks for staff visitors and outpatients
- Face masks for inpatients
- PPE determined by Covid-19 care pathway
- Aerosol Generating Procedures (AGP)
- PPE for Aerosol Generating Procedures
- Post AGP fallow times
- Sessional use of PPE
- Safe management of care equipment
- Safe management of the care environment
- Safe management of linen
- Safe management of blood and body fluids
- Safe disposal of waste
- Occupational safety
- Physical distancing
- Inpatient bed spacing and chair spacing
- Engineering & administration control measures in healthcare settings
- Resources and tools
- Rapid reviews
- Covid-19 education resources
- Covid-19 compendium.

54. Health Facilities Scotland (HFS) provided evidence and guidance on ventilation to the CNRG. It was the responsibility of ARHAI Scotland to incorporate the evidence into national guidance.

55. Any changes to IPC measures in Scotland were based on the best available scientific evidence, expert opinion and consensus at that time. The only exception to this was the offering of Respiratory Protective Equipment (RPE), to reflect health or social care worker's personal preference when they were administering CPR. This was not based on the IPC evidence base and, as such, was not an IPC measure. On 20 May 2020, a joint letter issued from CNO, CMO and NCD setting out a position statement on guidance for Personal

Protective Equipment (PPE) and Aerosol Generating Procedures (AGP), provided: [FMQ2/077- INQ000477445]. On discretionary access to FFP3 masks, this was after my tenure.

56. On 21 December 2021, WHO updated recommendations on the use of FFP2/FFP3 masks by health and care workers in light of the increased transmission of Omicron variant. I was not involved in the subsequent SG approach to this as the action took place after I resigned from my post.

57. Since July 2020, ARHAI Scotland published weekly validated statistics on the number of hospital onset Covid-19 infections in Scotland via the PHS website. The statistics were valuable for officials to identify and monitor Covid-19 case numbers and trends of hospital onset cases across Scotland. This data informed and supported the review of IPC measures, as well as understanding the capacity of Scottish healthcare services.

58. ARHAI Scotland routinely sent officials and health boards "Lessons Learned" reports which highlighted the lessons being identified from hospital clusters of Covid-19.

59. Officials attended Infection Control Nurses / Infection Control Manager meetings where the practical application of IPC measures and current challenges were discussed. This group supported the discussion which led to the development of the IPC webinars and the "It's Kind to Remind" campaign. These meetings were convened and chaired by NSS ARHAI representatives. Professional Nurse Advisors, the DCNO and officials from the HAI attended this meeting regularly. The meetings were weekly initially then moved to fortnightly and four-weekly. The agenda focused on new and emergent evidence (which was frequently evolving in the early days), guidance, and policy topics. Discussions covered aspects of what existing guidance needed to change based on new evidence and what new guidance was needed, the implications / operational challenges of implementing and embedding guidance and policy in a range of settings. There was free flowing two-way discussion involving most, if not all participants on the current operating environments, patient presentation and condition and scenario management and what was needed by Service to support them manage the emerging / continuing situation. Themes ranged from PPE, Transmission Based Precautions, Testing, Built Environment and staff concerns.

60. ARHAI representatives were responsive to feedback and sought input from those in attendance, seeking always to develop draft guidance and recommendations for SG to transmit into policy that would be practical and implementable whilst being focused on

keeping patients, staff and carers safe. The forum also considered the best approach to ensure staff understood what was needed, be that through basic cascade communication or specific education and training materials such as posters, webinars etc. There was also a significant element of co-design both locally and nationally to enable the operationalisation of policy into practice at pace. Critically, boards shared local guidance, development and approaches. The impact of new guidance and policy on services and staff and patient safety was discussed extensively. Risk mitigation, remediation and feasibility also featured heavily across all aspects of the pandemic response and recovery. Discussions on application of measures took a problem solving and solution focussed approach. Some of the challenges that ensued were around stakeholders having time to participate fully in meetings and in the development of guidance. Turnaround time would be tight, putting pressure on service-based stakeholders, however it was they in turn that were seeking rapid guidance / policy and support materials.

61. The "IPC during the Covid-19 pandemic – supporting, valuing and listening to health and social care workers" webinar took place on 17 March 2021. SG led on the development of the webinar with presentations delivered by key stakeholders (including RCN, ARHAI, Consultants in Infection Diseases, Head of IPC from a health board, Epidemiologist and Nurse consultant in IPC). The webinars covered the following:
    - Developing Covid-19 IPC guidance
    - Hierarchy of Controls (including PPE)
    - Risk and Data – the data that we have in Scotland and how that is used to inform interventions to reduce the risk to patients, residents, clients and staff
    - Clusters of Infection - what do we know?

62. The PowerPoint presentations were hosted on Turas, NHS Education for Scotland's (NES) digital platform for Health and Social Care professionals. It also hosted a question and answer document, which had the answers to every question posed during the webinar. NES has now archived these materials.

63. I was not, in my role as CNO, involved in the translation or interpretation of guidance for maternity services during the relevant period.

64. CNOD HAI/AMR team was also responsible for the drafting and publication of extended use of face mask guidance, as set out in paragraph 35.

IPC Guidance Timeline

65. Scotland-specific guidance was developed as the UK IPC guidance was hosted by Public Health England and included NHS England terminology which was causing confusion. The Infection Control Managers, HAI Executive Leads and the CNRG were all supportive of ARHAI creating Scotland-specific guidance. It was proposed in the CNRG minutes of 11 September 2020 [FMQ2/079 - INQ000323501] that ARHAI produce an addendum to the NIPCM manual site pulling together all Covid-19 IPC advice and toolkits currently available. It was also noted in the minutes that the differences in hospital testing policy between England and Scotland had given rise to confusion. There was a request for Scottish policy clarification e.g. when moving patients between Covid-19 pathways.

Date of Change	Change	Description of Change	Reason for Change
April 2020	Revised UK IPC guidance.	Publication of revised Covid-19 UK IPC guidance in light of emerging evidence and review of evidence by public health / health protection organisations across the UK and was a four nations decision to update PPE guidance.	In recognition of sustained community transmission of Covid-19 in the UK.
August 2020	Publication of the updated UK IPC Guidance.	Guidance for the remobilisation of Health and Care services.	This guidance superseded previous Covid-19 UK IPC guidance.
October 2020	The *Scottish Covid-19 Infection Prevention and Control (IPC) Addendum* for acute healthcare settings was published [FMQ2/014 – INQ000410953].	IPC guidance specifically for Scotland.	To ensure IPC guidance works within the Scottish context and provides all Covid-19 IPC guidance on one platform within the established *NIPCM*.

66. CNOD works closely with the HWD, providing clinical and professional advice across a number of their policy areas. The remit of the HWD during the pandemic was as follows:
    - Delivery of the Test and Protect workforce
    - Delivery of the Vaccinations workforce
    - Innovation around Wellbeing support
    - Amendments to NHS Terms & Conditions
    - Partnership relations with unions and professional bodies and NHS Employers
    - A range of employee / employer Covid-19 guidance for the NHS
    - Supporting health boards in relation to the redeployment of staff to essential clinical roles
    - Supporting additional recruitment including of staff returning to the service
    - Working with NHS NES and higher education partners to address key strategic issues and risks around healthcare student placements
    - Supporting the deployment of students into the workforce.

67. HWD shared vast amounts of information and guidance with NHS Scotland leaders, including NHS Chief Executives, health board Chairs, Human Resource Directors and Employee Directors. Distribution lists were extensive and kept up to date to ensure information was available to health boards at the earliest opportunity. Across the specified period there were fifteen occasions where SG officials issued guidance on Friday afternoons rather than delaying to the following week. This was to ensure Health Boards were kept up-to-date with policy changes in real time in the context of the public health crisis, for example, by sharing guidance on isolation exemptions, lateral flow testing for staff, IPC measures, and terms and conditions.

68. Health boards raised concerns through Chief Executives and Human Resource Directors groups regarding information being received late in the working week. They felt it was challenging to proactively implement guidance late on Friday afternoons. Care homes raised similar concerns. HWD colleagues took the feedback on board and ensured all colleagues were aware. The Interim NHS Scotland Chief Executive asked HWD staff to minimise the amount of correspondence issued to health boards wherever possible and put in place a temporary process where all communications were to be distributed through the Office of the Chief Executive of NHS Scotland. This was in response to feedback from the NHS Boards of the pressures they would be facing over the winter period, being stretched

to respond to the "normal" winter pressures, but with the added challenge of Covid pressures. This was for defined periods and was designed not to prevent issuing essential guidance, but to prevent health boards getting an onslaught of correspondence not related to managing their response to the pandemic. The relevant correspondence is provided: [FMQ2/017-INQ000469949]. During my time in post the request to consider minimising the amount of correspondence being issued was implemented over winter 2020/21 from 23 December 2020 to 23 April 2021, I am aware this also ran over the subsequent winter periods following feedback from Boards with the majority seeing some positive impact and building in some of the learning from feedback.

69. The Directorate for the Chief Operating Officer (DCOO) already had a positive, constructive and open relationship with NHS Scotland and all communications were issued using well-established and longstanding processes including through the regular chief executive meetings and annual board review process. While the UK Government and subsequently ARHAI Scotland held and maintained IPC guidance for Scotland, SG played a role in communicating updates and changes in IPC guidance to NHS boards and other stakeholders, including Unions. While there was regular communication with all stakeholders, there was no central mechanism in place to monitor the efficiency of communications.

Staffing capacity and staff support

Temporary Register

70. In my capacity as CNO, I was involved in a number of efforts to increase the number of nurses and midwives in the healthcare system to help respond to the Covid-19 pandemic. On 12 March 2020, I had a telephone conversation with the Chief Executive of the NMC, where they advised that the UK Government would bring forward emergency legislation to give the NMC, upon the declaration of a public health emergency by the Secretary of State, broad powers to temporarily register anyone it considered "fit, proper and suitably experienced". Over the following days and weeks, almost continual conference calls were held between the NMC and four country CNOs and their offices at various levels of seniority. Decisions on the eligibility criteria for and mitigation of risk presented by temporary registration were ultimately matters for the NMC within its statutory powers and under its public protection duty. The SG was not involved in subsequent decisions to amend the scope, eligibility criteria or duration of the NMC and other temporary registers. Though we were not informed of the Secretary of State's decision to extend the duration of

the temporary emergency registers into 2024 until shortly before it was announced, it was nevertheless a welcome development. The management of risk was for employers, commonly through deploying temporary registrants in areas of lower acuity, and with higher levels of supervision, thereby increasing substantive capacity for higher risk clinical settings.

71. There was regular engagement between the NMC executive team and CNOD to understand the implications of students supporting the response, also taking into account the views of other critical stakeholders including the universities, RCN and unions. However, the regulator was the final arbiter of these decisions, including first year students not being permitted to enter the substantive workforce (though they were allowed to join the Staff Bank as Healthcare Support Workers). Patient safety was the primary concern in agreeing which student cohorts should be offered the opportunity to join the workforce, recognising the need to balance support and professional supervision requirements against potential impacts on the workload of the registered workforce. The standards were agreed as suitable for students in the final six months of their course, having by that stage accumulated sufficient clinical and academic learning to be able to meet them. While the UK CNOs were informed in advance, this was a decision for the NMC Council.

72. The UK Coronavirus Act 2020 established emergency powers which meant that relevant professional healthcare regulators could register anyone who they considered was a fit, proper and suitably experienced person to be registered as a nurse or midwife or registered as a member of the profession in question in the context of the emergency. The Bill was introduced on 19 March 2020 and passed on 23 March 2020. This allowed temporary registers to be established by the regulators. On 27 March 2020, the NMC opened a temporary Covid-19 emergency register to encourage nurses and midwives who had left the register in the past three years to opt back in, should they wish to do so. It is important to note that this decision was taken collectively on a four nations basis. This emergency register expanded on 6 April 2020 to include overseas nurses and midwives who had completed entire Nursing and Midwifery Council registration process (excepting those who had undertaken Objective Structured Clinical Examination (OSCE) and again on 15 April 2020 to include nurses and midwives who had left the register in the previous four or five years.

73. I have been asked about any concerns brought to my attention regarding nurses and / or midwives on the temporary register. We were made aware anecdotally of instances where

temporary registrants coming forward to offer their services either encountered difficulty in finding a position appropriate to their skills and experience or were not offered a post by their preferred health board. The complexity of that matching process is perhaps now better understood, and further preparatory work would be useful. The Scottish Government's specific role was limited to the general promotion of NHS Scotland as a potential employment opportunity for temporary registrants. Regulatory issues, such as concerns over a temporary registrant's fitness to practise, would be addressed by the employer and regulatory body as with any other registrant.

74. With regard to communications to Higher Educational Institutions (HEIs) and students, the potential for students to be used in the workforce was announced (initially by NHS England) before much of the detail had been worked out, which meant that CNOD was asked questions it could not answer and both HEIs and students felt uneasy and worried about arrangements. Communications from regulators (e.g., the NMC) did not always fit the timelines being followed in SG, leading to confusion amongst students and HEIs. Differences between the four nations also led to confusion, particularly through social media discussion.

75. On Allied Health Professions (AHP) student deployment, AHP students were not extensively utilised in the workforce. There was some delay and confusion over their deployment.

76. Some HEIs reported that the quality of the education experience of students on paid placements was variable, with some work areas having very few patients (owing to redeployments and re-organisation of services), though it did allow them to undertake practice hours. If students had not been able to undertake paid placements, then the final year students may not have had enough practice hours to enable them to graduate and even more students would have been behind with practice hours culminating in a potential shortfall of new registrants. First year nursing, midwifery, and years 1–3 AHP students undertook no practice hours from the end of March 2020 until at least September 2020. This added to placement capacity issues but may have been unavoidable given the suspension of many health services.

77. In the event of a second wave the emphasis was on maintaining supernumerary placements rather than adding capacity to the health and social care workforce with students. Extra capacity could be provided by returners registered with the NHS NES portal.

78. The regulators for Nursing & Midwifery and AHP students took slightly different approaches at different speeds, meaning that the latter group of students were not sufficiently utilised.

Staff Wellbeing

79. On 10 April 2020, advice provided to Ministers from senior civil servants within HWD recommended the creation of a National Wellbeing Hub. This was scoped as an interactive website that provided a range of resources to help the Health and Social Care Workforce as they respond to the Covid-19 pandemic. It was developed to meet the identified need for a single point of access to wellbeing support for the workforce, and officially launched on 11 May 2020. In the period before the Wellbeing Hub was launched, work was undertaken on a digital inventory of general resources and materials using the existing Project Lift platform on a special Coronavirus Resources page. This was highlighted and shared in regular mailings and via social media channels.

80. In conjunction with the decision to create the Wellbeing Hub, on 1 May 2020, the Minister for Mental Health agreed to the establishment of a National Helpline for the Health & Social Care Workforce. This was an alternative to the already established helplines and was created specifically for Healthcare Workers.

81. On 10 August 2020 the then Cabinet Secretary for Health and Sport agreed to the establishment of the Workforce Specialist Service. This service offered confidential mental health assessment and treatment for regulated health, social care and social work professionals in Scotland. This service launched on 26 February 2021.

82. Furthermore, on 10 August 2020 the then Cabinet Secretary for Health and Sport agreed to provide a suite of services to support the wellbeing and mental healthcare needs of the Health and Social Care workforce during and beyond Covid-19.

83. On 14 September 2020, the then Minister for Mental Health announced the provision of funding for the workforce development programme to increase health boards' capacity and capability to deliver psychological interventions and therapies to support the mental health and wellbeing of the workforce. The programme included national and local delivery of training and supervision in psychological interventions and therapies.

84. On 21 December 2020 the Minister for Mental Health announced the establishment of the wellbeing groups, Oversight Group, Programme Board and Expert Advisory Group. These were established to discuss various programmes of work relating to supporting staff wellbeing and staff recovery, including the national initiatives. They also provided clinical and operational advice to support the mobilisation of the Workforce Specialist Service.

85. On 21 January 2021 the Cabinet Secretary for Health and Sport approved £500,000 funding for practical support, including refreshments to NHS Scotland staff, to support health and wellbeing.

86. All these wellbeing services were for health and social care workers, including returning retirees, students deployed early, redeployed non-clinical staff and volunteers. I was not involved in the creation of these wellbeing services and, as such, do not have additional insight to add.

Testing for nursing staff and midwives

87. My directorate, CNOD, were the policy leads responsible for asymptomatic healthcare worker Covid-19 testing using both Polymerase Chain Reaction (PCR) and Lateral Flow Device (LFD) tests; this was inclusive of healthcare assistants and midwives. I was not in tenure for the entirety of the testing programme but have set out the chronology in the table below for my time in post.

88. As can been seen by the timeline below, there was originally a focus on asymptomatic PCR testing in cancer and blood disorder units, long-term care of the elderly, and long-stay mental health facilities.

89. This changed in December 2020 with the introduction of LFD tests. At this point all patient-facing staff within hospital, Scottish Ambulance Service and Covid-19 Assessment Centres were offered test kits to take part in twice weekly asymptomatic testing [FMQ2/078 - INQ000241545]. This policy continued to expand so eventually all healthcare staff (not only patient facing) were able to access LFD tests for the purpose of asymptomatic testing from 7 April 2021 [FMQ2/022 – INQ000413478].

90. The SG's Testing and Contact Tracing Policy Division had oversight of LFD test availability and had regular meetings with the UK Government to manage stock, demand and the requirements of asymptomatic testing programmes. CNOD were engaged in the Testing

Programme Board which was a collaboration between the SG Director of Test and Protect (Christine McLaughlin) and National Services Scotland who had the operational responsibility for delivering the testing programmes. Through the process of delegation, the three CNOs were represented and engaged in this work; however, they were not called on to address any shortages of LFD tests.

91. CNOD was not aware of any NHS nursing or midwifery staff having difficulty in accessing LFD tests for the purposes of asymptomatic Covid-19 testing. NSS Procurement colleagues were members of the Expanded HCW LFD testing programme board. The boards / Primary Care Team for Pharmacy designated local distribution processes and I have no recollection of any board not being able to secure kits in a timely manner or in appropriate numbers. There may have been an occasional local issue about distribution and / or pick up but the kits were distributed through a rigorous and well-managed process by National Procurement.

92. Ministers were briefed in June 2021 on some of the key barriers and challenges identified in relation to asymptomatic lateral flow device (LFD) testing of healthcare staff. The main themes identified were summarised as:

    - **Implementation:** Challenges around the scale and speed of the rollout, resourcing issues and competing pressures
    - **Staff Buy-In:** Practical and cultural issues that can limit staff willingness to participate in the voluntary programme
    - **Accessibility/ Recording Difficulties:** in accessing physical test kits and the ability to record their results on the portal
    - **Data Quality:** Boards are currently unable to receive high quality, granular data about LFD uptake on a regular basis, which can constrain local monitoring and improvement work
    - **Communications and Messaging:** Ensuring messaging remains appropriate, consistent and effective. There can be challenges in ensuring staff do not become overloaded with communications.

93. The aim of the voluntary asymptomatic healthcare worker testing programme was to reduce the opportunity for nosocomial transmission of Covid-19 from staff to patients by removing staff who may be asymptomatic from the workplace. Although testing was offered on a voluntary basis, SG strongly encouraged all staff to take it up by highlighting the benefits to them, their families, their patients, and their colleagues.

94. Testing for healthcare workers was introduced to find cases and to reduce the opportunity for onward transmission to either the patients to whom they provided healthcare or the staff with whom they worked. By offering a 'self-test at home approach', those who were negative had minimal disruption to their day and anyone who tested positive was able to isolate immediately.

95. When the Healthcare Worker Asymptomatic Lateral Flow Device (LFD) Testing pathway was introduced studies suggested that LFD tests were sensitive at higher viral loads, but with a lower sensitivity than PCR tests. As such, they were considered more practical for detecting individuals who were infectious, rather than individuals who may have had Covid-19 in the recent past but were no longer infectious. However, this also meant that LFD tests were more likely to miss people with current infection at lower viral loads who may have been infectious or go on to become so. Staff were asked to remain vigilant to the development of symptoms that could be due to Covid-19 and continue to follow existing Infection Prevention and Control (IPC) measures.

96. On receiving a positive LFD test result, healthcare workers were initially requested to undertake a confirmatory PCR test. PCR test samples were required to perform Whole Genome Sequencing (WGS). A proportion of positive samples were sent for whole genome sequencing to improve understanding of virus transmission chains and to determine whether cases were likely to be linked for the targeting of appropriate public health measures. WGS was also used to identify and track potentially significant genetic changes that may have affected how easily the virus was passed on and the severity of the symptoms it causes. This allowed targeting of public health interventions to stop the spread of new SARSCoV-2 variants of potential concern and ensured that the tests in use to identify SARSCoV-2 remained fit for purpose.

97. Healthcare workers were informed that as of 6 January 2022, LFD positive tests should be treated as a confirmed positive case of Covid-19, meaning there was no longer a need for a confirmatory PCR test, provided: [FMQ2/018 - INQ000429280].

98. Contact tracing would commence following a positive PCR test result (or latterly a positive LFD test result). Assuming there had been no IPC failures (i.e. staff had used the correct PPE and maintained physical distancing and appropriate hand hygiene) then colleagues of the Covid-19 positive healthcare worker were not required to self-isolate.

99. As part of the LFD healthcare worker pathway, health boards were able to access their local data on numbers of tests and number / rate of positive tests which supported their local resilience planning (with the caveat that this would only represent those healthcare workers who updated the online system – we know that not all healthcare workers who tested engaged with this digital platform). Some health boards, however, did provide feedback in their LFD testing implementation evaluation return that they had experienced staff shortages.

Healthcare Worker (HCW) Covid-19 Testing Timeline

Date of Change	Change	Description of Change	Reasons for Change
June 2020	Staff were offered weekly Covid-19 Polymerase Chain Reaction (PCR) testing from 8 July 2020 [FMQ2/019 – INQ000359926].	Staff who work in specialist cancer services, or provide long-term care for the elderly, as well as staff working in residential mental health.	Advice from the Covid-19 Nosocomial Review Group (CNRG). CNRG was an advisory group which considered the scientific, technical concepts and processes that were key to understanding the evolving Covid-19 situation and potential impacts in hospitals in Scotland. Long term care of the elderly and long stay mental health facilities were predominantly areas where clusters of Covid-19 outbreaks were reported. Cancer groups were calling for testing as a way of reassuring patients.

July 2020	HCW testing guidance and FAQ published on the SG website, [FMQ2/020-INQ000429285], [FMQ2/021-INQ000359902].	Students included in the testing of HCW whilst on placement.	Recommendations given by CNRG.
December 2020	Publication of interim guidance on expansion of twice weekly Lateral Flow Devices (LFD) testing [FMQ2/022 – INQ000413478].	Twice weekly LFD testing for patient facing staff within hospital, Scottish Ambulance Service (SAS), and Covid-19 Assessment Centres. This programme had a phased roll-out. Education materials and guidance were provided by NHS Education for Scotland for the original launch of Innova LFD tests.	The Medicines and Healthcare products Regulation Agency (MHRA) confirmed that LFD could be used as a self-test for in-scope asymptomatic NHS staff in Scotland, in line with the guidance outlined below and the Standard Operating Procedure (SOP).
January 2021	Expansion of the HCW LFD testing programme.	To include Community Workforce, district nurses and Covid-19 vaccinators.	As part of the programme's phased roll-out approach.
February 2021	Expansion to the HCW LFD testing programme.	To include patient-facing primary care staff (general practice, pharmacy, dentistry, optometry), NHS 24 and SAS call handlers.	As part of the programme's phased roll-out approach.

100. As set out above, self-isolation guidance after a positive test was the remit of HWD colleagues although CNOD worked closely with them and provided clinical advice as well

as issuing joint letters with Director of Health Workforce and Chief Medical Officer on some updates to guidance for health and social care staff.

101. The timeline for respective changes to guidance is provided in the table that follows, which shows changes to self-isolation exemptions guidance for Health and Social Care staff as a result of changes to the Covid-19 self-isolation guidance for the general population, during my time in post.

Date of changes	Version	Overview of change
14/07/2020	Version 1	DL (2020) 20 – Quarantine (self-isolation) for NHS Scotland Staff returning to the UK - first version [FMQ2/023 - INQ000389185]
31/07/2020	Version 2	Changes to take account of changing position
14/08/2020	Version 3	Changes to take account of changing position
26/05/2021	Version 4	DL (2021) 13 – Quarantine (self-isolation) for NHS Scotland Staff returning to the UK: [FMQ2/085 – INQ000470086] 1) Advised NHS Scotland staff not to travel to an amber or red list country due to preventing new Covid variants from entering the UK.
23/07/2021	Version 5	DL (2021) 22 – Framework for the implementation of isolation exemptions for Health and Social care staff: [FMQ2/086 – INQ000469955] 1) New policy framework and accompanying staff fact sheet.
27/08/2021	Version 6	DL (2021) 24 – Update on isolation exemptions for Health and social care staff: [FMQ2/087 – INQ000469956]. No longer required to automatically self-isolate if double vaccinated with the second dose of Covid-19 vaccine.
05/11/2021	Version 7	DL (2021) 36 – Quarantine (Self-isolation) for NHS Scotland staff returning to the UK: [FMQ2/088 - INQ000470087] 1) Staff travelling abroad are encouraged to check Covid-19 infection rates in any potential destination and should do this in the full awareness that the status of their destination may change at short notice either in the run up to or during their trip.
24/12/2021	Version 8	DL (2021) 50 – Update on Self-isolation for Health and Social care staff: [FMQ2/089 – INQ000469957] Updated Policy Framework states that if a staff member declines daily LFD testing, they should not return to work in a physical setting and instead should work from home during the 10-day isolation period. This applies even if the member of staff cannot fulfil their role from home. 2) It also clarifies that staff are advised that they should also follow the SG guidance on isolating after the initial close contact, when they are not at work or carrying out work related activities.

Staff absences

102. Neither CNOD or I were directly involved in workforce capacity related to staff absence issues as these were also the remit of HWD and are set out in more detail in the Module 3 DG Health and Social Care corporate statement FMQ2/091-INQ000485979 submitted to the Inquiry on 18 June 2024. I was aware of staff absences by the NHS Capacity and Pressures Daily Reports that was issued to Ministers and various SG officials including CNOD on a daily basis.

103. In April 2020, HWD started receiving management information from the Scottish Standard Time System and Scottish Ambulance Service on staff absence. This was received daily from April to July 2020 and then weekly from 15 July 2020 thereafter. This management information provided insight into the types of absence in the NHS workforce and included newly developed special leave codes which identified and recorded Covid-19 related absences.

104. Typically, weekly overall absence rates varied between c. 14%-20%. By far the largest component of absence was planned absence, in particular annual leave. Annual leave represented c. 29%-55% of all absence. The second largest component was non-Covid-19-related sickness absence at c. 4-8% which represented c. 20%-40% of all absence.

105. Covid-19-related absence (including Covid-19 positive absence and absence for reasons relating to Covid-19 such as childcare, self-isolation etc) ranged between c. 0.2%-5.0% (and represented between c. 1%-7% of all absence).

106. In January 2021, HWD began commissioning workforce capacity reports from health boards. These reports were health boards' own individual assessments of their workforce capacity and pressures. Reports were initially provided daily and that was the case for my tenure. Reporting periods were decided in line with the stages of the pandemic and the waves of infection. The information from these health board self-assessments was combined with management information gathered on staff absence and provided as part of a wider report on capacity and pressures across the system. This wider report was used to brief Ministers using Bronze, Silver, and Gold Command structures. It was also shared with the winter pressures group and senior officials whilst being utilised to support planning. The information requested in these commissions to health boards evolved as HWD worked to further improve understanding.

Redeployment of staff

107. On 28 April 2020, the HWD and CNOD issued joint guidance on community deployment. The guidance clarified the SG's position that everything possible should be done to ensure a complete system health and social care response to Covid-19. It highlighted that this could only be done effectively by looking constantly at demand for services across the system and adjusting deployment and skills mix according to the changing demand profile. It also noted that as an increasingly integrated health and social care system, acute, primary care and social care services must work collectively to attend to the health needs of the people of Scotland. Information on mutual aid and guidance for staff who volunteered to be deployed in the care home sector was included. The relevant Directors Letter is provided: [FMQ2/024-INQ000469963].

108. I was not aware of issues and concerns regarding the lack of relevant training, the suitability of the roles to which staff were redeployed, and / or support for redeployed nursing staff and midwives.

Impact of the pandemic

109. Responding to the unique challenges presented by the Covid-19 pandemic took a significant, and understandable, toll upon the nursing workforce in Scotland, and across the UK. As such, understanding this toll was particularly important in order to ensure the wellbeing of officials and to identify opportunities to improve conditions where possible. HWD has policy responsibility for overseeing the National iMatter Continuous Improvement Model, which was developed by NHS Scotland staff and aims to engage staff in a way that feels right for people at every level. As a team-based tool, iMatter offers individual teams, managers, and organisations the facility to measure, understand, improve and evidence staff experience.

110. On 30 March 2020, Stephen Lea-Ross, Deputy Director of Health Workforce issued a letter to health boards asking them to pause various programmes of work due to the changing priorities from Covid-19. One of the programmes paused was the iMatter staff survey for 2020. At the Scottish Workforce Staff Governance (SWAG) Committee meeting on 16 July 2020, it was agreed by members (representatives from NHS Scotland, Trade Unions and SG Officials) that the annual iMatter staff survey for 2020 would be postponed and reinstated in 2021. This was due to the Covid-19 pandemic and pressures on health boards. It was also agreed, at that meeting, that conducting a wellbeing pulse survey for 2020 would be quicker for staff to complete and would focus and include the most relevant

topics for staff during the pandemic. The *Everyone Matters Pulse Survey National Report 2020* is provided: [FMQ2/025-INQ000429295].

111. Diane Murray, Deputy Chief Nursing Officer was invited to various Scottish Workforce and Staff Governance Committee in 2020. During that time, Diane was issued with papers that included agendas, minutes, provided: [FMQ2/026-INQ000429291], [FMQ2/027-INQ000429292], *Everyone Matters* pulse survey presentation, provided: [FMQ2/028-INQ000429289], and a letter to members informing them of the National Staff Experience Measurement 2020 process, provided: [FMQ2/029-INQ000429290]. Diane sent her apologies to these meetings due to a number of pressures on her time including a focus in social care, but she would have received the notes of meetings in order to be able to brief colleagues, including myself.

112. Staff experience within NHS Scotland is measured annually via the National iMatter Staff Experience Continuous Improvement Programme; however, in recognition of the changing priorities in responding to the Covid-19 pandemic, it was agreed, in partnership with the Scottish Workforce and Staff Governance Committee, that this be paused for 2020. A pulse survey approach was then developed in collaboration with key stakeholders, focussing on staff wellbeing and resilience during the recent period. This survey used quantitative and qualitative methodology, using four questions taken from the Office for National Statistics (ONS) Personal Wellbeing Questions, followed by nine questions from the existing iMatter survey that deal with staff experience of the workplace, including whether they feel supported and included. The survey also asked two qualitative questions inviting staff to describe what was most worrying them and what was supporting them, followed by two short questions about the work environment; finally the survey asked a suite of demographic questions as well as confirmation of staff groupings.

113. Analysis of the results enabled us to understand, on a national scale, how staff felt their experiences at work were being impacted by the pandemic and support assurance of maintaining the Staff Governance Standard. At local board level, a greater understanding was also gained on what was causing staff most concern about the workplace (i.e. patient care, safety at work and remote working) and on a personal level (contracting Covid-19, a second wave and general personal health). These insights, along with qualitative information gained in regard to support, allowed health boards, teams and managers to tailor staff engagement, discuss lessons learned and develop more robust action plans to support staff in working through that time, particularly in relation to health and wellbeing support for the workforce.

114. In the *Health and Social Care Staff Experience Report 2021*, provided: [FMQ2/030 – INQ000429262], the NHS NES Head of Programme in Workforce stated:

> "During the course of the pandemic, NES has been contributing to the overall health and social care system through our Digital, HR, and Clinical Directorate colleagues. We think this will be a source of pride both for those individuals who have made the contributions and also their colleagues. NES has adopted a proactive, wellbeing focus to supporting our staff throughout the pandemic. A very positive approach to working from home, with lots of practical and psychological support, and clear messages around looking after self and others. We continue to provide a high level of support and flexibility around home working. During lockdown this was especially beneficial in enabling people to balance caring commitments and NES work".

115. This approach provided a more appropriate and accessible avenue for staff to use their voice and provide feedback to SG and NHS health boards during a period of unprecedented pressure and change.

116. Through my CNOD team, I was aware of issues around fit of PPE including face fitting of specific types of face masks during the pandemic which impacted on staff with smaller and differing physiological face shapes, which had a particular impact on women, ethnic minorities and those who had facial hair (including for religious reasons). The inability to achieve an adequate fit as a result of a beard or face shape was known pre-pandemic, however, potential face fitting issues were first discussed at a Workforce Senior Leadership Meeting on 15 April 2020. I worked with the PPE Directorate to ensure there were a variety of PPE options available to staff, with my clinical and policy advisors sharing intelligence from health boards on face fit issues at weekly PPE meetings. The SG's PPE Team would take this information and use it to operationalise improvements, such as commissioning Alpha Solway to produce smaller face masks and enabling boards to access Jupiter hoods and parts. CNOD were anecdotally aware of issues with face fitting and were alerted to a letter sent by the BMA to the Department of Health and Social Care on 13 January 2021 setting out concerns around ill-fitting PPE. Ill-fitting PPE was not raised with me frequently, the process within NHS Scotland is that this is handled via the tried and tested processes in NSS. At no time did anyone (individual staff member, trade union or Executive Nurse Director) formally escalate any issue on ill fitting PPE. I had confidence that the established process worked and was the most efficient and effective process to raise issues around quality of supplies.

IPC measures

117. My directorate was responsible for communicating updates to IPC guidance to NHS Scotland boards. However, CNOD did not directly provide this advice or guidance. The advice or guidance to reduce the risk of transmission of Covid-19 to patients receiving treatment for non-Covid-19 conditions in healthcare settings was nationally developed and published by ARHAI Scotland.

118. As stated in the Module 3 DG Health and Social Care corporate statement **FMQ2/091 - INQ000485979** submitted to the Inquiry on **18 June** 2024, the process by which IPC guidance, protocols or standards were formulated is outlined below:

- Evidence reviewed by expert group
- Advice / recommendations received by policy team
- Reviewed internally, policy options developed
- Consultation (internal and external stakeholders) on policy options
- Ministerial briefing prepared
- Ministerial decision made
- SG communicated policy / guidance to health / social care providers.

119. Scientific evidence / advice was provided to the HCAI/AMR Policy Unit, by the CNRG and / or ARHAI Scotland. The evidence reviewed by these groups / organisations and the resultant advice received by the HCAI/AMR policy unit covered a wide range of topics including general Covid-19 IPC measures, RPE, physical distancing, healthcare worker and patient Covid-19 testing and face masks / face coverings guidance.

120. The relevant stakeholder groups such as: the Clinical Cell, NHS Scotland Human Resources Directors, Testing Programme Board, Healthcare Associated Infection Executive Leads, board Chief Executive meetings and WSLG were consulted on proposed IPC policy changes. The stakeholder groups were able to provide advice on their area of expertise in clinical, nosocomial infection, epidemiology, virology, and statistical modelling. At these meetings, SG Professional Clinical Advisors and policy colleagues attended, reviewed the information received and requested additional advice.

121. Officials prepared and presented the evidence and advice received from expert groups and bodies into a standard ministerial template which aimed to support Ministerial decision making. Briefings were developed in collaboration with other SG policy teams (CMOD, NCD, Primary Care, ASC, HWD, Testing Policy) as necessary.

122. Briefings were reviewed and cleared by Professional Clinical Advisors and SG Directors prior to issuing to Ministers. To support communication and awareness of potential policy changes and Ministerial decisions, relevant officials across SG were copied into the briefings that were sent to Ministers via email.

123. While the UK Government and subsequently ARHAI Scotland held and maintained IPC guidance for Scotland, SG played a role in communicating updates and changes in IPC guidance to NHS boards and other stakeholders, including Unions.

PPE and RPE

124. With regards to PPE, the CNOD HAI/AMR Policy Team was responsible for drafting and updating guidance on the extended use of face masks in adult hospitals and care homes for the elderly, which was first published in June 2020
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125. SG was aware that UK Government was moving to implement the use of face masks and face coverings in healthcare settings, therefore based on CNRG and SAGE advice supporting this move, Scottish Ministers made the decision to support consistency of approach across the UK and implement face mask guidance in health and social care settings in Scotland. The extended use of face mask and face covering guidance in Health and Social Care settings was a Covid-19 pandemic measure introduced primarily as a means of source control aimed at preventing contamination of the surrounding environment with Covid-19 particles generated by the wearer. The aim of this was to reduce the risk of Covid-19 transmission across all health and care settings to staff, service users and visitors. The extended wearing of face masks and face coverings guidance is applicable beyond the delivery of direct patient/service user care and is not to be confused with personal protective equipment (PPE) worn as part of standard infection control precautions or transmission-based precautions but rather is considered a supplement to IPC practices set out in the NIPCM and the care home infection prevention and control manual.

126. All other guidance on PPE was contained in the Scottish Covid-19 IPC Addendum, which was maintained by ARHAI Scotland. The Addendum provided a link to the extended use of face mask guidance.

127. On 5 June 2020, the WHO issued interim guidance about the use of face masks in the context of Covid-19. The WHO guidance reflected emerging evidence about transmission from symptomatic, pre-symptomatic and asymptomatic people infected with Covid-19 in

locations where there was sustained community transmission. In these circumstances, the guidance recommended the continuous use of medical grade face masks by health and social care staff working in clinical or care areas.

128. The CNRG considered the WHO guidance, as well as evidence from the SAGE Hospital-onset Covid-19 Working Group (HOCWG) that the use of face masks could reduce transmission of Covid-19. There was stronger evidence of masks reducing transmission from infected individuals than there was for masks preventing the wearer from becoming infected.

129. The review group also noted and attached particular importance to evidence of transmission events and asymptomatic carriage of Covid-19 in patients, residents and staff in hospitals and care homes in Scotland, where there were clusters of nosocomial infections.

130. This guidance was about the continual wearing of face masks by staff within acute and community hospitals and care homes. The group also reached conclusions about the wearing of face coverings by members of the public who visited these places, which was also reflected in the guidance.

131. While the WHO guidance recommended that a type I or II face mask was sufficient in these circumstances, our guidance recommended type IIR masks which are splash-resistant and which exceeded the WHO minimum standard, also providing a protective function for staff.

132. This guidance was not affected by anticipated or existing supply constraints.

133. A timeline for the updates to extended use of face masks and face coverings guidance is provided in paragraph 35, and a timeline for updates on the use of RPE is provided below, for my time in post. A departmental letter was issued in April 2022 setting out that responsibility for ensuring staff were given access to FFP3 masks, based on their personal preference, lay with the individual line manager. An individual risk assessment should be carried out by the line manager, in line with the then current guidance and with consideration of the staff member's overall health, safety, physical and psychological wellbeing, as well as personal views/concerns about risks: [FMQ2/080 - INQ000429256].

Respiratory Protective Equipment (RPE) Timeline

Note – the items below include change on RPE guidance based on staff preference and are not IPC related.

Date of Change	Change	Description of Change	Reasons for Change
October 2020	*Scottish Covid-19 IPC Addendum* was first published. (ARHAI Scotland guidance, not SG policy).	Personal PPE Risk assessment: Airborne precautions are not required for AGPs on patients/individuals in the low- risk pathway provided the patient has no other infectious agent transmitted via the droplet or airborne route. However, recognition that some staff remain anxious about performing AGPs on patients during this Covid-19 pandemic and therefore when prevalence is high, and where staff have concerns about potential exposure to themselves, they may choose to wear an FFP3 respirator rather than a FRSM when performing an AGP on a patient in the low-risk pathway. This is a personal PPE risk assessment.	To minimise staff anxieties during the pandemic.

134. Neither I nor my directorate were involved in testing the adequacy standard of fit of PPE and RPE for nursing and midwifery staff, but officials were linked in with the PPE policy team via weekly meetings and via the PPE Clinical Advisory Panel (CAP), so we were kept informed of any issues. As far as I recall, where there were problems with fit that could not be resolved with the wearer and, for example, face mask, then individual areas would seek

alternative styles if available or adapt the mask (such as double looping the elastic around the ear). This was essentially dealt with via the CAP.

135. Neither I nor my directorate were aware of any shortages in PPE or RPE for nursing and midwifery staff but were aware anecdotally of issues of supplies not being easily available to staff in some instances. I discussed this with the Chair of the executive Nurse Directors as well as SEND and was advised that managers worked tirelessly to move supplies around health board areas to ensure an adequate supply of PPE. I was advised that this meant that there was a sufficiency, albeit not an ideal situation. I was advised there was always a palpable sense of relief when stocks of PPE were at pre pandemic levels and ongoing supply was not an issue. Despite the unprecedented rise in global demand for PPE during the early months of the pandemic, as far as I am aware, Scotland generally maintained a reasonable supply of PPE. The SG worked quickly to establish new supply routes and NHS National Services Scotland extended their distribution network to include primary, community and social care settings. A seven-day a week helpline was set up in early April 2020 for NHS and social care staff to call in relation to any issues with PPE individuals were experiencing and helped to ensure that any problems could be resolved quickly.

Risk assessments

136. Risk assessments were undertaken by Occupational Health Services within boards, with the policy around this being held by HWD.

137. On 27 July 2020, a joint letter was issued from CNO, CMO, NCD and Health Workforce Director publicising a single national guidance document on occupational risk assessments for the new risks posed to health and social care staff by Covid-19, provided: [FMQ2/031-INQ000429263]. This guidance also applied to all healthcare students on placement.

138. The tool contained in the guidance was aimed at individual staff to help them to understand their own risk factors. The guidance also highlighted the responsibilities of the employer to minimise the risks in the workplace, making adjustments where possible, and referring to Occupational Health (OH) as appropriate.

139. The SG HWD had responsibility for this and published the occupational risk assessment guidance tool to support staff and line managers to understand and carry out effective risk assessments, and to have supportive conversations with staff to agree the best course of

action. HWD led on the development of this guidance in collaboration with NHS Occupational Health Consultants and using the clinically approved COVID-AGE calculator created by Association of Local Authority Medical Advisors. As this tool was applied by individuals and their managers, HWD do not have data on the numbers of staff for whom this guidance facilitated a return to work.

140. Work-based risk assessment was referenced in CNOD HAI/AMR Team extended guidance on use of face masks and face coverings in hospitals, provided: [FMQ2/032-INQ000429279], which set out that "there will be instances of staff who may suffer from breathing difficulties or suffer from genuine discomfort or distress when wearing a fluid resistant surgical face mask. We expect staff to be fully supported and appropriate steps taken locally to implement the guidance in a way that has regard to staff well-being. A workforce risk assessment should be undertaken".

141. I would have expected that risk assessments would have taken place at localised board level as part of the standard governance processes that exist.

Inspection of healthcare settings by HIS

142. In March 2020, Healthcare Improvement Scotland (HIS) suspended its existing acute hospital inspection programmes (the Healthcare Environment Inspectorate (HEI) inspection programme and the Older People in Acute Hospital (OPAH) inspection programme) owing to a request from SG policy officials to 'non-patient facing boards' to suspend non-urgent business and assess who their clinically qualified staff were, as well as any additional resources that could be deployed to support patient care. The relevant submission is provided: [FMQ2/033-INQ000429274].

143. On 30 May 2020, I wrote to HIS commissioning recommencement of hospital inspections focused on combined safety and cleanliness and older people, provided: [FMQ2/034-INQ000315565].

144. In June 2020, HIS and SG agreed a programme of inspection for community hospitals as they have a similar demographic profile of service users to those resident in care homes, which had emerged as an area of significant concern at the time. There were also concerns on the feasibility of recommencing acute hospital inspections at that stage of the pandemic because of the adverse impact this might have on the delivery of care. A Covid-19 focused

hybrid of the HEI and OPAH inspection programmes was designed for community hospitals.

145. In December 2020, I asked HIS to move focus from community hospitals to Covid-19 focused HEI style inspections in acute hospitals. These inspections recommenced on 7 December 2020. The Cabinet Secretary for Health and Sport had requested inspections be reinstated due to the number of Covid-19 related outbreaks in hospital sites. The purpose of these inspections was to provide public assurance about the quality of care with a specific focus on prevention of infection associated with the Covid-19 pandemic and provide learning to NHS Scotland where areas of learning were identified. These 'safety and cleanliness' inspections were to initially focus on those areas where there had been outbreaks.

Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) policy

146. Whilst I provided advice and support on infection control and Covid-19 clinical care guidance across DG Health and Social Care, I did not provide advice directly on DNACPR policy. The SG publication, *Clinical Guidance for Nursing Home and Residential Care Residents and Covid-19*, provided: [FMQ2/035-INQ000429281], which was published on 26 March 2020, set out that Anticipatory Care Plans (ACP) should be in place for as many residents as possible and that DNACPR paperwork should be in place where appropriate and discussed appropriately with residents or carers.

147. Advice from the UK CMO, British Medical Association (BMA) and Royal College of General Practitioners (RCGP) to GP practices on 10 and 17 April 2020 provided further guidance and support on having anticipatory care planning conversations with vulnerable and high risk patients, and made clear that there was no requirement for health professionals to have a DNACPR discussion as part of this conversation unless the patient wished to discuss it or the clinician felt strongly it was necessary to raise in conversation for the patient's wellbeing, provided: [FMQ2/036-INQ000429276], [FMQ2/037-INQ000259882].

148. In view of the concerns expressed about DNACPR in the media and in the Scottish Parliament, over whether there was a policy allowing the blanket use of DNACPR forms, Ministers made it clear in their public and parliamentary statements that they expected everyone supported by health and social care services to be treated with sensitivity, dignity and respect at all times, including during conversations around anticipatory care planning (ACP) with individuals and their loved ones, emphasising that no one should ever feel

pressured to agree to a specific care plan or completing a DNACPR form if they are not comfortable doing so. These concerns were not raised with me during the specified period.

149. The SG has had a policy and guidance on DNACPR in place since 2010, which was updated in 2016, provided: [FMQ2/038-INQ000429278], to reflect changes in guidance from the BMA, the RCN and Resuscitation Council (UK). Its purpose is to provide guidance and clarification for all staff in NHS Scotland regarding the process of making and communicating decisions about CPR. The guidance makes it very clear that characteristics such as age, disability or neurodivergence should never be the sole reason for considering whether a person would benefit from CPR. It also explicitly states that there is never a justification for blanket DNACPR policies to be in place. Additionally, the SG Ethical Advice and Support Framework, published on 29 July 2020, provided: [FMQ2/039-INQ000233594], emphasised this point and made clear that health conditions or disabilities that are unrelated to a person's chance of benefiting from treatment must not be a part of clinicians' decision making regarding accessing treatment. I was not aware of any blanket issuing of DNACPR notices, however I was aware of disquiet about a reminder sent early in the pandemic to ensure, where appropriate everyone should have advanced directives in place, including DNACPR, in place. It is my understanding that this was only a reminder for what would be expected practice was put in place to assist with ongoing healthcare delivery in what was expected to be a very demanding period.

Clinical Frailty Scale

150. The Clinical Frailty Scale (CFS) was developed in 2005 and is now used in more than 20 countries. It is employed both in routine clinical care and in research. The key idea behind the CFS is that as people age, they are more likely to have things wrong with them. Those things begin to impact on their function.

151. The CFS is derived from the Canadian Study of Health and Aging Frailty Index. Following assessment of a patient, a clinician can grade the degree of frailty present using the brief descriptions given on the tool (in addition to what they have ascertained from their overall assessment). The CFS is a nine-point scale based on clinical evaluation of mobility, energy, physical activity, and function. It is a quick and easy way to assess a person's level of frailty.

152. CFS is used in nursing care to determine the individual needs of patients, as opposed to just their service needs. This could include things such as additional assistance with

personal needs, such as feeding, washing or toileting, assistance with mobility and assistance with taking of medications.

153. I was not involved in advice, guidance or communications regarding the use of the Clinical Frailty Scale. I was also not aware of any concerns about the use of Clinical Frailty Scale during the relevant period. Guidance on the use of the CFS was issued as part of the Covid-19 Clinical Guidance and Ethical Framework Guidance Documents issued on 3 April 2020 by the CMO, provided: [FMQ2/040-INQ000363462], [FMQ2/041-INQ000363463].

154. The guidance advised that on admission to hospital, all adults should be assessed for frailty, irrespective of Covid-19 status. It was recommended that the CFS was used in all territorial health boards as part of a general assessment and clinicians should have awareness of its limitations particularly in younger patients and those with long-term conditions or disabilities. It stated that underlying comorbidities and health conditions should also be assessed, and that this should be documented in the clinical record.

155. SG also published an Equality Impact Assessment (EQIA) of the Covid-19 Clinical Guidance and Ethical Advice and Support Framework, provided: [FMQ2/042-INQ000182741], which took place over two meetings on 29 April and 25 June 2020. In considering the impact of the guidance, due regard was given to the statutory equality and human rights of the people of Scotland. The EQIA report considers whether the measures introduced by the guidance could:

- Constitute unlawful discrimination, harassment and victimisation;
- Constitute direct and / or indirect discrimination;
- Advance equality of opportunity between people who share a protected characteristic and those who do not; and
- Foster good relations between people who share a protected characteristic and those who do not.

156. SG worked closely and extensively with a wide range of stakeholders including Inclusion Scotland, Scottish Care, SCLD, EHRC, SHRC, the Scottish Academy of Medical Royal Colleges and many others to consider the impact of the guidance. CNO would engage with a wide variety of stakeholders including Scottish Care and RCN through correspondence and meetings when required to provide insight from a nursing perspective.

157. The EQIA led to agreement on the use of appropriate language in relation to the CFS and the limitations of using this in practice. A further appendix on the CFS was developed in collaboration with stakeholders and included in the guidance.

Maternity services

158. The CMidO reports professionally and managerially to the CNO, and they also work across other policy areas giving advice to Ministers on all matters related to women and children's policy.

159. The Maternity and Child Health Policy Team, CMidO, and Senior Medical Advisor held weekly and, in the early stages of the pandemic, twice-weekly meetings with Heads of Midwifery and Obstetric Clinical Directors in health boards. These meetings were the main forum for communications and information sharing between local maternity services and SG, and the information from those meetings was fed into national level COVID coordination meetings via CLAGS, PAG and through management chains.

160. During the early part of the pandemic (March–May 2020) I was informed through these meetings about changes to maternity services in health boards, including suspension of home birth services, withdrawal of some services (such as hypnobirthing classes and waterbirths), closure of community midwifery units, suspension of face-to-face antenatal care, IPC-led changes to the way services were delivered (e.g. Red and Green zones in maternity units), attendance at antenatal appointments, and changes to visiting / partner attendance in maternity services (antenatal, intrapartum and postnatal). I was not asked for a view, this was delegated to the CMidO.

161. The most commonly cited reasons by Health Boards for service changes were staffing challenges (owing to Covid-related absence and staff shielding) and IPC advice (for example in relation to provision of waterbirth and face-to-face antenatal classes). Boards did not, in the early stages of Covid-19, provide SG Maternal and Infant Health team or CMidO and Senior Medical Officer with any evidence in relation to the changes, and were not asked to do so. This was agreed due to the burden this would place on staff when they were already under pressure, with changes largely driven by advice or staffing issues.

162. In June 2020, as services started to remobilise, SG Maternal and Infant Health Team asked Heads of Midwifery to provide an update on the status of maternity service provision (issued from John Froggatt, Deputy Director Children and Families, Ann Holmes, Chief

Midwifery Officer, and a Senior Medical Officer), provided: [FMQ2/043-INQ000429275]. This gave a partial snapshot of the status of maternity services across Scotland. I was aware of the ask of boards and the response.

163. The CMidO held regular meetings with myself as CNO, participated in several of the SG Covid-19 forums (such as CLAGS and PAG) and had frequent informal communications by phone, email and Microsoft Teams with me, DCNO, CMO, and other senior staff leading the response.

164. Informed by discussions with Heads of Midwifery and Obstetric Clinical Directors, the SG issued a range of guidance to maternity services in Scotland, including several versions of our guidance Covid-19: Maternity Planned Care / Service Minimum Standards, first issued on 8 April 2020, provided: [FMQ2/044-INQ000414587]. That guidance, and subsequent versions updated as the pandemic proceeded, set out minimum agreed standards for planned maternity care during Covid-19. These guidance papers were signed off by the CMO and myself, then cleared through PAG. Anything new was highlighted in new versions. Changes included the establishment of the Covid-19 Assistance Helpline, publication of the Royal College of Midwives (RCM) guidance on homebirths and waterbirths, and in December 2020, the move to the levels-system.

165. Any concerns and issues were raised with SG via frequent and regular communications with Heads of Midwifery and Obstetric Clinical Directors (as outlined above). Public concerns were also highlighted in correspondence with the SG and through MSPs and in the media (including social media). The majority of concerns highlighted were focussed on the following themes:

- Risk of the virus to pregnant women and babies
- Visiting / partner attendance at appointments, in postnatal settings and in neonatal units
- Withdrawal of home birth and Community Midwifery Unit (CMU) Services
- Attending antenatal appointments and classes
- IVF services
- Vaccination safety
- Staff safety

166. Where Boards withdrew water birth, home birth and had to close CMU's, this would have limited pregnant women's choice in those areas as to where to give birth. Data was not at

that time available on choice of place of birth, and we do not collect data on numbers of waterbirths, so it is not possible to quantify impact. These services were restored quickly in many areas as staffing levels allowed and guidance was updated. CMidO outlined the expectation that services were returned as quickly as was possible at the regular meetings with Heads of Midwifery in early summer, and followed up directly with those Boards that were slower at reinstating these services.

167. As CNO, I was made aware of these concerns through CNOD. My view on this was that the action taken was appropriate. Each Board needed to take their own view – rather than take a blanket approach across Scotland – which ensured safety could be assessed at a local level and the best service possible could be provided. The risks of the suspension of maternity services were raised with the SG through the Heads of Midwifery forum. It was discussed by the CMidOs of Scotland, Wales, Northern Ireland and England; the RCM then developed and published guidance in April 2020, having received comments from the SG's professional advisors along with other UK nations. This guidance is provided: [FMQ2/045-INQ000429293].

168. The impact on pregnant women of changes in service provision is as described at a high level above. It is not possible to quantify the extent of the impact owing to the constantly (sometime daily) changes that had to be made to services based on staffing and other pressures that emerged. It was also not uniform as health boards responded differently based on a variety of factors. This included incidence of the virus in their area and subsequent impact on staffing, the flexibility that could be managed within the service (such as use of ancillary staff, availability of bank or agency staff), board geography (for example, in provision of home birth services) or IT and other support services (regarding online support). In addition, baseline provision of services was not uniform, as an example, there was no Scotland-wide provision of hypnobirthing classes pre-pandemic.

169. Core guidance on hospital visiting was developed by the Person Centred and Participation Unit, within DG HSC, and updated regularly by them. The guidance was cleared with me and other senior staff before being sent to Ministers. Visiting in maternity and neonatal settings was included in that guidance. From the very outset of the pandemic the guidance outlined that birth partners were essential visitors to maternity services. The guidance outlined practical consideration to support this, such as visitors wearing face masks and considering not restricting visiting times to prevent large numbers accumulating. It also outlined exceptions including if they were Covid positive, self-isolating for suspected or confirmed Covid-19 or if they had recently returned from a country requiring quarantine.

170.The maternity and neonatal elements of the visiting guidance were also replicated in maternity services guidance issued by the Maternity Policy team. Both the national and the maternity service guidance developed as the pattern of Covid-19 infection changed, for example introducing a staged approach to reintroduction of visiting with addition of one or two designated visitors, and return to full person-centred visiting, depending on the local stage of infection.

171.The CMidO and the Maternity Policy team were aware of some variations in application of visiting policies locally. In some cases, this was a result of local IPC advice and restrictions. In other cases, exceptions or 'workarounds' were required owing to local circumstances (one example is where a scanning room was not large enough to facilitate social distancing, so partners were asked to video call into scan appointments). When the SG policy team and CMidO were made aware of such variations they sought an explanation from boards, and in some cases, decisions were reviewed or alternatives sought.

172.As set out above, I was briefed regularly by the CMidO, and CMidO also briefed the wider leadership team in the context of the COVID coordination meetings.

173.The SG issued guidance on 8 April 2020 outlining that maternity services should maintain a minimum of six antenatal visits, linking to the RCM and RCOG guidance. As outlined above, CMidO and SG Policy met regularly with Heads of Midwifery to discuss temporary changes to service and staff shortages, and mitigations should they be required. Whilst there may have been very short-term challenges in individual health boards, at no time did any health board report via those meetings that they were not achieving the minimum contacts required.

174.The SG Guidance issued on 8 April, and updated regularly after that, also suggested that services consider alternative methods for care delivery, including Near Me, a service run by NHS Scotland, which allows members of the public to attend their pre-arranged appointment with a healthcare professional using a video call, rather than attending in person. In the frequent meetings between the CMidO and Clinical Directors, the advantages and limitations of remote technology were discussed and recognised. The SG Maternity Policy team and CMidO worked with the SG Near Me team, PHS and the Scottish Perinatal Network to develop advice for staff and patients on use of remote technology in maternity services. The guidance document *A Guide to Using NHS Near Me and Remote Monitoring in Maternity Services* was published in May 2020 and revised later

that year, provided: [FMQ2/046-INQ000429265]. In addition, SG policy teams, CMidO and the Senior Medical Officer for obstetrics initiated and funded work with the Scottish Perinatal Network to introduce remote monitoring of blood pressure and urinalysis kits for high-risk pregnant women, which included the use of remote technology for recording results. The use of remote technology in the ways described above were supported by the RCM and the RCOG, and by Scottish clinicians, and promoted by senior clinical leads in Scotland.

175. In July 2020 the decision was made to support funding of the create programme to help women and families who had a baby in neonatal care to stay in touch with their baby's care and progress by video technology, should either parent not be able to be present on the neonatal ward to care for their baby. I was not involved in this decision, but believe that, during the pandemic this technology served as an appropriate alternative to in-person visits whilst family visiting was restricted.

176. SG was aware of limitations in some areas regarding access to water birth in the early days of the pandemic due to IPC concerns about transmissibility of the Covid-19 virus in water. Guidance was produced by RCM and RCOG in April 2020 advising that women with suspected or confirmed Covid-19 diagnosis should not use pools or baths owing to the risk of cross contamination, provided: [FMQ2/047-INQ000429288].

177. I was not aware of any formalised restriction on elective caesarean sections, although it is possible that some boards may have had to reschedule elective sections depending on workload and staff absence and based on risk assessment (as happens in non-Covid service planning).

178. Maternity services were advised to follow UK Health Security Agency guidance on IPC in health settings, including the use of PPE. This advice was included in the SG maternity guidance that was produced on April 2020 and subsequently updated and is provided in paragraph 157 above (FMQ2/045 - INQ000429293).

179. The SG Maternal and Infant Health Policy Team has no record or recollection of discussions with Heads of Midwifery or Clinical Directors around access to interpreters or translators. However, discussions about difficulties of masks for lip readers and access to the Perspex versions for those circumstances were held. Transparent masks were introduced after my tenure as CNO. In May 2020, a report on masks was produced and noted that further work on transparent face coverings for the public and for use as PPE

should be taken forward. Transparent masks were distributed to Health Boards in November 2021 and started to be used in December 2021. The reason for the delay was the process for getting the specification approved and the mask accepted.

180. Heads of Midwifery and Clinical Directors shared with SG some of the anxieties women reported to them about being pregnant during the pandemic and the risks involved, particularly as they had been designated as clinically vulnerable, including concerns about attending hospital and missed appointments. Both CMO and CNO used the daily briefings to seek to provide information to pregnant women, for example to encourage them to attend appointments and to take up offers of vaccination.

181. Parents' concerns about access to babies in neonatal care were raised early in the pandemic with CMidO and the Maternity Policy Team by Neonatal Staff and access was addressed through visiting guidance, and later iterations of the SG maternity guidance, although some restrictions on access remained in smaller units where it was difficult to achieve appropriate distancing.

182. I was made aware through the CMidO of general concerns voiced by maternity service leaders on the impact of withdrawal of face-to-face antenatal education, particularly to those who were most marginalised and at-risk groups. My understanding is that these concerns were also raised about the amount of misinformation circulating in relation to Covid-19 and the impact that might have in particular on vulnerable women. I know that in response, the SG purchased and made available a package of online antenatal education (known as the Solihull course) for all women to access. The SG also produced two leaflets, one for pregnant women and for one for new parents (published and circulated in hard copy to maternity services in April 2020 and updated thereafter) about maternity care and newborn care during the pandemic. These leaflets were published in English and cascaded to maternity units for distribution, as well as being made available on the PHS website. A research report commissioned by PHS and the SG which identified how maternity care was experienced during the Covid-19 pandemic was published in April 2022, provided: [FMQ2/048-INQ000202968].

Shielding

183. Where appropriate my Directorate provided professional and clinical advice to the SG shielding team on IPC measures for those shielding but was otherwise not directly involved in the policy formulation. Relevant details of shielding policy and the Highest Risk List can

be found in the Module 3 DG Health and Social Care corporate statement FMQ2/091 - INQ000485979 submitted to the Inquiry on 18 June 2024. CNOD offered advice on IPC matters, specifically for NHS staff on the highest risk list returning to work [FMQ2/081 - INQ000477447].

184.The decision to categorise pregnant women as clinically vulnerable was a UK decision, agreed by all UK CMOs, in discussion with myself as CNO and CMidOs. To the best of my recollection, this decision was based on widespread agreement that pregnant women were more likely to be at risk due to experience from previous pandemics (including SARS, Swine Flu) and the pressures that pregnancy already put on organs such as lungs.

185.Initially, the four UK CMOs agreed the criteria for the cohorts that they assessed may be most at risk of severe illness or death should they contract Covid-19, on 18 March 2020.

186.Clinicians could also, based on their clinical judgement, add people to the shielding list who were clinically at the highest risk from Covid-19 but were not included in the groups. If someone thought they were in the highest risk group but had not received a letter, SG advice was they should contact their doctor. If people were newly diagnosed, or if clinicians felt it was required, SG continued to add to the central list to ensure people could be supported to shield.

<u>Other matters within the scope of Module 3</u>

<u>The NHS Louisa Jordan</u>

187.As previously mentioned, I was Chair of the Louisa Jordan Oversight Board, which oversaw the creation and ongoing use of the Scottish temporary medical facility. The agreement to build the new healthcare facility followed similar plans in NHS England and Wales and aligned to a key Ministerial priority in force at the time to ensure sufficient bed capacity to manage an increase in patients associated with the pandemic.

188.The decision to create one temporary hospital, the NHS Louisa Jordan situated at the Scottish Exhibition Centre / Scottish Events Campus (SEC) in Glasgow, was therefore taken as a contingency to ensure adequate hospital provision for Covid-19 patients if NHS Scotland's existing estate was fully utilised. The decision to build a new healthcare facility was balanced against the potential that any such facility may not be used, and that existing

estate capacity could instead be utilised. Initial modelling undertaken in March 2020 indicated that additional contingency was required.

189. Given the need for temporary hospital provision to be up and running by mid-April of 2020, when initial peaks of patient numbers were expected, accelerated governance processes were implemented to take forward approval for the hospital. An update was provided to the First Minister on 28 March 2020, and permission to proceed with commissioning agreed, provided: FMQ2/004g - INQ000261872].

190. Subsequently on 30 March 2020, the First Minister announced the commissioning of the temporary hospital at the SEC site in Glasgow. In announcing the facility, the First Minister referred to existing bed capacity across acute sites in Scotland, noting that:

- As of March 2020, 13,000 beds were in operation in NHS Scotland sites, with NHS boards working to ensure capacity of at least 3,000 for Covid-19 patients
- Work was ongoing to quadruple intensive care unit (ICU) capacity to 700
- The temporary facility would have initial capacity of a further 300 beds with potential to expand to 1,000 if needed.

191. A further press release on 1 April 2020 by the CSH confirmed that the temporary facility would be named the NHS Louisa Jordan. The hospital was operationally ready from 19 April 2020, and officially opened on 30 April 2020. The relevant press releases are provided: [FMQ2/050-INQ000470113], [FMQ2/051-INQ000470114].

192. Following the agreement to proceed and media announcements, regular updates were provided on capital and associated revenue costs for the NHS Louisa Jordan to both the Cabinet Secretary for Finance and the CSH.

193. On 18 March 2021 it was announced that the NHS Louisa Jordan would close on 31 March 2021, with ongoing activity pertaining to mass vaccination clinics relocated to the nearby SSE Hydro. The decision to close the facility recognised the work undertaken by the 14 NHS Territorial Boards to remobilise following the initial disruption caused by the pandemic, as well as the need to release capacity within SEC to operate as a working events and conference centre. This was important given SEC's expected role during COP26 which ran from 31 October to 13 November 2021. A briefing was provided to the Cabinet Secretary outlining the basis for decision, provided: [FMQ2/052-INQ000469991]. The costs of commissioning / build were incurred through NSS contracts and using existing

framework agreements. The total costs of the NHS Louisa Jordan including building, commissioning, operational costs and decommissioning were in the region of £70 million.

194. NSS supported the procurement and decommissioning of NHS Louisa Jordan.

Healthcare and treatment for patients with non-Covid-19 conditions

195. Neither I nor CNOD were involved in decisions to suspend non-urgent elective surgery and diagnostic screening programmes in response to the pressures of Covid-19.

196. My directorate communicated and signposted the NSS ARHAI guidance on clinical pathways to NHS health boards, but it was up to individual boards to operationalise these. I had no direct involvement in NHS departmental operational matters.

197. I was not involved in consideration of the use of private hospitals during the pandemic. Details of how and when these hospitals were used are provided in Module 3 DG Health and Social Care corporate statement **FMQ2/091-INQ000485979** submitted to the Inquiry on **18 June** 2024.

198. As outlined in paragraphs 171-172, CNOD's involvement in the use of new technology for supporting patients with non-Covid-19 conditions was done through the use of the Near Me service and conducted via CMidO.

199. Matters relating to the allocation of nursing staff were the remit of HWD as well as local NHS Boards. Further detail on this can be found in the Module 3 Health and Social Care Directorate corporate statement **FMQ2/091-INQ000485979** submitted to the Inquiry on **18 June** 2024.

Visiting restrictions in hospitals

200.SG clinical advisors within CNOD provided IPC advice to the SG Visiting Team but my directorate were not directly involved in producing guidance on visiting.

201.From January 2020 to April 2022, Healthcare Quality Improvement Directorate (HQI) led on the development of detailed guidance and principles to support Scottish health boards to manage hospital visiting during the pandemic. This was done in partnership with other SG teams whose policy responsibility included hospital services, principally mental health and maternity. The guidance was formulated in response to IPC and wider public health guidance, feedback from the Visiting Reactivation Forum (VRF), senior clinical advice and statutory regulations imposed between March 2020 and January 2022. As these guidelines and statutes changed throughout the pandemic, the hospital visiting guidance was adapted accordingly.

Palliative or 'end of life' care for patients with Covid-19

202.SG clinical advisors provided IPC advice to Palliative Care Team but neither I nor CNOD were directly involved in producing guidance.

203.In April 2020, CMOD published a Covid-19 Palliative Care Toolkit to provide health board planners with options that could be adapted and utilised locally in their response to Covid. The toolkit is now archived on the National Records of Scotland website provided: [FMQ2/053-INQ000479880].

Nursing and midwifery staff with Long Covid

204.During my time in post, I was not aware of any work specifically undertaken to support nursing and midwifery staff with Long Covid.

205.HWD are responsible for the maintenance of Guidance for Staff and Managers on Coronavirus hosted on NHS Scotland Staff Governance website, provided: [FMQ2/054-INQ000414550]. The current guidance signposts staff to the National Wellbeing Hub for advice on how to cope with Long Covid.

Future risks, reviews, reports and lessons learned exercises

206. The main forum for gathering feedback, learning and information from leaders in the nursing profession is the SEND meeting, a regular and ongoing forum established several years ago where CNO meets with the ENDs and discusses professional matters. This provides a forum for them to share information in a safe and trusting environment.

207. Due to the fact that I demitted office in February 2021, I did not have an opportunity to contribute to lessons learned – other than what we managed on an ongoing basis. Further information the involvement of the CNO with lessons learned exercises can be found in Professor McMahon's statement.

208. On balance, much of what happened when responding to the pandemic was predicated on a plan for flu without due consideration being given to other options that may have altered the course of the pandemic. There was an opportunity from January to March 2020 to take actions that were different rather than put actions in place that assumed we were going to be overwhelmed with the virus. We did not properly consider the aftermath of reducing most NHS services, including treatment of drug and alcohol use, or mental health, which could have taken place remotely or been categorised as essential and taken place with NPIs in place. The decisions we seemed to be taking were linear in their nature around how to create capacity in the NHS to save lives and provide access to clinical care rather than how to prevent the virus from circulating by the use of border control, earlier lockdown, testing and tracing. Current SG policy on social care is to have a mixed model of provision (public, third sector, private, charitable). The disjointed nature of the social care provision was a barrier in providing a comprehensive response to social care and starting off the pandemic with a health and social care workforce that was struggling with resilience in places was not ideal. By disjointed nature of social care, I found this to be so as care was being provided by a number of different organisations who were not necessarily connected. This meant that specialist and expert advice, or access to purchasing PPE was a challenge until other arrangements were put in place, which did happen as soon as it was recognised as being problematic. Whilst we recognised the impact the virus had on the more vulnerable in our society, I wonder if we could have done more during the pandemic to support such groups. With hindsight a number of measures may have been beneficial: enhanced financial support; improved access to healthcare – in particular to mental health services; strengthening efforts to address food security; improved social isolation support; changing restrictions to support new mothers to receive additional in person support from

family and friends; offering targeted support for children with additional needs; and more comprehensive support services for people who used drugs including alcohol.

209. For the future, improved preparedness, including public debate about what actions will be taken (with consequences – so trading wellbeing and education of our young people with increased transmission of the virus. This could be tolerated with a firmer grip of protecting care home residents and those who shielded – it just needs to be thought through). There is no doubt that additional funding is needed to invest in preparedness and emergency planning – the question of course is where that money comes from – along with additional investment in our health and social care workforce.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: **Personal Data**

Dated: 17 June 2024