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Statement No.: 9
Exhibits: CL9
Dated: 18 June 2024

UK COVID-19 INQUIRY
MODULE 3

WITNESS STATEMENT OF THE DIRECTOR GENERAL FOR HEALTH AND SOCIAL CARE

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, the Director General for Health and Social Care, will say as follows: -

1. This statement supplements the eighth corporate statement of DG Health and Social Care submitted to Module 3 of the UK Covid-19 Inquiry on 9 April 2024 and should be read in conjunction with that statement.

2. This statement provides additional information on the following topics:
   - NHS Scotland capacity
   - The effects of NHS Scotland staff contracting Covid-19
   - Primary care, including information on guidance, use of technology and triage processes
   - At home care during the pandemic
   - Antenatal, maternity, postpartum and neonatal care provided in Scotland during the pandemic
   - Non-Covid-19 services, including hip replacement surgery, heart disease treatment and child and adolescent mental health services
   - Long Covid
   - Lessons learned reports and exercises conducted by the Scottish Government (SG) relating to care pathways.

Capacity

3. The SG Directorate General for Health and Social Care (DGHSC) defines and measures capacity within NHS Scotland as the ability to provide care and services to meet the needs of patients. This includes measuring various resources such as beds, staff, equipment and infrastructure.

4. The SG measures the capacity within the NHS in several ways and through several means that changed during the Covid-19 period and as we have emerged. The Health Workforce Planning and Strategy Unit, within the Health Workforce directorate, are responsible for analysing the quarterly NHS workforce statistics published by NHS National Education Scotland (NES). From this analysis, we are able to understand trends in the workforce, understand where shortages exist and whether issues are local or national. Some examples are provided below:
    - On acute available staffed bed capacity and occupancy levels, Public Health Scotland (PHS) published official statistics on a quarterly basis and this continued throughout the pandemic. Given the need for more timely data, SG introduced a daily / weekly management information collection on acute bed occupancy (i.e. occupied beds as a percentage of available beds) in March/April 2020. The definitions used were adapted through the pandemic and as such were not suitable for trend analysis. Definitions were not consistent with definitions used in PHS published data. This management information was not published. It was used to crudely identify health board level acute bed occupancy rates.
    - On ICU beds, capacity and occupancy, on 13 May 2020, the Scottish Intensive Care Society Audit Group (SICSAG) published the first edition of their Covid-19 report [CL9/147 **INQ000352858** reporting on patients admitted to Scottish ICUs with Covid-19, based on data collected from the WardWatcher system. Further editions of this report were published throughout the pandemic, with ten editions being published in total, ending in April 2022. PHS / SICSAG published ICU occupancy and capacity statistics by presenting the number of patients receiving level 3 care as a percentage of baseline capacity.
    - On Accident and Emergency, SG continued to receive daily and weekly qualitative management information on attendance and time spent at A&E, on a site by site basis. Weekly statistics continued to be published by PHS.
    - On Cancer, throughout the pandemic, SG continued to receive monthly management information from PHS on 31-day and 62-day cancer waiting times performance and activity at cancer type and board level. SG also continued to receive weekly management information on cancer waiting times and cancer

referral volumes. Statistics on cancer waiting times and activity continued to be published quarterly by PHS.

- On planned care, SG started to collect weekly management information on outpatient and inpatient/day case activity in June 2020; and diagnostics activity from September 2020. Statistics on planned care waiting times and activity continued to be published quarterly by PHS. Statistics on cancelled procedures and scheduled procedures continued to be published monthly.
- On Covid-19, management information was published daily by SG and PHS on the number of Covid-19 patients in hospital and Covid-19 hospital admissions. The number of Covid-19 patients in ICU was also sourced from daily NHS Board submissions and published daily on gov.scot. The total number of patients in ICU was sourced from SICSAG management information (from the WardWatcher system). This was not published daily. From September 2020, new definitions were implemented to standardise the daily collection of NHS Board COVID-19 hospital and ICU occupancy data. Reporting evolved further in February 2021 to include Covid-19 ICU occupancy for patients staying longer than 28 days.
- On wider impacts on the healthcare system, from May 2020, PHS published weekly information on hospital admissions, A&E attendances, NHS 24 completed contacts, out of hours cases and consultations, Scottish Ambulance Service incidents. Where possible, this information was made available by age and deprivation.

5. Surge capacity planning involves identifying additional resources, creating readiness plans, and implementing policies to ensure the NHS is able to provide a service during periods involving a sudden rise in demand, such as during a pandemic, particularly for those with urgent needs.

6. The Four Hour Emergency Access Standard is the default measure of safety across the unscheduled care journey. Compliance with the Standard is contingent on effectively reducing attendances at A&E, building capacity by reducing unnecessary admissions, reducing length of stay and avoiding delayed transfers in care. The Unscheduled Care Programme incorporates two aspects of work to support these ambitions: the Redesign of Urgent Care and Unscheduled Care: Building Capacity for Recovery. Officials working as part of this programme monitor the statistical ability to meet the Emergency Access Target of 95% of admission, discharge and transfers within four hours, plus further relevant details.

7. The SG and NHS Scotland do not have a fixed definition of surge capacity. NHS Health Boards provide services and capacity as they think fit based on the needs of their local populations. SG has a range of weekly management information data on Scottish Ambulance Service (SAS), NHS 24, A&E, planned care and cancer waiting times and activity metrics, monitored by officials, to help provide situational awareness of how demand is impacting on the system. The level of capacity provided would therefore be the decision of individual NHS Health Boards.

8. NHS Scotland categorise hospital beds into various types based on their intended use and level of care they provide. These include:
    - General Ward Beds: These beds are typically used for patients who require general medical care and monitoring. Patients admitted to general ward beds may have a variety of medical conditions but do not require intensive care or specialised treatment
    - Specialist Ward Beds: Specialist ward beds are allocated for patients with specific medical conditions or needs. Examples include orthopaedic wards, cardiac wards, and respiratory wards, which are designed to provide specialised care and treatment
    - High Dependency Unit (HDU) Beds: HDU beds are for patients who need a higher level of monitoring and care than what is available in a general ward. They are equipped with more advanced monitoring equipment and may be staffed by healthcare professionals with specialised training
    - Intensive Care Unit (ICU) Beds: ICU beds are reserved for patients with critical and life-threatening conditions. These units are equipped with highly specialised medical equipment, and patients in ICU require continuous monitoring and intensive medical intervention
    - Maternity Beds: Maternity beds are designated for pregnant women who are admitted for childbirth or related medical care. These beds are often found in maternity wards and delivery units
    - Paediatric Beds: Paediatric beds are for children and adolescents who require medical care. Paediatric wards or units provide age-appropriate care and require specialised staff trained in paediatric medicine
    - Psychiatric Beds: Psychiatric beds are for patients with mental health conditions who require inpatient treatment and care. These beds are typically found in psychiatric hospitals or psychiatric units within general hospitals
    - Rehabilitation Beds: Rehabilitation beds are used for patients who require physical therapy, occupational therapy, or other forms of rehabilitation after surgery or illness. They are designed to help patients regain functionality and independence

- Day Beds or Day-Case Beds: These beds are used for patients who require a short period of care and do not need to stay overnight. Commonly used for minor surgeries and procedures, patients are admitted in the morning and discharged the same day
- Respite Beds: Respite beds are provided for individuals who require temporary care and support, often to provide relief to family caregivers.

9. The extent to which hospital beds can be reallocated for other usage will depend on multiple factors, including capacity, healthcare needs and unscheduled care demand. This will be discussed and agreed among healthcare professionals. Guidance on bed allocation was provided to health boards on 20 May 2020 from Interim Chief Executive, NHS Scotland John Connaghan, provided: [CL9/001-INQ000414534]. The guidance stated that individual health boards would need to decide at local level what an appropriate *de minimis* figure would be to provide appropriate safe contingency, given there are various service configurations throughout hospitals in Scotland.

10. The following tables show the average number of available beds in different categories as reported by Public Health Scotland (PHS). These include figures for January to March 2020.

Table: Average number of available staffed acute (inpatient and critical care) beds, and the average available acute staffed beds per 100,000 population from quarter 1 2020 to quarter 2 2022

Quarter	Average available acute staffed beds	Average available acute staffed beds per 100,000 population*
Jan–Mar-20	13,478	246
Apr–Jun-20	12,706	232
Jul–Sep-20	12,638	231
Oct–Dec-20	12,941	236
Jan–Mar-21	13,083	239
Apr–Jun-21	13,041	238
Jul–Sep-21	13,199	241
Oct–Dec-21	13,406	245
Jan–Mar-22	13,546	247
Apr–Jun-22	13,583	248

Data source: Beds by NHS Board of Treatment and Specialty to December 2020, Public Health

Scotland, provided: [CL9/002- INQ000468121].

** Population estimate data source: Mid-2021 Population Estimates Scotland, National Records of Scotland (nrscotland.gov.uk)*

Table: ICU level 3 bed capacity and ICU level 3 capacity per 100,000 population

ICU level 3 bed capacity	ICU level 3 bed capacity per 100,000 population
173	3.2

Data source: The Scottish Intensive Care Society Audit Group Report, 15 March 2022

11. The Scottish Intensive Care Society Audit Group Report, provided: [CL9/003-INQ000281050], states that:

> *"ICUs rapidly expanded level 3 capacity across the country in response to the pandemic. Baseline level 3 bed capacity is 173, and Health Boards confirmed the capability to provide invasive mechanical ventilation for 585 patients. In this section of the report, percentage level 3 baseline capacity is calculated using the sum of level 3 ACP days"* (pages 13-14).

12. The SG does not hold figures based on the PHS definitions of staffed acute beds (i.e. those used in the tables cited at paragraphs 10 and 16) at weekly or monthly periods, including for the period March 2020 through June 2022. PHS publish these statistics on a quarterly basis using the PHS definitions. While PHS do not publish monthly information, it is SG's understanding that they do hold that information for staffed acute beds. Furthermore, it is SG's understanding that PHS do not hold that information for weekly periods. It is SG's understanding that the PHS statistics on staffed acute beds includes ICU beds, however it is not possible to identify the ICU beds specifically as they will be grouped with other types of beds.

13. PHS also published statistics on daily ICU admissions; and ICU occupancy as a percentage of baseline occupancy in the SICSAG report on Covid-19 publication series covering the period 2 May 2020 to 15 March 2022.

14. SG did start to collect daily/weekly management information on occupied and unoccupied hospital beds at the start of the pandemic. However, this management information was not based on the same staffed acute bed definitions and data sources used by PHS. In order to manage the data provision burden, each NHS Board used its own local definitions and data

sources, with some NHS Boards changing those definitions during the relevant period. This basic daily/weekly management information was intended to provide crude snapshot in time information on NHS Board level acute bed occupancy rates – rather than trend information.

15. The table below shows the SG beds management information and how that compared to PHS published statistics on acute bed numbers and occupancy.

	PHS published quarterly data			SG internal MI daily data		
Quarter ending date	PHS published available staffed acute beds	PHS published occupied acute beds	PHS published occupancy	SG MI available staffed beds	SG MI occupied beds	SG MI Occupancy
30/06/2020	12,706	7,825	61.6%	12,129	7,837	64.6%
30/09/2020	12,638	9,691	76.7%	12,068	9,691	80.3%
31/12/2020	12,941	10,319	79.7%	12,335	10,367	84.0%
31/03/2021	13,083	10,602	81.0%	12,083	10,234	84.7%
30/06/2021	13,041	10,716	82.2%	12,277	10,600	86.3%
30/09/2021	13,199	11,096	84.1%	12,347	10,871	88.1%
31/12/2021	13,406	11,408	85.1%	12,493	11,153	89.3%
31/03/2022	13,546	11,678	86.2%	11,997	10,994	91.6%
30/06/2022	13,583	11,839	87.2%	11,438	10,720	93.7%

Note: Boards provided MI data to SG as a snapshot at midnight each day. Quarterly figures presented in the table above were calculated by taking the average of all Wednesday snapshots from the daily MI data, in each of the quarters. For context, PHS published occupancy for June 2019 was 87.1%.

16. In addition to the capacity and occupancy information, a wide range of management information and published statistics was available on NHS activity. Key activity data is set out in paragraph 4.

Table: Average available staffed acute beds year-to-year (inpatient and critical care)

Year	2017/18	2018/19	2019/20	2020/21	2021/22
NHS Scotland	13,429	13,080	13,229	12,841	13,297

Data source: Acute Hospital Activity and NHS beds Information for Scotland: Annual – Year

ending 31 March 2023, Public Health Scotland, provided: [CL9/004-INQ000346174].

Table: Vacancy numbers and rates for the three main NHS Scotland healthcare worker staffing groups as at December 2019 and March 2020

NHS Scotland Healthcare worker roles by job family	Vacancies in whole time equivalent (WTE*) Dec-19	Vacancy percentages by job family Dec-19	Vacancies in whole time equivalent (WTE) Mar-20	Vacancy percentages by job family Mar-20
Medical & Dental consultants	480.8	8.2%	184.5	3.3%
Nursing & Midwifery	3,606.9	5.6%	2,294.5	3.6%
Allied health Professionals	724.3	5.7%	416.0	3.3%

**Whole time equivalent - (WTE)*

Data source: The TURAS Data Intelligence website, an NHS Education for Scotland-run platform for sharing analytics derived from workforce and employment data held within the digital platform TURAS, relevant reports provided: [*CL9/005- INQ000468116].*

17. The following table presents a breakdown of numbers of all employed consultants, doctors in training, other trained doctors and general practitioners. These figures are based on the population of Scotland as of mid-2021, which was estimated to be 5,480,000.

Staff Group	September 2019 (headcount)	September 2020 (headcount)	Staff per 100,000 population (headcount) as September 2022
General Practitioners	5,049	5,121	95.1

Staff Group	Staff in post December 2019 (WTE)	Staff in post March 2020 (WTE)	Staff per 100,000 population (WTE) as March 2020
Consultant	5,509.6	5,606.3	110.0
Doctors in Training	5,928.5	6,110.9	117.7

Other trained Doctor	2,242.3	2,032.0	49.5

Data source: The TURAS Data Intelligence website, an NHS Education for Scotland-run platform for sharing analytics derived from workforce and employment data held within the digital platform TURAS, relevant reports provided: [CL9/006 - INQ000468132].

18. On 11 March 2020 John Connaghan (Chief Performance Officer, NHS Scotland, and Director of Delivery and Resilience) wrote to NHS Chief Executives to request local mobilisation plans preparing for Covid-19, provided: [CL9/007-INQ000326477]. The plans set out in detail how health boards would maximise intensive care capacity while seeking to maintain essential services.

19. Following this, the Cabinet Secretary for Health and Sport (CSH) made a statement to the Scottish Parliament on 17 March 2020, provided: [CL9/008-INQ000470076], confirming that while NHS Scotland was well advanced in work to double intensive care unit capacity to 360 beds, the scale of the pandemic meant the priority was now to quadruple ICU capacity to more than 700 beds as quickly as possible.

20. On 20 March 2020 a decision was made to utilise private hospital capacity for the treatment of urgent elective procedures (predominantly urgent cancer cases) since bed capacity was limited because of Covid-19 admissions.

21. On 24 March 2020, the CSH made a further statement to the Scottish Parliament setting out plans to quadruple ICU capacity to more than 700 beds as quickly as possible. This statement is provided: [CL9/009- INQ00316379] and the relevant section can be found on pages 5-6. Guidance provided to health boards on 20 May 2020, provided earlier in the statement [CL9/001-INQ000414534], was as follows: (i) Acute general beds: from 1 June until further notice, NHS boards to ensure Covid-19 provision at least the number of confirmed cases in acute hospitals plus 50% contingency. NHS boards to retain capability to reinstate share of the re-purposed 3,000 beds capacity within 7 days; (ii) ICU beds: from 1 June until further notice, NHS boards to ensure Covid-19 provision at least the number of confirmed cases in ICU plus 50% contingency. NHS boards to retain capability to reinstate share of the initial ICU surge capacity (585 beds) within 7 days. NHS boards continue to develop contingency plans to put in place share of the maximum ICU surge capacity (700+ beds).

22. On 26 March 2020, the Chief Performance Officer sent an email to health board Chief Executives to request immediate work to bring in as many anaesthetic machines as possible

to increase ventilation capacity with the next seven days, provided: [CL9/010-INQ000414530]. This advised NHS boards to overcome obstacles by being as innovative as possible within safe operational boundaries and maximise what could be made available while reserving a minimum number to deliver cancer care and other urgent care safely.

23. On 30 March 2020 a submission was sent to Ministers to provide an update on the health board mobilisation plans and seek agreement on the next steps, including the associated service, financial and strategic policy issues, provided: [CL9/011-INQ000468136].

24. During March and April 2020 the decision to create one temporary hospital (NHS Louisa Jordan), situated at the Scottish Event Campus (SEC) in Glasgow, was taken by the CSH as a contingency measure to ensure adequate hospital provision for coronavirus 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.

25. 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, provided: [CL9/012- INQ000261872], and permission to proceed with commissioning agreed. Subsequently on the 30th of March 2020, the First Minister announced the commissioning of the temporary hospital at the SEC site in Glasgow, provided: [CL9/013-INQ000414531].

26. 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. The temporary facility would have initial capacity of a further 300 beds with potential to expand to 1,000 if needed.

27. The hospital was operationally ready from 19 April 2020, and officially opened on 30 April 2020.

28. The NHS Louisa Jordan was not ultimately required to treat Covid-19 patients, as capacity in existing care settings proved adequate for handling the number of infected patients, but on 20 May 2020, the Interim Chief Executive of NHS Scotland, John Connaghan, advised boards the NHS Louisa Jordan retained capability for a further 1,000 Covid-19 patients, if required.

Although the NHS Scotland Estate was at capacity it still managed to handle all Covid-19 patients so, as stated, the Louisa Jordan was never required for treatment of Covid-19 patients. Had it been utilised for Covid-19 patients, the decision to admit any individual would have been a clinical one based on the ability of the Louisa Jordan to treat that individual patient. As a safeguard and to provide extra flexibility, the facility was initially to be used by those who had been through hospital treatment and were recovering from their symptoms. However, as described, the facility was never used for this but rather for outpatients, vaccinations and training. This in itself alleviated some of the impact on wider capacity issues.

29. In July 2020, the hospital played a crucial role in supporting the remobilisation of NHS Scotland. By 31 March 2021, staff at the hospital had carried out more than 32,000 outpatient and diagnostic appointments, trained over 6,900 healthcare staff and students, and vaccinated approximately 175,000 people across the Greater Glasgow and Clyde area. The site also supported the Scottish Blood Transfusion Service, with more than 500 donations being carried out, as well as providing Occupational Health services for the University of Glasgow for nearly 1,000 people. If required, the hospital continued to remain ready to accept Covid-19 patients at a few days' notice.

30. 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 fourteen NHS territorial boards to remobilise following the initial disruption caused by the pandemic, as well as the need to release capacity within the SEC, to allow the site to be able to operate as a working events and conference centre. Further information on the NHS Louisa Jordan is provided in M3HSCD01.

31. In April 2020 the First Minister updated the Scottish Parliament on the work to quadruple intensive care capacity to more than 700 beds for Covid-19 patients. The parliamentary Official Report, which records all discussion from the parliamentary session in question, is provided: [CL9/014-INQ000329216], and the relevant section begins on page 64. The FM advised Parliament that the initial target of doubling intensive care capacity in Scotland to 360 beds had been achieved, with the expectation that approximately 250 of these would be available exclusively for Covid-19 patients while the others were in use for other urgent care. The FM then advised that work was underway to quadruple intensive care capacity to more than 700 beds for Covid-19 patients. Ventilators had been ordered from a range of manufacturers, and NHS boards had been working to repurpose operating theatre anaesthetic machines for use as ventilators in the meantime.

32. As the FM had stated in this update to Parliament, ventilators from a range of manufacturers were ordered, and work had begun on repurposing operating theatre anaesthetic machines for use as ventilators to bridge the gap between the number of ICU ventilators available in March 2020 and the number predicted to be required to meet a maximum ICU surge position. There were approximately 700 anaesthetic machines in NHS Scotland at that time and, as elective surgery was suspended, these were mostly available. Since there was a global shortage of ICU ventilators, the availability of the anaesthetic machines that could be used as ventilators, as a short-term measure, allowed the maximum ICU surge position to be achieved regarding equipment. This also allowed time for National Procurement to source more suitable ICU ventilators. In addition, a collaborative arrangement was agreed between the NHS and the independent sector to ensure available capacity was utilised. The treatment of patients would include urgent surgical specialties and procedures that the independent hospitals were well configured to deliver. As a contextual note here, there are five private hospitals across Scotland, with differing capabilities, offering varying services, providing a total of 213 beds, 16 theatres, and with a nursing headcount of just over 300.

33. From January through March 2020 the Performance and Delivery Division's Business Intelligence Unit (BIU) worked with Health Resilience Division to develop intelligence on NHS capacity including ICU surge capacity, hospital single rooms, and acute hospital capacity. This work built upon the information held by NSS Health Facilities Scotland and the official statistics held by ISD (now known as PHS). This included work with the Scottish Intensive Care Society Audit Group (SICSAG) on ICU baseline capacity which fed into work on ICU expansion. The management information and intelligence on activity and capacity was used to inform policy and performance management to help protect and scale up the capacity of the NHS (in particular ICU) which was a priority throughout the pandemic, for example, the development of the mobilisation planning in March 2020. In general, the BIU supported the comparisons on baseline capacity, targeted capacity, actual occupancy and modelled demand. All analytical work after 24 March 2022 was developed by the Health and Social Care Analysis Division, Population Health Directorate.

34. The Chief Operating Officer and the Interim Director of Health Finance and Governance wrote to NHS board Chief Executives on 24 April 2020, provided: [CL9/015-INQ000414533], confirming that they were content in principle with board mobilisation plans for acute services and the activities that had been undertaken to date. They recognised at this stage that it was appropriate to pause the rollout of additional acute capacity, with the exception of the requirement to quadruple ICU provision. Initiating a short pause would allow SG to take stock of the activity undertaken, reassess the emerging modelling data, and collectively plan the

next phase of mobilisation.

35. By 13 March 2020, a weekly 'Covid-19: Modelling spread & impact in Scotland' slide pack was produced based on the modelling work undertaken by the COVID-19 Modelling and Analysis Hub (C-19 MAH) and this was used to update NHS Mobilisation Planning. From this work, estimates of surge capacity were calculated and provided to SAGE on 13 March 2020 to support modelling.

36. To support planning for health, social care and resilience services in Scotland, modelling was provided to Heath Board Chief Executives and Chief Operation Officers, from 8 April 2020, on estimated Covid-19 cases, their impact on hospital bed numbers and ICU bed numbers, and fatalities. These estimates were based on the reasonable worst case for a range of scenarios based on compliance with social interventions. It showed three scenarios: a baseline with no social interventions, a scenario based upon 40% compliance with current social restrictions, and a scenario based on 60% compliance. They showed weekly estimates (including peak demand within each week) for the first 23 weeks of the epidemic. Next steps were to provide modelling for each Health Board in terms of the required peak surge capacity. Where deficiencies with Health Boards vs capacity against peak were noted, immediate discussions were held to seek remedies. Following this, a modelling overview and Excel pack was distributed from late October 2020 and continued throughout the pandemic and was presented at National Incident Management Team (NIMT), National Planning Meetings and Meetings with Board Chief Executives.

37. On 11 March 2020, NHS Scotland's Chief Performance Officer wrote out to all Health Boards asking them to prepare local mobilisation plans in response to the COVID-19 emergency. The plans cover the whole system response in terms of acute, primary, community and social care.

38. The key asks in terms of Boards' acute response to the Covid-19 emergency were: firstly to double then quadruple their ICU capacity (to around 700 beds); maximise their bed capacity, whilst protecting cancer, maternity, urgent and emergency care, including by halting their elective activity; by working with their planning partners to eradicate delayed discharges by the end of April (prioritising 'home first' and innovative solutions). Health Boards were tasked with initially doubling and then quadrupling their base adult ICU provision as a key part of their mobilisation plans, in response to the Covid-19 emergency. The ability to support a major incident and provide business critical services are dependent on the availability of ICU capacity both for emergency and planned surgical intervention or in response to a major incident.

39. On the 16 April 2020, NHS Scotland Chief Performance Officer and Director of Delivery and Resilience wrote to the Cabinet Secretary for Health and Sport detailing an update and advice on key operational performance across NHS Scotland in response to the current emergency.

40. A letter from the Interim CE for NHS Scotland to NHS CEs in May 2020 stated that:

    In line with the Government's Framework for Decision Making, there was a need to achieve a careful balance in managing our healthcare capacity going forward. As informed by expert advice and modelling, we will need to continue to protect our core capacity to respond to the virus, alongside the commitment to treat emergency, urgent and maternity cases. Revised drafts of mobilisation plans (detailing to July) were to be submitted detailing which services (including timescales) could be re-introduced safely while maintaining appropriate capacity for response to Covid-19. The plans were informed by the clinical prioritisation of services and the national guidance/policy frameworks including those relating to testing and PPE.

41. On 20 May 2020, guidance was issued to health board Chief Executives outlining what the SG expected boards to maintain to ensure Covid-19 resilience for ICU and general acute beds, provided earlier in the statement [CL9/001-INQ000414534]. This was informed by up-to-date activity tracking and modelling and was designed to ensure the safe and incremental restart of some paused activity, whilst maintaining appropriate Covid-19 resilience planning and protecting support for social care. Boards were expected to include an update responding to this expectation in their remobilisation plans (RMP1) returns, which were due by 25 May 2020. These have been provided: [CL9/016- INQ000467907], [CL9/017- INQ000467949], [CL9/018-INQ000467950], [CL9/019- INQ000467953], [CL9/020- INQ000467954], [CL9/021-INQ000467955], [CL9/022- INQ000467956], [CL9/023- INQ000467965], [CL9/024-INQ000467966], [CL9/025- INQ000467967], [CL9/026- INQ000467968], [CL9/027-INQ000467969], [CL9/028- INQ000245770], [CL9/029- INQ000467971], [CL9/030-INQ000467972], [CL9/031- INQ000467973], [CL9/032- INQ000467974], [CL9/033-INQ000467975], [CL9/034- INQ000467976], [CL9/035- INQ000467977], [CL9/036-INQ000467980], [CL9/037- INQ000468022], [CL9/038- INQ000468023], [CL9/039-INQ000468033], [CL9/040- INQ000468034]. A submission sent to Ministers on 3 June 2020 providing an assessment of the workforce implications arising from the first–phase mobilisation plans provided by health boards, including an assessment of risk, competing pressures, available mitigation and emerging challenges, is provided: [CL9/041-INQ000468135].

42. In June 2020 the National Clinical Director (NCD), Professor Jason Leitch, wrote to the

independent sector stating that the implementation of these changes following the decision to utilise private hospital capacity for the treatment of urgent elective procedures, predominantly urgent cancer cases, would be undertaken on a phased timeline, with cancer treatment being made available as soon as possible to support the ongoing reconfiguration in NHS boards, provided: [CL9/042- INQ000315558].

43. On 3 July 2020, the Director of Planning, on behalf of the Interim Chief Executive of NHS Scotland, commissioned the second iteration of the remobilisation plans (RMP2) from the territorial health boards. These returns, provided: [CL9/043- INQ000468050], [CL9/044-INQ000468051], [CL9/045- INQ000468052, [CL9/046- INQ000468053], [CL9/047-INQ000468054], [CL9/048- INQ000468055], [CL9/049- INQ000468092], [CL9/050-INQ000468096], [CL9/051- INQ000468102], [CL9/052- INQ000468103], [CL9/053-INQ000468104], [CL9/054- INQ000468105], [CL9/055- INQ000468106], [CL9/056-INQ000468107], [CL9/057- INQ000468108], [CL9/058- INQ000468109], [CL9/059-INQ000468110], were expected to reflect moving to safe delivery of as many normal services as possible, ensuring capacity to deal with the continuing presence of Covid-19 and preparing for the winter period. On 21 July 2020, the Director of Planning wrote to Territorial and National health boards with additional information to support their RMP2 returns, detailing the benefit of taking a consistent national approach to clinical prioritisation for elective activity while allowing for flexibility to reflect local circumstances, provided: [CL9/060-INQ000414535].The intention was to ensure available capacity was used to treat those with the most urgent clinical need and that the approach taken was consistent across the country.

44. On 21 December 2020 the Interim Chief Executive of NHS Scotland wrote to health boards regarding preparations for January 2021 and maintaining critical services in response to the restrictions announced on 19 December 2020, provided: [CL9/061-INQ000470110]. The letter advised that boards could pause all non-urgent elective and routine services during January and February 2021 to help free up capacity to manage service pressures.

45. In April 2021 John Connaghan, Gregor Smith (Chief Medical Officer (CMO)) and Alex McMahon (Chief Nursing Officer) jointly commissioned a short life working group to consider ICU baseline capacity and associated factors in preparation for winter 2021/22. The terms of reference are provided: [CL9/062- INQ000468046]. The Short Life Working Group on ICU Baseline Bed Provision provided advice on what the bed uplift should be, including the financial implications. The group was established to support the overall Redesign of Urgent Care through understanding modelling data; to inform ICU requirements ensuring effective workforce and capacity planning; and specifically to:

- Mitigate the effect of Covid-19 resurgence and / or general winter pressures on other non-Covid-19 service provision. This was largely in relation to maintaining surgical operating capacity through access to critical care and avoidance of theatre / HDU staff redeployment
- Mitigate the negative effects of Covid-19 resurgence on staff health and wellbeing and, in turn, recruitment and retention, through improved flexibility and training, minimising disruption and stress of ad hoc redeployment
- Consider optimum service models between extra consolidated ICU beds and improved staff flexibility. Balancing investment between 'ring-fenced' new ICU beds and investing in improving flexibility across wider critical care; considering opportunities to explore new ways of working, training and consolidating new role development
- Consider regional / national network support and mutual aid.

46. The group recommended that ICU beds were increased by 30, meaning that the baseline NHS Scotland ICU capacity would be uplifted from 173 to 203 beds, submission provided: [CL9/063- INQ000244267]. Recommendations of the group were aimed at building an optimal critical care model and supporting the medium-term development and long-term sustainability of ICU provision. On 1 June 2021, the CSH committed to this in a speech to Parliament during a debate on health recovery, provided: [CL9/064-INQ000292498]. The relevant section can be found on pages 17-18 of the Official Report, where the CSH is recorded as having stated that "we will permanently increase the number of ICU beds from 173 to at least 203".

47. In May 2021 the Short Life Working Group on ICU Baseline Bed Provision committed to a second phase report to provide further detail to support health boards with the implementation phase, provided: [CL9/065-INQ000468041].

48. The membership sought to understand how SG could support boards to implement the uplift of 30 beds, including the provision of appropriate facilities. In June 2021 the Chief Operating Officer issued letters to inform the mainland health boards to implement the ICU uplift in time for winter 2021–2022, including specific provisions to support island boards. An example, sent to NHS Tayside, is provided: [CL9/066-INQ000414536].

49. In November 2021, the Chief Operating Officer of NHS Scotland commissioned a second group, the ICU Uplift and Escalation Group, to provide assurance on the delivery of the uplift of 30 beds, including how the uplift would surge escalation and wider reporting arrangements. The key findings of the report, provided above, were as follows:

ICU Escalation Capacity

- Learning from earlier waves in the pandemic had suggested that it would no longer be appropriate to ask health boards to maintain the ability to double, treble, and in extremis to quadruple baseline capacity as part of escalation plans. Prior to the Covid-19 pandemic, double capacity was standard escalation policy in terms of influenza pandemic planning, with any further expansion being implemented only in extremis
- To ascertain the level of escalation capacity in the system, a review of the Winter Checklist for Covid Surge Capacity was cross-referenced with other recent returns on Covid Surge Capacity sent to SG. This confirmed that the level of available workforce to support surge capacity was now less than at the start of the pandemic due to the restarting of previously paused services, high levels of non-Covid-19 service pressure, increased staff absence in conjunction with the impact of sustained pressure on staff wellbeing and ability to recruit and retain staff
- A review of centrally SG-held equipment and consumables (i.e. smaller items used in treatment like syringes, cannulas, blood pressure cuffs or needles) had also been carried out and the required equipment and consumables remained available and sufficient to meet surge needs to support at minimum 700 ICU beds. The report recommended that SG commit to funding and maintaining this level of support until a formal review in June 2022
- A four-stage policy was proposed to reconcile standard escalation policy (i.e. baseline, doubling, in extremis) with the capacity figures submitted to SG by health boards. The revised escalation policy would provide an assessment of the level of risk in the system which would guide both Ministerial decision making and mutual aid arrangement across and within health boards.

Impact of escalation

- It was recognised that any escalation beyond Stage 2 (occupancy exceeding 300 beds) would represent a crisis situation, which would not be sustainable for a prolonged period. This level of escalation would carry significant risk and require substantial scaling back of services and redeployment of staff. Any degree of escalation would be subject to staff availability, would dilute specialist skill mix and may dilute the staff to patient ratio, all with consequent increased risk to patient safety and outcomes
- In addition, the resultant impact of increasing ICU surge capacity across acute sites on planned care would, in almost all instances, reduce planned activity. However, the reasons for this were recognised to be multifactorial across boards and therefore the

level of impact could be difficult to quantify

- Increasing the revised ICU surge capacity would require both staffing and estate to be deployed elsewhere, including but not limited to theatre nurses, anaesthetists, recovery areas, beds. Where acute sites had a significant surgical cancer commitment, these planned services would need to be retained and protected as much as possible in comparison to other sites where more routine planned surgery could be reduced considerably to accommodate ICU escalation
- Where inpatient wards were utilised for ICU escalation, day case surgery could continue but would be dependent upon staffing which again was variable across boards as a result of either vacancies or absence. Some acute sites would also be impacted differently where theatre recovery areas were being utilised for ICU, limiting the level of day case activity
- Improvement in arrangements to support mutual aid for ICU bed capacity including the development of a decision-making framework and strengthening of patient transfer capacity would, the report noted, improve overall resilience and equity of access
- The report also noted that all decisions on escalation and mutual aid should be supported by a regional and national approach to collation of bed occupancy and staff availability on the digitalised Critical Care Real Time Staffing Resource, which was at the time being developed by CNOD and due for implementation by end of December 2021.

Recalibrating and Reporting the ICU Bed Base

- The group found that as a result of health boards moving towards combined critical care units, published data suggested there could be an underreporting of ICU occupancy. In addition, there were some discrepancies between Scottish Intensive Care Society Audit Group (SICSAG) data and SG reporting
- It proposed that following implementation of the baseline and the revised escalation policy, internal SG reporting of capacity and pressures in critical care should also be updated to more accurately reflect pressure in the system
- From 2 December 2021, SG reporting was to assess occupancy levels against the new baseline of 205. However, the majority of this work – including how the new baseline would affect the reconciliation of SICSAG and SG data and capacity modelling – would be progressed and concluded following approval of the recommendations in this report

50. Following this, a further letter from the new Chief Operating Officer, John Burns, was issued to mainland NHS board Chief Executives confirming that assurance had been provided the agreed additional capacity would be in place by 1 December 2021. An example, sent to NHS Ayrshire and Arran, is provided: [CL9/067-INQ000414537].

The effects of NHS Scotland staff contracting Covid-19

Staff absence

51. From April 2020 the SG's Health Workforce Directorate (HWD) received information from the Scottish Standard Time System and the Scottish Ambulance Service relating to staff absence which included a breakdown of the reasons for absence. Before this period there was no data on Covid-related absence. During the period from April 2020 to 28 June 2022 Covid-related absence weekly rates ranged from c. 0.6% –5.8%. The table below lists monthly absence data by number of staff, from April 2020 to June 2022 and the total head count employed by NHS Scotland. This aggregated data included those who had tested positive as well as those in self-isolation or who were absent to care for children. It is therefore not possible from the available absence data to give an exact percentage of staff who contracted Covid-19 either at work or separately.

Table: Absence numbers for NHS Scotland staff from April 2020 to June 2022

Week ending	Number of staff absence by medical and dental, nursing and midwifery & other staff absences	Head count of employed NHS Scotland staff (recorded quarterly)
28 April 2020	7,235	--------
26 May 2020	6,123	--------
30 June 2020	4,452	171,574
28 July 2020	4,241	--------
25 August 2020	1,299	--------
29 September 2020	1,587	170,573
27 October 2020	2,900	--------
24 November 2020	3,173	--------
29 December 2020	2,855	172,572
26 January 2021	5,151	--------
23 February 2021	3,949	--------
30 March 2021	3,393	177,706
27 April 2021	2,710	--------
25 May 2021	1,157	--------
29 June 2021	2,356	178,025
27 July 2021	1,888	--------
31 August 2021	3,089	--------
28 September 2021	2,246	179,313
26 October 2021	1,838	--------
30 November 2021	1,771	--------
28 December 2021	3,316	180,653
25 January 2022	3,612	--------
22 February 2022	3,655	--------
29 March 2022	6,218	181,723
26 April 2022	2,989	--------
31 May 2022	1,743	--------
28 June 2022	3,739	179,849

Data source: The TURAS Data Intelligence website, an NHS Education for Scotland-run platform for sharing analytics derived from workforce and employment data held within the digital platform TURAS.

Deaths

52. The figures on staff who died from Covid-19 during the relevant period were provided to HWD from NHS Scotland health boards. This followed a letter issued to NHS Scotland's Human Resource Directors on 7 April 2020, provided: [CL9/068-INQ000414581], requesting that health boards formally notify the SG of any deaths within NHS Scotland staff during that period. This was followed up on 24 April 2020 with published guidance advising that all health boards must report the death of any NHS Scotland staff member who died from Covid-19 and confirmation that the incidents, where appropriate, were reported to the Health and Safety Executive (HSE) as advised in their guidance, provided: [CL9/069-INQ000147395].

53. Between 13 April 2020 to 20 July 2022, the SG was notified of 27 deaths by the health boards caused by or suspected to be related to Covid-19. No further notifications have been received since July 2022.

54. In these cases, it is not possible to determine from the available data whether Covid-19 was acquired whilst the NHS staff member was at work or whether it had been acquired elsewhere. There is a possibility that some health and social care workers may have acquired Covid-19 as a result of being treated as patients themselves. In some circumstances this may be known, or assumed as known, but the source of infection will be difficult to determine accurately in all cases.

Staff employment data and ethnic grouping

55. Published data supplied by NHS Education for Scotland on TURAS lists the total head count of NHS Scotland staff as shown on the table below:

Date	NHS Scotland Staff
31 March 2020	167,022
31 March 2021	177,706
31 March 2022	181,723
30 June 2022	179,849

Data source: The TURAS Data Intelligence website, an NHS Education for Scotland-run platform for sharing analytics derived from workforce and employment data held within the digital platform TURAS.

56. The following table lists equality and diversity data for the NHS Scotland workforce from 31 March 2020 to 31 March 2022. The data is split into the percentage of staff within the specific ethnic group. This data has been published on the TURAS Data Intelligence website and is therefore available online at NHS Scotland Workforce Data.

Ethnic groups	Year	% of staff	Year	% of staff	Year	% of staff
Not known	2020	15.9%	2021	18.4%	2022	18.9%
White Scottish	2020	56.5%	2021	55.1%	2022	54.9%
White – Other British	2020	8.7%	2021	8.6%	2022	8.7%
White – Irish	2020	1.2%	2021	1.2%	2022	1.3%
White – Gypsy traveller	2020	0.0%	2021	0.0%	2022	0.0%
White – Polish	2020	0.1%	2021	0.2%	2022	0.2%
White - Other	2020	3.3%	2021	3.3%	2022	3.3%
Mixed or Multiple ethnic group	2020	0.4%	2021	0.4%	2022	0.5%
Asian – Indian	2020	0.9%	2021	0.9%	2022	1.0%
Asian – Pakistani	2020	0.4%	2021	0.5%	2022	0.5%
Asian – Bangladeshi	2020	0.0%	2021	0.0%	2022	0.1%
Asian – Chinese	2020	0.3%	2021	0.3%	2022	0.3%
Asian – Other	2020	0.6%	2021	0.6%	2022	0.6%
Caribbean or Black - Black	2020	0.0%	2021	0.0%	2022	0.0%
Caribbean or Black - Caribbean	2020	0.0%	2021	0.0%	2022	0.0%
Caribbean or Black - other	2020	0.1%	2021	0.1%	2022	0.1%
African - African	2020	0.5%	2021	0.5%	2022	0.6%
African - other	2020	0.1%	2021	0.1%	2022	0.1%
Other ethnic group - Arab	2020	0.0%	2021	0.0%	2022	0.1%
Other ethnic group - Other	2020	0.3%	2021	0.3%	2022	0.3%
Declined	2020	10.6%	2021	9.5%	2022	8.5%

Data source: The TURAS Data Intelligence website, an NHS Education for Scotland-run platform for sharing analytics derived from workforce and employment data held within the digital platform TURAS.

57. The proportion of the 27 recorded NHS workers who died from Covid-19 or Covid-related causes was as follows: 55% (15) white British, 4% (1) African, 4% (1) Filipino and 37% (10)

unknown. This correlates with the proportion of staff from ethnic minority backgrounds working within NHS Scotland.

58. It is not currently possible to triangulate staff absence data with the NHS Scotland Workforce Data on the ethnic composition of the workforce, so absence percentages by ethnic group cannot be provided.

Coronavirus Life Assurance Scheme

59. On 14 May 2020, Scottish Ministers established a special temporary scheme that provided a lump sum and survivors benefits upon the death in service of those working for, or providing services on behalf of, an NHS Scotland health board, special health board, NHS National Services Scotland (Common Services Agency) and Healthcare Improvement Scotland, who did not otherwise have equivalent life assurance cover provided through NHS Pension Scheme membership. The letter from the HWD outlining the scheme is provided: [CL9/070-INQ000414575]. It was applicable only where Covid-19 was a documented factor in their death and where they had been working in clinical environments where it may reasonably be concluded that they contracted the disease while performing their duties. Full details of this scheme, which closed on 30 June 2023, including scheme rules and application form, are detailed on the pensions.gov.scot website.

60. Concerns were raised by Higher Education Institutions in relation to pre-registration students on clinical placements, and their concern around the lack of cover should any of these students contact Covid-19 on their placements and die or become disabled. The scheme was therefore extended to ensure to ensure that a single £60,000 lump-sum payment was made available to the next of kin of all students from Higher Education Institutions who undertook clinical placements on NHS premises as part of a programme of study. The relevant Ministerial submission is provided: [CL9/071- INQ000244369], as is the letter provided to Health Boards: [CL9/072- INQ000468133].

61. In total 19 claims were paid out from a total of 21 applications to this scheme, with the total payout to claimants and families being £1.438 million.

Recording of deaths

62. The certification of a person's death is a matter that falls within the clinical responsibility of medical practitioners, who must be satisfied, on the balance of probabilities, as to the likely

cause of death. Medical practitioners are aware that the medical certificate of a cause of death (MCCD) is a legal document and information included in such a document must be made to the best of their knowledge and belief.

63. Scotland's CMO, jointly with Police Scotland, the Crown Office and Procurator Fiscal Service (COPFS) and the National Records of Scotland (NRS), issued guidance to doctors for death certification during the Covid-19 pandemic. This guidance was issued to support doctors in making the most appropriate determination when certifying a death. The guidance was (and is) kept under review to ensure it included best practice and was in line with the most up-to-date information. All iterations are provided: [CL9/073-INQ000316375] [CL9/074-INQ000222906], [CL9/075- INQ000222907], [CL9/076- INQ000316374].

Primary Care

64. The SG set out its overall guidance for General Practitioners (GPs) on 17 March 2020, provided: [CL9/077-INQ000414584]. The *National Supporting Guidance for Scottish General Practice* brought together a range of guidance to support GPs, General Practice nurses, practice and community nursing teams, other clinicians in the multidisciplinary team, and practice management and administration staff to coordinate response activities for the Covid-19 pandemic. This was developed and collated by the Primary Care Division in the SG on the basis of advice provided by its professional and clinical advisors. It was accepted and co-signed by both the British Medical Association's (BMA) Scottish General Practitioners Committee and the Royal College of General Practitioners (RCGP).

65. GPs were advised to view the guidance alongside the joint SG, BMA and RCGP letter to GP practices issued on 13 March 2020, provided: [CL9/078-INQ000280657], as well as the Circular to Health Boards issued by the SG on 5 March 2020, provided: [CL9/079-INQ000414585].

Use of technology for remote appointments

66. The guidance, as provided above [CL9/077-INQ000414584], noted that following the publication of *Annex C: Suspension of Online Booking Systems* all online appointment systems should be suspended with immediate effect.

67. GPs were advised to send SMS (text) notifications to all patients with a link to NHS Inform making patients aware of the screening criteria for triage and where to get help and advice.

68. The video consulting service Near Me (powered by the Attend Anywhere platform, a browser-based video call application) provided video-based access to appointments across Scotland. Originally NHS-only, from October 2020 it became available across a range of public services offering convenience and flexibility and reducing the need for travel.

69. GPs were advised to implement NHS Near Me (Attend Anywhere) in the practice for all appropriate consultations. The guidance noted that NHS Near Me could also be utilised to support remote working, although access to the patient's clinical record would be required.

Triage of patients prior to in-person consultation

70. The SG guidance in March 2020 quoted the following advice from Health Protection Scotland:

"Triage of Patients: Primary Care practices are advised to make every effort to triage patients by telephone to avoid the patient presenting at the practice unnecessarily and minimising any contact with patients with respiratory symptoms. Practices should consider if they are going to triage all appointment requests into the practice or only triage COVID-19 calls. They should also consider if initial clinical triage and follow up consultation will be done as one call or as two separate interactions."

71. The guidance further noted that there were a number of actions which practices should implement / consider as a matter of urgency:

- Suspend online booking systems;
- Introduce processes to triage all appointment requests (on the day or in future)
- Identify the most appropriate clinical members of the practice team to carry out this role and ensure that they have appropriate internal training, guidance and support to carry out this role
- The RCGP Action Cards should be reviewed and amended to reflect the agreed practice processes if required and then circulated to the appropriate members of staff
- Review all current booked appointments with all clinical staff and consider if they need to go ahead or could be changed to a telephone or NHS Near Me remote consultation instead
- Have clear, prominent and up to date signage at the entry door to the practice and on external windows regarding coronavirus (such as "do not enter if anyone in your home has a cough or fever – go home and call practice")

- Inform patients the practice website, social media, texts etc. as well as posters in the waiting room and notices on practice information screens not to come to the practice
- Consider the use of social media such as Facebook and Twitter to communicate with patients and share links to NHS Inform
- Consideration should be given as to how to communicate with vulnerable groups such as frail elderly, learning disabilities and other vulnerable groups
- Put an up-to-date Covid-19 message on the practice phone line advising patients of the screening criteria (for those who should not come into the practice without phoning for triage) and directing appropriate patients to the NHS Inform website
- Send SMS (text) notifications to all patients with a link to NHS Inform making patients aware of the screening criteria for triage and where to get help and advice
- Implement NHS Near Me (Attend Anywhere) in the practice for all appropriate consultations.

72. GPs were advised that decisions on whether to continue to bring in some patients for face-to-face consultations or use alternatives (such as a telephone or NHS Near Me reviews) should be based on a clinical judgement considering the balance of risk and benefit.

Changes to GP home visits

73. GPs were advised in March 2020 that practices should start taking steps to review the broad spectrum of current GP services to assess how additional capacity might be released if required. Any decision on whether to suspend or limit services would need to be based on clinical judgement and on the risk to patients (in particular considering the needs of vulnerable patients).

74. Included among the areas that could be considered for review by the practice were home visiting protocols and any other routine visits such as community hospitals or care homes.

Advance care plans and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) notices

75. The guidance advised practices to review vulnerable patients' Anticipatory Care Plans and Key Information Summaries (KIS) and noted this could also be an opportunity to discuss issues such as DNACPRs or Power of Attorney with patients.

Referral of patients to secondary care

76. The guidance did not cover the referral of patients to secondary care because advice to GPs on referrals to secondary care would primarily come from their own health boards which work out local pathways (i.e. agreed steps that will be taken to provide care to patients through different healthcare services).

Management of patients with long-term health conditions

77. GPs were advised that practices should start taking steps to review the broad spectrum of current GP services to assess how additional capacity might be released if required. Any decision on whether to suspend or limit services would need to be based on clinical judgement and on the risk to patients (in particular considering the needs of vulnerable patients). Included among the areas that could be considered for review by the practice were long term condition / chronic disease reviews.

Repeat prescriptions and medication reviews

78. GPs were advised to:

- Review their repeat and acute prescription request processes to reduce or stop the need for patients to present at the practice to request their prescriptions
- Discourage patients from requesting prescriptions over the telephone to ensure that practice phone lines were not blocked with non-urgent requests
- Consider the needs of vulnerable patient groups when developing new prescribing systems or arrangements
- Consider how all prescribing clinicians could best utilise their skills
- Introduce or maximise online repeat prescription processes where possible
- Consider arrangements such as Community Pharmacy for vulnerable patients who might find it difficult to order their medication online
- Not make changes to repeat prescription durations or support patients trying to stockpile to avoid putting a strain on the supply chain and exacerbating any potential shortages
- Consider putting suitable patients on serial prescribing as soon as possible on a staggered basis
- Consider the process for passing signed prescriptions to local community pharmacies to reduce the number of staff interactions

- Consider the process for the management of prescriptions for telephone, NHS Near Me and remote working consultations
- Consider alternative ways in which patients could collect their medication without having to present at the dispensing practice.

79. As set out above, GPs were advised that practices should start taking steps to review the broad spectrum of current GP services to assess how additional capacity might be released if required, taking into consideration the needs of patients, particularly vulnerable patients. Included among the areas that could be considered for review by the practice were medication reviews.

Guidance on at-home care

Self-isolation

80. NHS Inform was the primary source of population-wide self-isolation guidance and Covid-19 information for the public throughout the pandemic. NHS Inform is Scotland's national health information service and includes the provision of both telephony advice and support as well as online information. It also provides a self-care tool for different conditions, and signposts advice on where to access relevant medical or other support. Guidance on self-isolation periods on NHS Inform was agreed by the SG and NHS Inform colleagues, including clinical input, following Ministerial decisions on any changes to guidance. These decisions were underpinned by advice from SG clinicians and PHS public health advice.

81. The key amendments to population-wide guidance between March 2020 and May 2022 (when 'stay at home guidance' replaced self-isolation guidance) included:
    - 13 March 2020 – All people with symptoms of coronavirus should stay at home for seven days
    - 30 July 2020 – All people with symptoms of coronavirus should stay at home for 10 days. Contacts of a positive case should stay at home for 14 days
    - 14 December 2020 – All people with symptoms of coronavirus, and close contacts, should isolate for 10 days
    - 3 August 2021 – Fully vaccinated close contacts of a positive case could end isolation on receiving a negative PCR test result
    - 6 January 2022 – The isolation period was reduced from 10 to seven days for people who were fully vaccinated and tested positive. Close contacts of a positive case who were fully vaccinated were no longer requested to isolate

but instead asked to take an LFD test for seven days and only isolate from when one of those tests was positive

- 1 May 2022 – Stay at Home guidance was introduced, replacing population-wide isolation guidance, which broadly mirrored UK Government guidance that moved away from the concept of isolation periods and requested that people stay at home when they were unwell and had specific symptoms

82. Sector-specific isolation guidance, for instance in relation to health and social care workers, clinical settings or Critical National Infrastructure (CNI) exemption schemes, were provided through alternate means.

83. The SG's Highest Risk List Division (HRL), formerly the Shielding Division, also issued communications to those at highest risk via SMS or provided input into letters issued by the CMO for Scotland. Where advice was issued to the general public, extra advice was shared with highest risk people. This advice would typically recommend extra caution but would ultimately suggest they should continue to follow the advice of their GP or specialist clinician, who best knew their health condition and circumstances.

84. Advice from the SG for those with respiratory diseases was to take up the offer of a booster when invited for vaccination and to stay at home or wear a face covering if they felt unwell with a respiratory infection.

85. HRL signposted help with transport to vaccination appointments through the National Vaccination Helpline who would link individuals with local support services.

86. HRL agreed to fund the National Assistance Helpline, which was to be run by local authorities. The helpline was established to help people on the highest risk list access food, medicines and other support services.

87. HRL also published a *Balancing the Risk of Daily Activities* booklet, provided: [CL9/080-INQ000327747], which comprised guidance on how to make things like work, shopping and healthcare as safe as possible, as well as sources of support including mental health support.

<u>Seeking further advice and medical attention</u>

88. Information on how to contact NHS services for advice was provided on the NHS Inform website. Besides the guidelines on self-isolation mentioned above, guidance on testing,

vaccines and self-help on Covid-19 was set out. Whilst this website is overseen by NHS 24, a special health board, the SG had a role in jointly agreeing some of the messaging set out on NHS Inform relating to Covid-19 guidance on testing, isolation and vaccination.

89. NHS Inform also included guidance on when to seek medical attention as part of the self-care and self-help information provision on Covid-19. The SG did not have specific input into the provision of clinical care recommendations through NHS Inform or other platforms.

Ante-natal care, maternity services, postpartum and neonatal care

Plans up to 1 March 2020

90. No NHS Scotland national level plans were put in place specifically for antenatal care, maternity services and postpartum care between notice of Covid-19 first being received and 1 March 2020. However, discussions of these subjects had commenced at a UK level, and on 9 March 2020, the guide *Coronavirus (COVID-19): Infection in Pregnancy*, provided: [CL9/081-INQ000176662], was published by the Royal College of Surgeons, Royal College of Midwives, Royal College of Paediatrics and Child Health with input from the Royal College of Anaesthetists, Public Health England and Health Protection Scotland, based on the evidence available at that time.

Guidance and care delivery from 1 March 2020 onwards

91. SG officials from the Maternity and Neonatal Policy Team, alongside Professional Advisors from the CMO Directorate and CNO Directorate (Midwifery, Obstetric and Paediatric), established weekly meetings with Obstetric Clinical Directors and Heads of Midwifery (these were sometimes twice weekly at the start of the pandemic). All Covid-related issues relevant to maternity services were discussed at these meetings, including:
    - The maintenance of antenatal care
    - Online / remote access to maternity care and services
    - The availability of midwives, specialist obstetricians and other maternity staff
    - The availability of resources, including clinicians, for caesarean deliveries
    - The impact of infection control measures in hospitals
    - The management of miscarriages and ectopic pregnancies
    - The availability of resources to assist with home births
    - The availability of birthing pools, pain relief and anaesthetics; timely access to emergency services for maternity care

- The nature and number of healthcare staff present in delivery suites
- The average length of postnatal hospital stays.

92. On 9 June 2020, as part of remobilisation plans, the SG's Directorate for Children and Families wrote to all Scottish NHS board Heads of Midwifery asking them to return a template outlining the current maternity service provision, including staffing levels, and service provision in antenatal, intrapartum and postnatal care. It was requested that this information be returned on a monthly basis. A summary report of replies received was compiled, provided: [CL9/082-INQ000468047]. Details of responses from individual health boards can be found within this report, but in summary, areas covered included levels of midwifery staffing, availability of obstetric consultants and trainees, availability of consultant anaesthetists and trainees, the percentage of antenatal appointments that were not attended by patients, and what support was available at the antenatal, intrapartum and postnatal stages (including mental health support, remote appointment provision, provision of epidural analgesia, infant feeding support, and infant screening services).

93. The SG decided not to seek the return of subsequent templates owing to:
    - The emergence of further waves of the pandemic and the changing variation in Covid-19 levels between boards
    - The ongoing staffing pressures within services and the variable impact that this had from day to day and week to week on services
    - The incomplete nature of the returns received. All boards responded to the first request, but it took time and some boards provided incomplete answers.

94. The decision not to seek further returns was taken by the Maternal and Infant Health policy team later in the summer of 2020, in discussion with professional advisors. Heads of Midwifery and Obstetric Clinical Directors had reported that completing the template was difficult and time consuming. Whilst SG gleaned a lot of information from the template and it informed further development of the guidance document *Delivering Maternity Services Through the COVID Pandemic*, it underlined what was already known about pressures in the system from regular engagement with Heads of Midwifery and Obstetric Clinical Directors. The situation was changing rapidly at the time and lockdown restrictions were starting to be imposed at a local level, so SG were introducing variations in what could be provided in different parts of the country. The decision to stop the collection of data was based on the balance of the resource required locally to compile and return the template with the limited added value from having the information.

95. As a result, other than the incomplete set of returns included above, there is no systematically collected national data covering the delivery of maternity services. In reaching the decision the policy team considered the impact of the absence of the data; however, as mentioned above, this was balanced against asking hard-pressed staff to spend time compiling a return which delivered limited added value to the information already held. SG are not aware of any specific practical impact of not continuing to collect that information. If specific questions arose around service delivery – for example though queries via Ministers' offices, media, social media, correspondence or Parliament – then SG officials would follow up directly with the relevant board for response.

Primary guidance for maternity and neonatal services

96. The SG Children and Families Directorate published guidance on 3 April 2020 entitled *Maternity COVID-19 Planned Care / Service Minimum Standards*, provided: [CL9/083-INQ000414587]. This guidance outlined minimum agreed standards for planned maternity and neonatal care during the state of emergency declared for the coronavirus and described which services should be stopped, adapted, continued or commenced across antenatal, intrapartum and postnatal care.

97. The first iteration of the guidance was developed at speed to give clarity to maternity services on minimum agreed standards for planned maternity care during the declared state of emergency. It reflected areas where discussions or other intelligence had revealed emerging variation in practice. On clinical issues, the guidance was based on evidence or expert advice, or an extension of that advice into those service areas. The guidance set out the expectation that all boards would adapt to local circumstances and continue to provide the maximum amount of scheduled antenatal and postnatal maternity care, and birth options as possible in relation to local staffing and other circumstances, reducing to the minimum only as a last resort. It also set out the expectation that boards would return to normal service provision as quickly as possible once the state of emergency was lifted and staffing returned to normal. Boards were encouraged to maximise the use of Near Me / Attend Anywhere / phone technology to deliver as much care to women in their home or near home as possible to minimise attendance at maternity units. It also set out expectations in relation to delivery of the Best Start policy programme in that where boards had capacity, work could continue with an expectation that normal service and Covid-19 work would be prioritised. The guidance outlined that data would not be collected in relation to Best Start or expected in relation to national audit programmes. In relation to the national mortality audit, the Mothers and Babies

Reducing Risk through Audit and Confidential Enquiry (MBRRACE-UK) surveillance system, a UK-wide information-gathering and audit programme looking at maternal deaths, stillbirths and infant deaths which has run since May 2012, teams were asked to submit as much data as possible while balancing this with their clinical duties.

98. There are over 40 distinct service recommended actions within the first version of the guidance, and more in the four subsequent versions, provided: [CL9/084- INQ000414539], [CL9/085- INQ000467905], [CL9/086- INQ000414540], [CL9/087- INQ000320538]. For many of the recommendations, the third column (titled 'Details/Alternatives') cites the expert guidance behind the action. For example, the action of ceasing CO monitoring (that is, the monitoring of carbon monoxide levels in pregnancy through a breath test usually administered during the first antenatal appointment) resulted from guidance from the National Centre for Smoking Cessation and Training and the Royal College of Obstetricians and Gynaecologists (RCOG), and on water birth following guidance from the Royal College of Midwives / RCOG.

99. Many of the other changes were based on some of the fundamental elements of the Covid response, such as reducing face-to-face contact as much as possible to reduce risk of infection, including changes to antenatal parent education classes and changing delivery methods for antenatal and postnatal care to include use of the Near Me video appointment service where appropriate. The guidance also recommended care at home as much as possible, and reducing visitors in line with national guidance, although birth partners remained as essential visitors throughout the pandemic.

100. Version 3 reflected the introduction of the National Route Map and 'phases' (July version) and then in December Version 4 reflected the SG's Strategic Framework with the five protection levels (0-4). The final version (September 2021) reflected remobilisation and ongoing Covid- 19 management.

101. All versions of the guidance were developed jointly by the Maternal and Infant Health policy team and SG professional advisors. The guidance was developed in close consultation with Heads of Midwifery and Obstetric Clinical Directors through a weekly Webex call and by email. RCM, HIS, and NES were also involved in the weekly Webex meetings and invited to comment.

102. The guidance complemented the *National Clinical Guidance for Nursing and AHP Community Health Staff during Covid-19 Pandemic* (3 April 2020). It was shared with the Royal College of Midwives, the Scottish Heads of Midwifery Group and the Scottish Obstetric

Clinical Directors Group prior to publication and their comments taken into account. SG does not hold a copy of their comments or the specifics of how they were applied.

103. The guidance differed from clinical practice or guidelines in place prior to the pandemic, for example the National Institute for Health and Care Excellence (NICE) Guidelines, Keeping Childbirth Natural and Dynamic (KCND), Maternity Pathways Guidance (Scotland), Royal College of Obstetricians Guidelines and Royal College of Midwives Guidelines. The main differences were in changes to delivery of services in light of the pandemic restrictions, including cessation of face-to-face group classes, cessation of carbon monoxide monitoring, and outlining specific visiting requirements for maternity, in line with advice and guidance produced for the pandemic, as highlighted previously. In regular discussions with Heads of Midwifery, Obstetric Clinical Directors and Neonatologists, SG was aware of both staff concerns and concerns raised by service users as in relation to service changes and other aspects of the pandemic. These were also highlighted through correspondence, Parliament and media. These sources allowed common concerns to be identified and addressed either in guidance, or in other areas, for example to colleagues leading on visiting, PPE or testing. A Covid-19 Impact Assessment was undertaken in April 2020, coordinated by the Professional Advisory Group (PAG) secretariat and subsequently published. Maternity policy interests were represented in that Impact Assessment.

104. On 19 May 2020 an updated version of the guidance was circulated, provided above [CL9/084-INQ000414539], which amended the previous guidance and included updates to signpost other relevant published guidance (such as on telemedicine / Near Me and SG guidance on proactive management of critical care). The same groups were consulted on this version of the guidance. Seven versions of the guidance were published between April 2020 and June 2021 each new version had changes based on the evolving understanding of the pandemic and how to respond. The first version was circulated on 8 April 2020. In the 19 May 2020 version, the additions to the previous version were highlighted in yellow. There were approximately 21 changes to the second version of the guidance. These primarily signposted new guidance which had been published since the previous version, including guidance on workforce planning for midwifery issued by CNO, guidance on use of telemedicine in maternity issued by the Perinatal Network, guidance on occupational health concerns for pregnant women in the workplace issued by RCOG, and guidance on critical care in maternity services issued by SG. It also highlighted new support infrastructure such as the National Assistance Helpline, information on the Neonatal Expenses Fund, advice on birth registration, and signposted leaflets / online information for parents. As before, SG content changes to the guidance were made in discussion with the clinical forum and policy officials consulted with

clinicians on the revised version. However, there are no retained records of the comments received in relation to the amendments.

105. In December 2020 a further update to the guidance was published titled *Guidance for Delivering Maternity and Neonatal Services During the COVID-19 Pandemic*, provided: [CL9/086 INQ000414540]. It noted that this version superseded the Maternity Covid-19 Planned Care / Service Standards. The document was based on the Covid-19 infection virus levels that were in place at the time as described in *Scotland's Covid-19 Strategic Framework,* provided: [CL9/089-INQ000339830], and also included information on testing, remobilisation, training and neonatal care. Again, the same groups were consulted on this version, though comments are not retained. The changes in this version primarily reflected the move to Covid-19 levels 1-4 and the guidance was aligned with the framework guidance for those levels.

106. In September 2021 a further update to the guidance was published, entitled *Delivering Maternity and Neonatal Services through the COVID-19 Pandemic: Beyond Level Zero*, provided: [CL9/087 - INQ000320538]. This was set within the context of further development of Covid levels and remobilisation guidance and as per previous versions, included staffing guidance in the Annex. This version provided updated guidance for NHS Boards on the management of maternity and neonatal services in Scotland in its continued response to Covid-19 and to aid Boards with local service planning. It provided a collation of guidance relevant to the essential provision of maternity and neonatal care and how that should be applied to meet the needs of women and families. It was set within the context of the relevant version of Scotland's Covid-19 Strategic Framework and the move from the Levels system to a focus on normal delivery of care alongside a response to local pressures. It noted the emergence of the Omicron variant alongside recovery activity. It noted commencement of research to capture women's experience of care during Covid-19, and it also noted latest guidance on testing. In addition, it highlighted the advice that vaccination was strongly recommended during pregnancy, as pregnant women had been categorised as 'at risk' and part of priority group 6.

107. This guidance was shared ahead of publication with Heads of Midwifery, Obstetric Clinical Directors and Neonatal colleagues, though officials have been unable to locate records of inputs or outcomes of discussions in relation to this version of the guidance. From officials' recollection of the engagement with clinical staff at the time, they had by this point moved to monthly Covid-19 meetings with Heads of Midwifery and RCM, and with Obstetric Clinical Directors and the neonatal community. The guidance was circulated for discussion with this group to invite discussion, and ongoing comment and updates would have been picked up in

the context of those meetings.

Home monitoring

108. In April 2020 there was a request to facilitate the rapid expansion of home monitoring to reduce the requirement for pregnant women to attend in-person maternity services. The impetus for looking at this was to reduce risk of virus transmission by reducing the requirement to attend hospital and find alternative methods to deliver care, in particular for those who were shielding. In the case of very high-risk pregnant women, in some cases they may have been attending clinics weekly for blood pressure monitoring and urinalysis. SG co-ordinated mobilisation of an expert group to develop clinical guidance and information leaflets for women, and separately worked with NSS on procurement of home monitoring equipment. The expert group was pulled together by the Scottish Perinatal Network and the SG. They produced and published a Service Pathway, guidance and an information leaflet for pregnant women for maternity services on home blood pressure monitoring, provided: [CL9/091- INQ000414542], [CL9/092- INQ000414543], [CL9/093- INQ000414544]. In addition, the SG procured and distributed to NHS Maternity Services (through NHS National Services Scotland) over 1000 approved-in-pregnancy blood pressure monitors and cuffs and home urinalysis kits.

Guidance on infant feeding

109. The SG developed and issued guidance for infant feeding services, first issued on 31 March 2020, provided: [CL9/094- INQ000414545]. The guidance outlined that the infant feeding services delivered throughout NHS boards should continue to deliver the minimal standards which would protect the establishment and maintenance of breastfeeding and safe formula feeding.

110. The SG worked with Health Protection Scotland, the SG Covid Co-ordination Unit, Chief Nursing Officer Directorate (CNOD) (oversight by CNOD Covid Co-ordination Team), professional advisors in Government, the Breastfeeding Leadership Team (board leads) and Maternal and Infant Nutrition leads, linked into Health Visiting Leads and Family Nurse Partnership (FNP) leads locally to develop the guidance.

111. The SG subsequently managed the implementation of this guidance through regular reporting from health visiting / FNP teams and with their leads on a weekly, later fortnightly, basis.

Nursing and Community Health – staff guidance

112. Clinical guidance was developed for all NHS staff working in community and Health and Social Care Partnerships (HSCPs) during Covid-19, and published on 7 April 2020, provided: [CL9/095- INQ000114287]. It included sections on Children and Young People and Community Child Nursing, which outlined the proportionate and risk-based approach to visits, contacts and assessments of children and young people across Scotland, and also included guidance on infant feeding, looked-after children and shielding.

Visiting guidance (maternity and neonatal)

113. Guidance on visiting in maternity and neonatal settings was included within Scottish Covid-19 hospital visiting guidance. In July 2020 service-specific guidance was issued to maternity and neonatal services on person-centred visiting in those services. This guidance supplemented the national guidance on visiting (published on 30 June 2020) and reflected the specific circumstances of visiting in maternity and neonatal services and followed a significant number of queries on how these changes applied across maternity and neonatal settings from midwives, members of the public, MSPs and the media. This guidance is provided, as is the updated version from November 2020: [CL9/096- INQ000468048], [CL9/097- INQ000468049].

114. Guidance outlined the approach to visiting in antenatal, intrapartum and postnatal settings, and highlighted particular circumstances that should be considered. In particular, the guidance highlighted that, in the antenatal period, women could identify one supportive person to accompany them to antenatal or postnatal appointments and scans, provided that person was not ill or showing any symptoms of coronavirus. It also highlighted, in guidance on antenatal and postnatal home visits, that where anyone in the family home did not live in the same household, they must observe indoor physical distancing in line with the general guidance when maternity staff were visiting. Regarding labour and birth it highlighted that women could be accompanied by a birth partner (as an essential visitor) and a second birth partner if requested, in an obstetric, alongside or freestanding midwifery unit, and for a home birth subject to the need to maintain physical distancing wherever possible. It also allowed women to be accompanied during induction by their partner. In postnatal care, it outlined that women could identify one designated visitor who would be able to visit them whilst in hospital, on the antenatal and postnatal ward in addition to one birth partner (as an essential visitor). It also stated that where women required additional support in the form of, for example, a carer, advocate or translator, or, in the case of a minor, a parent, this person could attend in addition

to the first support person.

115. In neonatal care the guidance outlined that parents should not be viewed as visitors in neonatal care. It also included guidance on the return to person-centred visiting aligned to the phases.

116. The guidance was developed with SG professional advisers and visiting policy colleagues to ensure consistency, and also in discussion with Health Protection Scotland colleagues. This guidance was revised and reissued in December 2020 to reflect the changing Covid circumstances at that time, and introduced guidance associated with the Covid-19 levels zero to five, with five being the most restrictive (a return to essential visiting only) and zero being more permissive with additional visitors described. The guidance was described as 'minimum standards' and suggested boards should consider whether additional visitors could be enabled throughout care, subject to local context, risk assessment and individual patient needs. It also highlighted that boards could consider exceptions on a case-by-case basis, for example on compassionate grounds to allow attendance in end of life situations. Appended to the guidance was a set of Q&As which answered some frequently asked questions, for example on attendance of children.

Covid-19 general guidance

117. General Covid-19 clinical guidance for maternity and neonatal care, including guidance on managing patient flow through maternity services, was issued from SG. Guidance issued 8 April 2020 is provided earlier in the statement [CL9/083-INQ000414587], as is guidance issued 18 May 2020 [CL9/084-INQ000414539]. Guidance published 26 July 2020 is provided: [CL9/098- INQ000343330], guidance issued 1 December 2020 is provided earlier in the statement [CL9/**086 -**INQ000414540], as is guidance published 1 September 2021 [CL9/ **087 -** INQ000320538].

Guidance for women on maternity care

118. The SG and PHS jointly developed a *COVID-19 Information for Pregnant Women* information leaflet providing guidance on maternity care during the pandemic, provided: [CL9/099-INQ000414547]. The leaflet was updated as information evolved. PHS and SG also worked jointly to develop Covid-19 information for pregnant women on the NHS Inform website.

119. The leaflet was first published on 15 April 2020. The information in the leaflet and on NHS Inform was reviewed and updated regularly as required.

120. Maternity professionals in SG, PHS and in NHS Scotland contributed to the development of the advice.

121. No previous guidance or advice on coronavirus in pregnancy existed before the pandemic.

Information leaflet for families on care for babies

122. The SG and Public Health Scotland jointly developed an information leaflet COVID-19 Parent Information for Newborn Babies, provided: [CL9/100-INQ000414548], providing guidance on caring for newborn babies during the pandemic. PHS Scotland and the SG also worked jointly to develop Covid-19 information for new parents on the NHS Inform website. This information was also reviewed and updated regularly as required.

123. The leaflet was first published on 15 April 2020. The information in the leaflet and on NHS Inform was reviewed and updated regularly as required.

124. Paediatric and maternity professionals in SG and in NHS Scotland contributed to the development of the leaflet and advice. This information was also reviewed and updated regularly as required.

125. No previous guidance or advice on the care of babies in relation to coronavirus existed before the pandemic.

Online antenatal classes

126. Antenatal classes (including parent education) prior to the pandemic were traditionally delivered face to face in a group environment in a health setting (such as a clinic). With the advent of Covid-19 and the introduction of lockdown instructions to stay at home and cease all non-essential contact, the introduction of physical distancing measures to prevent spread of infection, and the unknown impact of the virus on pregnant women, it was no longer possible to deliver group antenatal classes in a classroom setting. SG issued advice to boards to stop group antenatal classes in April 2020 in the Covid-19 maternity guidance (highlighted above – this was circulated to all maternity services via Heads of Midwifery and Obstetric Clinical

Directors and also copied to Medical and Nurse Directors in NHS boards). In light of this advice to stop group antenatal care, the SG procured an online antenatal course, the Solihull Online Antenatal Course, and made it freely available to all pregnant women in Scotland, via advertising on NHS Inform and the parentclub.scot website. A flyer was produced, and stocks circulated to all maternity services to give to pregnant women advertising the course and how to access it, provided: [CL9/101-INQ000414549]. Some health boards were able to move elements of antenatal education to online platforms over time (such as hypnobirthing classes).

127. The leaflet advertising the online course and how to access it was first circulated to Heads of Midwifery, Health Visitor Leads and Family Nurse Practitioner leads on 17 April 2020.

128. SG policy teams and professional midwifery advisors reviewed the content of the course and worked with the course providers to reflect Scottish-specific content. It was then validated and released.

129. Prior to the pandemic antenatal education was usually via local face-to-face antenatal classes provided by the health board. The online course was rolled out as a temporary replacement until such time as face-to-face classes could resume.

Vaccination advice, information leaflet and campaign

130. The SG provided extensive guidance on Covid-19 vaccination in pregnancy.

131. The SG followed Joint Committee on Vaccinations and Immunisations (JCVI) advice on Covid-19 vaccination in pregnancy. Initial JCVI advice in December 2020 indicated that while the available data at that point did not indicate any safety concern or harm to pregnancy, there was insufficient evidence to recommend routine use of Covid-19 vaccine during pregnancy.

132. It was recommended that Covid-19 vaccination in pregnancy should be considered where the risk of exposure to Covid-19 infection was high and could not be avoided, or where the person had underlying conditions that put them at very high risk of serious complications. The advice emphasised that in such circumstances, clinicians should discuss the risks and benefits of vaccination with the woman, including the absence of safety data for the vaccine in pregnant women. This guidance was formally issued through a CMO letter on 1 January 2021, provided: [CL9/102-INQ000376306].

133. This approach was followed within the Flu Vaccination and Covid-19 Vaccination programme (FVCV) until further advice for this group was offered by JCVI in Spring 2021. In April 2021 the JCVI updated its advice relating to vaccination during pregnancy. Based on new data that showed no safety concerns in around 90,000 pregnant women who were vaccinated, the JCVI advised that those who were pregnant should be offered vaccination at the same time as non-pregnant people, based on their age and clinical risk group. The data from the study in the United States involved mainly mRNA vaccines, including Pfizer-BioNtech and Moderna. On that basis the JCVI recommended that Pfizer or Moderna vaccines should be used for this group where available. Those who had already received their first dose of the AstraZeneca vaccine were recommended to continue with AstraZeneca for their second dose. This change was communicated to health boards via CMO letter on 7 May 2021, provided: [CL9/103-INQ000414577].

134. A further CMO letter was issued on 18 August 2021 requesting health boards encourage pregnant woman to take up the offer of Covid-19 vaccination, provided: [CL9/104-INQ000235116].

135. This guidance was supplemented by campaigns from the SG Marketing and Communications team, promoting vaccine uptake in pregnant women.

Door-drop information

136. Information sent to Scottish households as part of door-drop campaigns included guidance for those who were pregnant.

Guidance for Pregnant Healthcare Staff

137. The HWD provided a single national guidance document on coronavirus directing NHS Scotland staff to verified sources of advice. This was first published on 30 March 2020 and regularly updated to reflect the latest scientific evidence, ensuring a best practice approach to staff and patient safety, provided: [CL9/105-INQ000414550]. The guidance listed various subjects including but not limited to health conditions, BAME staff and pregnancy. The pregnant workforce were directed to the Royal College of Obstetricians and Gynaecologists' guidance on what healthcare workers should do if they were pregnant during the pandemic.

138. On 24 April 2020, version four of this guidance, provided: [CL9/106-INQ000414551], was updated, with amendments to the section for pregnant healthcare workers that reflected the Royal College of Obstetricians and Gynaecologists advice of 21 April 2020.

139. On 3 July 2020, version nine of this guidance was published, provided: [CL9/107-INQ000414552], with amendments to the section for pregnant healthcare workers following the Royal College of Obstetricians and Gynaecologists advice, which had been updated on 22 May 2020.

140. On 28 July 2020, version 10 of said guidance was published, provided: [CL9/108-INQ000414553]. HWD advised that a Covid-19 occupational risk assessment should be used to undertake individual risk assessments for all pregnant workers. It recommended that staff continue to follow RCOG advice setting out how to conduct a risk assessment when pregnant.

141. On 13 January 2021, version 12 of said guidance was published, provided: [CL9/109-INQ000414554]. HWD advised that pregnant staff should continue to follow the UK-wide advice for pregnant employees.

142. On 22 November 2021, a Director's letter was published and issued to NHS Scotland boards setting out how UK-wide pregnancy guidance affected staff, provided: [CL9/110-INQ000414555]. This followed the Department of Health and Social Care (DHSC) revised guidance for pregnant employees and their employers, which had been updated on 2 November 2021.

143. On 25 May 2022, the SG contacted stakeholders to confirm that the Covid-19 occupational risk assessment tool and UK guidance on pregnant staff had been withdrawn, provided: [CL9/111-INQ000414556]. This meant there was no longer a specific approach to managing a pregnant employee's risk from Covid-19. However, the non-Covid-specific risk assessment process for pregnant staff was still to be followed.

Pre-existing guidance

144. Prior to the pandemic, the HSE had already produced UK-wide risk assessment guidance for pregnant workers, provided: [CL9/112-INQ000414557]. This guidance remained extant throughout the pandemic and still stands today. The HSE stipulates that:

"Employers are responsible for providing a safe working environment while effectively managing risks to the health and safety of all workers, including women of a childbearing age. You must carry out an individual risk assessment for pregnant workers and new mothers. This applies to workers who:

- *are pregnant*
- *have given birth in the last 6 months, or*
- *are currently breastfeeding."*

145. The legislation underpinning this guidance was (and is) also outlined on the HSE website, provided: [CL9/113-INQ000414558].

Assessment of the willingness of pregnant women to seek care

146. There were no specific data or reports giving consideration to the willingness of pregnant women to seek care during the period in question. The DGHSC received anecdotal feedback from services via weekly Heads of Midwifery and Obstetric Clinical Director meetings that indicated that some women were concerned about in-person attendance at appointments owing to risks of contracting Covid-19 themselves, or passing it on to vulnerable family members (in particular those with health conditions that would put them or family members into the shielding category).

147. In 2021, jointly with PHS, SG commissioned the *COVID Experiences of Pregnancy Study*. The study surveyed women who were pregnant during the Covid-19 pandemic and HSC staff to identify how maternity care was experienced. The study was carried out by researchers at the University of Aberdeen and the University of Dundee.

148. The report *Perinatal Experiences during the COVID-19 Pandemic in Scotland* was published on the outputs of this study on 6 April 2022, provided: [CL9/114-INQ000202968].

Assessment of the impact of the pandemic on the delivery of neonatal care

149. Similar to maternity services, a weekly meeting was convened by the Scottish Neonatal Network, and a lead neonatal clinician from each board was invited. DGHSC was represented at all of the Neonatal Covid-19 meetings by a member of the Maternal and Infant Health team. SG's senior medical advisor for paediatrics also attended many of the meetings. This was an opportunity to discuss emerging issues, find answers and solutions, to share information on activity at a national level, and to discuss emerging good practice at a local level. Issues that emerged through this forum which needed to be addressed at a national level could then be raised in the appropriate forum. The main issues of concern were sourcing and sharing of clinical information about transmission of Covid-19 to newborns, risks of and how to manage Covid-19 illness in newborns, concerns about staffing, PPE, visiting, and latterly vaccination.

150. Concerns raised would be highlighted via the main SG forums set up to manage Covid-19 communications, including the Health and Social Care Management Board (HSCMB), the SITREP and PAG. The majority of issues that were raised with the relevant SG policy team were followed up with professional advisors, with the Royal Colleges or with other policy teams within SG who led on these issues, and would then be fed back into the next meeting. These issues were numerous and varied, and in many cases required clarification to be provided in relation to application of a particular piece of guidance to neonatal units. For example, when issues were raised about access for parents or extended families to neonatal wards, the Maternal and Infant Health policy team raised this with the SG team leading on guidance on hospital visiting, meaning it would either be reflected in their visiting guidance or in the maternity and neonatal specific visiting guidance. In another example, general concerns were highlighted on access to PPE, and the SG Maternal and Infant Health team sourced the latest advice from the SG team leading on provision of PPE and relayed that back to the neonatal community via these meetings.

151. In response to concerns from clinical teams, SG procured the use of the vCreate system in all neonatal units in Scotland. vCreate is a secure video messaging service that allows clinical staff to communicate with parents via video link to assess premature newborns' development remotely and securely. Clinical teams were concerned about follow-up from neurodevelopmental teams in their assessments of premature infants via virtual clinics. vCreate was already being used in this way in other parts of the NHS, and neonatal clinicians presented a business case seeking to extend the use into neonatal neurodevelopmental follow-up. vCreate has a secondary purpose of allowing clinical staff to record and send videos and photo updates to parents whose babies are on the neonatal unit, but who are not able to visit. This enables parents to be involved, to support family integrated care, reduce separation anxiety and facilitates bonding. It also supports families to share videos with clinical staff, allowing remote neurodevelopmental follow-up post discharge. The neonatal teams have asked for continued funding for the programme, as it has been well received and widely used for neurodevelopmental follow-up. The pilot evaluation is provided: [CL9/115-INQ000468118].

Plans to enable screening, care and treatment for colorectal cancer

152. The National Cancer Treatment Response Group met weekly from March 2020 to June 2020. This was replaced by the National Cancer Recovery Group which met weekly from June 2020. Both groups provided regular updates and information about the impact Covid-19 had

on cancer services. Officials were in regular contact with tumour-specific oncology networks to track any service impact as well as regular contact between officials and clinical leads and service managers. Existing information sources, such as the weekly and quarterly Cancer Waiting Times datasets were monitored. New data sources were established with Regional Cancer Networks to track the delivery of cancer surgery, and a new national platform was developed by PHS to monitor pathological cancer diagnoses (November 2020) and Systematic Anti-Cancer Treatments (SACT) activity (July 2021).

153. The National Cancer Treatment Response Group membership from March to June 2020 was as follows:

Chair	Scottish Government Senior Medical Officer
Deputy Chair	SACT and UK Links
Scottish Government	Cancer Access (Team Lead)
	Cancer Access (Clinical Advisor)
	Cancer Policy (Team Lead)
National Services/MSNs Representative	National Services Division - National Medical Advisor
Systemic Anti-Cancer Therapy (SACT) Lead Representative	WoSCAN Regional SACT Group & National SACT Governance Group - Chair
Radiotherapy Lead Representative	Clinical Director - Grampian
Nursing Representative	SEND/Scottish Cancer Lead Nurse Consultant
Network Clinical Leads Representative	SCAN Clinical Lead

154. From June 2020 onwards, the membership of the National Cancer Recovery Group was as follows:

Chair	Scottish Cancer Taskforce Chair/ Scottish Government Senior Medical Officer
Vice Chair	Senior Medical Officer (Oncology)
Scottish Government	Cancer Policy (Team Lead) Cancer Access (Team Lead) Cancer Access (Clinical Advisor) Diagnostics Policy (Team Lead) Primary Care Policy (Team Lead) Screening Policy (Team Lead) Nursing Policy Representative Chief Pharmaceutical Officer Director of Screening, National Screening Oversight
National Services Division (NSD)	National Medical Advisor
Cancer Network Manager	Representative (rotating)
Cancer Network Clinical Lead North Cancer Alliance (NCA)	Representative
Cancer Network Clinical Lead South East Scotland Cancer Network (SCAN)	Representative
Radiotherapy Lead Representative	Clinical Director – Grampian
Data, Systemic Anti-Cancer Therapy (SACT), and UK Links Representative	National Cancer Treatment Group Chair / Cancer Network Clinical Lead West of Scotland Cancer Network (WoSCAN) Representative
SACT Lead Representative	SACT Lead Representative
Patient Representative	Patient Representative
Primary care	Chair, Scottish Primary Care Cancer Group
Nursing	Scottish Cancer Lead Nurse, Nurse Consultant Group Representative

155. Guidance documents and frameworks were published to support the continued treatment and prioritisation of cancer patients during the pandemic. The published guidance included:

- *Interim Governance Framework for Cancer Medicines in Adults* (published 28 April 2020), provided: [CL9/116-INQ000414561]
- *Framework for the Recovery of Cancer Surgery* (published 14 June 2020 and updated 25 August 2020), provided: [CL9/117-INQ000470000]
- *Interim Guidance on Restarting Cancer Treatment after an Infection of COVID-19* (24 April 2020), provided: [CL9/118-INQ000414563].

156. The *Guidelines for Cancer Treatment During COVID-19 Pandemic*, including colorectal cancer, were first published on 20 March 2020: [CL9/119-INQ000414606].

157. In March 2020 a proposal to pause bowel screening was agreed by Ministers under the condition that samples that had already been received and those already in the process continued to be followed up. DGHSC liaised with internal and external stakeholders to seek information, advice, risk assessments and recommendations in relation to initiating a pause to the adult screening programmes, including bowel screening. This information was shared with the Ministers and Cabinet Secretary through emails and submissions, and First Minister's Questions and government-instigated question (GIQ) documentation were submitted. Officials also sought answers to follow-up questions posed by the Ministers and Cabinet Secretary to support their decision making. Specifically, this included:

- Submissions setting out proposals to pause the adult screening programmes, including bowel screening, while continuing with pregnancy and newborn screening. This included information regarding the views and advice given by other stakeholders, such as National Services Division (NSD), who supported a pause
- Sharing a risk assessment regarding pausing bowel screening. This included details of why a pause was being proposed; the risks of continuing or pausing bowel screening; considerations if the bowel screening programme were to be paused; and a recommendation to pause bowel screening subject to the following:
    - Proceed to pause the Screening Programme in line with any decision made to cease colonoscopy services
    - Proceed to pause the Screening Programme in line with any decision made to cease incoming / outgoing mail by Royal Mail / third party providers
    - Monitor continued service and move to pause immediately if impact on laboratory was such that kits within system could continue to be tested. Programme paused and appropriate start up procedures / timescales / impact considered

- Responses to queries and further requests from Ministers.

158. Work done to support pausing the programmes, including providing information and support, included providing a briefing setting out information and lines for the pause to adult screening programmes and progressing a GIQ in the Scottish Parliament announcing a pause to screening.

159. The pause was initiated from 30 March 2020. A submission to Ministers regarding prioritisation of health policy areas, sent on 13 March 2020, is provided: [CL9/120-INQ000260941], as is a submission advising a pause in adult screening programmes, sent on 16 March 2020: **[CL9/121 - INQ000250577]** In response the Cabinet Secretary for Health and Sport requested further clinical advice on the risks of pausing the three cancer-related screening programmes and an assessment on the level of staff resource released and where they would be deployed to, with evidence they were needed in the redeployed area. The subsequent further advice was provided on 18 March 2020: **[CL9/122 - INQ000250654]**

160. In April 2020 the Bowel Screening Programme Board discussed the pause and the work required for restart. It was noted that while the programme continued to process any returned kits, there could be positive results where referrals would be delayed. The content of the positive result letter was amended to inform recipients of this delay.

161. A submission was sent to the Ministers on 13 May 2020, provided: [CL9/123-INQ000250723], regarding key concerns about restarting the bowel screening programme. It was noted that restarting the programme required careful consideration as all but emergency procedures had been paused during the pandemic. It was noted that this had resulted in backlogs of urgent suspicion of cancer (USC), routine and surveillance procedures.

162. The British Society of Gastroenterology (BSG) published guidance on 1 May 2020 which suggested that until Covid-19 testing became routine, services would only be able to operate around 50% capacity, but this could increase to 75% if additional level 2 PPE and decontamination requirements were met. A paper was submitted to complement the submission recommending the creation of the National Screening Oversight Function (NSOF) to carry out work necessary in order to restart the programme, provided: [CL9/124-INQ000250724]. This was approved on 15 May 2020.

163. On 8 June 2020, a submission was sent to the Ministers, provided: [CL9/125-INQ000250415], outlining the recommendations of the Scottish Screening Committee (SSC) on the process and timescales for restarting the adult population screening programmes, as

well as a recovery plan with timescales:

- Stage 1 – June 2020. Establish readiness to restart each adult screening programme on a national level. Work was already ongoing during Stage 1 to model capacity within boards. As part of the Bowel Screening Programme capacity was assessed in local boards to deal with onward referrals to colonoscopy services, which had stopped for all but emergency services during the first phase of pandemic response
- Stage 2 – July 2020. It was proposed that all health boards restart screening colonoscopy. Health boards would be provided with numerical Faecal Immunochemical Test (FIT) values to enable local prioritisation of those awaiting further investigation, including colonoscopy
- Stage 3 – Possibly from September 2020. Managed recommencement of routine screening with new participants starting as normal around their 50th birthday
- Stage 4 – Potential changes to the screening programme across a range of dates. Begin new approach to screening. Explore possibility for programme redesign, taking into account the balance of risk for participants and new restrictions along with new ways of working made necessary by Covid-19.

164. On 10June 2020, an updated submission was sent to the Minister for Public Health, Sport and Wellbeing, provided: [CL9/126-INQ000250417]. It noted:

"While patients are not at increased risk of contracting COVID-19 from the colonoscopy procedure itself, asymptomatic patients can shed viral load in faeces, and the realities of managing the impact of bowel prep where toilets are not available on a one-to-one basis means that the environment pre and post procedure (even when scrupulously managed) may place participants at increased risk of contracting COVID-19 from asymptomatic patients. The SSC therefore recommends an initial focus on patients already awaiting a colonoscopy in phase 2 (including those who had an abnormal FIT test prior to the pause), before FIT tests are once again issued to the wider, asymptomatic population. Numerical FIT values for participants on colonoscopy waiting lists will be provided to health boards to enable them to prioritise screening participants alongside symptomatic patients who may also have a FIT value from a symptomatic test. This would be a short-term solution to help clear the significant backlog for colonoscopies in some boards and would not become standard practice in the programme."

165. The Minister confirmed local boards were already starting to resume colonoscopies and include tests for those who had returned their kits prior to the pause. The screening programme would provide FIT values to support prioritisation.

166. It was noted in papers sent on 11 August for a board meeting taking place on 18 August, provided: [CL9/127- INQ000468119], that it did not look like the September deadline would be realistic for restarting the Bowel Screening Programme. Of the 14 health boards, nine were ready to restart screening in September, but four were not ready. One board had yet to confirm but was expected to be ready. Specifically, it was recommended by the Bowel Screening Programme Board that the programme should restart on a national basis when health boards had cleared their colonoscopy waiting lists to pre-Covid levels. However, those four boards had not cleared their waiting lists at the time the papers for this meeting were sent out, and therefore were considered not ready for the restart at that time.

167. In October 2020 bowel screening resumed with the restart of posting bowel screening kits.

168. The SG does not hold data on the annual number of patients screened for colorectal cancer or the annual number of patients screened in each of the three years prior to this. The SG also does not hold information about the annual number of patients awaiting a diagnosis for colorectal cancer or those who have received a diagnosis of colorectal cancer. This data would have to be requested from PHS.

Cancer waiting times in Scotland

169. There is currently no waiting times standard in Scotland that measures performance from referral to diagnosis.

170. In NHS Scotland, 95% of cancer patients should receive their first treatment within 31 days of a decision to treat. The 31-day standard applies to all patients, regardless of the route of referral. In practice, the numbers of patients receiving their first treatment within this 31-day target timeframe were as follows:

Performance against the 31-day standard from date decision to treat to first cancer treatment for all cancer types recorded			
Quarter ending	Number of eligible referrals	Number of eligible referrals that started treatment within 31 days	% Treated within 31 days
Mar-20	6,466	6,217	96.1%
Jun-20	5,052	4,903	97.1%
Sep-20	4,985	4,905	98.4%
Dec-20	5,711	5,631	98.6%
Mar-21	5,791	5,657	97.7%
Jun-21	6,322	6,203	98.1%
Sep-21	6,329	6,136	97.0%
Dec-21	6,391	6,207	97.1%
Mar-22	5,996	5,776	96.3%
Jun-22	6,380	6,090	95.5%

171. In NHS Scotland, 95% of cancer patients should receive their first treatment within 62 days of an urgent suspicion of cancer (USC) referral being made. The 62-day standard applies to patients urgently referred with a suspicion of cancer by a primary care clinician / general dental physician, patients referred by one of the national cancer screening programmes, and direct referrals to hospital where the signs and symptoms are consistent with the cancer diagnosed, as per the Scottish Referral Guidelines e.g. self-referral to A&E. The numbers in practice were as follows:

Performance against the 62-day standard from receipt of an urgent referral with suspicion of cancer to first cancer treatment for all cancer types recorded			
Quarter ending	Number of eligible referrals	Number of eligible referrals that started treatment within 62 days	% Treated within 62 days
Mar-20	3,832	3,244	84.7%
Jun-20	3,053	2,567	84.1%
Sep-20	3,053	2,666	87.3%
Dec-20	3,502	3,017	86.2%
Mar-21	3,589	2,978	83.0%
Jun-21	3,953	3,324	84.1%
Sep-21	4,010	3,339	83.3%
Dec-21	4,143	3,279	79.1%
Mar-22	3,861	2,968	76.9%
Jun-22	4,072	3,107	76.3%

Cancelled Treatments for Colorectal Cancer and Private Sector Usage

172. The SG does not hold data on cancelled treatments for colorectal cancer, which is managed locally by health boards. Data of this nature at the time, as now, would be held at local health board level. Private sector hospitals were utilised during the relevant period to provide a "Covid-free" environment for predominantly urgent care, including cancer patients.

Elective Hip Replacement Surgery

173. There were steps taken at board level to protect some aspects of elective surgery at the beginning of the pandemic. This was in line with the guidance issued to pause planned care and the introduction of the Clinical Prioritisation Framework that focused on cancer cases and being prepared for traumas. Health boards were provided with this framework, but beyond this, clinical decisions were made at a local level. Capacity maximised to support surgery included that of the NHS Golden Jubilee Hospital, which supported boards with urgent cases and some routine elective hip replacement. There was no SG national guidance issued on elective hip replacement surgery.

174. On 11 March 2020 NHS boards had paused non-urgent elective activity to be able to continue to provide a response to Covid-19 patients and manage the infection control requirements and advice. On 8 July 2020 the Chief Operating Officer (COO) wrote to NHS

Scotland Chief Executives setting out the process for local decision making on pausing non-urgent elective activity until the end of July 2020. Throughout the pandemic NHS boards were asked to prioritise critical and life-threatening care.

175. The Clinical Prioritisation Guidance issued: [CL9/128-INQ000343250] (pages 7-18) stated that patients should be classified in the following groups:

- Priority level 1a Emergency – operation needed within 24 hours
- Priority level 1b Urgent – operation needed with 72 hours
- Priority level 2 Surgery – scheduled within 4 weeks
- Priority level 3 Surgery – scheduled within 12 weeks
- Priority level 4 Surgery – may be safely scheduled after 12 weeks.

176. The Clinical Prioritisation Framework was published on 16 November 2020, provided: [CL9/129-INQ000468120]. This framework was based on existing guidance from the UK Colleges of Surgeons and the Federation of Surgical Specialty Associations (FSSA). It was developed by a short life working group chaired by the Deputy Chief Medical Officer (DCMO).

177. Health boards were advised to maintain essential and urgent services including critical care capacity, maternity, emergency services, mental health provision and critical cancer services. On the latter, the *Framework for the Recovery of Cancer Surgery* remained applicable and boards were advised to continue to follow that guidance, provided earlier in the statement [CL9/117 - **INQ000470000]**

178. The Vanguard units in Shetland / Orkney and at the Golden Jubilee also supported boards with urgent cases and some routine elective hip replacement.

179. There was no SG guidance on hip replacements, nor was SG involved in developing any other guidance on this subject.

180. Waiting times data is not available at procedure level, only at specialty level, therefore data for all orthopaedic inpatient / day case patients has been provided.

Table: Number of orthopaedic inpatients / day case patients waiting at year end

Year	Dec-17	Dec-18	Dec-19	Dec-20	Dec-21	Dec-22
Orthopaedic patients waiting	*	19,331	20,845	25,646	36,385	43,648

**Data not available owing to missing NHS Tayside data.*

Data source: Inpatient, Day Case and Outpatient Stage of Treatment Waiting Times - Monthly and quarterly data to 30 June 2023, Public Health Scotland, provided: [CL9/130- INQ000468123].

Table: Number of orthopaedic Inpatients/day case patients seen by year end

Year	Dec-17	Dec-18	Dec-19	Dec-20	Dec-21	Dec-22
Orthopaedic patients waiting	*	*	45,809	22,954	25,377	31,968

**Data not available owing to missing NHS Tayside data.*
Data source: Inpatient, Day Case and Outpatient Stage of Treatment Waiting Times - Monthly and quarterly data to 30 June 2023, Public Health Scotland, provided above.

Table: Annual number of patients who received elective hip replacement (excludes revisions) with NHS Scotland from 2017-2022

Year	Number of patients
2017	7,799
2018	7,834
2019	8,066
2020	4,104
2021	5,130
2022	6,342

Data source: Scottish Arthroplasty Project National report 2023, Public Health Scotland, provided: [CL9/131- INQ000468124].

Table: Number of completed outpatient appointments, number of completed outpatient appointments under 12 weeks and proportion of patients who waited under 12 weeks for Orthopaedics, NHS Scotland, by quarter ending

Quarter ending	Number Seen	Number of patients waited under 12 weeks	% waited under 12 weeks
31/03/2019	42,028	27,687	65.9%
30/06/2019	43,873	30,991	70.6%
30/09/2019	43,148	30,653	71.0%
31/12/2019	43,404	30,738	70.8%
31/03/2020	37,992	28,353	74.6%
30/06/2020	15,318	12,271	80.1%
30/09/2020	26,386	18,868	71.5%
31/12/2020	28,099	19,579	69.7%
31/03/2021	28,887	20,572	71.2%
30/06/2021	34,182	26,002	76.1%
30/09/2021	37,110	27,321	73.6%
31/12/2021	38,464	25,258	65.7%
31/03/2022	38,573	24,923	64.6%
30/06/2022	38,905	27,149	69.8%

Data source: Inpatient, Day Case and Outpatient Stage of Treatment Waiting Times - Monthly and quarterly data to 30 June 2023, Public Health Scotland, provided above.

Table: Number of patients waiting for an outpatient appointment, number of outpatients waiting under 12 weeks and proportion of patients who were waiting under 12 weeks for Orthopaedics, NHS Scotland, at quarter ending

Quarter ending	Patients waiting	Number of patients waiting under 12 weeks	% waiting under 12 weeks
31/03/2019	35,202	23,641	67.2%
30/06/2019	35,905	24,985	69.6%
30/09/2019	35,871	24,510	68.3%
31/12/2019	30,925	21,134	68.3%
31/03/2020	27,693	19,055	68.8%
30/06/2020	29,077	7,260	25.0%
30/09/2020	33,248	15,425	46.4%
31/12/2020	32,475	14,639	45.1%
31/03/2021	30,893	13,888	45.0%
30/06/2021	36,941	21,926	59.4%
30/09/2021	40,662	21,774	53.5%
31/12/2021	37,471	18,526	49.4%
31/03/2022	36,679	21,092	57.5%
30/06/2022	40,433	23,558	58.3%

Data source: Inpatient, Day Case and Outpatient Stage of Treatment Waiting Times - Monthly and quarterly data to 30 June 2023, Public Health Scotland, provided above.

Table: Number of inpatient / day case attendances, number of inpatient / day case patients seen under 12 weeks and proportion of inpatient / day case patients who waited under 12 weeks for Orthopaedics, NHS Scotland, by quarter ending

Quarter ending	Number Seen	Number of patients waited under 12 weeks	% waited under 12 weeks
31/03/2019	11,799	5,075	43.0%
30/06/2019	11,256	5,320	47.3%
30/09/2019	11,388	5,430	47.7%
31/12/2019	11,366	5,500	48.4%
31/03/2020	9,947	4,461	44.8%
30/06/2020	775	542	69.9%
30/09/2020	5,322	1,301	24.4%
31/12/2020	6,910	2,270	32.9%
31/03/2021	4,265	1,788	41.9%
30/06/2021	8,335	2,611	31.3%
30/09/2021	6,497	2,233	34.4%
31/12/2021	6,280	2,305	36.7%
31/03/2022	6,261	2,183	34.9%
30/06/2022	7,704	2,429	31.5%

Data source: Inpatient, Day Case and Outpatient Stage of Treatment Waiting Times - Monthly and quarterly data to 30 June 2023, Public Health Scotland, provided above.

Table: Number of inpatient / day case patients waiting, number of inpatient / day case patients waiting under 12 weeks and proportion of inpatient / day case patients who were waiting under 12 weeks for Orthopaedics, NHS Scotland, at quarter ending

Quarter ending	Patients waiting	Number of patients waiting under 12 weeks	% waiting under 12 weeks
31/03/2019	19,080	12,137	63.6%
30/06/2019	19,682	11,958	60.8%
30/09/2019	20,009	12,040	60.2%
31/12/2019	20,845	12,426	59.6%
31/03/2020	21,494	11,807	54.9%
30/06/2020	23,673	3,350	14.2%
30/09/2020	24,658	6,336	25.7%
31/12/2020	25,646	7,959	31.0%
31/03/2021	29,306	8,035	27.4%
30/06/2021	29,515	9,041	30.6%
30/09/2021	32,109	9,557	29.8%
31/12/2021	36,385	10,009	27.5%
31/03/2022	40,333	10,482	26.0%
30/06/2022	42,133	9,861	23.4%

Data source: Inpatient, Day Case and Outpatient Stage of Treatment Waiting Times - Monthly and quarterly data to 30 June 2023, Public Health Scotland, provided above.

181. The SG does not hold details of cancelled operations. However, during this time patients were not booked, rather than actively cancelled. This was due to the clinical prioritisation guidance and focus on cancer and emergency patients. The number of cancellations will show the patients who were booked and did not get surgery on the day or near the day due to various reasons. PHS continued to collect and publish numbers of cancelled planned operations throughout the pandemic, which can be found on their website.

182. There were no national contracts in place for Trauma and Orthopaedics; however, there may have been some small contracts in the board for private healthcare providers to help provide hip replacement operations.

Table: The number and proportion of NHS Scotland patients who had an elective hip replacement completed in private sector but were NHS funded, as a proportion of the total number of elective hip replacements

Year	Number of elective hip replacements completed in private sector but were NHS funded	Total number of elective hip replacements carried out	No. of private elective hip replacements as a % of total hip replacements
2017	169	7,799	2.2%
2018	132	7,834	1.7%
2019	495	8,066	6.1%
2020	309	4,104	7.5%
2021	174	5,130	3.4%
2022	128	6,342	2.0%

Data source: Scottish Arthroplasty Project National report 2023, Public Health Scotland, provided above.

183. The data of patients who received hip replacements from private contracts is not held or available to the SG.

Table: Number of hip replacements completed in private sector but were NHS funded, by year

Year	Number of hip replacements completed in private sector but were NHS funded
2017	169
2018	132
2019	495
2020	309
2021	174
2022	128

Data source: Scottish Arthroplasty Project National report 2023, Public Health Scotland, provided above.

Table: The number of hip replacements in private sector which were self-funded or funded by insurance

Year	Number of hip replacements
2017	1,142
2018	1,218
2019	1,496
2020	1,436
2021	2,755
2022	2,824

Data source: Scottish Arthroplasty Project National report 2023, Public Health Scotland, provided above.

184. National guidance was issued on Infection Prevention Control (IPC) measures. Local boards managed the implementation of this guidance.

185. The use of Vanguard Unit for Orkney and Shetland was an innovative solution to ensure hip replacement and other elective orthopaedic surgery pathways were provided during the Covid-19 pandemic. This supported patients in the island boards to be able to receive their treatments.

Ischaemic Heart Disease

186. Heart transplants are one form of treatment for heart disease. All heart transplants in Scotland are carried out in the Golden Jubilee National Hospital (although in limited circumstances, including paediatric cases, heart transplants for patients resident in Scotland are carried out by the Freeman Hospital in Newcastle).

187. There were 57 heart transplants carried out on Scottish residents between 1 March 2020 and 28 June 2022. 54 of these were carried out at the Golden Jubilee National Hospital. The other three heart transplants were carried out at the Freeman Hospital in Newcastle.

188. Primary and secondary care will lead on risk assessments and testing for heart disease and some patients might be referred to the transplant units for potential transplantation.

189. Scottish Ministers did not make any specific plans to continue heart transplantation during the pandemic and did not issue any guidance apart from the *Transplant Recovery Plan* which was issued to all three Scottish transplant units in summer 2020, provided: [CL9/132-INQ000414567].

190. Whether to proceed with a heart transplant during the relevant period in Scotland was entirely a decision for the Golden Jubilee National Hospital, made via clinical and operational reasoning. This was because they had very few Covid-19 patients in their hospital and had sufficient capacity to be able to segregate these patients from any heart transplant patients. They were therefore able to continue to offer transplants for their urgent patients when suitable hearts were offered for them.

191. In March 2020, implementation of the Human Tissue (Scotland) (Authorisation) Act 2019 was delayed from Autumn 2020 to Spring 2021 in order to prioritise the SG and NHS response to the Covid-19 pandemic. The Act came into effect on 26 March 2021.

192. The *Scottish Donation and Transplantation Plan* was published in March 2021, provided: [CL9/133-INQ000414568]. This covers all transplantation and does not include anything specific on heart transplantation.

193. The SG published the *NHS Scotland Heart Failure Transition and Recovery Plan in response to Covid-19* on 25 May 2020, on the Heart Failure Hub Scotland, provided: [CL9/134-INQ000469982].

194. This plan recommended that, as the NHS transitioned from an emergency to recovery phase, NHS boards should adopt a tiered approach to heart failure care. It made the key recommendations that:

- Service planning should comply with Public Health and Health Protection Scotland guidance
- Active clinical triage should be undertaken by specialist clinicians
- Pro-active inpatient and outpatient heart failure care should be provided to all patients at intermediate and highest risk
- Consultations should be undertaken using telephone call, video call or face-to-face methods as appropriate and specific provision should be made for shielded patients
- Heart failure teams should be appropriately resourced to manage the backlog in addition to potential increases in patient numbers resulting from Covid-19

- Recovering access to echocardiography, cardiac device implantation and long-term condition management would be crucial for the delivery of safe heart failure care
- Community point of care diagnostics, ambulatory / remote monitoring and patient self-management strategies should be prioritised for implementation where these were not currently available.

195. The following table shows annual number of patients who received a positive diagnosis of ischaemic heart disease during the relevant period, and the annual number of patients who received a positive diagnosis of ischaemic heart disease in each of the three years prior to the Covid-19 pandemic:

Table: Numbers of incident cases for coronary heart disease, NHS Scotland

Year	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22p
Number of cases	17,968	18,536	18,499	18,304	17,372	18,191

p = data for 2021/22 are provisional and subject to change in future analyses
Data source: Scottish Heart Disease Statistics - Year ending 31 March 2022, Public Health Scotland, provided: [CL9/135- INQ000468125].

196. Waiting times data are not available to the SG. However, the data for all cardiology outpatients and inpatient / day case patients has been provided:

Table: Number of Completed Outpatient Appointments, Number of completed outpatient appointments under 12 weeks and proportion of patients who waited under 12 weeks for Cardiology, NHS Scotland, by quarter ending

Quarter ending	Number Seen	Number of patients waited under 12 weeks	% waited under 12 weeks
31/03/2019	13,495	11,726	86.9%
30/06/2019	14,838	13,540	91.3%
30/09/2019	14,069	11,716	83.3%
31/12/2019	13,754	11,706	85.1%
31/03/2020	12,472	10,144	81.3%
30/06/2020	4,947	3,896	78.8%
30/09/2020	7,084	5,311	75.0%
31/12/2020	9,163	6,900	75.3%
31/03/2021	9,440	6,888	73.0%
30/06/2021	9,977	7,702	77.2%
30/09/2021	10,113	7,438	73.5%
31/12/2021	10,656	7,109	66.7%
31/03/2022	11,639	7,221	62.0%
30/06/2022	11,911	7,731	64.9%

Data source: Inpatient, Day Case and Outpatient Stage of Treatment Waiting Times - Monthly and quarterly data to 30 June 2023, Public Health Scotland, provided above.

Table: Number of patients waiting for an outpatient appointment, number of outpatients waiting under 12 weeks and proportion of patients who were waiting under 12 weeks for Cardiology, NHS Scotland, at quarter ending

Quarter ending	Patients waiting	Number of patients waiting under 12 weeks	% waiting under 12 weeks
31/03/2019	8,563	8,096	94.5%
30/06/2019	9,465	8,571	90.6%
30/09/2019	9,630	8,519	88.5%
31/12/2019	9,523	8,472	89.0%
31/03/2020	8,816	7,795	88.4%
30/06/2020	7,883	2,892	36.7%
30/09/2020	9,151	4,886	53.4%
31/12/2020	9,590	5,590	58.3%
31/03/2021	9,977	6,465	64.8%
30/06/2021	12,428	8,452	68.0%
30/09/2021	13,852	8,349	60.3%
31/12/2021	14,651	8,161	55.7%
31/03/2022	15,522	9,760	62.9%
30/06/2022	16,601	10,291	62.0%

Data source: Inpatient, Day Case and Outpatient Stage of Treatment Waiting Times - Monthly and quarterly data to 30 June 2023, Public Health Scotland, provided above.

Table: Number of inpatient / day case attendances, number of inpatient / day case patients seen under 12 weeks and proportion of inpatient / day case patients who waited under 12 weeks for Cardiology, NHS Scotland, by quarter ending

Quarter ending	Number Seen	Number of patients waited under 12 weeks	% waited under 12 weeks
31/03/2019	3,025	2,586	85.5%
30/06/2019	2,790	2,479	88.9%
30/09/2019	2,957	2,356	79.7%
31/12/2019	2,799	2,433	86.9%
31/03/2020	2,661	2,094	78.7%
30/06/2020	1,229	925	75.3%
30/09/2020	2,068	1,410	68.2%
31/12/2020	2,390	1,721	72.0%
31/03/2021	2,341	1,810	77.3%
30/06/2021	2,390	1,916	80.2%
30/09/2021	2,463	1,983	80.5%
31/12/2021	2,343	1,673	71.4%
31/03/2022	2,395	1,657	69.2%
30/06/2022	2,470	1,712	69.3%

Data source: Inpatient, Day Case and Outpatient Stage of Treatment Waiting Times - Monthly and quarterly data to 30 June 2023, Public Health Scotland, provided above.

Table: Number of inpatient / day case patients waiting, number of inpatient / day case patients waiting under 12 weeks and proportion of inpatient / day case patients who were waiting under 12 weeks for Cardiology, NHS Scotland, at quarter ending

Quarter ending	Patients waiting	Number of patients waiting under 12 weeks	% waiting under 12 weeks
31/03/2019	2,057	1,853	90.1%
30/06/2019	2,207	1,902	86.2%
30/09/2019	2,217	1,941	87.6%
31/12/2019	2,339	1,928	82.4%
31/03/2020	2,052	1,519	74.0%
30/06/2020	2,251	1,029	45.7%
30/09/2020	2,320	1,395	60.1%
31/12/2020	2,310	1,518	65.7%
31/03/2021	2,265	1,553	68.6%
30/06/2021	2,597	1,917	73.8%
30/09/2021	2,752	1,862	67.7%
31/12/2021	2,842	1,876	66.0%
31/03/2022	3,017	1,993	66.1%
30/06/2022	3,300	2,080	63.0%

Data source: Inpatient, Day Case and Outpatient Stage of Treatment Waiting Times - Monthly and quarterly data to 30 June 2023, Public Health Scotland, provided above.

197. All heart transplants are considered as unscheduled operations as they rely on a suitable deceased donor being found and that organ being offered to a suitable patient. Owing to heart transplants being unscheduled, they are rarely cancelled except in cases where the heart is found to be unsuitable for the transplant.

198. No heart transplants were cancelled between 1 March 2020 and 28 June 2022 for reasons related specifically to Covid-19.

199. As a result of the prolonged need to focus on emergency care, the Covid-19 pandemic had a considerable impact on capacity within NHS Scotland to provide outpatient care, including for patients with ischaemic heart disease.

200. The following table shows the number of emergency admissions for patients requiring urgent treatment for heart attacks by year:

Table: Number of discharges for Heart attack, Emergency, NHS Scotland

Year	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Number of Discharges	9,631	9,762	10,007	10,154	9,884	9,900

p = provisional data

Data source: Scottish Heart Disease Statistics - Year ending 31 March 2022, Public Health Scotland, provided above.

201. During the pandemic, private healthcare providers were utilised for urgent patients, including cancer patients, to provide a 'Covid-free' environment. The SG does not hold any information on how these private healthcare providers were used to provide treatment of NHS ischaemic heart disease patients specifically. The Scottish Cardiac Audit Programme (SCAP), run by PHS, does not currently hold data relating to private sector hospitals, though PHS is working to understand if private sector hospitals will contribute to the programme in future. To date, SCAP has not held private sector data relating to heart disease.

202. Infection prevention control measures were set up to support early assessment, detection and isolation of suspected or confirmed cases of Covid-19, in the recognition that the virus could cause severe harm to any individual.

203. The SG does not hold any information about changes made to treatment protocols or specialist clinical guidance as a result of IPC measures that were specific to the treatment of ischaemic heart disease.

204. The DGHSC produced advice on Covid-19 specifically for people with chronic heart disease, provided: [CL9/136-INQ000414569]. This was last updated on 15 January 2021.

205. The advice said that the symptoms of Covid-19 for people with chronic heart disease were the same, but that heart failure symptoms (fluid retention or breathlessness) or chest pain (angina) could become worse, in which case people should speak to their GP or local Heart Failure Liaison Nurse.

Child and Adolescent Mental Health Services

206. Child and Adolescent Mental Health Services (CAMHS) are provided by 14 regional boards in Scotland, with national services being commissioned by the National Services Division of National Services Scotland.

207. Regional CAMHS services are agreed and commissioned by regional planning groups, with leadership support from the Regional Directors of Planning. CAMHS funding has increased to £125m (2021/22 figures).

208. The SG has set a target and made a commitment to support boards to allocate 1% of their NHS operating budget to CAMHS (approximately £140m at 2021/22 figures) by the end of this Parliament.

209. Delegation and leadership arrangements for CAMHS vary across health boards.

210. Within the Highland Council area, responsibility for delivery of CAMHS is maintained by the health board. This arrangement also applies in Lothian, Tayside and Forth Valley.

211. CAMHS in the Argyll and Bute Local Authority area is delegated to the Integrated Joint Board (IJB), with similar arrangements in the remaining nine health board areas. There is a lead IJB for CAMHS.

212. The following tables show the number of new referrals in Scotland to CAMHS / Children and Young People's Mental Health Services (CYPMHS) who have been referred by a general practitioner, a school or other organisation or who have self-referred. The SG does not hold data broken down by referral type.

Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
3584	2562	3182	2776	2232	2273	2960	3082	3329	2785	3132

Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
3245	2642	840	1328	1884	1783	2336	3336	2932	3497	3028

Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
2110	2509	3280	2951	3638	3604	2174	2519	3189

Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
3124	3741	3156	3048	3200	3753	2589	3193	3431

213. The SG's data is focused on numbers of referrals received and accepted, rather than those not accepted (many of which receive support from other parts of the children's services network).

214. As such, the numbers of children accepted have been provided in tables below, as are the numbers of those not accepted.

215. Statistics categorising reasons for a referral not being accepted cannot be provided but common reasons include:

- Duplicate referrals
- Referrals made in error
- The referral information not meeting the National CAMHS Specification referral criteria
- The child or young person having moved out of the board area, or cases where the child or young person would be better supported by another service (the National CAMHS Service Specification specifies the need for 'personal and meaningful signposting' in such cases)
- The child or young person having not attended first appointments.

Table: CAHMS accepted referrals in 2020

Referrals Accepted (2020)	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
NHS Ayrshire & Arran	103	36	54	75	87	102	145	136	168	129
NHS Borders	32	9	16	34	16	38	41	32	35	31
NHS Dumfries & Galloway	72	23	28	54	67	87	136	83	133	75
NHS Fife	171	42	78	145	138	194	273	247	306	243
NHS Forth Valley	98	40	18	49	41	33	83	83	60	56
NHS Grampian	95	12	93	169	159	174	270	220	282	262
NHS Greater Glasgow & Clyde	524	164	279	377	250	458	623	549	618	535
NHS Highland	129	59	74	77	95	101	173	132	152	134
NHS Lanarkshire	217	14	63	116	135	178	217	201	257	202
NHS Lothian	380	171	244	291	277	317	418	456	480	402
NHS Orkney	8	1	5	6	3	7	5	..	..	..
NHS Shetland	4	3	4	4	13	14	14	13	7	4
NHS Tayside	124	35	59	83	70	101	152	114	146	124
NHS Western Isles	10	3	5	8	7	11	26	9	17	9
Scotland	1967	612	1020	1488	1358	1815	2576	2275	2661	2206

Table: CAHMS accepted referrals in 2021

Referrals Accepted (2021)	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
NHS Ayrshire & Arran	88	111	167	126	172	224	105	118	159	154	196	207
NHS Borders	24	23	41	37	50	60	30	37	36	51	49	62
NHS Dumfries & Galloway	47	64	64	71	69	83	45	53	88	61	100	87
NHS Fife	159	167	244	253	256	263	155	191	262	205	320	216
NHS Forth Valley	43	63	98	117	128	66	44	27	44	47	62	53
NHS Grampian	168	195	229	256	317	286	129	193	277	267	278	278
NHS Greater Glasgow & Clyde	382	503	696	506	606	622	339	448	523	567	684	552
NHS Highland	106	100	118	114	177	135	116	90	149	95	186	130
NHS Lanarkshire	127	185	287	188	302	272	120	182	216	260	258	193
NHS Lothian	360	440	465	523	550	605	360	390	390	519	592	506
NHS Orkney	..	7	9	..	..	..	..	..	..	..	..	..
NHS Shetland	3	3	6	7	11	6	8	9	14	8	13	10
NHS Tayside	89	95	165	117	162	142	83	110	177	143	117	134
NHS Western Isles	10	15	14	19	17	15	6	16	11	11	17	13
Scotland	1606	1971	2603	2334	2817	2779	1540	1864	2346	2388	2872	2441

Table: CAHMS accepted referrals in 2022

Referrals Accepted (2022)	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
NHS Ayrshire & Arran	153	173	207	156	187	252
NHS Borders	38	27	66	40	51	58
NHS Dumfries & Galloway	90	115	130	59	109	98
NHS Fife	256	232	258	142	207	181
NHS Forth Valley	42	75	74	62	86	112
NHS Grampian	266	146	292	207	128	239
NHS Greater Glasgow & Clyde	571	591	610	448	514	575
NHS Highland	118	130	127	104	118	120
NHS Lanarkshire	213	253	292	187	261	220
NHS Lothian	498	541	569	434	504	612
NHS Orkney	..	..	..	10	12	12
NHS Shetland	16	12	7	4	15	17
NHS Tayside	121	138	188	110	154	136
NHS Western Isles	14	15	16	12	19	8
Scotland	2396	2448	2836	1975	2365	2640

Table: CAHMS referrals not accepted in in 2020

Referrals Not Accepted (2020)	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
NHS Ayrshire & Arran	51	21	19	29	23	51	55	40	26	37
NHS Borders	18	11	9	6	13	12	14	14	31	14
NHS Dumfries & Galloway	46	4	10	8	13	12	24	33	32	36
NHS Fife	65	22	34	32	27	54	71	37	45	55
NHS Forth Valley	35	13	22	27	37	41	48	41	68	66
NHS Grampian	32	4	27	47	48	48	85	82	91	90
NHS Greater Glasgow & Clyde	105	22	26	46	66	82	119	126	150	132
NHS Highland	0	3	5	18	19	24	19	24	26	31
NHS Lanarkshire	128	81	71	71	74	81	165	101	128	155

NHS Lothian	111	23	39	57	51	68	95	105	130	122
NHS Orkney	0	0	0	0	0	0	0	...	...	...
NHS Shetland	3	1	4	3	0	2	7	1	7	7
NHS Tayside	81	23	42	52	54	46	58	53	102	77
NHS Western Isles	0	0	0	0	0	0	0	0	0	0
Scotland	675	228	308	396	425	521	760	657	836	822

Table: CAHMS referrals not accepted in 2021

Referrals Not Accepted (2021)	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
NHS Ayrshire & Arran	30	17	33	22	25	30	24	34	20	31	23	15
NHS Borders	11	10	17	10	15	14	11	12	36	15	19	26
NHS Dumfries & Galloway	16	25	25	44	58	32	23	36	43	48	45	34
NHS Fife	35	48	49	51	49	42	30	39	43	33	39	29
NHS Forth Valley	30	33	41	40	71	129	72	60	125	100	95	61
NHS Grampian	53	71	83	69	87	92	94	70	59	62	53	72
NHS Greater Glasgow & Clyde	99	111	134	116	194	181	129	148	197	180	237	145
NHS Highland	16	14	23	16	31	39	21	36	51	23	28	24
NHS Lanarkshire	103	78	103	94	125	108	119	63	99	70	144	130
NHS Lothian	78	91	126	111	116	106	75	100	100	114	139	133
NHS Orkney	...	0	0	...	...	...	...	...	...	...	...	...
NHS Shetland	3	5	1	2	4	2	2	2	2	4	5	4
NHS Tayside	30	35	42	42	46	50	34	55	68	56	42	42
NHS Western Isles	0	0	0	0	0	0	0	0	0	0	0	0
Scotland	504	538	677	617	821	825	634	655	843	736	869	715

Table: CAHMS referrals not accepted in 2022

Referrals Not Accepted (2022)	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
NHS Ayrshire & Arran	15	29	24	10	20	24
NHS Borders	16	17	24	24	29	16
NHS Dumfries & Galloway	35	26	49	19	23	29
NHS Fife	48	43	59	38	53	38
NHS Forth Valley	53	75	53	16	32	63
NHS Grampian	82	77	161	97	131	100
NHS Greater Glasgow & Clyde	158	166	235	156	225	225
NHS Highland	18	39	29	23	32	29
NHS Lanarkshire	59	71	72	43	57	59
NHS Lothian	134	150	155	119	138	137
NHS Orkney	...	...	...	0	0	0
NHS Shetland	3	2	3	1	1	0
NHS Tayside	31	57	53	68	87	71
NHS Western Isles	0	0	0	0	0	0
Scotland	652	752	917	614	828	791

216. Guidance on the provision of mental health services during the pandemic is provided: [CL9/137-INQ000414570], [CL9/0138-INQ000414579]. SG issued a set of Principles on 1 May 2020 [CL9/138-INQ000414579]) applicable to all mental health services, setting out the expectation that urgent mental health support services would continue to be provided. This stated that, "*During the Covid-19 pandemic, clinical community and hospital services must continue in response to people whose mental health and wellbeing are at particular risk and/or in crisis, including where changes in arrangements for the provision of care and treatment would lead to unacceptable risk and detriment.*"

217. The Principles also set out potential changes to the way in which patients might access appointments, and stated that, "*Face to face therapeutic contact should only occur where there is no telephone or video alternative, or where the required service cannot be delivered other than face to face (e.g. emergency assessments, physical monitoring, and intensive home support).*" The same document also outlined the considerations that needed to be given to people with inequalities or co-occurring conditions, stating that: "*The public sector equality duties apply. Treatment must be fair and equitable with no discrimination; importantly this includes those people who are affected by Covid-19…Additional care should be taken with people who are vulnerable at this time. Service users with specific needs should be particularly considered. For instance those with a learning disability, neurodevelopmental disorder or dementia who may not understand and/or have difficulty accessing or complying with Scottish Government Covid-19 guidance*".

218. The SG was clear that responsibility for considering the impact of this guidance on individuals and inequalities presentations rested with clinicians and health boards / IJBs. "Inequalities presentations" is a way of describing people who may access services who may have one or more protected characteristic or who may experience inequality due to issues such as social deprivation. Boards and local authorities are responsible for providing services to their local populations, and it is for them to consider the impact of implementing the Principles on their local populations.

219. The SG clearly set out its expectations in the letter to boards and local authorities issued on 1 May 2020 from the Minister for Mental Health and Wellbeing, as provided

above [CL9/138-INQ000414579]. This included a statement that the Principles had been drawn up based on the ten principles of the Mental Health (Care and Treatment) (Scotland) Act. The SG believed it was important to set out in the guidance [CL9/0137-INQ000414570] and [CL9/138-INQ000414579] on how care and treatment should continue to be reasonable, proportionate, justifiable, and based on the principles of the Mental Health Act, the Health and Social Care Standards, etc.

220. The SG does not hold waiting times for Children and Young People's Mental Health services. This data is published quarterly by PHS. The following tables show the median waits experienced from referral to treatment, which may be of interest to the Inquiry.

Table: Median wait times from referral to treatment in Scotland (in weeks)

Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
11	10	14	16	7	9	6	6	7	8	10	9	8

Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
8	7	5	7	8	6	7	8	7	8	10	8	9	11	10

221. The SG does not hold any data on the number of children and young people compulsorily admitted to psychiatric inpatient care under the Medical Health Act (2003). The Mental Welfare Commission collects this data in its Mental Health Act (Scotland) Annual Monitoring Report.

222. In addition, the SG and Convention of Scottish Local Authorities (COSLA) also published the following guidance:

- The *National CAMHS Service Specification* (February 2020), provided: [CL9/139-INQ000414571]
- The *National Neurodevelopmental Specification: Principles and Standards of Care* (September 2021), provided: [CL9/140-INQ000414572]

- A final report of the Children and Young People's Mental Health and Wellbeing Programme Board (December 2020).

223. In addition to these documents, the SG also established a Children and Young People's Mental Health and Wellbeing Joint Delivery Board with COSLA in April 2021.

224. The platform 'Near Me' was established and DGHSC developed guidance for the use of this in a range of psychological and mental health settings in 2020.

225. The SG does not hold any data on the impact the Covid-19 pandemic had on providing treatment to existing CAMHS / CYPMHS patients receiving treatment on an inpatient basis. This information will be available through The Mental Welfare Commission.

226. During the pandemic, the number of commissioned psychiatric beds for children and young people remained at 54. Bed availability fluctuated due to infection prevention control (for example, isolation of children and young people and staff).

227. As a general comment, staff availability also fluctuated as a result of illness and unavailability. The SG does not hold data about staff availability in CAMHS because this is a day-to-day operational matter for NHS Boards. It is the role of the individual health boards to manage their own staff numbers and availability. Through various stakeholder forums and our ongoing direct communication with Boards, the SG heard informal feedback that staff availability was fluctuating for a number of reasons, such as illness and unavailability of staff.

228. During the pandemic, CAMHS workforce was –March 2020: 1075.3; June 2022: 1231.0 – increase of 155.7 WTE. (NB: June 2023: 1359.5 WTE – increase of 284.2 WTE since Mar 2020, largely due to the Recovery & Renewal funding in March 2021).

229. During the Covid-19 pandemic, the SG provided significant amounts of bespoke funding to support children and young people's mental health.

230. The SG also focused on prevention and early intervention approaches, including self-help resources.

231. The following table shows how resources were allocated.

Table: CYPMH Covid- 19 allocations 2020-21

Project	Amount (£)	Source - Direct Govt or NHS
Allichat App - support for young people with stress / anxiety	50,000	Direct Govt
Eating Disorder Online Peer Support Resource - additional capacity in response to Covid-19	31,200	Direct Govt
The Spark - relationships helpline and associated counselling for families	768,620	Direct Govt
Inspiring Scotland - Monitoring and Governance Support for The Spark	5,000	Direct Govt
Young Scot - Support for the Mental Wellbeing of Young People	105,000	Direct Govt
Eating Disorders - BEAT Helpline and National Officer Post	42,963	Direct Govt
C&YP - Community Mental Wellbeing Services - Covid Response	11,250,000	Direct Govt
Covid-19 Mental Health Support for Students - to SFC	1,320,000	Direct Govt
Total	13,572,783	

Table: CYPMH Covid- 19 allocations 2021-22

Project	Amount (£)	Source - Direct Govt or NHS	Date Allocated	How/Allocation Method	Distributed Regionally
CAHMS Improvement - Waiting List Backlog	4,250,000	Direct Govt	June	NHS Board Allocation (All territorial Boards)	No
CAHMS Improvement - Neurodevelopmental Assessments	3,060,000	Direct Govt	Sept	NHS Board Allocation (All territorial Boards)	No
CAHMS Improvement - CAMHS to Age 25	8,500,000	Direct Govt	June	NHS Board Allocation (All territorial Boards)	No
CAHMS Improvement - Implement CAMHS Service Specification	16,400,000	Direct Govt	June	NHS Board Allocation (All territorial Boards)	No
CAHMS Improvement - LD, Forensic & Secure Care	700,000	Direct Govt	Sept	NHS Board Allocation (All territorial Boards)	No
CAMHS Improvement - National Data & Information Programme	500,000	Direct Govt	Oct	NHS Board Allocation (NHS GG&C)	No
CAMHS Improvement - Various (OoO; IHTT; Liaison Teams)	4,920,000	Direct Govt	Sept	NHS Board Allocation (All territorial Boards)	No
CAMHS Improvement - Intensive Psychiatric Care Provision	1,650,000	Direct Govt	Sept	NHS Board Allocation (All territorial Boards)	No
Young Scot - Aye Feel Public Information Campaign	79,834	Direct Govt	Dec/Mar	Grant	No

Young Scot - Aye Feel Hub	81,904	Direct Govt	Dec/Mar	Grant	No
CAMHS Neurodevelopmental Spec Tests of Change Improvement	331,371	Direct Govt	Mar	Grant	No
Total	40,473,109				

NB: 2021/22 allocations were sourced from the Mental Health Recovery and Renewal Fund. The purpose of the fund was to support SG response to the mental health impacts of the COVID-19 pandemic through delivery of the Mental Health Transition and Recovery Plan actions.

232. Throughout the relevant period, the SG placed a significant focus on a whole systems approach. The Children and Young People's Mental Health and Wellbeing Programme Board met until late 2020 and steered key work jointly with COSLA, including developing the CAMHS Specification and initiating new community-based mental health and wellbeing supports for children and young people.

233. The Joint Delivery Board, also jointly chaired with COSLA, was formed in April 2021 and supported the delivery of the Programme Board recommendations, including a New Neurodevelopmental (ND) Specification and the further development of community-based support, which has matured since its inception with more than 300 supports in place and over 45,000 children, young people and family members benefiting in the second half of 2022 alone.

234. The board included a wide range of stakeholders and lived experience participation – both groups provided an invaluable source of evidence on impact, conclusions, lessons and recommendations about children, young people and families mental health policy delivery during this period.

235. For CAMHS and ND Specifications, DGHSC engage with boards and IJBs directly through the boards' Annual Delivery Plans and the CAMHS improvement plans. These plans review impact and performance and make recommendations to Ministers quarterly about which boards require enhanced support from the Principal Professional Adviser in CYPMH. DGHSC also work with Directors of Regional Planning and National Services Division on the regional and national aspects of the National CAMHS Service Specification.

Long Covid

236. As part of the SG response to the pandemic, in October 2020 the Chief Scientist Office (CSO) launched a funding call seeking applications which aimed to investigate the longer-term effects of Covid-19.

237. Following an independent expert review process, nine projects were funded with a total funding commitment of £2.5 million. The funding outcome was announced in December 2020. These funded projects are as follows:

- COV/LTE/20/04 - *Amplifying the voices of people with lived experience to improve understanding, support, treatment and education. Share-to-improve: Long Covid experience (COv-VOICES) Study.* Professor Kate Hunt. University of Stirling. £299,883
- COV/LTE/20/06 - *Defining and understanding the longer-term effects of COVID-19: A mixed methods study exploring the frequency, nature, and impact of 'long COVID' in the Scottish population.* Professor Jill Pell. University of Glasgow. £299,562
- COV/LTE/20/08 - *COVID-19: Tracking Persistent Symptoms in Scotland (TraPSS).* Professor Nic Sculthorpe. University of the West of Scotland. £239,358
- COV/LTE/20/10 - *Prevention and early treatment of COVID-19 long term effects: a randomised clinical trial of resistance exercise*. Professor Colin Berry. University of Glasgow. £286,660
- COV/LTE/20/15 - *Developing and validating a risk prediction model for long COVID-19.* Professor Aziz Sheikh. University of Edinburgh. £189,659
- COV/LTE/20/26 - *Clinical phenotyping to enable targeted treatment of persistent cognitive symptoms after COVID-19.* Professor Alan Carson. University of Edinburgh. £290,941
- COV/LTE/20/28 - *Longer term impact of COVID-19 infection people with diabetes. Dr Robert Lindsay.* University of Glasgow. £295,201
- COV/LTE/20/29 - *Evaluating emerging models of community rehabilitation for people experiencing the effects of long-COVID to inform responsive service delivery across Scotland.* Professor Kay Cooper. Robert Gordon University. Dr Edward Duncan. University of Stirling. £296,545
- COV/LTE/20/32 - *Lived experience of long term COVID-19 on NHS workers in health care settings in Scotland: a longitudinal mixed methods study.* Dr Nicola Torrance. Dr Aileen Grant. Robert Gordon University. £294,605

On completion of the research, project teams work with the CSO Public Engagement Group to produce project final reports. These are published on the CSO website. Those completed and published at present are provided: [CL9/141- INQ000316278], [CL9/142- INQ000468127], [CL9/143-INQ000468128], [CL9/144- INQ000468129].

238. Health and Social Care Analysis (HSCA) Division worked closely with the Office for National Statistics (ONS) which led on the collection of Long Covid data as part of the Coronavirus Infection Survey (CIS).

239. CIS provided key data to estimate the prevalence of ongoing symptoms following Covid-19 infection and subsequent activity limitation at Scotland and UK level. HSCA briefed Ministers and officials on the monthly estimates produced from CIS to provide regular updates on prevalence in Scotland.

240. In July 2021, the SG commissioned NHS National Services Scotland to conduct a mapping exercise of NHS boards to identify how services were being delivered across Scotland to support people with Long Covid, and associated support needs of NHS boards.

241. NHS National Services Scotland established a short-life working group to consider the results of the mapping exercise and identify next steps required. In September 2021, the SG announced the establishment of a £10 million Long Covid Support Fund to support the capacity needs of NHS boards in responding to Long Covid.

242. The short-life working group met in September and November 2021. It recommended the establishment of a National Strategic Network, which was established by NHS National Services Scotland in March 2022.

243. In March 2022, all regional health boards were invited to submit a gap analysis and application for funding via the National Strategic Network. Following this process, an initial £2.54 million was made available to territorial NHS boards for the financial year 2022-23 from the Long Covid Support Fund to support the delivery and development of support and services for people with Long Covid.

244. In addition, the SG worked with NHS 24 to develop a dedicated Long Covid microsite on the NHS inform platform, which launched in October 2021.

245. This microsite was accompanied by a SG-commissioned marketing campaign delivered across community pharmacy and GP practice premises in October and

November 2021 to raise awareness of sources of information and support for people with Long Covid.

246. The *COVID-19 rapid guideline: managing the long-term effects of COVID-19* was developed in Autumn 2020. The CMO and Deputy National Clinical Director, as well as the SG's Clinical Guidance Cell, Clinical Leads Advisory Group for Scotland (CLAGS) and PAG were consulted during the development of the guideline.

247. This guideline was developed by NICE, the Scottish Intercollegiate Guidelines Network (SIGN) and the RCGP. The guideline was published on the NICE website on 18 December 2020, provided: [CL9/145-INQ000238545].

248. The SG developed an accompanying *Implementation Support Note* first published on 5 May 2021, provided: [CL9/146-INQ000232014], intended to provide information for clinicians to support the implementation of the clinical guideline's recommendations in Scotland. The resource was developed with input from stakeholders including those from CLAGS, the Clinical Guidance Cell, Specialty Advisors to the CMO, senior medical advisors to the SG, people with lived experience and the third sector.

249. The SG worked with SIGN to support the development of the decision support toolkit *Managing the long-term effects of COVID-19*, which was released in September 2021.

250. The toolkit provides clinicians with a single, integrated point of access to key information from the clinical guideline on managing the long-term effects of Covid-19 and the SG's accompanying *Implementation Support Note*, available via both a web-based platform and a mobile app.

Lessons learned regarding care pathways

251. A range of topics were considered when preparing this corporate statement in relation to recommendations DGHSC would make to strengthen the resilience of care pathways in the event of a future pandemic.

252. Blanket shielding advice is one lever to consider using in future – however, considering people at highest risk through a four harms approach will require strong consideration being given to alternatives, particularly in terms of providing the tools for individuals to make their own personal risk assessments based on their circumstances and the advice of their GP or clinical team. Support should then be targeted to those individuals who through choice and necessity self-isolate.

253. After a PHS evaluation concluded that less stringent measures may be a realistic alternative, there is a recommendation for taking a less restrictive approach in future. This approach may lessen the issues of exacerbating frailty, physical deconditioning and mental health impacts, with their resultant increased pressure on the health and social care system.

254. Being on the "Highest Risk List" in the longer term made people feel more vulnerable. Confidence leaving their home, physical activity, quality of life and mental health were all negatively affected. Whilst it is difficult to take a fully individualised approach to protecting people at highest risk, providing guidance which emphasises the need for people to take advice from their own GP or specialist clinician in order to protect themselves from the beginning is one approach to consider rather than giving blanket advice. Essentially it is also the actions of others that we need to consider in the protection of people at higher risk and influencing – particularly if taking a truly person-centred approach.

255. SG should take advice from Royal Colleges and clinical experts in regard to clinical prioritisation to ensure tests and treatments are carried out as safely and timeously as possible for suspected cancer patients, based on clinical risk.

256. Supporting shared aid across NHS health boards would maximise available capacity and minimise backlog growth during the pandemic.

257. Protected 'green sites' for cancer treatments should be initiated to ensure continued access to cancer services. This would also help reduce anxiety for patients attending 'hot sites' which was experienced during the Covid-19 pandemic.

258. The redeployment of staff integral to cancer services (e.g. endoscopy) should be avoided, while activating upskilling initiatives for those displaced, to build resilience into services post-pandemic.

259. As noted in the eighth corporate statement of DGHSC, submitted to Module 3 of the UK Covid-19 Inquiry on 29 March 2024, the Scottish Government is committed to learning lessons from the pandemic and making improvements to planning and responses to future challenges. As such, we will continue to reflect upon the impact of Covid-19 on healthcare in Scotland and look forward to being able to consider the report and recommendations from Module 3 of the UK Covid-19 Inquiry in due course as part of this process of making improvements based upon lessons learned.

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: 18 June 2024