Witness Name: Caroline Lamb
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UK COVID-19 INQUIRY
MODULE 3

WITNESS STATEMENT BY 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: -

Overview

1. This statement is one of a suite provided for Module 3 of the UK Covid Inquiry and these should be considered collectively.

2. The Scotland Act 1998 made provision for a Scottish Government (SG) of Ministers, and a Scottish Parliament to which they would be accountable.

3. The Module 2/2A statement from the Director General (DG) Strategy and External Affairs provided to the Inquiry on 23 June 2023 sets out a detailed explanation of the competence of the Scottish Parliament and Scottish Ministers under the 1998 Act as amended by the Scotland Acts of 2012 and 2016 and other legislation. Those include broad executive and legislative competence over most aspects of health and social services.

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

5. This statement provides in-depth and wide-ranging information on the structures in place for healthcare provision at the start of the pandemic and how these changed throughout the relevant period, as well as providing insight into how healthcare systems were

impacted by Covid-19 and the attendant responses from the SG. The statement covers the following broad areas:

- The accountability of Ministers and Senior Civil Servants within the SG with responsibility for healthcare;
- The structure of the DG Health and Social Care (DGHSC) family, and changes to this over the relevant period;
- The responsibilities and structure of NHS Scotland in the relevant period;
- Governance and decisioning making structures for the DG HSC family in the relevant period;
- An overview of key instances of cooperation and joint working with the UK Government and other devolved administrations on healthcare during the relevant period;
- Information on pandemic planning and response activities within the SG;
- Details on the responsibilities and actions of the Scottish Ambulance Service and NHS 24 during the pandemic;
- Information on a variety of issues and actions relating to the healthcare workforce and staffing in Scotland, including, but not limited to, recruitment, retention and wellbeing
- Information on the use of medical equipment, including Personal Protective Equipment (PPE), in Scotland during the pandemic;
- Details on the communication and engagements efforts of the SG to provide information on the healthcare response to Covid-19 in Scotland;
- Information regarding the numerous expert advisory groups set up in relation to the healthcare response to Covid-19 in Scotland;
- Details on how the healthcare elements of the SG's response to Covid-19 were funded;
- An overview of the myriad elements of Infection Prevention and Control that were included in the SG's healthcare response to Covid-19;
- Details on how the pandemic affected the capacity of different healthcare services within Scotland;
- Information on the handling of discharging of patients from healthcare settings in Scotland during the pandemic;
- A description of the issues and actions involved in shielding policies in response to Covid-19;
- The changing use of technology in healthcare settings throughout the pandemic;
- An overview of the various lessons learned exercises and reports commissioned by the SG in response to Covid-19 that are relevant to healthcare.

Accountability in and of the Scottish Government

6. The Public Health etc. (Scotland) Act 2008 (the 2008 Act) sets out the duties of Scottish Ministers, Health Boards and local authorities to continue to make provision to protect public health in Scotland. These are without prejudice to existing duties imposed on the Scottish Ministers and Health Boards in the National Health Service (Scotland) Act 1978 and existing environmental health legislation.

7. The organisational structure for DG Health and Social Care has been previously provided to the Inquiry: [CL8/001 - INQ000469941].

8. Currently four Ministers hold portfolio responsibility for aspects of health and social care:
   - Cabinet Secretary for NHS Recovery, Health and Social Care
   - Minister for Public Health, Women's Health and Sport
   - Minister for Mental Wellbeing and Social Care
   - Minister for Drugs Policy.

9. Ministerial post holders for the period from January 2020 to April 2022 are listed below:

   Cabinet Secretary for Health
   - Jeane Freeman (Cabinet Secretary for Health and Sport) - June 2018 to May 2021
   - Humza Yousaf (Cabinet Secretary for Health and Social Care) - May 2021 to March 2023.

   Junior Ministers for Health
   - Clare Haughey, Minister for Mental Health - June 2018 to May 2021
   - Joe FitzPatrick, Minister for Public Health, Sport and Wellbeing - June 2018 to December 2020
   - Mairi Gougeon, Minister for Public Health and Sport - December 2020 to May 2021
   - Maree Todd, Minister for Public Health, Women's Health and Sport - May 2021 to March 2023
   - Kevin Stewart, Minister for Mental Wellbeing and Social Care - May 2021 to March 2023.

10. As specified by the Civil Service Code, in the same way that Ministers are accountable to Parliament, civil servants are accountable to Ministers. The DG HSC is Caroline Lamb,

who has been in post since January 2021. The DG HSC is responsible for the Health and Social Care Directorates, detailed in paragraph 13, also referred to as the DG HSC family.

11. The DG HSC is a member of the SG's Corporate Board, the designated Portfolio Accountable Officer for Health and Social Care Directorates and the Chief Executive of the NHS in Scotland. As Accountable Officer, the DG HSC is personally answerable to Parliament and has a personal responsibility for the propriety and regularity of the finances under their stewardship and for the economic, efficient and effective use of all related resources. Accountable Officers are responsible for putting in place frameworks for SG Executive Agencies, non-ministerial offices and SG sponsored bodies that set out their own accountability arrangements.

12. All DG HSC post holders from January 2020 to April 2022 are listed below.

Director General and Chief Executive of NHS Scotland

- Malcolm Wright - June 2019 to May 2020
- John Connaghan - Interim CEO, April/May 2020 to January 2021
- Elinor Mitchell - Interim DG, April/May 2020 to December 2020
- Caroline Lamb - January 2021 to date.

13. DG HSC leads more than 1,700 staff across 11 directorates within the core SG and as Chief Executive of NHS Scotland, has oversight of the Health Boards in Scotland. These directorates and agencies are responsible for putting Government policy into practice.

14. DGs are responsible for families of directorates and the DG HSC line-manages the Health and Social Care Directors and senior clinical advisers such as the Chief Medical Officer (CMO), Chief Nursing Officer (CNO) and National Clinical Director (NCD). DG HSC delegates financial responsibility for budgets and expenditure incurred against these budgets to individual Directors through the Scheme of Delegation.

15. The Directorates that contribute to the delivery of policy for health and social care, as well as the administration of the NHS, social care and public health systems, include:

- The Directorate of the Chief Medical Officer
- The Directorate of the Chief Nursing Officer
- The Directorate for Chief Operating Officer, NHS Scotland

- The Directorate for Digital Health and Care
- The Directorate for Health Finance, Governance and Value
- The Directorate for Health Quality and Improvement
- The Directorate for Health Workforce
- The Directorate for Mental Health and Wellbeing
- The Directorate for Primary Care
- The Directorate for Population Health
- The Directorate for Social Care and National Care Service (NCS).

16. The list of Directorates provided above changed during the pandemic. Some Directorates were altered, with some new Directorates being added.

17. During the pandemic, the DG HSC family played a central role in the SG response by directly mobilising and harnessing support and delivery from national and local partners from NHS and social care staff, the clinical, analytical and scientific community through to local authority and third sector partners.

18. The DG HSC family are responsible for maintaining a high standard of care for the people of Scotland, providing support to health and social care services and workforce, and improving the health of the population. The DG HSC family serves both a policy and delivery function, with responsibility for the development of national policy for health and social care as well as oversight of the NHS. The DG HSC family is not solely focused on treating and preventing ill health. Its aim is to promote and sustain good health; complete physical, mental and social wellbeing.

19. Addressing the determinants of health is not solely the responsibility of the DG HSC family. Cross-government collaboration is being driven through the promotion of what is in effect a "health in all policies" approach. This approach means ensuring that the health and wellbeing implications of "non-health" policies are considered. It is reflected in Scotland's National Performance Framework, which includes the aim to increase the wellbeing of people living in Scotland. Work is underway in areas such as drugs policy, homelessness, child poverty and early years programmes in education and justice. Such an approach recognises the significant contribution non-health policy can make to improving health outcomes, as part of an overall commitment to national outcomes.

DG HSC family structures throughout the pandemic

20. A summary of structural and responsibility changes is provided below. Alongside each area of responsibility is a list of their functions during the period of January 2020 to April 2022.

- Directorate for Covid Health Response (DCHR) created in March 2020
- Directorate for PPE created in April 2020
- Directorate for Testing and Protect created in April 2020
- Directorate for Covid Public Health created in June 2020 (replacing DCHR)
- Directorate for Outbreak Management created in June 2020
- Directorate for Community Health and Care stood down in June 2020 (with responsibilities moved to the Directorate for Mental Health & Social Care and the Directorate for Primary Care)
- Directorate for Mental Health & Social Care created in June 2020, in December 2021, a separate Directorate for Mental Health was established, and all social care divisions formed part of a new Social Care and National Care Service Development Directorate.
- Directorate for Primary Care created in July 2020
- Shielding Division, sitting in the Directorate for Population Health, created in July 2020 - re-named as Covid Highest Risk Division in June 2021
- Directorate for Vaccine Policy and Strategy created in February 2021

21. Many of the teams responsible for policy and operational oversight of pandemic response measures, including testing, and vaccinations were developed out of functions in the Directorate of Population Health. A number of those functions generated new teams and ultimately new Directorates. In relation to the central policy and briefing co-ordination function, which was situated in Directorate for Population Health from January 2020, the main transition point was the creation of the Directorate for Covid Health Response (DCHR) on 16 March 2020, led by Richard Foggo and Donna Bell who became joint directors of the DCHR until June 2020 at which point it was replaced by the Directorate for Covid Public Health, led by Richard Foggo.

The Directorate for Covid Health Response

22. The DCHR was run as a single team with flexible resources, working seven days a week, on shift patterns.

23. On 20 April 2020, the secretariat team within the new Directorate formed a DG Health Hub when the Scottish Government Resilience Room (SGoRR) introduced eight "Group Hubs" for Covid-19 focused work across SG. The hub workstreams were reviewed and updated regularly to take account of the rapidly evolving situation. Subsequently, the DG Health Hub along with the Briefing and Liaison team moved to the DG HSC family on 1 June 2020, led by Michael Kellet as Deputy Director.

24. In May 2020, the DCHR was reviewed internally by its Directors. This review was required to respond to the developing path of the pandemic and as well as the difficulties in sustaining a "matrix" approach. The review identified the need for greater clarity of relationship between DCHR functions, new functions that would be required (e.g. vaccinations) and existing functions in the Directorate for Population Health.

The Directorate for Covid Public Health

25. On 1 June 2020, Richard Foggo was appointed as sole Director for Covid Public Health (CPH), with Donna Bell moving to become Director for Mental Wellbeing and Social Care. Following Richard Foggo's appointment, Elizabeth Sadler replaced him as Interim Director for Population Health between June and September 2020. Michael Kellet took over as Interim Director for Directorate for Population Health after September 2020.

26. The CPH Directorate was initially made up of the following divisions, and headed up by the Deputy Directors (DD) listed:
    - Covid Ready Society – Lesley Shepherd, with Elizabeth Sadler taking over in October 2020. Elizabeth Sadler was joined by Marion McCormack as joint DD in April 2021
    - Covid Testing and Contact Tracing Policy Division – Niamh O'Connor, before being joined by John Nicholson as joint DD in July 2020
    - Vaccinations (until February 2021 when it then moved to a new Directorate for Vaccinations) – Derek Grieve
    - Community Surveillance – John Nicholson, before being replaced by Angus Macleod and Marion McCormack in July 2020. Andy Bracewell joined as joint DD in October 2020 with Marion McCormack moving to the Directorate for Vaccinations shortly after
    - HSC Analytical (HSCA) Hub – Anita Morrison and Nicola Edge
    - Covid-19 Data and Intelligence Forum – co-chaired by Scott Heald (PHS Head of Statistics) and Anita Morrison (Head of HSCA) set up in June 2020 to ensure effective co-ordination and coherence across the various Covid-19 data and intelligence

streams that flow within and between SG, PHS and NSS as the main providers of Covid-19 data and analytical products and infrastructure solutions.

27. The work of the Directorate for Covid Public Health continued to expand, and divisions were established to manage emerging policy strands of work in; Test Trace Isolate, Transmission, Vaccines, Port Health, Legislation, HPS Liaison, Data, Excess Deaths, and Social Distancing. Liaison with HPS continued but was also expanded to wider SG and other sectors to ensure that an accurate and timely flow of public health advice was provided.

28. The Directorate also provided DD oversight for the Covid-19 Advisory Group (C19AG), led by Daniel Kleinberg. Additional DD support was added in July 2020 with Angus Macleod, Marion McCormack and Frank Strang joining the Senior Management Team (SMT). Angus Macleod and Marion McCormack took over Community Surveillance Division, with John Nicholson and Niamh O'Connor leading Testing and Contact Tracing Policy Division. Frank Strang provided support without a division, then moved to the newly created Care Home Pandemic Division in spring 2020 until he moved to support the return of schools within the Higher Education/Further Education Directorate in Summer/Autumn 2020.

29. Although all teams had a role in delivery, their primary functions were policy development including formulating advice to Ministers.

30. There were three primary functions of the Director for Covid Public Health from June 2020 that are relevant to how advice was formed to assist Ministerial decision making:

- management responsibility for the divisions (and other functions) in Covid Public Health, with line management responsibility for the DDs;
- co-ordinating liaison with both PHS and Directors of Public Health, which included the establishment of a "Daily Huddle" at which information was shared (this was not a decision-making forum). This was in addition to ongoing daily liaison calls with PHS;
- lead policy adviser on public health, working closely with senior clinicians (CMO, CNO and the NCD) to provide advice on the development of key Covid-19 strategies within the DG HSC family, including Test and Protect, Community Surveillance, Vaccinations, Certification, and on the health and social care contribution to the Four Harms decision making process. The Director for Covid Public Health would attend SGoRR meetings (both official and Ministerial), Four Harms meetings, topic specific deep dives with Ministers including the First Minister. Further information on the Four

Harms process is contained within the Module 2A Strategy and External Affairs statement, provided to the Inquiry on 23 June 2023.

31. A document showing details of the policy area and respective Deputy Directors is provided: [CL8/002 - INQ000147350].

32. The private sector engaged with the Directorate for Covid Public Health and provided information through meetings and discussions on a variety of subjects. Their views helped shape the policies on various issues, including in developing our delivery systems on:
    - Certification
    - Test and Protect
    - Key Workers
    - Testing
    - Vaccines
    - Shielding.

33. The Directorate for Covid Public Health disbanded in June 2022 when it re-merged with the Directorate for Population Health. At that point, the Director of Covid Public Health became Co-Director for Population Health along with the Director for Test and Protect, Christine McLaughlin. Michael Kellet, who had been Interim Director for Population Health from 21 September 2020, left the Directorate in August 2022 to join PHS as their new Director of Strategic Planning and Performance.

The Directorate for PPE

34. In April 2020, a new Directorate for PPE was established to provide strategic and coherent co-ordination in relation to all aspects of the provision of pandemic PPE in Scotland. The Directorate for PPE then became a Division of the Health Finance, Corporate Governance and Value Directorate in July 2020. It later became a Unit in Health Infrastructure, Investment and PPE Division in January 2021.

35. Paul Cackette, as Director of PPE, was responsible for delivering the Directorate's remit of drawing together five strands of corporate priorities:
    - PPE for Health and Social Care staff and patients, with a focus on supply and distribution to frontline health and social care staff for Pandemic Preparedness Response (PPR) in accordance with professional advice

- PPE for non-health and social care users, supporting wider public service workforce supply and distribution of PPE in accordance with professional advice
- co-ordinating Scotland's involvement in a four nations approach to PPE
- working with Scottish companies on Scotland's own PPE manufacturing capacity
- enhancing stakeholder consultation and communications both across SG and with wider partners including COSLA, Society of Local Authority Chief Executives and Senior Managers (SOLACE) and resilience partners.

36. The PPE Strategy and Governance Board was set up in May 2020, originally to bring together senior leaders from various organisations with an interest in PPE issues, and steer operational decision making. Regular meetings were set up, with the first meeting held on 6 May 2020, and the frequency of meeting was kept under review and adjusted as required. Initially, these virtual meetings were held weekly until 19 May 2020, with a move to fortnightly (until 29 October 2020) then monthly as the pandemic progressed and PPE supplies stabilised until the Board stood down after the final meeting on 28 April 2022.

37. The Chair of the Board was as follows:
    - May 2020 – June 2020, Director, PPE Directorate
    - July 2020 – December 2020, Deputy Director, PPE Division
    - January 2021 – April 2022, Deputy Director, Health Infrastructure, Investment and PPE Division.

38. Meetings were attended by SG officials, and representatives from NHS NSS, Scotland Excel, Scottish Enterprise and latterly APUC (Advanced Procurement for Universities and Colleges). Scottish Government Board members were as follows:
    - Deputy Director, Health Infrastructure (Chair)
    - Director of Scottish Procurement and Property Directorate
    - Director of Health Finance, Corporate Governance and Value Directorate
    - Deputy Director for Manufacturing and Industries
    - Deputy Director of Enterprise & Innovation
    - Head of Operations and Assurance Unit, Early Learning and Childcare
    - Deputy Director, Community Justice, Directorate for Justice.
    - Chief Executive, Scotland Excel Chief Executive, Scotland Excel
    - Director of National Procurement, Commissioning & Facilities, NSS
    - Head of High Value Manufacturing, Scottish Enterprise

- Head of Category – Estates and Facilities, APUC
- Head of Cross-Cutting Policy Team, PPE Division (latterly Head of PPE Unit)
- Head of Data Management, PPE Division
- Business Manager, PPE Division (secretariat – latterly Head of PPE Action Plan Implementation and Policy, PPE Unit)

39. Subject matter experts attended when required to provide information, advice and guidance and / or to report progress on specific items.

40. As defined in the terms of reference, all decisions made by the PPE Strategy and Governance Board were recorded in the minutes. In circumstances where the group was unable to reach a consensus, the Chair had the authority, as the person accountable for the delivery of the PPE Sustainability Strategy, to make the final decision. Updates were provided to the Cabinet Secretary for Health and Sport/Social Care, and when appropriate their views / approval were sought. The Scottish Government PPE Action plan was published in October 2020, and responsibility for this was formally written into the Board's terms of reference in November 2020. From approximately June 2021 to April 2022, the Board took the primary role of overseeing the PPE Futures Programme of work to take forward the Action Plan. When that Programme ended, the Board had completed its work and stood down on 28 April 2022.

41. All significant decisions taken regarding PPE within the PPE Directorate / Division/ Unit were overseen by the Strategy and Governance Board during its period pf operation. All decisions made by the PPE Strategy and Governance Board were recorded in the minutes, which were published on the SG website.

42. A Future Pandemic PPE supply programme was established to ensure lessons were embedded and is provided: [CL8/003- INQ000468163]. These lessons included:
    - **Issue:** The Scottish Government could have been better prepared to respond to the Covid-19 pandemic by taking account of previous pandemic exercises.
      Context: The pre-Covid-19 pandemic stockpile was based on an influenza pandemic.
      Actions taken: The agreed future approach sees Scotland moving away from the previous 4 nations approach to the pandemic stockpile. This will ensure the stockpile is managed to minimise wastage and has inbuilt flexibility to include additional items of PPE should clinical guidance on the use of pandemic PPE change as well as new and/or innovative PPE as it becomes available. A bought in surge capacity will

support the pandemic PPE stockpile at the beginning of any future pandemic to counteract price fluctuations and shortages caused by increased demand.

- **Issue:** The cost of PPE increased during the early response phase of the pandemic.
  Context: In the early stages of the Covid-19 pandemic there was an unprecedented increase in demand for pandemic PPE and at the same time supply chains were under pressure from the reduced ability to ship PPE from abroad and, in some cases, from foreign governments embargos on the export of PPE.
  Actions taken: A bought in surge capacity will support the pandemic PPE stockpile at the beginning of any future pandemic to offset price fluctuations caused by increased demand. Procurement should prioritise short supply chains where it is able to do so.
- **Issue:** During the early stages of the Covid-19 pandemic, some contracts were awarded without competition.
  Context: Due to the international supply crunch, contracts had to be awarded quickly to ensure supply. Emergency procurement procedures had to be followed. No bias was identified in awarding these contracts.
  Actions taken: A key objective is to ensure a secure and sustainable PPE supply to Scotland, in business as usual and pandemic events. A built in surge capacity and national PPE stockpile will significantly reduce the likelihood of a repeat of the early months of Covid-19, and the need to rely on emergency procurement procedures.
- **Issue:** Difficulties in prioritising supply.
  Context: Local Government Authorities felt that health care was prioritised over social care in PPE supply. Local Authorities felt that equal importance should be placed on both sectors.
  Actions taken: Local authorities and other public sector organisations will be able to 'opt in' to joint procurement arrangements and a national pandemic PPE stockpile, managed by NHS NSS. For organisations that choose not to opt in to the arrangements, guidance will be available on how they can prepare for any future pandemic.

The Directorate for Testing

43. On 6 April 2020, Annabel Turpie was appointed Director of Testing. Ian Davidson was the Deputy Director leading on testing capacity across Scotland to support a Test, Track, Isolate approach to managing Covid-19 until 29 May 2020. The Directorate for Testing took on policy and operational oversight responsibility from DCHR from 6 April 2020 until 29 May 2020. Policy responsibility for Test and Protect was transferred back to the

Directorate for Covid Public Health in June 2020, but operational oversight remained separate, with Jill Young and Christine McLaughlin appointed co-Directors of Test and Protect in June 2020. Christine McLaughlin joined the Directorate for Covid Public Health in June 2021 to share director duties with Richard Foggo.

44. Caroline Lamb was delivery director for Contract Tracing and Isolation from May 2020 to August 2020.

45. Prior to September 2020, advice on key decisions relating to social care workforce testing was led by the Testing Division and the CNO Directorate with input from the Adult Social Care Pandemic Response Division. From September 2020, the Pandemic Response Division took the lead on social care workforce testing. Advice on care home resident testing was led by PHS.

46. Key relevant papers relating to Test and Protect have been provided, including clinical advice, advice to Ministers and letters sent to stakeholders: [CL8/004- INQ000147357] [CL8/005 - INQ000147356] [CL8/006 - INQ000147428] [CL8/007 - INQ000147429] [CL8/008 - INQ000147363] [CL8/009- INQ000147364] [CL8/010 - INQ000147365] [CL8/011 - INQ000147366] [CL8/012 - INQ000147358] [CL8/013 - INQ000147359] [CL8/014 - INQ000147360] [CL8/015 - INQ000147361] [CL8/016 - INQ000147362] [CL8/017 - INQ000147367] [CL8/018 - INQ000147368] [CL8/019 - INQ000147369] [CL8/020 - INQ000147460] [CL8/021 - INQ000147371] [CL8/022 - INQ000147372] [CL8/023 - INQ000147373].

The Directorate for Outbreak Management

47. Paul Cackette was appointed Director for Outbreak Management in June 2020, with Penelope Cooper taking over in November 2020 when Paul Cackette retired from SG. This Directorate was made up of three divisions covering Policy, Strategy and Response. The Outbreak Management Response division transferred from the Directorate for Outbreak Management to Covid Public Health in October 2020 and Andy Bracewell, Head of Outbreak Management Response, joined Angus Macleod and Marion McCormack as joint Deputy Directors for Community Surveillance. The original Directorate for Outbreak Management became the Directorate for Covid Co-ordination on 1 May 2021. This Directorate continued to sit in DG Strategy and External Affairs (not DG HSC), but they worked particularly closely on certain functions.

The Shielding Division

48. The Shielding Programme was established in March 2020 to identify, protect, support and advise people considered to be at highest risk of severe illness or death should they contract Covid-19, with Michael Chalmers as the initial Director. A Shielding Division was then formally established, sitting in the Directorate for Population Health from July 2020 onwards. The Division was led by Orlando Heijmer-Mason as Deputy Director. The Division was re-named the Covid Highest Risk Division in June 2021. This followed a decision on 28 June 2021 to rename the Shielding List of approximately 185,000 people, the "Highest Risk List", given people were no longer being asked to shield, and the name was causing some confusion. The Division eventually merged into the Covid Ready Society Division in August 2022, following the closure of the Highest Risk List in Scotland during May 2022, and after the Covid Public Health Directorate merged with the Directorate for Population Health.

49. The Shielding Policy team provided information directly to Ministers including but not limited to, return-to-work policy, risk assessments and NPIs such as face coverings for those HSC workers considered to be at highest risk from Covid-19, who were on the Shielding / Highest Risk list. Clinical Leads Advisory Group (CLAGS) members fed into the Shielding policy team via the CLAGS meetings and secretariat.

The Directorate for Vaccine Policy and Strategy

50. In June 2020 a Vaccines Division was created in the Directorate for Covid Public Health. This was led by Derek Grieve. From August 2020 to January 2021, Caroline Lamb was also Delivery Director for the Flu and Covid Vaccination Programmes. The Directorate for Vaccine Policy and Strategy was established on 15 February 2021, headed up by Stephen Gallagher, in the position of Director. Jamie MacDougall was the Deputy Director responsible for Vaccine Strategy.

51. The new Directorate for Vaccine Policy and Strategy remained unchanged until 30 April 2022, when it was merged back into the Directorate for Population Health as the Vaccinations Division.

The Directorate for Community Health and Care

52. The SG sets out the overall strategic framework and legislative basis for the delivery of adult social care while local authorities have a statutory responsibility to provide the services.

53. The Public Bodies (Joint Working) (Scotland) Act 2014 requires local authorities and NHS boards to work together through Integration Authorities to plan, commission and deliver services. In most cases this is achieved through an Integrated Joint Board (IJB). IJBs are responsible for the planning of adult social care services, as well as some health services and other functions. These services were previously managed separately by NHS boards and local authorities and are now delegated to IJBs. Although responsibilities may be delegated, local authorities and NHS boards remain accountable for the statutory duties conferred on them by legislation. Local authorities are accountable to the electorate, NHS boards are accountable to Scottish Ministers and the Scottish Parliament and the electorate. IJBs are jointly accountable to local authorities and NHS boards through their voting membership and via reporting to the public. As distinct legal entities, IJBs are corporately responsible and accountable for complying with all relevant law when carrying out their services. In Scotland, adult social care is delivered by a wide range of partners including the public, independent and third sectors. There are also several regulatory bodies with an interest in the health and social care sectors that will scrutinise the operations of IJBs.

54. There are 31 Health and Social Care Partnerships (HSCPs) across Scotland that are responsible for adult social care, adult primary care and unscheduled adult hospital care. They were established in 2016 to bring together health and social care into a single integrated system, as previously these services would have been managed separately by NHS Boards and local authorities. HSCPs are tasked with delivering the services that the IJBs commission.

55. Currently, Donna Bell is Director for Social Care and National Care Service Directorate. Previously, social care formed part of the Directorate for Mental Health and Social Care, also under Donna Bell, and prior to that, part of the Community Health and Care Directorate under Elinor Mitchell. Elinor Mitchell was the Director at the outset of the pandemic, with the Directorate including two social care divisions, in addition to primary and community healthcare, as set out below:

- Adult Social Care Division – led by Deputy Director, Jamie Macdougall;
- Health and Social Care Integration Division – led by Deputy Director, Alison Taylor.

56. The Adult Social Care Division covered adult social care policy, and the reform programme, social care workforce and fair work, Care Inspectorate sponsorship, Adult Support and Protection, Unpaid Carers policy, Independent Living Fund, Survivors in Care, Assisted Communications and Sensory Impairment.

57. At the start of the pandemic, both the Health and Social Care Integration and Adult Social Care Divisions came together to support the pandemic response for the social care sector. The Care Homes Pandemic Division was then subsequently formed under Frank Strang, and supported by professional adviser, David Williams. This Division oversaw the provision of support to the care home sector during the initial stages of the pandemic. The remit of the Division was then widened to include provision of support across all social care and was renamed to Adult Social Care – Responding to the Pandemic Division, led by Deputy Director Anna Kynaston and then Jennifer Veitch.

58. From June 2020, the Directorate for Mental Health and Social Care was established, and in October 2020 the Directorate restructured to support recovery and renewal whilst continuing to support pandemic response. The revised structure had five social care divisions as below and two mental health divisions:
    - Responding to the Pandemic – supporting key areas such as Covid-19 testing, vaccination, PPE and practice guidance across adult social care provision – Deputy Director, Anna Kynaston (replacing Frank Strang)
    - Remobilisation, Recovery and Reform – Deputy Director, Kate Hall
    - Policy and Delivery - Deputy Director, Gillian Barclay
    - Governance, Evidence and Finance – Deputy Director, Iain MacAllister
    - Support for the Independent Review of Adult Social Care – Deputy Director, Alison Taylor.

59. These divisions were revised or augmented in September 2021 to a new structure as follows:
    - Adult Social Care Workforce and Fair Work Division – led by Deputy Director, Ian Turner. Responsible for supporting and developing policies for the social care workforce including responsibility for workforce planning and development, recruitment, leadership, skills and training across the adult social care workforce, and personal assistants

- Improving Social Care Quality Standards and Delivery Division – led by Deputy Director, Simon Cuthbert-Kerr. Responsible for adult social care policy including leading on care at home, unpaid carers, care home charging policy, Self-Directed Support, assisted communications and GIRFE (Getting It Right For Everyone)
- Regulation Improvement and Integration Support Division - led by Deputy Director, Iain MacAllister. Responsible for the sponsorship of the Care Inspectorate and the Independent Living Fund Scotland; and for Adult Support and Protection, financial support for social care providers (sustainability payments), cross-cutting work to strengthen regulation and improvement in social care
- Resilience and Pressure Unit - led by Deputy Director, Gillian Barclay. Responsible for responding to the significant challenges being placed on operational delivery of social care in Scotland
- National Care Service Development – Deputy Director, Anna Kynaston. Responsible for the development of the National Care Service
- Adult Social Care Pandemic Response – Deputy Director, Jennifer Veitch. Responsible for engagement with the adult social care sector on pandemic response and guidance on areas such as face masks, testing and care home visiting and embedding good practice and improvement based on learning from the pandemic and building foundations for the recovery of the sector.

60. In December 2021, a separate Directorate for Mental Health was established, led by Interim Director Hugh McAloon. All social care divisions subsequently formed part of a new Social Care and National Care Service Development Directorate, led by Donna Bell.

61. The Social Care and National Care Service Development Directorate leads on Social Care policy with a focus on supporting people to lead independent lives in their own communities, and creation of a National Care Service (NCS), a cross government priority, with the aim to transform our community health and social care support and services, empowering people to thrive, with human rights at the core.

62. Within this Directorate, a Responding to the Pandemic Division was created to combat the issues created by the pandemic across the totality of social care. This Division has since been renamed to Adult Social Care Oversight and Assurance Support with Jennifer Veitch as the Deputy Director. This division has supported, among other things, engagement with the adult social care sector on pandemic response and guidance on areas such as face masks and testing and care home visiting.

The Primary Care Directorate

63. The Primary Care Directorate was formed in July 2020. The Directorate included the Dentistry Division from the Directorate for Population Health and GP Division from the Directorate of Community Health and Care, it took over formal National Board Sponsorship arrangements for NHS 24 and SAS, inclusive of Primary Care Out of Hours Services. Aidan Grisewood was appointed as the Interim Director of Primary Care from its inception and was in post until June 2021, after which he was replaced by Tim Mcdonnell.

64. Tom Ferris, as Chief Dental Officer (CDO), had responsibility for Dentistry Division. Naureen Ahmad, as Deputy Director for General Practice, had responsibility for General Practice Policy. Heather Campbell was the Deputy Director with responsibility for primary care out-of-hours services and NHS 24 and SAS Sponsorship. Heather Campbell was in post until January 2022.

65. The Directorate also had approximately 15 professional advisers from across dentistry, optometry and general practice who provided support to the policy teams. They came from clinical and management professional backgrounds, working at senior levels in their organisations.

66. Primary healthcare is and remains the first point of contact for people seeking treatment, medical advice, prescriptions, or referrals to specialist care. At least 90% of all health contacts take place in primary care settings. Whilst primary care is often associated with GP services, for governance and delivery purposes, it also consists of dentists and dental nurses, pharmacists and pharmacy technicians, optometrists, dispensing opticians, and audiologists. Primary care also plays an essential role in supporting the provision of urgent and unscheduled care both in-hours and out-of-hours, including working with NHS 24 and SAS.

67. Most primary care services are delivered by Independent Contractors (ICs). Over the period January 2020 to April 2022, Primary Care Directorate – and its predecessor divisions – oversaw the implementation of policy relating to IC contracts and provided funding to deliver services in relation to general practice, dentistry, and optometry. It also oversaw wider policy around primary care services that were outwith core contractual terms and conditions. Clinical governance was not the responsibility of Primary Care Directorate and as noted in the sections on General Practice and Dentistry below, it is the

responsibility of Health Boards and HSCPs. Changes to clinical practice did not sit within Primary Care Directorate and remained the responsibility of the CMO.

68. For urgent primary care, out-of-hours services were provided by Health Boards. The Primary Care Directorate oversaw funding and monitored delivery of this service as part of broader NHS performance structures that reported to the COO. NHS 24 and SAS are national Health Boards and were part of the central governance structures for all Health Boards. Primary Care Directorate continued to provide sponsorship to both SAS and NHS 24 during Covid-19.

69. Primary Care Directorate utilised a number of governance groups and organisations to interact and connect with the IC and broader national Primary Care community, including Chief Officers' Recovery and Remobilisation Group, British Medical Association (BMA), RCGPs/SG Trilateral, BMA/SG Bilateral, Chief Officer/SG Bilateral, Directors of Dentistry's Group, Primary Care Leads, Short-life sub-group on Primary and Community Health Care (PCSG).

70. The Primary Medical Services (Scotland) Act 2004 amended the National Health Service (Scotland) Act 1978, by placing a duty on Health Boards to provide or secure "primary medical services" for their populations. Health Boards can contract with GPs to deliver services and / or run their own.

71. As noted above, most general practices in Scotland are run by GPs as ICs. The GP partners contract with the Health Board to deliver general medical services and in turn they receive funding based on the size and demography of their patient list and other factors such as demographics and rurality to deliver services. These services are delivered via the GP partner(s) who lead a multi-disciplinary team of practice employed and, increasingly, Health Board employed staff. In practices run by Health Boards, all staff are salaried. This GP governance and delivery arrangement remained in place through the pandemic.

72. The contract, colloquially known as the "GP contract", focuses on delivery of medical services to patients and related terms and conditions. Health Board run practices operated under section 2C of the 1978 National Health Service (Scotland) Act and are and remain colloquially referred to as "2C practices".

73. The terms and conditions of the GP contract were and remain negotiated nationally between the SG and the BMA. Wider policy around GP services that may not be wholly covered in by the terms of conditions of GP contracts are negotiated and agreed by the SG and BMA.

74. Day to day contract management took place at Health Board and HSCP level through Primary Care teams who provide support, advice, development of services, and clinical governance to general practice.

75. Under section 1 of the Public Bodies (Joint Working) 2014 Act, a set of Health Board functions must be delegated to IJBs. IJBs took steps to plan and commission these functions. Consequently, several key functions were delegated to IJBs for HSCPs to deliver, including primary care and the development of multi-disciplinary teams to support general practice as part of Phase One of the 2018 GP Contract.

76. Section 25 of the NHS (Scotland) Act 1978 provides for NHS Boards to plan with independent dental contractors for the provision of General Dental Services.

77. Independent dental contractors were required to meet Terms of Service as set out in Schedule I (Part II) of the NHS (General Dental Services) (Scotland) Regulations 2010. The terms of service make requirements on independent contractors when they register a patient, as a child (capitation arrangement) or adult (continuing care arrangement).

78. As NHS boards plan with ICs, assurance around clinical governance fell to the relevant geographic Health Board.

79. The majority of the 1,050 dental practices in Scotland are independent, providing a mix of NHS and private dental care. Around 10% of practices are Public Dental Service, providing NHS services where staff, including the dentists, are employed by the respective NHS board.

80. NSS Practitioner Services, made and continue to make payments on behalf of NHS boards to independent contractors.

81. Section 26 of the NHS (Scotland) Act 1978 ("1978 Act"), provided: [CL8/024 - INQ000183003], places a duty on Health Boards to enter arrangements with "contractors" (which can be a body corporate, or optometrist registered with the General Optical

Council, or an ophthalmic medical practitioner (OMP) registered with the General Medical Council (GMC) for the provision of NHS eye examinations. The services provided under these arrangements are known as General Ophthalmic Services (GOS).

82. Despite the "contractor" terminology, there is no "contract" as such in GOS. Optometrists, OMPs and bodies corporate can apply to be included on a Health Board's Ophthalmic List for GOS provision in the Health Board's area. There are two parts to an Ophthalmic List: Part 1 details the contractors (optometrists, OMPs and bodies corporate) and Part 2 details those optometrists and OMPs who can "assist" a contractor in GOS provision in the Health Board area.

83. While community pharmacy is classed as a "primary care" service, policy responsibility does not sit within the Primary Care Directorate; rather it sits with the Pharmacy and Medicines Division within the Directorate for the CMO.

84. The Public Bodies (Joint Working) (Scotland) Act 2014 at Section 1(8) states that Health Boards must delegate prescribed functions. General dental, ophthalmic and pharmaceutical services are included in schedule 3 of the Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Regulations 2014. This means that since 2014, HSCPs have had a commissioning role but not a contractual or delivery role in these services. These have been delegated to IJBs with IJBs responsible for planning and commissioning these functions.

The Health Workforce Directorate

85. Health Workforce was an established Directorate prior to the pandemic. However, following Gillian Russell's appointment as Director on 16 March 2020, existing staff resource pivoted to have an almost exclusive focus on supporting the response to the pandemic.

86. Work within existing divisions was reprioritised and a Health Workforce Directorate Hub was created to deal with the significant increase in correspondence and provide central co-ordination for briefings and requests. A Wellbeing and Leadership Division was established in April 2020, recognising the need for nationally led services to provide support for staff across HSC.

87. The Health Workforce Directorate had a significant range of functions to support the NHS workforce. During the late spring and summer of 2020, the Directorate was restructured into three core workforce divisions: Workforce Planning and Development, Workforce Pay, Practice and Partnership and Workforce Leadership, Culture and Wellbeing. In responding to the pandemic, Health Workforce was responsible for:

- workforce planning and monitoring of the Test and Protect workforce
- workforce planning and monitoring of the Vaccinations workforce
- innovation around wellbeing support
- amendments to NHS Terms & Conditions
- partnership relations with unions and professional bodies and NHS Employers
- a range of employee/employer Covid-19 guidance for the NHS
- supporting Health Boards in relation to the redeployment of staff to essential clinical roles
- supporting additional recruitment; including of staff returning to the service
- working with NHS National Education Scotland (NES) and higher education partners to address key strategic issues and risks around healthcare student placements
- supporting the deployment of students into the workforce.

88. The Director of Health Workforce also facilitated engagement between Malcolm Wright, who was then DG HSC, and the military, with a view to bringing in expertise on strategic command capability. The military provided support to the DG over a period of several months to enable optimum pandemic response and capability building, including improving resilience and creating effective challenge to internal thinking and delivery proposals at pace and scale.

89. A chronology of the key decisions on which Health Workforce supplied advice to Ministers is provided: [CL8/025 - INQ000147408].

90. Changes to the senior leadership of the Directorate are provided below:

- Shirley Rogers, Director of Health Workforce left the post on 13 March 2020. Gillian Russell took over the post on 16 March 2020 and is still in post.
- Sean Neill, Deputy Director for Health Workforce left his post in March 2020 and returned as the Interim Director of Health Workforce (new post) from April 2020 until March 2021. This was an additional post in recognition of the scale of work for the existing Director.
- Stephen Lea-Ross was promoted to Deputy Director of Health Workforce in March 2020 and is still in post.

- David Miller was appointed as Chief People Officer for the Office of the Chief Executive NHS Scotland in April 2020. David returned to work for NHS Scotland in December 2022.
- Laura Zeballos was promoted to Deputy Director of Pay, Practice and Partnership (new post) in May 2020. Laura is still in post.
- Victoria Bowman joined as Deputy Director of Pay, Practice and Partnership on 17 August 2020. The post is a job share with Laura Zeballos. Victoria Bowman took a career break on 31 January 2023.
- Catherine McMeeken joined as Deputy Director of Wellbeing, Leadership and Talent Management in October 2020 and left the post in April 2023.

The Directorate for the Chief Operating Officer

91. The Directorate for the Chief Operating Officer (DCOO), NHS Scotland (formerly the Directorate for Performance and Delivery (DPAD)) was an established Directorate before the pandemic. The Directorate seeks to achieve the best health and care outcomes for people by supporting NHS Scotland to deliver the best possible performance.

92. The Director leading DCOO at the start of the pandemic was John Connaghan (Director for Performance and Delivery). He was both Director for Performance and Delivery and Interim Chief Executive of NHS Scotland (between April and December 2021). He was designated as Chief Operating Officer (COO), NHS Scotland in January 2021 and remained in this post until June 2021 when John Burns took over, who remains in post.

93. The three key policy divisions involved in the response to the Covid-19 pandemic were:
    - Health Emergency Preparedness, Resilience and Response Division (Health EPRR and previously Health Resilience Unit)
    - Performance and Delivery Division
    - Health Planning and Sponsorship Division.

94. Health EPRR led on:
    - the initial stages of supply and procurement of PPE to NHS Scotland including liaising with the other UK Nations (until the SG PPE Directorate was established in April 2020);
    - support for the Ministerial Group chaired by Ivan McKee, then Minister for Trade, Investment and Innovation, established to lead on the procurement and supply of medical devices and equipment, alongside NSS and other SG directorates;

- national pre-Covid-19 pandemic stockpiles of PPE, other consumables, antivirals, and antibiotics, including working with other UK nations;
- supporting NHS Scotland in exercising pre-pandemic working with key stakeholders.

95. From a Health EPRR division perspective, there were various PPE issues during early 2020 including procurement decisions, developing principles of stock sharing with other UK nations, delegating use of the pandemic stockpiles to the NHS, providing spending authority for procurement and surveying of NHS boards on their usage of FFP3. Supporting documents on this are provided: [CL8/026 - INQ000147461] [CL8/027 - INQ000147374].

96. The EPRR Division manage policy development for national emergency planning, resilience and response for NHS Scotland. This includes developing organisational resilience frameworks for implementation by Health Boards. They also work with NHS Boards to assess progress towards meeting the organisational resilience standards.

97. Their work involves advising ministers on health plans and programme investments to support organisational resilience and lead ministerial advisers on national incidents. They also work collaboratively with internal and external stakeholders in Scotland and the UK to plan and deliver signature events.

98. Health EPRR Division led pandemic planning arrangements on behalf of the DG HSC family over several years prior to Covid-19 and developed well-established approaches and structures to pandemic planning across NHS Scotland. This included co-production of UK four nations Pandemic Influenza Strategy 2011 and cross-Directorate working within the SG through the Pandemic Flu Readiness Board.

99. Health EPRR also provided relevant guidance to NHS Boards in Scotland to improve both their specific pandemic planning and more broadly, their emergency preparedness and resilience. Key documents in that regard include *the UK Influenza Pandemic Preparedness Strategy 2011* and related *Pandemic Influenza Communications Strategy 2012 for Health & Social Care*, provided: [CL8/028 - INQ000102974] [CL8/029-INQ000144590]. More broadly, EPRR issued general guidance to Health Boards on preparing for emergencies and on NHS Organisational Standards for Resilience, which included both general and specific pandemic-related standards on which Boards reported, provided: [CL8/030 - INQ000102971]. EPRR also played a role in co-ordinating the involvement of NHS Boards in Scotland level exercises (for example, Exercise Silver

Swan in 2015) as well as the involvement of SG and some NHS officials in the UKG Exercise Cygnus in 2016.

100. The Performance and Delivery Division led on:

- testing capacity and demand;
- actions to increase the number of ventilators and subsequently the number of ICU beds available across NHS Scotland during the initial months of the pandemic in 2020;
- utilisation of the private sector to increase capacity;
- de-mobilisation decision – pause in elective care;
- development and publication of the framework for the clinical prioritisation of elective care to support boards to take decisions on how they prioritise patients;
- re-mobilisation planning and decision to restart elective services;
- delivery of the NHS Recovery Plan, provided: [CL8/031 - INQ000228406];
- ongoing monitoring and reporting on NHS Board performance for both planned and urgent / unscheduled care;
- delivery for Redesign of Urgent Care including actions to control attendances to Accident and Emergency;
- engagement with PHS around data and intelligence on the trajectory of the ongoing spread of virus.

101. Health Planning and Sponsorship Division led on:

- providing a co-ordinated approach to evidence and information on capacity and pressures across health and social care;
- Remobilise, Recover Re-design: the Framework for NHS Scotland, provided: [CL8/032 - INQ000147375];
- The Mobilisation Recovery Group (MRG) which was established as an advisory group to Ministers in support of the above Framework;
- Operational Planning (including de and re-mobilisation planning) policy for NHS Boards;
- increasing intensive care (ICU) capacity on a permanent basis - commissioned jointly by the COO NHS Scotland, CMO, and CNO;
- NHS acute capacity indicator(s) used to determine the geographical 'Levels' approach to suppressing the virus;
- NHS Board Performance Escalation Framework (with any decision to escalate a Board to the highest stage taken by CHS with advice from the HSCMB);

- NHS Board Annual and Mid-Year Reviews;
- National Planning and Performance Oversight Group (NPPOG).

102. From a Planning and Sponsorship division perspective, a timeline of decisions is provided: [CL8/033 - INQ000147376].

103. The Health Planning and Sponsorship Division also held the following meetings:
    - Mobilisation Recovery Group (MRG) Meetings. This advisory group was established under the Remobilise, Recover and Redesign: National Framework for Scotland. It provided input to decisions on resuming and supporting service provision but was not itself a decision-making group;
    - ICU Uplift Short Life Working Group (SLWG) Meetings. The ICU uplift SLWG made recommendations to the COO, CMO and CNO, and then to the Cabinet Secretary for Health and Sport (CSH). The CSH took the final decision to implement an additional 30 Level 3 intensive care beds (for patients requiring highest levels of clinical support) across Scotland on a permanent basis. The SLWG did not have decision making authority. The SLWG was reconvened in November/December 2021 with a reduced membership to make recommendations on changes to the ICU surge escalation policy;
    - National Planning and Performance Oversight Group (NPPOG) - the purpose of the Group was to provide oversight of planning, performance, and escalation issues within the context of SG sponsorship arrangements. The Group informs, advises and provides assurance to the HSCMB on issues of planning, prioritisation, performance, and risks impacting on Health Boards and their delivery partners, and acts as a forum for managing exceptions and change control;
    - Health EPRR and Public Health Divisions were invited to be part of some of the Four Nations Ministerial health department meetings. Supporting documents are provided: [CL8/034 - INQ000147378] [CL8/035 - INQ000147379] [CL8/036 - INQ000147380] [CL8/037 - INQ000147377];
    - Daily direct engagement between COO and Ministers. Ministerial Private Office would set the agenda and communicate key decisions from these meetings. Where Health EPPR were involved, there may have been a pre-call prior to the actual meeting to review agenda and consider Scotland's position e.g. on PPE issues.

The Directorate for Healthcare Quality and Improvement

104. Healthcare Quality and Improvement was an established Directorate prior to the pandemic. The Directorate was led by Linda Pollock, Director and supported by the National Clinical Director, Professor Jason Leitch. The Directorate has overall responsibility for policy on safety in healthcare, person-centred care, healthcare quality, palliative and end of life care, health policy for armed forces and veterans in Scotland and clinical priorities such as cancer, heart disease, respiratory disease, neurological disease, rare diseases, and many other clinical conditions. In addition, the Directorate also covers the development of policy to support improvement within NHS Scotland, the Office of the Chief Designer, NHS Scotland communications and the Leading Improvement team, among others.

105. From January 2020 to April 2022, the HQI Directorate also had overall responsibility for the following:

- Hospital visiting guidance: HQI led on the development of detailed guidance and principles to support Scottish Health Boards to manage hospital visiting during the pandemic. This was done in partnership with other SG teams whose policy responsibility included hospital services, principally mental health and maternity. The guidance was formulated in response to Infection Prevention Control (IPC) and wider Public Health guidance, feedback from the Visiting Reactivation Forum (VRF), senior clinical advice and statutory regulations imposed between March 2020 and January 2022. As these guidelines and statutes changed throughout the pandemic, the hospital visiting guidance was adapted accordingly;
- Co-ordination and responding to correspondence from members of the public believing they were at the highest risk from Covid-19 but had not received a shielding letter;
- Development of supporting material for specific clinical conditions such as rare disease, neurological conditions, and cancer (not including shielding advice); including provision of additional support for highest risk;
- Facilitation and secretariat function for the Clinical Lead Advisory Group Scotland (CLAGS);
- Development and publication of the Respiratory Care Action Plan, provided: [CL8/038 - INQ000147417] (considering the impact of the pandemic on respiratory care);
- Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and Anticipatory Care Planning (ACP). HQI Directorate took over responsibility for DNACPR in November 2020 from Health and Social Care Integration Division within the Community Health and Social Care Directorate, as part of the wider Palliative and End of Life Care Policy. There was a collaborative approach to co-ordinating letters and guidance

notes primarily for General Practices (GPs) and social care in residential and nursing homes, as well as for those who were identified as being at higher risk and highest risk (shielding). Letter and guidance notes covered a range of issues including DNACPR and ACP. Specific working groups or decision-making bodies in relation to DNACPR were not established, but the team contributed directly to joint correspondence and guidance. Some close work was also involved with the then Chair of the Royal College of GPs (RCGP) and Scottish GP Committee (BMA), as well as HIS;

- Anticipatory Care Planning - HQI Directorate had responsibility for the existing policy on Anticipatory Care Planning. The team worked with NHS 24 and HIS to update the NHS Inform page on Anticipatory Care Planning, provided: [CL8/039 - INQ000147418], and develop a video with HIS to support the public to understand exactly what was involved in an ACP conversation. There was an ACP Strategic Group led by HIS with SG involvement;
- Hospices – the HQI worked with Scottish Hospices through the Scottish Hospices Leadership Group to establish financial support required by hospices due to the impact of Covid-19. This included £10m in June 2020 and a further £16.9m in March 2021;
- Cancer: the cancer policy team and cancer advisory groups within the DG HSC family provided advice to the CMO and Ministers regarding new practice and guidance. In the immediacy of the pandemic, the Cancer Treatment Response Group was established. In June 2020, a new oversight committee, the National Cancer Recovery Group (NCRG) was established, which had oversight of the National Cancer Treatment Group (NCTG), national cancer data group and the national cancer quality steering group. NCTG provided oversight of the established Systemic Anti-Cancer Therapy; (SACT) / Radiotherapy (RT) Subgroup and the Covid-19 National Cancer Medicines Advisory Group. Following a review completed by NHS National Services Division (NSD) in December 2020 and the publication of the National Cancer Plan that month, a new governance model was implemented and is largely still in place to date. The NCRG provided oversight for the following established subgroups which had a role in the pandemic response: SACT Programme Board, Surgery Programme Board (since discontinued), RT Programme Board, and the Cancer data programme board. The SG held regular meetings of the NCRG (Cancer Treatment Response Group – its predecessor), and its subgroups, which discussed various matters. These meetings were not attended by Ministers but were attended by policy officials across Government (cancer, diagnostics, vaccinations, screening). In addition, clinical leads from across cancer services were represented on the group and regional cancer

network managers were represented. The groups approved various pieces of clinical guidance for use in cancer services in Scotland. This included the development and dissemination of the cancer surgical prioritisation framework (based on existing guidance by the Federation of Surgical Associations (FSSA), the Systemic Anti-Cancer Therapy (SACT) prioritisation framework and managing SACT RT for Covid-19 positive cancer patients. This was based on clinical advice from governance groups and wider clinical networks;

- Independent Healthcare – provided advice, via HIS, to independent services regarding services they were able to provide throughout Covid-19 and testing of staff. Also provided briefing and advice to Scottish Ministers regarding services able to be delivered during Covid-19 and HIS independent healthcare budget. Exchanges with Chief Dental Officer, Finance, and other policy areas were carried out by the Openness and Learning Team;
- Long Covid – Briefing and advice to Scottish Ministers regarding the establishment of Scotland's long Covid-19 service and of a strategic network to have oversight of the service.

106. The directorate works with Ministers and stakeholders to lead medical and public health professionals and provide clinical advice on professional standards and guidelines which:
    - lead medical and public health professionals to improve the mental and physical wellbeing of people in Scotland;
    - encourage sport and physical activity;
    - provide effective health protection services, disease surveillance and outbreak management;
    - provide clinical advice through the CMO/DCMOs on professional standards and guidelines;
    - invest in medical research, particularly related to the NHS and its services.

The Chief Medical Officer's Directorate

107. Further information regarding the responsibilities and activities of the CMOD can be found within M3CMODS01, a corporate statement provided on behalf of CMOD to Module 3 of the UK Covid-19 Inquiry on 23 February 2024.

108. In April 2020, the CMOD published a Covid-19 Palliative Care Toolkit to provide Health Board planners with options that could be adapted and utilised locally in their response to

Covid-19. The toolkit is now archived on the National Records of Scotland website, provided: [CL8/040 - INQ000479880].

The Chief Nursing Officer's Directorate

109. The CNOD is responsible at national level for all matters that relate to the professional leadership of nurses, midwives, Allied Health professionals (NMAHP) and Healthcare Scientists (HCS) across Scotland. Given the impact of the NMAHP/HCS profession on improving health and delivering world class safe and effective healthcare, it supports the achievement of the best health and care outcomes by providing leadership of the professions.

110. The CNOD provides expert clinical and policy advice, both internally and externally, in relation to all aspects of NMAHP/HCS, Regulation of Healthcare Professionals, and Healthcare Associated Infection / Antimicrobial Resistance.

111. The Directorate is responsible for:

- providing policy and professional advice to Ministers on matters relating to the education and workforce development of the professions for which CNOD have leadership, Healthcare Associated Infection/Antimicrobial Resistance, Professional Healthcare Regulation and wider strategic and policy aims for the various professions within its remit;
- overseeing the current student nurse, midwife, and paramedic intake on an annual basis;
- maintaining visible professional leadership and providing quality advice within Government and within the wider health and social care system in Scotland and the UK on issues relating to nursing, midwifery, allied health professions and health-care science;
- successfully implementing the Health and Care (Staffing) (Scotland) Act 2019, which is being delivered in partnership with the Healthcare Staffing Programme operated by HIS and the Safe Staffing Programme operated by the Care Inspectorate. The Act will support Scotland's Health Boards and care services to have the right number of staff in the right place and is the only comprehensive safe staffing law anywhere in the UK. The commencement of key provisions within the Act were delayed during Covid-19 in order to allow NHS Scotland to adopt an emergency footing in response to the pandemic, outstanding provisions within the Act are due to come into force later in 2024;

- leading on all professional and policy aspects of healthcare-associated infection policy and antimicrobial resistance;
- leading on Professional Healthcare Regulation including matters relating to Scotland's interests in overarching UK-wide reform of professional healthcare regulation.

The Directorate for Health Finance and Governance

112. Richard McCallum has been the Director of Health Finance and Governance since March 2021, having been the Interim Director between December 2019 and March 2021.

113. During the pandemic, Alasdair Black was Interim Deputy Director for Health Finance and Alan Morrison was Interim Deputy Director for Health Infrastructure and Investment. When the Directorate for PPE became a Division of Health Finance, Corporate Governance and Value Directorate in July 2020, Caroline Jack was Interim Deputy Director until December 2020, with Alan Morrison assuming responsibility when PPE became a Unit in Health Infrastructure, Investment and PPE Division in January 2021.

114. The Directorate for Health Finance, Corporate Governance and Value was an established Directorate prior to the pandemic, operating as a dedicated financial management service for the DG HSC family. The Directorate works with internal stakeholders and external stakeholders (NHS boards and HSCPs) to:
    - devise and implement financial strategy for the health and social care portfolio;
    - financially manage NHS boards, delegated health functions within the HSCPs and internal health directorates;
    - devise and implement policy and structured investment in NHS infrastructure;
    - provide advice, insight and intelligence to Ministers and policy colleagues on inter- and cross-portfolio matters.

<u>NHS Scotland</u>

115. The National Health Service (Scotland) Act 1978 places a duty on the Cabinet Secretary responsible for healthcare (CSH) to promote a comprehensive and integrated health service, designed to improve the physical and mental health and wellbeing of people as well as to prevent, diagnose and treat illness. The CSH will make decisions that they consider are likely to assist in discharging that duty.

116. Scotland has 14 geographical Health Boards and six non-geographical special boards, supported by NHS National Services Scotland (NSS) and Healthcare Improvement Scotland (HIS), that are accountable to the SG and Scottish Ministers.

117. NHS Health Boards are legal entities established under the 1978 Act, with HIS later established under the Public Sector Reform (Scotland) Act 2010.

118. NHS Health Boards are required by legislation to promote the improvement of the physical and mental health of the population and the prevention, diagnosis and treatment of illness. To ensure the delivery of this, NHS Health Boards are delegated responsibilities by the CSH to plan, commission and deliver healthcare services and take overall responsibility for the health and wellbeing of the communities they serve.

119. NHS Health Boards' governance arrangements must be aligned to the Blueprint for Good Governance standards set by the SG, provided: [CL8/041 - INQ000147344]. These focus on setting strategic direction, holding executives to account for delivery, managing risk, engaging with stakeholders, and influencing organisational culture.

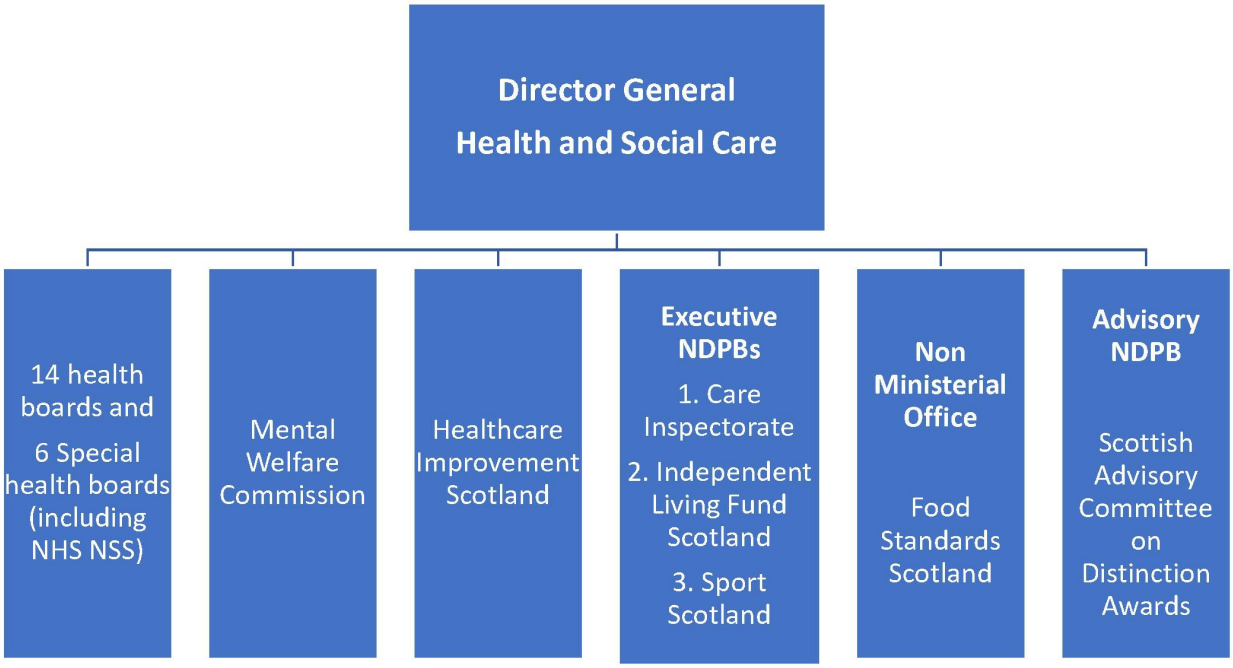
120. The NHS (Scotland) Act 1978 sets out both direction-setting and emergency powers that allow Scottish Ministers to secure the effective continuance of services. On 17 March 2020, the CSH advised the Scottish Parliament that, under sections 1 and 78 of the National Health Service (Scotland) Act 1978, the NHS would be placed on an emergency footing for at least three months, provided: [CL8/042 - INQ000470076]. The CSH set out that she was giving instruction to the NHS and individual Health Boards to do all that was necessary to manage the expected sustained increase in the number of cases of Covid-19 and signalled that, if required, new regulations would also be brought before Parliament to achieve that aim. This statement to Parliament was followed on 17 March 2020 by a letter from the DG HSC and Chief Executive of NHS Scotland to all Chairs and Chief Executives of Health Boards. This letter stated that, in announcing the emergency footing, the CSH would utilise the direction making powers, where necessary, to instruct Health Boards to carry out certain actions in order to maintain the resilience of the NHS through the challenges brought by Covid-19.

121. Subsequently, the Coronavirus (Scotland) Act 2020, was passed on 1 April 2020, and the Coronavirus (Scotland) (No.2) Act 2020 was passed on 20 May 2020. The CSH also made use of the direction-setting powers contained in Section 2 of the NHS (Scotland) Act 1978 on 4 June 2020 to seek assurance commitments on testing in care homes.

Within the Coronavirus (Scotland) (No.2) Act 2020, powers were given to Health Boards to direct care home providers on matters related to Covid-19 to ensure appropriate standards of care. Further powers were included in the Act to allow Ministers to apply to a court for an Emergency Intervention Order (EIO) to nominate a person to act as an officer to enter and occupy the accommodation where there was serious risk to life, health or wellbeing. The Act also included powers for local authorities and health bodies to purchase distressed care homes or care at home service providers.

Public and sponsored bodies

122. In recognition of the whole-system nature of Scotland's population health challenges, Public Health Scotland (PHS) was established on 1 April 2020. It is jointly sponsored by, and has dual accountability to, both the SG and to local government via the Convention of Scottish Local Authorities (COSLA). This is a unique feature for a Scottish public body and requires a commitment to shared decision making, planning, and performance management in relation to the work of PHS. The graphic below sets out details of other relevant HSC public bodies:



123. Health Protection Scotland (HPS) and Information Services Division (ISD) were replaced when Public Health Scotland (PHS) became fully operational on 1 April 2020, most of their functions were transferred into PHS.

124. The Director of Health Finance was responsible for the sponsorship of NSS and the NSS internal divisions HPS and ISD until those two internal divisions ceased to operate on 1 April 2020. Richard McCallum was appointed Director of Health Finance and Governance in December 2019.

125. PHS is a Special Health Board and was established by the Public Health Scotland Order 2019 (the 2019 Order) on 7 December 2019. It became fully operational from 1 April 2020. PHS was created to consolidate the national public health functions of health protection, health improvement and healthcare public health, underpinned by data, intelligence, and research functions. PHS is responsible for functions which were previously carried out by HPS, ISD and NHS Health Scotland (NHSHS), which was previously a national Special Health Board, now dissolved). Most of those staff were transferred into PHS from NSS as of 1 April 2020. NHS NSS is formally known as the Common Services Agency (CSA) and continues to exist.

126. PHS is Scotland's national public health improvement body. It works with partners in the public, private and third sectors to prevent disease, reduce health inequalities, and improve and protect health and wellbeing, and emphasise preventative approaches. It is involved both in developing and disseminating evidence and supporting national and local government to shape policy and programmes to help achieve a fairer, healthier Scotland. It also delivers specialist national services and provides advice, support and information to professionals and the public to protect people from infectious and environmental hazards. In terms of information services, the organisation is driven by data and intelligence and provides a range of statistical information and analysis. It uses the full range of data (national and local, quantitative, and qualitative) to offer vital intelligence to partners across the system.

127. COSLA was formed in 1975 to represent the views of Scotland's 32 local authorities to central government. It also acts as the employers' association for local authorities. To reflect the crucial role of local government in public health matters, a unique joint sponsorship arrangement is operated with COSLA, which means that they are consulted on all strategic decision making, planning and performance monitoring for PHS. COSLA are consulted on Ministerial appointments to the PHS Board and lead a merit-based

process to nominate two local authority councillors to the Board to represent the local government perspective (appointed by Scottish Ministers). COSLA are represented on the interview panels for the PHS Chief Executive, Chair and Board members.

128. Employees in NHS Health Scotland (NHSHS), ISD, and HPS (except staff in Antimicrobial Resistance and Healthcare Associated Infection (ARHAI), which remained in NSS) were transferred to PHS under the Transfer of Undertakings (Protection of Employment) Regulations 200691 as amended by the Collective Redundancies and Transfer of Undertakings (Protection of Employment) (Amendment) Regulations 2014. This is known as TUPE. Letters were issued to staff in March 2020, advising them that their employment with NHSHS/NSS would transfer to PHS with effect from Wednesday 1 April 2020. TUPE provides for the protection of employees in the event of a change in the employer to ensure that their rights are safeguarded. Therefore, all staff transferred to PHS on their current terms and conditions of employment. PHS had 1,143 members of staff on day one.

129. At its inception, PHS had three directorates and one service area: the Clinical and Protecting Health Directorate; the Data and Digital Innovation Directorate; Place and Wellbeing Directorate and the Strategy, Governance and Performance service area. All staff were allocated to one of the four areas for day one. The Chief Executive, three Directors and the Head of Strategy, Governance and Performance together made up the Senior Leadership Team (SLT).

130. The Clinical and Protecting Health Directorate's purpose is to protect the people of Scotland from infectious and environmental hazards; enable high-quality clinical and public health knowledge, research, and innovation; and improve clinical and public health practice by using audits at a national and local level.

131. The Data and Digital Innovation Directorate's purpose is to harness the power of innovation and data science to transform, expand and release the potential of data and information assets to lead a data-driven approach to improving public health outcomes nationally and locally.

132. The Place and Wellbeing Directorate's purpose is to provide world class evidence, data and public health expertise to drive improvements in the health of the Scottish population. This includes areas such as the economy and poverty, mental wellbeing, and healthy and sustainable places.

133. The Strategy, Governance and Performance service area/directorate's purpose is to provide critical internal and external functions for the organisation. With responsibility for strategic planning, performance, people and communications, this directorate leads, drives and supports the organisation to deliver, with impact, the ambitious transformation programme.

134. Staff and functions from the legacy bodies transferred across to PHS except for i) the ARHAI staff and the function of HPS, which remained within NHS NSS; and ii) several corporate services staff from NHSHS, who transferred to NSS under the shared services arrangement. It was originally intended that the ARHAI function, which was part of HPS, would transfer into PHS. However, when the SG and COSLA consulted on the establishment of PHS in Summer 2019, it was made clear that ARHAI would remain within NHS NSS considering a then-ongoing independent review of the Queen Elizabeth University Hospital, which looked at whether the design, build, commissioning and maintenance of the hospital had had an adverse impact on the risk of Healthcare Associated Infection, following the deaths of three patients between December 2018 and February 2019, which had been linked to rare microorganisms. The report produced from this external review was published in June 2020, provided: [CL8/332 - INQ000469723], but the wider review of where ARHAI Scotland should be hosted remained paused owing to ARHAI's involvement in the Covid-19 response. In October 2023, the ARHAI Scotland Location Review, a review that will recommend where ARHAI Scotland should sit, commenced, led by two Co-Chairs who sit independently of SG. The report has not yet been completed.

135. Given that HPS were involved in public health communications regarding the pandemic from January 2020 to 1 April 2020, for continuity and to avoid public confusion, the HPS brand continued to be used after PHS became operational. The CSH agreed to the HPS branding no longer being used on 15 March 2022.

136. Together, SG and COSLA developed PHS's initial strategic priorities. These were shared with the Chief Executive Officer for PHS on 14 February 2019 in the first commissioning letter, which was countersigned by the Minister for Public Health, Sport and Wellbeing, Joe Fitzpatrick, and the COSLA Spokesperson for Health and Social Care, Stuart Currie, provided: [CL8/043 - INQ000470105].

137. Despite the pressures of the pandemic response, PHS published its Strategic Plan 2020–23 on 29 September 2020, meeting the target set in the Target Operating Model. The plan was clear that as Scotland's national public health body, PHS had a role to play in contributing to all six of Scotland's Public Health Priorities. The plan set out four cross-cutting areas that PHS would prioritise between 2020 and 2023. They represented complex challenges that required the collective action of partners across the system:
    - Covid-19: maintaining and developing our pandemic response;
    - Community and place: with a focus on prevention and the reduction of inequalities, working with local partners to make a real difference in communities;
    - Poverty and children: investing in children during the pre-school years, and acting to reduce poverty and differences in income will contribute to improvements in all measures of health and wellbeing over the long term;
    - Mental wellbeing: helping national policy makers and local government understand levels of mental wellbeing and help them influence the factors that shape it, whilst collaborating with local services to improve access and outcomes.

138. The central theme of the 2020–23 Strategic Plan was collaboration.

139. The responsibilities of accountable officers for parts of the Scottish Administration and accountable officers for public bodies are detailed in the accountability section of the Scottish Public Finance Manual, provided: [CL8/044 - INQ000102908].

140. As noted previously, the DG HSC is the Portfolio Accountable Officer for NHS Scotland, including the national NHS bodies: PHS and NSS.

141. PHS is sponsored by the Director of Population Health. Until April 2023, PHS sponsorship was with within the responsibilities of the Deputy Director (DD) of the Health Protection Division.

142. The Director for Population Health and the Deputy Director for Health Protection had responsibility for creating PHS and overseeing and ensuring effective relationships between the SG and PHS which support alignment of PHS's business to the SG's Purpose, National Outcomes and high performance by Public Health Scotland. The sponsorship role transferred from Richard Foggo (Director) and Derek Grieve (DD) to Liz Sadler (DD) on 1 March 2020. It subsequently transferred to Caroline Lamb (Director) in the Directorate for Digital Health and Care from July 2020 to December 2020 in her role as Delivery Director for contact tracing. After that, the responsibility returned to the Health

Protection Division in the Population Health Directorate with Michael Kellet (Director) and Jo Swanson (DD). The changes reflected the evolving response by the SG to the pandemic and the fact that Richard Foggo was moving to lead the new Covid Response Directorate.

143. The Health Protection Division worked closely with the PHS Chief Executive, Angela Leitch, and were answerable to the Portfolio Accountable Officer for maintaining and developing positive relationships with PHS which were characterised by openness, trust, respect, and mutual support. The Health Protection Division was supported by the PHS Sponsorship Team in discharging these functions. This is the normal point of contact for PHS when dealing with the SG.

144. Specific responsibilities of the sponsorship team include:

- discharging sponsorship responsibilities in line with the principles and framework set out in the Strategic Engagement between the SG and Scotland's NDPBs, provided: [CL8/045 – INQ000469942], and ensuring that joint sponsorship is suitably flexible, proportionate, and responsive to the needs of the Scottish Ministers and PHS;
- ensuring that appointments to the PHS Board are made timeously and, where appropriate, in accordance with the code of practice, provided: [CL8/046 - INQ000469943], for Ministerial Appointments in Scotland;
- proportionate monitoring of PHS's activities through an adequate and timely flow of appropriate information, agreed with PHS, on performance, budgeting, control, and risk management;
- addressing in a timely manner any significant problems arising in PHS, alerting the Portfolio Accountable Officer, joint COSLA sponsor lead and the responsible Minister(s) where considered appropriate;
- ensuring that the objectives of PHS and the risks to them are properly and appropriately considered in the SG's risk assessment and management systems;
- informing PHS of relevant SG policy in a timely manner.

145. The SG PHS Liaison: COVID response function (previously known as the HPS Liaison Team) was established in March 2020 because of the rapidly emerging Covid-19 pandemic. The team was originally situated within the Covid Health Response Division, then located within the SG Covid Ready Society Division of the Covid Public Health Directorate from June 2020.

146. The rationale for the team's establishment originated from HPS within PHS, who had requested support in managing the significantly increasing demands for specialist public health advice being requested from across the SG and the sustained pressure, pace of change and urgency of decision making.

147. The liaison team adapted to the evolving needs of the pandemic response and changing SG and Public Health Scotland (PHS) structures. The liaison team provided a recognised communications route from SG into PHS and from PHS into SG on pandemic response matters, which allowed officials in both organisations to ask questions, seek advice and connect with their counterparts in the other organisation through a centralised and jointly recognised channel.

148. For example, as the makeup and membership of teams was often changing, the liaison team connected SG and PHS individuals/teams with shared interests and facilitated joint discussions where necessary. The liaison team would track and prioritise requests for information and advice, ensuring they were answered. It would also maintain a high-level overview of current and future SG/PHS activity in order to brief colleagues appropriately on any potential implications for them.

149. The liaison team attended a daily cross-organisational PHS huddle attended by staff from across PHS where current response activity, priorities, risks and issues were summarised and briefly discussed. Each team would provide an update. This allowed the liaison team to maintain an informed overview of the developing situation from both the SG and PHS perspective. PHS colleagues were able to ask the liaison team questions about current SG activity, and the liaison team could seek any additional information from the relevant SG leads as necessary following the huddle.

150. The liaison team also convened regular joint meetings to discuss current and potential changes to PHS guidance, maintaining an overview of the activity, tracking changes and bringing together relevant SG, PHS and NSS (ARHAI) officials where necessary to provide assurance, discuss the handling and drafting of any proposed changes and the policy environment.

151. The liaison team also chaired and convened an informal SG/PHS update meeting that brought together pandemic response leads from across both organisations. This provided a further joint forum to provide updates on SG/PHS response activity, discuss emerging issues, risks, priorities, and ask questions and link with counterparts in the other

organisation. If necessary, the liaison team would undertake further investigations on particular issues to gather more information and report back.

152. Agreed templates and forms were also key to streamlining communication between the SG and PHS and tracking requests. These were used particularly for guidance reviews to collate and communicate information both internally and with PHS.

153. In June 2020, at the request and approval of the CSH, the liaison team put in place a process for formal review of guidance – the Policy Alignment Check (PAC) Process. A wide range of guidance played a significant role throughout the pandemic, and it was critical that it was both aligned to and clearly reflected rapidly evolving SG policy, given the changing circumstances of the pandemic. This was of particular importance owing to the role it played in ensuring societal compliance with the range of non-pharmaceutical measures (NPIs) to delay or mitigate the spread of the Covid-19 virus.

154. As outlined in the PAC agreement from June 2020 and updated process agreed in September 2020, provided: [CL8/047- INQ000468139], [CL8/048 - INQ000468140]. PAC was implemented in order to improve and speed up the process of ensuring alignment of guidance with SG policy.

155. Every effort was made to meet a 24-hour turnaround with the aim to meet a daily 3pm PHS HPS deadline for web publishing to reduce delay and the risk of compromising clinical safety. A 24-hour turnaround was not always possible in practice due to interdependencies with the updating of separate pieces of guidance, the complexity of changes or significant changes causing versions to be superseded, for example with the emergence of new variants.

156. In cases of review delays, the liaison team communicated with senior colleagues in SG and PHS HPS Teams. Meetings were also set up as required to progress updates, discuss any issues and to progress the guidance quickly by both of the aforementioned teams working together effectively.

157. The summary table below outlines the number of guidance documents that were reviewed as part of the PAC process and the average time of that review noted. A full version is of the table is provided: [CL8/049 - INQ000468141].

SUMMARY TABLE			
Year	**Pieces of guidance processed through PAC**	**Types of guidance**	**Working days taken**
2020	10	– 3 Care Homes – 1 SCRC – 1 Health Protection Teams – 1 Non-Healthcare Guidance – 1 Sampling and Laboratory Investigations – 1 Primary Care – 1 Domiciliary Care – 1 Contact Tracing	143 14.3 working days on average
2021	11	– 5 Care Homes – 1 Prisons – 1 SCRC – 2 Health Protection Teams – 1 Healthcare Settings – 1 Contact Tracing	106 9.6 working days on average
2022	14	– 4 Care Homes – 1 Prisons – 3 SCRC – 4 Health Protection Teams – 1 Workplaces and Community Settings – 1 Non-Healthcare Guidance	151 10.8 working days on average
Total	**35**	**35**	**400**

			11.4 working days on average

158. Given the volume of guidance developed and updated routinely and frequently by HPS, the majority of which involved only minor changes, it was not expected that every guidance change be subject to the full PAC process and minor changes could be confirmed as exempt. Through agreed steps undertaken by both SG and HPS colleagues, the PAC process provided clarity in public messaging and confirmation that HPS guidance was aligned with and correctly interpreted Government Covid-19 policy. It also recognised that policy was the domain and responsibility of SG, and that professional public health/health protection guidance was the domain and responsibility of HPS. These respective roles are set out in *Management of Public Health Incidents: Guidance on the Roles and Responsibilities of NHS led Incident Management Teams,* provided: [CL8/050 - INQ000130954], in particular relating to agreed practice when at incident level 5 (a "catastrophic" national incident in which the overall response is led by the SG).

159. In February 2021, following engagement with PHS, the HPS liaison function was integrated into the PHS Sponsorship Team in the Health Protection Division within the Population Health Directorate. This was designed to increase resilience, consolidate communication channels, and strengthen key working relationships at strategic and tactical levels between SG and PHS.

160. As part of the transfer, a review of the liaison function was undertaken in line with the revised requirements of the pandemic response and changing context. Following this phased review, the consensus reached by colleagues in the SG and PHS concluded that most of the activities carried out by the liaison team had merged into a business-as-usual state. As such, the PAC process was discontinued on 25 May 2022 before the wider liaison function was also officially stood down at the end of May 2022.

161. Necessarily, an extraordinarily close and effective working relationship emerged between the SG (and Ministers) and PHS/HPS through the initial stages of the pandemic. This featured daily joint calls between SG and PHS teams, feeding into briefing and advice, agreeing amendments to clinical guidance, and sharing evolving clinical evidence. The SG Sponsorship team met with their PHS counterparts on a weekly basis to discuss current and emerging issues and there was a regular formal performance review meeting with the PHS Chief Executive, usually monthly in 2020 due to the pace of events and

decision making. The Minister for Public Health and COSLA Health spokesperson also met regularly with the PHS Chief Executive and Chair to discuss risks and issues.

Governance and decision making

162. While Scottish Ministers have ultimate responsibility for all health and social care decisions made, there are clear governance structures and escalation points within the SG, the DG HSC family, Health Boards and Integration Joint Boards (IJB) to best serve the people of Scotland.

163. The Scottish Cabinet is the main decision-making body for the SG. Cabinet business is bound by the Scottish Ministerial Code and operates using collective responsibility. The primary role of the DG HSC family in relation to Cabinet is to provide advice to the Cabinet Secretary for NHS Recovery, Health, and Social Care (previously Cabinet Secretary for Health and Sport) and to draft and advise on papers going to Cabinet in the Cabinet Secretary's name.

164. The Health and Social Care Management Board (HSCMB) is the main decision-making body of the DG HSC family and its membership comprises all Directors within the DG family. The remit of the HSCMB is to be collectively responsible for the strategy and performance of the NHS and the DG HSC family, ensuring that resources are best used to respond to the priorities and deliver the best services possible for the people of Scotland. Individually, each Director holds accountability for their area, and they work collaboratively, under the direction of the Director General/Chief Executive of the NHS (DG/CE), to ensure delivery against the full portfolio of work. This approach is also underpinned by the appraisal process for everyone as well as the annual Certificates of Assurance (COA) exercise that flows through the DG/CE to the Permanent Secretary. The DG/CE is held to account by the Permanent Secretary, with HSCMB being used as the vehicle by which the DG/CE discharges their function.

165. HSCMB takes decisions on the implementation of policy decisions and the management of financial commitments. It promotes robust assurance processes (risk management, financial and performance) for the NHS and provides assurances quarterly to Health and Social Care Assurance Board (HSCAB).

166. The HSCMB is chaired by the DGHSC. HSCMB provides advice and assurance to the DG/CE on the range of matters covered by the portfolio. This supports the DG/CE in their decision making.

167. Currently, the membership comprises:

- Caroline Lamb – DG Health & Social Care
- Gillian Russell – Director of Health Workforce
- Richard McCallum – Director of Health and Social Care Finance, Digital and Governance
- John Burns – Chief Operating Officer, NHS Scotland
- Richard Foggo – Co-Director of Population Health
- Christine McLaughlin – Co-Director of Population Health
- Donna Bell – Co-Director of Social Care and NCS Development
- Angie Wood – Co-Director of Social Care and NCS Development
- Tim Mcdonnell – Director of Primary Care
- Stephen Gallagher – Director of Mental Health
- Andrew Watson – Director for Children and Families
- Gregor Smith – Chief Medical Officer
- Jason Leitch – National Clinical Director
- Alex McMahon – Chief Nursing Officer
- Iona Colvin – Chief Social Work Adviser
- Fiona Hogg – Chief People Officer.

168. Pre-pandemic, HSCMB usually met weekly. The frequency of the meetings then changed from March 2020 to June 2022, with additional meetings held as required by the situation.

169. To tackle the virus, many aspects of the DG HSC family, NHS and social care services had to be flexible and adapt to a new normal. Structures and governance arrangements adapted and were altered at pace during the emergency phase of the pandemic.

170. Strategic decisions relating to the response to Covid-19 were made by Ministers. DG HSC and HSC Directors, including the CMO, Deputy CMO (DCMO), CNO, National Clinical Director (NCD) and Chief Scientist Officer (CSO) attended briefing meetings where advice was discussed. If actions were agreed at such meetings, they were recorded, but typically advice was written, submitted to Scottish Ministers, then agreed or not, which was again

recorded. Officials from across the DG HSC family provided a breadth of Ministerial submissions and advice across a wide range of key areas.

171. The CMO and DCMOs, CNO and NCD, along with DG HSC family Policy Directors, regularly attended meetings with the First Minister, Cabinet Secretaries, Special Advisers, other relevant SG Directors, and policy civil servants through a Director Briefing meeting.

172. There were daily meetings within the DG HSC family at official level (including but not limited to HSCMB; daily huddles with senior officials; Ministerial meetings). There were also weekly "Four Harms" meetings, which often required pre-meetings with DG HSC Directors and senior clinicians (such as CMO or DCMO). Additionally, the DG HSC family held preparation sessions to support the CSH's attendance at Cabinet (every Tuesday) or at SG Resilience Room (SGoRR) meetings.

173. For pre-meeting briefings, where possible best practice was followed by ensuring a written briefing was provided well in advance of any significant meeting to allow appropriate time for consideration and review. However, during the pandemic, the pace of briefing increased, and the time allowed for preparation and consideration of advice shortened accordingly and so written briefings were not always provided. Submissions were used to communicate information and advice to ministers on policy developments and issues. Wherever possible, impact assessments were provided to support decisions made by Ministers. Decisions made that were not supported by formal equality impact assessments were the decision to implement the extended use of face mask and face covering guidance in healthcare settings, and the decision to develop and implement asymptomatic healthcare worker Covid-19 lateral flow device testing. On the former, it should be noted that an EQIA was in place for the National Infection Prevention and Control Manual (NIPCM) and that this policy was an extension of control measures already in place via the NIPCM. An EQIA has been carried out for standing down the extended guidance. Both policies sat in line with infection prevention and control advice and had endorsement from both local and UK level advisory groups/bodies. Because of their demonstrable impact on levels of Covid-19 transmission in healthcare settings, there was a high degree of urgency in developing and implementing these policies as quickly as possible, though it is acknowledged that they should have been preceded by a formal EQIA.

The HSC Planning and Assurance Group

174. The decision to reconstitute HSCMB to form the HSC Planning and Assurance Group (PAG) was taken on 24 March 2020.This refinement to the existing operating model was undertaken to reflect the move to crisis response across DGHSC with a greater focus on operational delivery and ministerial support. The PAG met on 11 occasions in total. On 13 May 2020, the Group agreed to revert to HSCMB by the end of the month and held its last meeting on 20 May 2020.

175. Following the publication of the Covid-19 Route Map, provided: [CL8/051 - INQ000256709], the meeting agenda contained space for a discussion about the preparations for each review of the regulations. Decisions on whether the regulations could be further relaxed were not decisions which were made at HSCMB, however. When decisions were taken to relax regulations, HSCMB's role was to make sure that the health and social care system and services were in a state of readiness to implement any ensuing changes.

176. In addition to HSCMB/PAG, between 18 March and 6 April 2020, Directors' daily calls took place to provide updates and allow for rapid operational decisions to take place. Actions were recorded.

177. On 24 March 2020, the DG HSC family set out the intention to implement a strategic command structure: Gold, Silver and Bronze commands with HSC PAG as the strategic Gold-level body which would temporarily replace HSCMB. The suggested approach was based on the ability to:

- Match provision to demand in the acute sector
- Ensure resilience and responsiveness in the community
- Maintain critical areas of business.

178. The model for this new approach and PAG's place within the governance structure are set out in the following paragraphs. PAG's role as strategic (Gold-level) drove the business at tactical (Silver) and operational (Bronze) levels. Assurance flowed back through the system to the PAG.

179. The PAG was the reconstituted HSCMB for the initial phase of the Covid-19 crisis. The Group was collectively and individually accountable for the strategy and performance of the NHS and the DG HSC family, ensuring that resources were best used to respond to Covid-19, to save lives, protect the health and social care system and support Ministers.

180. The PAG took decisions on the implementation of policy decisions and the management of financial commitments. It promoted robust assurance processes (risk management, financial and performance) for the NHS and the DG HSC family. It determined which matters were delegated to other relevant stakeholders and groups.

181. To allow the remit, standard operating procedure and papers to be prepared, the new PAG met for the first time on Monday 6 April 2020 and continued to meet twice weekly through to mid-May 2020. PAG regularly reviewed the risks around the Health and Social Care Response to Covid-19.

182. On 20 May 2020, after meeting on a total of 11 occasions, PAG agreed to stand down and to revert to weekly HSCMB meetings. This change signalled a return to the established governance and accountability structure, where HSCMB and HSCAB provide the lines of accountability and governance for the DG HSC family, under the SG Audit and Assurance Committee and SG Corporate Board.

Four Harms

183. The Director of Covid Public Health, senior members of the Covid Public Health team, along with senior clinicians and other DG HSC family Directors contributed to the SG's Four Harms Group (in line with the terms of reference and agreed membership of that group, provided: [CL8/052 - INQ000232945], [CL8/053 - INQ000103003]). The four harms were as follows:

1) Direct Covid-19 health harms – primarily, the mortality and morbidity associated with contracting the disease
2) Broader health harms – primarily, the impact on the effective operation of the NHS associated with large numbers of patients with Covid-19, and its knock-on effects on the treatment of illness
3) Social harms – the harms to wider society, in terms (for example) of education attainment because of school closures
4) Economic harms, for example through the closure of businesses.

184. For DG HSC family officials and clinicians, typically this would primarily involve providing advice at the Four Harms meeting, chaired typically by DG Strategy and External Affairs (DG SEA), on matters in relation to harms 1 and 2, while contributing to discussion on the

other two harms. The output from these meetings informed production of advice to Cabinet. Minutes from relevant Cabinet meetings will record those discussions. In short, the views of officials would be fed in at the Four Harms meetings, typically on a Friday, chaired by DG SEA, and then fed in through the drafting process of the Cabinet paper for the subsequent week, typically Tuesday.

Co-operation and joint working with the UK Government and devolved administrations (DAs)

185. Officials from SG met regularly with counterparts from other devolved administrations in relation to different subjects throughout the pandemic. The Module2/2A statement from the Director General (DG) Strategy and External Affairs provided to the Inquiry on 23 June 2023 sets out information on intergovernmental liaison about the pandemic.

186. There were daily conference calls set up by the UK Government (UKG) and attended by officials from Health Resilience and Health Protection forming the early Covid-19 response, provided: [CL8/054 - INQ000147345]. These included the Healthcare Ministerial Implementation Group (Health MIG), provided: [CL8/055 - INQ000131023], and Four Nations Ministerial calls, provided: [CL8/056 - INQ000147475].

187. The four nations Health Ministers met regularly from 20 April 2020. A timeline of these meetings has been provided above [CL8/056 - INQ000147475]. Regular quadrilateral engagement also took place with UK Cabinet Office officials and DHSC officials who led on different policy areas at points from January 2020 to April 2022. There was also frequent direct engagement with each of the four nations at a policy level.

188. In addition to cooperation, the UK has a seat as a member state on international organisations, such as the World Health Organisation (WHO) and the World Health Assembly (WHA). Whilst Scotland is not a member state, information provided by these relevant international organisations was provided to the Health Protection Network and the CMO. The CMO received verbal updates from Professor Chris Whitty, CMO for England.

189. Within the UK, there was regular co-operation and dialogue on the use of NPIs and at times, where specific NPIs were being implemented on a large scale, such as March 2020 and the run-up to Christmas 2020, a significant degree of co-ordination. A focus for that co-operation and co-ordination was the shared basis through which expert advice was

offered (e.g. Scientific Advisory Group for Emergencies (SAGE), the Joint Biosecurity Centre (JBC) and UK-wide approaches in related areas (e.g. on the "furlough" scheme and in following Joint Committee on Vaccination and Immunisation (JCVI) advice in the vaccine roll-out), which led to a general tendency towards consistency in approach across the four nations.

190. Ultimately, decisions on NPIs in Scotland were made by Scottish Ministers in line with the relevant published strategic framework. Given differences in the characteristics of each of the four nations (e.g. geography, socio-demographic profile, and school term dates), differences in epidemiological conditions at particular times, and differences in the political standpoints of each of the governments – particularly when the role of judgement in decision making on NPIs was key – there were a number of significant differences in approach to NPIs across the four nations. This reflects recognised practice on how to deal with infectious diseases where tailored approaches are essential to achieve the best outcome and to avoid aggravating inequalities. For example, England had three nationwide lockdowns whereas Scotland technically only had one nationwide lockdown, though it came close to a second when only some island communities remained out of Level Four restrictions in early 2021.

191. The UKG held numerous meetings on the use of NPIs and shared expert advice. A more detailed response on this matter is covered in the CMO Module 2/2A corporate statement provided to the Inquiry on 31 March 2023. These meetings were primarily conducted via Microsoft Teams and were focused on discussion and awareness raising, not decision making. There was a series of weekly Whitehall-led calls where DAs were invited to listen in and update on a range of matters, including NPIs. These related directly to the UK Gold, Silver and Bronze structures. The CMO was invited to the UK Gold discussions, but SG policy officials were not normally invited to listen into these. The Silver and Bronze meetings took place without devolved officials, and the weekly Whitehall meetings where DA officials were present were really readouts of the discussions at the bronze and silver meetings.

192. SG representatives attended the Four Nations meetings virtually, and where appropriate, informed Ministers of the policy intention of UKG. These updates were included in daily sit-reps to Ministers. There was regular dialogue on the use of NPIs and a significant degree of co-ordination, and the joint advice provided led to the necessary regional decisions being made, taking into consideration geographical or socio-demographic profile differences in epidemiological conditions at times. In addition, policy leads would

contact their counterparts in the DAs on an ad-hoc basis as required. For example, the UKG organised and led policy leads meetings on various NPIs, such as face coverings and physical distancing.

193. There was cooperation with the UKG on aspects of procurement, including the ICU stockpile. Caroline Lamb was Delivery Director for ICU expansion from March 2020 to May 2020. ICU medical equipment planning to support ICU expansion was led by the SG and the NHS ICU Resilience Group. This included representatives from SG, NHS NSS National Procurement (NP), Scottish Critical Care Delivery Group, and Health Facilities Scotland, in consultation with NHS board critical care clinicians and clinical engineering leads.

194. In addition to the procurement of ventilators and equipment to support ICU expansion in NHS Scotland, as undertaken by NHS NSS NP, an additional layer of resilience was made available to SG during the pandemic via the DHSC procurement of a UK ICU stockpile of equipment and consumables which was available to the devolved administrations on an allocated basis. Through joint working and regular meetings held by the DHSC, the DAs were kept up to date and informed on the availability of the UK stockpile as well as any UK-wide issues in relation to supply continuity, which was being impacted by the global demand for ICU medical equipment and consumables.

195. Up to 8.2% of the UK ICU stockpile was made available to NHS Scotland. While most of these supplies were not preferred brands / specifications, NHS Scotland benefitted from a range of medical equipment that helped to bolster resilience across the service.

196. For Shielding / Covid-19 Highest Risk policy, joint decisions were made at Four Nations CMO calls. Calls were regularly held between the four nations, with counterpart Shielding / Highest Risk Policy officials in the UKG, Welsh Government and Northern Irish (NI) Executive coming together to share information and learning.

197. A four nations PPE governance group was established at the beginning of the outbreak to ensure decisions on the procurement of PPE were transparent across the UK partners and consider the different views and responsibilities across the four nations. This group, the Strategic PPE Four Nations Board, was chaired by the Department of Health and Social Care and was attended by SG and other devolved governments' officials. The group's Terms of Reference is provided: [CL8/057 - INQ000414607]

198. A protocol was initially drawn up to formalise agreement on the way in which the UK pandemic stockpile would be distributed as part of the Covid-19 response. The first protocol was drawn up to meet urgent temporary needs. However, as these needs were met, along with an increase in PPE stock and domestic supplies, the protocol was redrafted to focus on longer term collaborative procurement.

199. There was then a pause while a revised protocol was agreed. The Cabinet Secretary for Health and Sport gave her agreement to the PPE Unit to the revised four nations PPE protocol on 16 February 2021 and details of the remit as of April 2021 following that agreement are below.

200. The Strategic PPE Four Nations Board's remit as of April 2021 was as follows:

- Provide oversight and assurance to Ministers of all four nations that the strategic aims of the UK-wide protocol to support collaboration on the sourcing and supply of PPE are being met;
- Support the understanding of Covid-19 related PPE supply across the four nations through the sharing and consideration of country-level data and intelligence on PPE;
- Facilitate UK-wide PPE demand modelling, sharing information on each country's stock positions, modelled requirements, and planned procurement strategies to meet these requirements and coordinate strategies for meeting expected demand and planning of future strategies;
- Consider the impact on supply and demand of any change in the use of PPE, including any changes to guidance on the use of PPE.

201. The variations in approaches to handling the pandemic between SG and UKG also resulted in differences in public health messaging for Scotland-specific issues. This messaging was integrated into the wider SG approach on Covid-19 communications and engagement. This meant that the SG messaging had to be clear that requirements were still in place in Scotland, if not in the rest of the UK, to help ensure as much adherence as possible. This formed part of SG's FACTS messaging on NPIs. FACTS was an acronym used to promote the following behaviours: Face covering, Avoid Crowded places, Clean hands regularly, Two-metre distance, Self-isolate.

202. The SG's face covering policy was retained within legal requirements longer than the UKG policy. There was also a variation in approach in relation to the face covering

exemption card scheme, in that Scotland implemented a physical card whilst UKG offered a digital downloadable card, provided: [CL8/058 - INQ000147349].

203. Meetings in which the SG participated involving the four nations are provided in the following table:

Meeting	Formal decisions at meeting?	Additional information	Additional information processes?
Four Nations Health Ministers call	No. High level discussion between health ministers and updates from respective nations.	Ministerial-level meeting to discuss a range of health issues, often including Covid-19 related matters. Frequency varied from weekly to fortnightly to monthly.	A rough agenda is sent out by Secretary of State private office in advance, with input from DG offices if there is anything they wish to raise that should be added. No official minutes or actions are taken but there are unofficial internal notes / distributed by SoS private office.
UKG-DA Board	No, though discussions in relation to formal decisions (or decisions to be made/escalated) are held. UKG Secretariat share minutes, actions, etc.	Senior official meeting to discuss the four nations' testing programme. UKG-DA secretariat holds minutes, action logs and Terms of Reference (ToR).	UKG-DA engagement team will often organise targeted "breakout" meetings based on discussions in this call, finance, operations, policy. The UKG-DA Board has had short-life working groups or extra meetings running between the monthly call, for example, in relation to facilitating the smooth transition for all nations for the National Testing Programme or reviewing outcomes and implications for a spending review.
Change Board (renamed the Strategy, Prioritisation and Change Board).	No, though discussions in relation to formal decisions (or decisions to be made / escalated) are held.	Chance to raise issues directly with UKG senior officials.	UKG-DA engagement team will often organise targeted "breakout" meetings

	UKG Secretariat share minutes, actions.	Focussed on areas within the Test and Trace portfolio of significant change. ToR and scope varied.	based on discussions in this call, e.g. finance, operations, policy. UKG-DA team will update via email or call on any actions taken from the call.
UKG NHS Test and Trace Portfolio Delivery and Oversight Board.	No. SG officials are invited for awareness; no DA input.	Meeting used to gain early sight of UKG plans and subsequently raise issues where SG not being involved.	
"Front Door" Meetings (has had various names under different iterations, e.g. Portfolio Delivery Forum).	No.	This acts as a triage forum for programmes looking to enter the Test &Trace portfolio.	Offers SG early sight of upcoming UKG work.
Finance QUAD.	No. For awareness in advance of Investment Board meeting later in week.	This is a heads-up for BJTs that will go to Investment Board that week.	This is primarily a meeting between UKHSA, HMT and Cabinet Office. SG may raise questions at the end of each BJT discussion, but otherwise observes.

Technologies Validation Group (soon turned into UKHSA Testing Supplies Governance).	No. Updates around testing technology in pipeline, validation and evaluation exercises.	DAs feed into UKG process on validation of new testing technologies and decisions made in respective DG administrations around applicability to own setting.	
Design Authority Review Group (DAR) (UK) (eventually merged with Service Design Authority).	No.	To receive early sight of new technologies procurement by UKG on behalf of DG administrations and potential new testing pathways to be onboarded.	
DA Weekly Operations Meeting and Policy meetings (soon turned into a combined "Operations, Policy and Strategy" meeting).	No. UKG DA team catalogue minutes, track actions.	Opportunity for DG Administrations to raise issues with specific operational, policy and strategy leads. Leads of UKG teams use this to share updates on developing operations and/or policy and horizon scanning.	UKG-DA engagement team will engage via email and / or organise meetings based on discussions or issues raised from this call, usually to sort operational issues.
DSHC – MHRA Meeting A and Meeting B.	No.	To hear updates on DHSC/UKHSA discussion with the MHRA and raise issues.	
Testing Programme Investment Board.	Yes, taken by senior UKHSA/UKG finance officials.	Member of the Investment Board to opt in and out of procurement and commercial decisions.	Minutes and outcomes of decisions tracked by Investment Board secretariat and outcomes shared with senior officials.
UKHSA sit-rep.	No.	Cadence varied from daily to thrice weekly to twice weekly.	Able to reach out to UKG DA engagement team or specific UKHSA leads for further information afterwards.

		Daily performance report on capacity and demand – troubleshooting opportunity for various UKHSA team leads. DG administrations receive invites to observe and listen.	
Testing Evaluation Board, and Quality Group (has had various names under different iterations).	No.	Provides the latest information on evaluation of the Testing Programmes.	Feeds into SG Clinical Governance Group and CADI.
Testing Supply and Demand Management meeting(s).	Overall no, though small operational decisions are made at this call (such as on movement of LFD stock between warehouses).	DG administrations invited to attend for information and sometimes input. UKHSA demand modelling and operational colleagues receive modelling data and operational updates from DAs which inform decision making around supply.	
National Testing Programme Memorandum of Understanding (NTP MoU) meetings.	Yes. UKHSA team engage with DG administrations regarding creation, revision, amendments for the NTP MoU.	The creation of the NTP MoU and the subsequent revisions and iterations of the past few years are done by UKHSA and DG administration officials. All of these have to ultimately be signed off by respective health ministers for approval.	

The Joint Biosecurity Centre

204. The Joint Biosecurity Centre (JBC) was established in summer 2020 by the UK Government DHSC to provide evidence-based independent analysis to inform local and national decision making in response to Covid-19 outbreaks. On 10 August 2020, an agreement on the 'Participation of the Devolved Administrations in the Joint Biosecurity Centre', provided: [CL8/059 - INQ000203652] [CL8/060 - INQ000470078], (hereafter referred to as the Political Agreement) was agreed between the Secretary of State for Health (SSH) and respective Health Ministers in the devolved administrations. Following the completion of the Political Agreement, an Agency Agreement, provided: [CL8/061 – INQ000470079], underpinning the political commitment and providing the legal basis for JBC's operation on a UK-wide basis was finalised at official level and approved by Ministers. When the JBC was merged with Public Health England (PHE) and parts of DHSC, the JBC went on to form the Data Analytics and Surveillance directorate of the newly formed UK Health Security Agency (UKHSA) in October 2021. The Agency Agreement has been extended and is still in place.

205. The JBC worked collaboratively with the DAs to help inform public health responses in respective jurisdictions, although health is a devolved matter in Scotland, Wales, and NI. The JBC provided analysis and assessments to decision-makers and did not take or direct operational decisions on outbreak response in any nation. The Agency Agreement extension and the Political Agreement governing this relationship underpinned the JBC's commitment to this approach.

206. Health ministers from all four nations attended the JBC ministerial board, and the devolved administrations were represented on the JBC steering board and the JBC technical board. The JBC was established to provide early warning of Covid-19 outbreaks across the UK, as defined by section 1 of the Coronavirus Act 2020.

207. The JBC had three core functions:
    - gathering and analysing data about Covid-19 infection to inform analytical products;
    - provision of assessment or guidance to help inform decisions about measures that it may be appropriate to implement to control the spread of Covid-19;
    - provision of advice on the Covid-19 alert level.

Contact tracing

208. Caroline Lamb was the delivery director for establishing the contract tracing and support for isolation programme from May 2020 to August 2021.

209. Throughout the pandemic, officials in the Testing and Contact Tracing Division engaged with counterparts from the DAs through the range of structures and meetings which are detailed in this statement. In addition to this, infrequent communication by email took place to discuss matters relating to testing, contact tracing and isolation, both to understand decision making and evidence base in other nations and to ensure that officials could brief Scottish Ministers on decisions and the response that was being progressed elsewhere in the UK.

210. Testing and contact tracing policy and delivery engagement with counterparts in other nations of the UK was undertaken regularly, and information on policy choices in other nations was provided to the Scottish Ministers for awareness. Engagement through the structures set out enabled officials from all four nations to share emerging policy thinking and identify where there were any differences in the approach to be adopted in each nation and share that information with Ministers as part of the decision-making process in Scotland. Some decisions taken by the UKG influenced funding available to the SG. Where this was the case, those impacts were considered as part of the decision making and policy development process and were able to be discussed on a four nations basis through the meetings and structures that were in place.

211. Test and Protect utilised parts of the UK's Four Nations testing programme, in which DAs received a share of services instead of Barnett consequential funding. This meant that when the UKG acted to expand or reduce the scope of testing, it had an impact on the SG's available capabilities and capacity.

Pandemic Planning and Response

212. The overarching strategy for responding to a pandemic is set out in the UK Pandemic Influenza Strategy from 2011.

213. The distinctions between diseases which are high consequence, emerging and novel, endemic and those that have pandemic potential, and go on to become pandemics in some cases, are complex. In practice, an existing or new pathogen with the potential to become a pandemic with catastrophic consequences will emerge as an outbreak and the profile of the risk and the subsequent management will determine how it develops.

214. In practice, before 2019, Scotland shared with the rest of the UK the *2011 Influenza Pandemic Strategy*, provided earlier in the statement [CL8/028 – INQ000102974], and that remains in place to this day. That strategy is based on pandemic influenza. As with the response to Covid-19, a novel or known infectious disease will initially be dealt with under normal health protection policy and guidance to the point when the need for different administrative and policy arrangements is identified.

215. Alongside the procedures and practice of dealing with High Consequence Infectious Diseases and the pandemic plan from 2011, there are specific arrangements made for the administration and policy response to Covid-19. Regarding High Consequence Infectious Diseases, the key operational document is the *Manage*ment of Public Health Incidents guidance, first published in 2011, provided: [CL8/062 - INQ000380897], and last updated in 2020, alongside SG internal guidance on managing urgent and out of hours public health notifications.

216. On 11 March 2020, the Scottish Government asked NHS Boards to pause non-urgent elective activity to be able to continue to respond to Covid-19 patients and manage the infection control requirements and advice. On 14 May 2020, John Connaghan, Interim Chief Executive NHS Scotland, wrote to NHS Boards requesting planning phased restart of services and asked for responses by 25 May 2020, provided: [CL8/063 - INQ000117322]. He then wrote to NHS Scotland Chief Executives on 8 July 2020 setting out the process for local decision making on pausing non urgent elective activity until the end of July 2020. To monitor Health Board reductions from October 2020 onwards, weekly Elective templates were submitted to the Planned Care Policy team. On 21 December 2020, John Connaghan wrote to boards regarding preparations for January 2021 and maintaining critical services in response to the restrictions announced 19 December 2020. 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, provided: [CL8/064 - INQ000470110]. On 2 August 2020, John

Burns, NHS Scotland Chief Operating Officer wrote to NHS Scotland Chief Executives extending this until end of August 2021 due to the extended pressures of Covid-19, provided: [CL8/065 - INQ000470109]. This was extended further on 2 September 2021 to the end of September 2021.

217. Throughout the pandemic, NHS Boards were asked to prioritise critical and life-threatening care. Emergency Departments remained open as normal, but NHS Boards provided triage at the "front door" to prevent anyone who did not need to be there clinically from entering the Emergency Department to ensure social distancing and reduce infection control risks. Throughout 2020 A&E sites saw a significant reduction in attendances.

218. Those delivering primary care were impacted and necessarily constrained by IPC measures throughout the relevant period and would otherwise autonomously adjust their services to meet demand within the contractual and legal framework set by SG. In conjunction with Health Boards, the Covid-19 escalation framework was implemented to monitor delivery of services and build intelligence to inform any central support or response required to general practice capacity. As a result of the level of aerosol-generating procedures (AGPs) within dental settings, activity within the sector during the relevant period was particularly impacted and therefore unable to respond to population need. SG IPC policy was informed by specific advice from ARHAI Scotland. As such, NHS dental teams were required to stop, pause, and adjust patient services in the light of public health and IPC guidance. A regular series of CDO letters provided updates to the sector on the development of Scottish and UK Government in respect of the pandemic and how that would impact on the delivery of dental services. Practice teams were involved in formulation of specific advice to patients as part of a wider communication on accessing health care during the pandemic.

Scottish Ambulance Service (SAS) and NHS 24

219. The SAS and NHS 24 utilised their own escalation processes to support demand management and preserve core services within their organisation.

220. From 18 March 2020, SAS provided daily reports to the SG sponsorship team and central intelligence function on the number of attended incidents, including figures on both non Covid-19 and suspected Covid-19 incidents. This was evaluated both

daily and twice weekly within SG by colleagues from the COO's office, Primary Care and the Deputy COO. Throughout the period, SAS constantly reviewed the situation and altered their Resource Escalation Action Plan level (REAP) accordingly. The REAP decision was and remains an independent decision for the SAS Executive Management Team. The levels of REAP are:

- REAP Level 4 (red) - Critical Impact/Service Failure/Major Incident
- REAP Level 3 (amber) - Significant Impact
- REAP Level 2 (green) - Moderate Impact
- REAP Level 1 (white) - Normal Service Delivery.

221. This, along with regular discussions with SAS officials, led to a formal request for an extra £20m funding heading into the winter of 2021. This allowed SAS and SG to explore options to expand the workforce and the types of responses, on both a temporary and permanent basis to enable the service to transport patients to a hospital or care setting, given the clinical infection controls that were in place. Details of this investment are provided at paragraphs 641-645. The funding was monitored by the Health Finance Directorate and the Sponsorship team.

222. During the relevant period, NHS 24 was required to develop a complete system response to the Covid-19 emergency. This included developing and establishing a range of Covid-19 specific channels and assets across the service as the forefront of digital access to self-help advice, including Test and Protect and the National Covid-19 Helpline. Rapid establishment of Covid-19 hubs and community assessment centres in primary care were established to minimise referrals to hospitals. NHS 24 took decisions under their delegated accountability framework to pause or cease some of their business-as-usual activity and redeployed staff and expertise to Covid-19 channels. Accelerated enhancement of NHS 24 digital services including the heavily promoted use of NHS Inform for all public and professional facing content related to Covid-19. The Chief Executive of NHS 24 and Executive Team of NHS Scotland updated the Sponsorship Team and the Office of the COO through regular engagement including daily and weekly reporting against their Key Performance Indicators (KPIs). Pressures were escalated accordingly.

Workforce and staffing

223. The Health Workforce Directorate issued *Pandemic Flu: Guidance on Health Workforce Issues for NHS Scotland Boards* in 2009, provided: [CL8/066 - INQ000102972]. The guidance was developed to provide a framework for local decisions on workforce and human resource issues. As all NHS Scotland Boards had local pandemic influenza groups, the guidance was intended to supplement local plans. It covered a range of topics including potential sources of staffing, protecting the welfare of healthcare workers and information on staffing for areas of non-pandemic health conditions including mental health, GP services, local authority care, essential independent sector provision and medical services in prisons and detention centres. It also provided advice on the use of independent sector staff.

224. The guidance outlined principal areas for NHS Board pandemic preparation including mapping the workforce; identifying the impact on absence levels; putting in place support systems for staff and developing training for staff to help in responding to the pandemic.

225. NHS Scotland Boards have operational responsibility for deploying staff in accordance with their service provision responsibilities. Mutual aid arrangements exist for the provision of support between Health Boards. SG does not directly oversee these: they are managed at an operational level. Guidance on sourcing staff to allocate to areas of most need asked boards to consider:

- Internal Redeployment due to the suspension of services;
- Bank staff;
- Sharing staff at local level;
- Drawing on former staff;
- Staff released to work in NHS services by independent providers;
- Ready and registered staff currently not working;
- Health related staff from Higher Education Institutions / Colleges;
- Members of the public volunteering;
- National recruitment appeals.

226. Health Boards were asked to plan for the sustained pressure on staff of a pandemic influenza including the need for clear digital communication to tackle potential staff fear and practical resources including catering and sleeping spaces. The need to plan for increased demands for counselling and other services were outlined.

227. The guidance was not updated or re-issued after 2009 and Health Workforce Directorate does not have information on how it was applied at an NHS Board level in preparing for a pandemic or in response to the Covid-19 pandemic in 2020. At the onset of the pandemic, staff within the Health Workforce Directorate were not aware of the guidance that had been issued in 2009, which in effect became superseded by new guidance issued from March 2020.

228. The Health Workforce Directorate provided guidance to all NHS Scotland Health Boards on 13 March 2020, provided: [CL8/067 - INQ000470082]. The guidance set out principles for how NHS boards should take a fair and consistent approach to managing staff absence arising from Covid-19, including symptomatic self-isolation (at that time for seven days). The guidance also set out some general principles for supporting staff health, safety and wellbeing, leave, working at other sites / across board boundaries and the recruitment of supplementary staffing, including bank staff on fixed term contracts.

229. Thereafter, further guidance was issued by Directors' letters covering the following topics:

- establishment of a National Recruitment Portal;
- the deployment of Nursing and AHP students on paid placement;
- testing, including asymptomatic testing and self-isolation;
- Covid-19 risk assessment and shielding guidance, and a range of circulars on terms and conditions amendments.

230. A description of each of these letters follows.

231. The Director's letter, provided: [CL8/068 - INQ000452504], on the establishment of a national recruitment portal was issued on 28 March 2020 to NHS Scotland Health Boards. The purpose of the letter was to inform all Health Boards that in order to enable speedy deployment and employment across health and social care, NHS Education for Scotland (NES) had been commissioned to build a national 'Health and Social Care Covid-19 Accelerated Recruitment Portal'. It was to facilitate emergency registrants across professional groups to provide their details. The portal would support applications from returners and students to priority areas in health and social care acute, primary, community and social care settings.

232. The Director's letter on the deployment of nursing and AHP students on paid placements was issued on 28 April 2020 to NHS Scotland Health Boards, provided: [CL8/069- INQ000469963]. The guidance letter was developed in response to NHS Scotland Health Boards being asked to deploy health board staff to community settings during the Covid-19 pandemic. The purpose of the letter was to ensure that staff could be deployed to community settings safely and effectively and set out some high-level principles that Health Boards should consider alongside local operational arrangements. On 24 June 2022, a Director's letter was issued to NHS Scotland Health Boards' Chief Executives, Human Resource Directors and Directors of Finance stating that temporary Covid policies should be removed, provided: [CL8/070 - INQ000468167].

233. The Director's letter on testing, including asymptomatic testing and self-isolation was issued on 27 October 2020 to NHS Scotland Health Boards, provided: [CL8/071 - INQ000468168]. The purpose of the letter was to provide guidance to NHS and care home employers on the importance of eligible staff undergoing weekly asymptomatic routine Covid-19 testing, and what to do should staff choose not to be tested. The guidance was only applicable for weekly asymptomatic testing. It advised that where a staff member had symptoms, they should self-isolate and book a test as per the national guidance. Where there was a local outbreak or cluster of Covid-19, arrangements for testing should be put in place locally by infection prevention and control teams. On 16 August 2021, a Director's letter was issued to NHS Scotland Health Boards notifying staff and managers of a change to the twice-weekly Lateral Flow Device (LFD) testing kit for testing healthcare workers, provided [CL8/072 - INQ000468169]. The standard kits were to move from being Innova-manufactured testing kits to Orient Gene ones effective from 16 August 2021. On 22 August 2022, a Director's letter was issued to NHS boards notifying them that there was a change in policy to adopt a proportionate approach to risk in testing policy, easing the service pressures resulting from management of individuals continuing to test positive with PCR and not being clinically infectious, provided: [CL8/073 - INQ000468170].

234. The Director's letter on Covid-19 risk assessment and shielding guidance was issued on 27 July 2020 to NHS Scotland Health Boards, provided [CL8/074 - INQ000429263]. The purpose of the letter was to publicise a single national guidance document on occupational risk assessments for new risks posed to health

and social care staff by Covid-19. The guidance also applied to all healthcare students on placement. The risk assessment tool would support staff and line managers to understand and carry out effective risk assessments, and to have supportive conversations with staff to agree the best course of action.

235. Clare Haughey MSP, Minister for Mental Health, wrote to all NHS Scotland employers on 26 March 2020 about Mental Health and Wellbeing support during Covid-19 and highlighted key messages for staff, provided: [CL8/075 - INQ000470083]. On 14 April 2020, the Health Workforce Directorate wrote to all NHS Scotland employers highlighting employers' duty of care during Covid-19 pandemic. Guidance on the importance of protecting staff welfare and information on newly developed national wellbeing provision was issued throughout 2020, 2021 and 2022.

236. Health Workforce Directorate are currently working on updated health workforce pandemic guidance for NHS Boards applying the lessons identified during Covid.

Staffing and Workforce

237. The availability of healthcare staffing was impacted over the course of the pandemic. This was in accordance with the overall epidemiological trajectory of the virus across sequential waves of infection. Differential impacts on overall staff availability were observed at different points during the pandemic, and between Health Boards, reflecting localised conditions. This included periods in which there was a higher incidence of infection in certain Health Board locations. There were undoubtedly many variables affecting the overall impact of the virus on staffing availability, for any given service, at any given time. Workforce capacity was also heavily influenced by other factors including decisions made in relation to the suspension and remobilisation of certain services at different points during the pandemic, such as planned care services, and the imposition of necessary IPC measures.

238. Throughout the acute phase of the pandemic (March 2020 to April 2022) the overall recorded incidence of absence related to Covid-19 was typically lower than the incidence of unplanned absence for non-Covid-related sickness absence. Throughout the pandemic, as would be observed ordinarily, planned absence rates,

including for holidays, maternity, paternity, and other special leave, significantly exceeded unplanned absence rates.

239. In statistical terms, there were significant periods of time during the acute phase, particularly the periods between notable variant waves, in which the overall incidence of Covid-related absence and the associated impact on staff availability was modest. This is especially the case when looking at the aggregate staffing data for the NHS. However, both the aggregate data and the disaggregated data for Health Boards and for job families do not necessarily sufficiently illustrate the impact of staffing availability on individual services and indeed on overall service provision, particularly where individual services rely on limited numbers of suitably qualified staff.

240. The following factors also need to be considered in terms of the impact of the pandemic on staff availability:

- Staffing numbers for staff in post were not static. There were active recruitment campaigns in many areas for much of the acute phase. Recruitment in 2020, 2021 and 2022 significantly outstripped mean average recruitment rates in the preceding decade. Turnover was also suppressed in the 2021/22 financial year. Staffing numbers as of March 2020 and June 2022 overall for NHS Scotland and for key job families are provided below;
- In addition to considering overall staff in post and their distribution across NHS Scotland Health Boards, staff availability, or rather workforce capacity, is directly affected by decisions to stand-down/suspend services, alongside decisions to seek to remobilise and recover services (as noted above), alongside patient demand for those services;
- It was noted in the absence statistics that there was typically a higher incidence of Covid-19 related absence amongst nursing and midwifery staff as compared with other clinical staff groups. There are potentially many reasons for this, including differences in patterns of direct staff-patient and patient-patient contact, and differences as between job families in how diligently absence, and the reason for that absence, is recorded in other staff groups. Overall absence rates in the medical and dental job family are much lower than for other job families.

241. In addition to the statistical data available during the acute phase, SG introduced a "workforce capacity and pressures" reporting template, through which boards provided a qualitative assessment of workforce capacity including any specific challenges. This was refined over the course of the pandemic to include a black, red, amber, green (BRAG) rating. This information was used to support wider briefing on health system capacity. When considering both the quantitative and qualitative information in the round, staffing capacity progressively became a more significant challenge for Health Boards as they moved through successive waves of the pandemic, particularly in the winter of 2021/22 which coincided with the emergence of the Omicron variant.

242. The NHS Scotland staffing complement on 31 March 2020 was 143,440 Whole Time Equivalent (WTE) and 155,182 WTE on 30 June 2022.

243. There was no consistent or significant reduction in staff availability during the pandemic. This staffing complement can be broken down as follows:

Job Family	31 March 2020 (WTE)	30 June 2022 (WTE)	Difference
All Medical Specialties	13,161.3	13,964.6	+803.3
All Dental Specialties	588	573.6	-14.4
Nursing and Midwifery	60,811.8	64,193.8	+3,382
Administrative Services	26,120.4	29,538.7	+3418.3
Support Services	12,930.2	13,492.3	+562.1
Allied Health Professionals	12,065.3	12,926.3	+861
Healthcare Science	6,295.4	6,723.3	+427.9
Other Therapeutic Services	5,104	6,081.1	+977.1
Ambulance Support Services	2,616.2	3,701.8	+1085.6
Medical and Dental Support	2,014.3	2,085.6	+71.3
Personal and Social Care	1,443.8	1,668.5	+224.7
Unallocated/Not known	289.8	233.2	-56.6

244. When planning for workforce there is an applied assumption of a predictable absence of 22.5%. This is, however, not a core planning assumption for all job families. The 22.5% assumption was exceeded on two occasions between 2020 and 2022. These were the festive holiday periods from 28 December 2020 to 4 January 2021 (c. 26–30%) and 2021–22 (c. 25–28%).

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

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

247. Covid-19 related absence, including Covid positive absence and absence for reasons relating to Covid-19 such as childcare, self-isolation, ranged between c. 0.6%–5.8% and represented between c. 1%–7% of all absence.

248. Workforce Absence Forecast modelling was carried out in winter 2021 and winter 2022. This projected absence for the next six weeks. The modelling improved over time and was used to support briefing, both internally for SG colleagues and Health Boards. It was not directly utilised as a workforce planning tool, owing to the limited time period which could reliably be projected through the modelling. It was, however, used to assess whether emergency interventions would need to be made emergency interventions, such as securing additional capacity from the military. The job family most affected by Covid-19 absences was nursing and midwifery, which tended to have marginally higher rates of Covid-related absence compared to other job families (between 1 and 2 percentage points higher in the baseline data). It is of note that Covid-19-related sickness absence in NHS Scotland followed the same trajectory as the infection in the population.

249. Over the course of the pandemic some services were stood down. These were re-introduced in stages, although re-introduction was subject to variation, services being re-introduced and then stood down again, resulting from the trajectory of the pandemic, including the emergence of new variants.

250. There was also the introduction of new services, such as Covid-19 vaccinations and Test and Protect. Some existing services were expanded, such as laboratory

services, to support the response to the pandemic. These new and expanded services were developed at pace and sustained for the duration of the pandemic. To comprehend the availability of staff fully, it must be taken in context with the increased staff in post and the increased demand for staff to deliver new and expanded services.

251. A national approach to contact tracing went live on 28 May 2020 linked to the established arrangements for testing and support for isolation. This built on local outbreak response arrangements supported by Health Board Protection Teams. In August 2020, the DG HSC wrote to all Health Boards requesting that they ensure a sufficient workforce be identified to support operation of the system, whilst noting that further work was underway to model national capacity requirements. In September 2020, the then NHS Chief Executive, John Connaghan, wrote to Health Boards setting out national capacity requirements for the system, spread across all territorial Boards and the National Contact Centre (NCC) based within NSS. A requirement for a total daily capacity equivalent to 600 WTE staff was identified. This remained the position for most of the pandemic period, with territorial Boards and NSS being funded to deliver this level of "core" capacity until September 2022. In addition, NSS worked to build additional surge capacity. This was undertaken through both the development and operation of a staff bank for the NCC and the procurement of services via commercial suppliers. This allowed capacity to be dialled up and down in line with Covid-19 transmission rates. It is important to recognise that contact tracing formed one component of the wider Test and Protect system which, as of March 2022, was being supported by approximately 7,000 staff. Of those, c. 3,600 were employed by NHS Scotland Health Boards. Owing to the change of the testing and contact tracing model over the summer of 2022, Health Boards concluded several secondment opportunities and managed to return 1,443 staff back to substantive roles. This left 2,157 fixed-term staff to either be redeployed, supported to move to another role in another sector or to depart the organisation on or before 30 September 2022. Health Boards managed to redeploy a total of 1,219 staff into a substantive, already funded roles in Health Boards. A further 750 members of staff decided to depart NHS Scotland.

252. In November 2020, SG issued correspondence to Health Boards acknowledging the need for expanded vaccinator capacity. The request was made to Health Boards to draw on the primary care workforce as well as suitably trained Health Care Support Workers to augment their existing vaccinator capacity. Health Boards were asked to

deliver enough trained vaccinator capacity to deliver 160,000 vaccine doses per week in the initial weeks (1–3) of the programme, with further ramp-up planned throughout the remainder of December and early 2021. The initial target throughput equated to a requirement of approximately 527 WTE vaccinators nationally.

253. As the position became clearer with regards to the rate of vaccine supply and other critical assumptions around key aspects of the delivery programme, SG moved to publish its vaccine deployment plan on 14 January 2021. In support of that plan, the SG Covid-19 Vaccination Delivery Director wrote to Health Boards on 12 January 2021 requesting that they work to secure a workforce requirement of 1,400 WTE vaccinators, a limited number of whom may be involved in seasonal flu vaccinations, and 800 support staff by the end of January 2021. This workforce complement would provide capacity to administer in the region of 325,000 vaccinations a week. The letter also asked Health Boards to consider how they could increase capacity further with a view to delivering 400,000 doses per week. Modelling suggested this would require a workforce in the region of 1,700 WTE vaccinators and 950 WTE support staff.

254. A process involving weekly collation of management information pertaining to the vaccinations workforce was also established from January 2021. That data showed a peak of c. 1,470 WTE vaccinators being deployed in March 2021, supported by c. 940 support staff to deliver the initial programme of vaccination activity.

255. Following the initial vaccination roll-out, workforce requirements varied to reflect fluctuating demand. JCVI advice on the scope of booster programmes either on a seasonal basis or in response to new variants was taken into account. Again using management information, the workforce reached its peak in December 2021, with c. 1,540 WTE vaccinators deployed. This peak coincided with a significant spike in cases linked to the Omicron variant. As part of the work to establish a sustainable vaccination workforce, it was recognised that reliance on the primary care workforce, optometrists, dentists, pharmacists, and GPs, should be limited to support wider recovery of those services. Accordingly, the sessional rates agreed for the participation of optometrists, dentists and GPs was removed from 31 March 2022.

256. The removal of sessional rates also coincided with the issuing of further guidance to Health Boards to support future vaccination workforce planning. The guidance was

issued by letter, on 16 March 2022. It set an expectation that Health Boards maintain sufficient workforce to deliver up to 200,000 doses of vaccine per week at peak times, with c. 75% of that capacity comprising retained / substantive staff and the remainder being delivered through a flexible workforce model, such as a staff bank.

257. Given the fast-moving nature of development of vaccines throughout the pandemic, the last-minute introduction of vaccines and updates to the Covid-19 Green Book Chapter meant that national Covid vaccine protocols were sometimes issued late to Boards, who then had to push them through their own internal governance structures before vaccines could be administered the following week. In some instances, new protocols were issued by SG on a Friday, with the expectation that they would be in place for clinics on a Monday. National Vaccine Protocols are signed off by CMO and approved by Ministers. Sudden changes caused difficulties for both national and local partners as processes became compressed.

258. In January 2021, Health Workforce Directorate began commissioning workforce capacity reports from Health Boards. These reports were Health boards' own individual assessments of their workforce capacity and pressures. The frequency of these submissions varied. Reports were initially provided daily but subsequently were reported on a weekly and then a fortnightly basis. Reporting periods were decided in line with the stages of the pandemic and the waves of infection. The information from these Health Board self-assessments was combined with management information gathered on staff absence and provided as part of a wider report on capacity and pressures across the system, provided: [CL8/076 - INQ000468177]. This wider report was used to brief Ministers using Bronze, Silver, and Gold Command structures. It was also shared with the winter pressures group and Senior Officials whilst being utilised to support planning. The information requested in these commissions to Health Boards evolved as the Health Workforce Directorate worked to further improve understanding.

259. Based on qualitative information received from Health Boards, changes in demand pattern meant it became more difficult for Health Boards to match available workforce with services. This was evidenced through monitoring of Health Boards own assessments of workforce capacity. The nature and reasons for changing demand for the healthcare workforce during the pandemic are complex and multifaceted. Throughout the pandemic demand for different NHS services would

increase and decrease through time. Demand factors were influenced not just by the total demand, such as the number of presentations at A&E, but by the nature and acuity of the presentation, high-occupancy level and length of stay, which increased over the pandemic, alongside other productivity inhibiting factors such as the IPC requirements and measures to manage in-hospital outbreaks. Additionally there were seasonal variations to unscheduled care demand too which is observable in the capacity and pressures reporting when looked at over time. There was also compromised access to primary and community care services.

260. As two examples, the demand for workforce within ICU settings increased during Covid peaks, particularly pre-vaccine, and the demand for workforce in a care settings would reduce when elective care was suspended, resulting in a redeployed workforce. The demand for workforce changed for many reasons, including but not limited to the stage of the pandemic, pandemic communications, lifestyle changes, the suspension of routine services and the spread of other communicable diseases, as well as the continuing change in demand caused by an aging population profile.

261. In recognition of the evolving demand for workforce, SG supported Health Boards via multiple programmes.

262. On 18 March 2020, in response to Covid-19, the SG issued a national call for returners to NHS Scotland. This was initially managed through logging expressions of interest through a repurposed International Recruitment Service. By the end of March 2020 approximately 2,000 individuals across the medical, nursing, and allied health professions had registered their interest. In March 2020, the professional and regulatory bodies wrote to individuals who had left the professional registers within the last 36 months to advise that they would be automatically subject to emergency registration, pursuant to the passage of the Coronavirus Act 2020. NHS Education for Scotland then wrote to all 1,162 individuals with an address in Scotland who the GMC had admitted to the emergency register to encourage them to apply to return to work for NHS Scotland.

263. On 24 March 2020, CSH formally commissioned NHS NES to create a national accelerated recruitment portal. The portal was the gateway to accelerated recruitment across HSC to enable those with relevant skills and experience to volunteer to support services as part of the emergency response. It was developed to help facilitate deployment of emergency registrants across professional groups and

support applications from returners and students to priority areas in health and social care across acute, primary, community and social care settings. The portal, accessible through the NHS Careers website, went live on 29 March 2020 and was announced by the CSH on 30 March 2020.

264. Health Workforce Directorate worked closely with NHS NES, the Medical Schools of Glasgow, Aberdeen, Dundee and Edinburgh, the GMC, the BMA, the Academy of Royal Colleges, and Universities Scotland regarding the potential early deployment of medical students into NHS Scotland. In April 2020, two options for volunteering to bolster the health workforce were made available to final year medical students as the GMC agreed to provisionally register all final year medical students once they have graduated. The first option was an interim Foundation level (FiY1) doctor once they have graduated and received their provisional registration or, where this opportunity was not available or not sought, as a Healthcare Support Worker (Agenda for Change Band 4). Final year medical students were offered the interim foundation year contract from May to 10 July 2020, following the early graduation of the 2020 cohort. These contracts were terminated on 10 July 2020; this allowed students to take a break for summer leave before being placed within HBs as FiY1 trainee doctors with contracts starting on 5 August 2020. Those medical students who were further away from graduating were also encouraged to volunteer for Healthcare Support Worker roles if they received agreement from their medical schools that this would not impact on their studies and the completion of their degrees. The CMO sent an open letter to all final year medical students on 1 April 2020 outlining these options, provided: [CL8/077 - INQ000470104].

265. Initial action to boost the NHS Scotland workforce to combat Covid-19 focused on recently retired staff and university students. As part of this effort, contact was made with thousands of students of nursing, midwifery, Allied Health Professions, biomedical science and medicine in Scotland's Higher Education Institutions. In addition to the recruitment of students NHS NES asked Higher Education Institutions to provide names of staff who would be interested in being deployed during the initial period of the pandemic as part of their work on the recruitment portal. The mobilisation of nursing and midwifery students and the use of final year medics formed a significant staffing mitigation in spring 2020 providing at peak around 5,000 additional bodies to the service.

266. A total of 18,369 expressions of interest were received via the Portal. The figure was reduced as a considerable number of these expressions of interest were either identified as duplicates (1600) or came from registrants who later withdrew from the process (5400). 6,767 individuals were deployed via the Portal (including 5,346 students). An additional 3,167 applicants were passed to the Scottish Social Services Council for processing into social care employment.

267. The Health Workforce Directorate worked with the Scottish Terms and Conditions Committee to review and adjust terms and conditions to provide supplementary workforce capacity throughout the pandemic. Adjustments included annual leave carry-over for 2020–2021 and a buy-back of annual leave over 2021–2022. Guidance was first issued on 16 April 2020 by the Health Workforce Directorate to NHS Boards outlining arrangements for staff to have the flexibility to carry forward untaken annual leave where they had been unable to take their full annual leave entitlement because of Covid-19. The guidance highlighted the need to ensure NHS Scotland staff were well supported, could maintain their health, and that wellbeing and minimum leave requirements were clearly outlined. Overtime payment restrictions were also amended during the pandemic.

268. On 28 April 2020, the Health Workforce Directorate and CNO issued guidance on community deployment. The guidance clarified the SG's position that everything possible should be done to ensure a complete system health and social care response to Covid-19. It highlighted that this could only be done effectively by looking constantly at demand for services across the system and adjusting deployment and skills-mix according to the changing demand profile. It also noted that as an increasingly integrated health and social care system, acute, primary care and social care services must work collectively to attend to the health needs of the people of Scotland. Information on mutual aid and guidance for staff who volunteered to be deployed in the care home sector was included, provided earlier in the statement: [CL8/069-INQ000469963.

269. To help address rising demand in the winter period of 2020, remaining portal applicants' information was distributed to Health Boards on 23 November 2020. Health Boards were encouraged to ensure that any further suitable registrants who had been admitted to the emergency and temporary registers, who wished to return to local employment within NHS Board areas had the opportunity to do so. Ongoing liaison with the GMC, Nursing and Midwifery Council, Health and Care Professions

Council and General Pharmaceutical Council ensured that the regulators were signposting relevant opportunities to registrants.

270. A submission, dated 26 November 2020, providing Ministers with an updated summary assessment of health workforce capacity over the winter period, is provided: [CL8/078 - INQ000468180].

271. On 27 September 2021, letters were sent by Chief Professions Officers (CMO, DCNO, Chief Allied Health Professions Officer and CSO) to staff that remained on the emergency registers of the regulatory bodies, encouraging them to return to the service if they continued to be interested in doing so, as part of a national call to arms.

272. The NHS and Care Winter Package of additional funding announced by the CSH on 5 October 2021 included several measures to bolster staff capacity including:

- Recruiting 1,000 additional NHS staff to support multi-disciplinary working;
- £40 million for "step-down" care to enable hospital patients to temporarily enter care homes, or receive additional care at home support, with no financial liability to the individual or their family towards the cost of the care home;
- Over £60 million to maximise the capacity of care at home services;
- Up to £48 million to increase the hourly rate of social care staff to match new NHS band 2 staff;
- £20 million to enhance Multi-Disciplinary Teams, enable more social work assessments to be carried out and support joint working between health and social care;
- £28 million of additional funding to support primary care;
- £4.5 million to support Health Boards to attract at least 200 registered nurses from outwith Scotland by March 2022.

273. In the first week of March 2020, internal SG discussions about the use of nursing, midwifery and allied health profession students in the workforce began. The main aim was to increase the health and social care workforce capacity as staff sick absence was expected to be high and health and social care services expected to be stretched.

274. The UK Coronavirus Act 2020 established emergency powers which meant that relevant professional healthcare regulators could register anyone who they considered was a fit, proper and suitably experienced person to be registered as a nurse or midwife or registered as a member of the profession in question in the context of the emergency.

275. The Bill was introduced on 19 March 2020 and passed on 23 March 2020. This allowed temporary registers to be established by the regulators.

276. On 27 March 2020, the Nursing and Midwifery Council opened a temporary Covid-19 emergency register to encourage nurses and midwives who had left the register in the past three years to opt back in, should they wish to do so. It is important to note that this decision was taken collectively on a four nations basis.

277. This emergency register expanded on 6 April 2020 to include overseas nurses and midwives who had completed entire Nursing and Midwifery Council registration process except Objective Structured Clinical Examination (OSCE) and again on 15 April 2020 to include nurses and midwives who had left the register in the previous four or five years.

278. The Nursing and Midwifery Council did not open a temporary register for students' registrations, but students entered the workforce in the below capacities:

- Final year: paid placements at band 4. Contract ended on 30 September 2020 or sooner if they were ready to go on the permanent register;
- Third year honours: paid placements at band 4, if able to complete hours for registration by 30 September 2020, or at band 3 if not, with contract ended on 30 August 2020;
- Second year: could opt into the workforce on a paid placement at band 3. Contract ended on 30 August 2020;
- First year students did not go on placement but did academic studies;
- Students were able to access local support e.g. Occupational Health contacts, employee assistance provider (EAP) information, and psychological support.

279. SG issued guidance to Health Boards on 18 January 2021, provided: [CL8/079 - INQ000469964], setting out SG's policy position on the employment of healthcare

students during the pandemic. Health Boards were permitted to recruit nursing, midwifery, Allied Health Professionals, and undergraduate medical and dental students as bank workers and could offer less than full time, fixed term contracts through staff banks. It noted that students employed with less than full-time contracts should be deployed for a maximum of 15 hours per week and contracts would be offered at bands 2, 3 and 4, commensurate with prior work experience and their level of study.

280. If final year allied health profession students had finished placements, they could go on the register and had the same terms and conditions as qualified Allied Health Profession staff. The plan was then for them to go back to university and finish their education. Final year students on the temporary register who were employed on a fixed term NHS contract were paid at the starting point of Agenda for Change Band 5. However, by the time this was implemented, most students had finished their education so very few did this. Years 1–3 did not go out on placement.

281. Students were able to access local support e.g. Occupational Health contacts, employee assistance provider (EAP) information and psychological support.

282. Final year trainee biomedical students (not support staff) who were on UK-approved programs and who had completed all their clinical practice placements, could join the workforce early, while being paid at Band 5, as detailed in Annex 21 of Agenda for Change terms and conditions of service.

283. Universities continued to provide support to students and if they moved into laboratory practice, they had the further support of a line manager. Students were also able to access organisational support e.g. occupational health services.

284. The Health and Care Professions Council also opened a temporary register on 27 March 2020. This included former registrants who had de-registered in the past three years.

285. On 19 March 2020, the Nursing and Midwifery Council issued a joint statement with the UK four nations regarding expanding the nursing workforce in the Covid-19 outbreak, provided: [CL8/080 - INQ000232032]. Further statements were issued on 20 March (joint midwifery statement) and 25 March 2020, provided: [CL8/081 - INQ000470413] [CL8/082 - INQ000417725].

286. On 23 March 2020, the CSH wrote to Higher Educational Institutions to inform them of the SG's intention to deploy students into settings that were appropriate to their competence, provided: [CL8/083 - INQ000250906].

287. On 27 March 2020, the Healthcare Science Officer wrote an open letter to final year biomedical science students asking them to agree to become part of their local health and social care workforce to assist with the Covid-19 pandemic response, provided: [CL8/084 - INQ000414591].

288. Similarly, on 30 March 2020, the Chief Allied Health Professions Officer wrote an open letter to final year allied health professional students within the last six months of study asking them to agree to become part of their local health and social care workforce, provided: [CL8/085 - INQ000470118].

289. Communicating with students across all four nations of the UK who were completing degrees required for roles in the healthcare workforce proved to be complex. The potential for students to be used in the workforce was announced (initially by NHS England) before much of the detail had been worked out, which meant that CNO Directorate was asked questions it could not answer and both Higher Education Institutions and students felt uneasy and worried about arrangements. Communications from regulators, such as the Nursing and Midwifery Council, did not always fit the timelines being followed in SG, leading to confusion amongst students and HEIs. As an example, NMC statements on students were issued prior to SG being in contact with Scottish HEIs, provided: [CL8/080 - INQ000232032] [CL8/081 - INQ000470413]. Emails from the time confirm that social media was being used to communicate details of published statements. Differences between the four nations also led to confusion, particularly through social media discussion. A key example of this occurred on 11 March 2020, when Simon Stevens, the then Chief Executive of NHS England, announced at a CNO England summit that students would be used in the workforce, a statement which was picked up in UK-wide media. Internal Scottish Government discussion regarding this announcement is provided: [CL8/088 - INQ000468156]. This announcement came earlier than any confirmation by SG to stakeholders on deployment of students and without prior notice, which had the potential to cause confusion.

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

291. Student experience: some HEIs reported that the quality of the education experience of students on paid placements was variable, with some work areas having very few patients owing to redeployments and re-organisation of services, though it did allow them to undertake practice hours.

292. Practice hours and registration: if students had not been able to undertake paid placements, then the final year students may not have had enough practice hours to enable them to graduate and even more students would have been behind with practice hours.

293. Loss of practice hours: first year nursing, midwifery, and years 1–3 AHP students undertook no practice hours from the end of March 2020 until at least September 2020. This added to placement capacity issues but may have been unavoidable given the suspension of many health services.

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

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

Military Aid to Civilian Authorities (MACA)

296. The SG sought military assistance from the Ministry of Defence on several occasions during the pandemic. The assistance received was in line with the support received by all home nations and fully met the requirements of the MACA principles.

297. In January 2021, 12 military planners were working in support of the national programmes for vaccination and testing, with a predominant focus on vaccine-

related issues. A further 23 planners were attached to each territorial Health Board providing local planning support. Outside of these Military Aid to Civilian Authorities tasks, Joint Military Command Scotland provided military liaison officers to each Local Resilience Partnership and had a Joint Regional Liaison Officer and small team co-ordinating the integration of military operations with the civil authority.

298. As part of efforts to support the initial phase of vaccination activity in early 2021, approximately 100 military staff were deployed to support the set-up of vaccination sites. Thereafter, arrangements were implemented to provide Health Boards with access to up to 109 military personnel to support direct delivery of vaccination activity. These personnel would form either "Vaccinator Quick Reaction Force" (V-QRF) teams, usually comprising ten military vaccinators and often accompanied by an independent prescriber; or "Vaccine Support Force" (VSF) teams tasked with supporting the set-up and operation of vaccination centres. Personnel were managed as a national resource and were not all deployed continuously.

299. Accounting for the evolving vaccine supply position and acknowledging the requirement to maximise delivery capacity within Boards, access to these personnel was extended in March 2021 and expanded to provide for access of up to 138 individuals. This expansion reflected the preferred vaccinator-to-support-staff ratio in operation across the wider programme. The requirement for Military Aid to Civilian Authorities support was reviewed regularly thereafter, with personnel deployed as needed throughout spring and summer 2021.

300. In autumn 2021, SG and NHS Scotland Boards determined that further military support could assist in alleviating significant pressures in acute settings and the SAS. Additional support was also requested to support the increased pace of the vaccination programme.

301. Within acute settings in several Health Boards, Military Aid to Civilian Authorities was sought for registered health care professionals, combat medical technicians and general duties personnel. Prior to requesting military assistance, many Health Boards, in addition to redeployment of staff and other measures, had temporarily postponed many non-urgent elective procedures to free up staff and beds for urgent care. Some emergency departments had tripled the number of beds in use at this time.

302. At its peak, 114 drivers and support staff were requested to support the SAS as demand on ambulance services had increased dramatically. The knock-on effect of high demand in emergency departments had seen wait times for ambulance handover increase significantly, reducing available resource to respond to emergency responses.

303. The winter 2021 vaccination programme increased in both scale and pace because of JCVI advice to include boosters to 50–59 year olds and first doses to 12–17 year olds. The pace was exacerbated by a delay in the JCVI advice which resulted in revised programme delivery starting in mid-September rather than early September. This resulted in a build-up of outstanding boosters due to eligible 50–59 year olds of c. 1.1 million. The resultant combination of outstanding doses and maintaining the programme at pace outstripped the capacity of the health vaccination workforce, necessitating the deployment of 121 military personnel across 11 mainland territorial Health Boards from 1 November to 2 December 2021.

304. Further JCVI advice recommended the inclusion of boosters for 40–49 year olds and second doses for 16–17 year olds, further increasing pressure on the programme and making it imperative that the older cohorts were vaccinated fully before most of these younger cohorts became eligible for their boosters / second doses. In addition, there was a need to offer vaccination boosters to all those aged 18 and above by the end of January 2022. Military deployment was therefore extended and a further 100 vaccinators were sought. The Military Aid to Civilian Authorities deployment was kept under continual review and redeployment directed according to the changing needs of the programme.

305. Military Aid to Civilian Authorities support to the National Vaccination programme was stood down in January 2022. Service Personnel stood down at the end of February 2022 from Acute Care Support tasks. The SAS Non-Emergency Driver Support Military Aid to Civilian Authorities continued until 31 March 2022.

Additional workforce measures

306. In addition to recruitment and redeployment measures, the Health Workforce Directorate implemented several policy interventions to support NHS Boards in addressing challenges with workforce capacity.

307. In March 2020, the Health Workforce Directorate paused programmes of work to free up NHS Scotland capacity to respond to the pandemic. Paused programmes of work included: the introduction of the Independent National Whistleblowing Officer role and the Whistleblowing Standards; the Annual Staff Governance Monitoring for 2019/2020; the National (Once for Scotland) Workforce Policies Programme; iMatter and Distinction awards; and discretionary points schemes. These programmes would have required engagement from Human Resource Directors, Chief Executives, and staff across the NHS.

308. With Shielding restrictions initially due to be lifted on 31 July 2020, the Health Workforce Directorate published occupational risk assessment guidance to enable those who no longer needed to shield to consider their return to work. The tool supported staff and line managers to understand and carry out effective risk assessments, and to have supportive conversations with staff to agree the best course of action. The Health Workforce Directorate led on the development of this guidance in collaboration with NHS Occupational Health Consultants and using the clinically approved COVID-AGE calculator created by Association of Local Authority Medical Advisors. As this tool was applied by individuals and their managers, the directorate does not have data on the numbers of staff for whom guidance facilitated a return to work.

309. In summer 2021, the Scottish Health and Social Care workforce was impacted by high community Covid transmission rates, with self-isolation policy of contacts contributing to staff absence. The Health and Social Care Directorate asked PHS to provide a clinical assessment of potential exemption for Health and Social Care staff from self-isolation policy. Health Workforce Directorate then worked with the CMOD, CNOD and the Social Care Directorate to develop the policy framework. The policy enabled fully vaccinated and asymptomatic Health and Social Care staff who have been a contact of someone with a positive Covid-19 test to be exempted from self-isolation requirements under specific circumstances. This guidance was issued on 23 July 2021. Separate guidance for other critical national infrastructure staff was issued at the same time. The Health and Social Care workforce guidance was updated as the virus and evidence evolved. As Health Boards were able to use the policy at their own discretion, the Health Workforce Directorate does not have data on the impact of this framework on staff absence rates.

Impact of testing on workforce

310. The availability of Covid-19 testing had both a positive and negative impact on the availability of healthcare staff to work in face-to-face healthcare settings.

Negative:

- Inevitably, as those testing positive were rightly required to self-isolate, the number of staff able to work was reduced.

Positive:

- Asymptomatic Covid-19 testing supported early identification of infection resulting in a lesser opportunity for nosocomial transmission amongst healthcare workers;
- Symptomatic testing was prioritised for healthcare workers in May 2020. This allowed those healthcare workers who had respiratory symptoms to get a test and if negative (and the individual was well enough) continue to work;
- "Testing to release" supported healthcare workers to return to work early (<10 days) if they were well and had two consecutive negative Covid-19 test results.

311. Voluntary asymptomatic Covid-19 testing was initiated for healthcare workers in June 2020. This was initially by means of a Polymerase Chain Reaction (PCR) test for healthcare workers who cared for highly vulnerable patient groups (haemato-oncology, long term care of the elderly, long term mental health services). The aim of this was to reduce the opportunity for nosocomial transmission of Covid-19 from staff to patients by removing staff who may be asymptomatic from the workplace.

312. In December 2020, Lateral Flow Device (LFD) testing for Covid-19 was introduced, again on a voluntary basis, initially to patient-facing staff. This then gradually expanded to all NHS and Primary Care staff. Although testing was offered on a voluntary basis, SG strongly encouraged all staff to take it up by highlighting the benefits to them, their families, their patients, and their colleagues.

313. Testing for healthcare workers was introduced in order to identify cases as early as possible, thus reducing the opportunity for onward transmission to either patients or colleagues. By offering a "self-test at home" approach, those who tested negative

had minimal disruption and those who tested positive were able to isolate immediately.

314. It was proposed that this targeted approach would have the greatest impact on the rates of nosocomial transmission. It would therefore support the economy and allow wider society to return to a normal way of life. The data collected on the electronic data capture portal (ePortal) indicated that a potential nosocomial transmission event was avoided for every person who tested positive via LFD test and self-isolated as a result.

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

316. On receiving a positive LFD test result, healthcare workers were initially requested to undertake a confirmatory PCR test. PCR test samples were required to perform Whole Genome Sequencing (WGS). A proportion of positive samples were sent for whole genome sequencing to improve understanding of virus transmission chains and to determine whether cases were likely to be linked for the targeting of appropriate public health measures.

317. WGS was also used to identify and track potentially significant genetic changes that may have affected how easily the virus was passed on and the severity of the symptoms it causes. This allowed targeting of public health interventions to stop the spread of new SARSCoV-2 variants of potential concern and ensured that the tests in use to identify SARSCoV-2 remained fit for purpose.

318. Healthcare workers were informed that as of 6 January 2022, LFD positive tests should be treated as a confirmed positive case of Covid-19, meaning there was no longer a need for a confirmatory PCR test, provided: [CL8/089 - INQ000429280].

319. Over this period, contact tracing would commence following a positive PCR test result, or latterly a positive LFD test result. Assuming there had not been any infection prevention and control failures, staff using the correct PPE, maintaining physical distancing and following appropriate hand hygiene protocol, then colleagues of the Covid-19 healthcare worker were not required to self-isolate.

320. As part of the LFD healthcare worker pathway, Health Boards were able to access their local data on numbers of tests and number/rate of positive tests. This assisted with their local resilience planning. Data was caveated as it only represented those healthcare workers who engaged and updated the online system. Some Health Boards, however, did provide feedback in their LFD testing implementation evaluation return that they had experienced staff shortages.

321. Prior to the rollout of LFD testing in November 2020, the Workforce Planning and Development Division submitted a briefing to the CSH, provided: [CL8/**078 -** INQ000468180]. This detailed the worst-case scenario workforce absence assumptions from the introduction of routine testing of all patient-facing healthcare workers in all hospitals, SAS and Covid-19 Assessment Centres over the winter period.

322. A key risk identified in this briefing was that testing more healthcare workers could result in a higher proportion of the workforce self-isolating owing to positive test results. This would then have an impact on service delivery and, in some cases, could potentially result in the pausing of service delivery. However, the benefits of reducing nosocomial transmission between healthcare workers were also outlined.

323. In July 2021, a policy was introduced where healthcare workers were exempt from self-isolation if they had been in contact with a positive case, were fully vaccinated, had no ongoing exposure, were PCR negative and undertook daily LFD testing during what would otherwise be their self-isolation period. This policy was designed to protect health and social care service provision by allowing staff who voluntarily wish to end self-isolation to do so safely.

324. In January 2022, workforce colleagues also provided an update to the policy on self-isolation for health and social care staff, which introduced LFD testing to release previously Covid-19 positive health and care staff from self-isolation early

(from day seven) if they had two consecutive negative LFD test results. This allowed staff to return to work earlier than the standard 10 days.

325. Covid-19 testing of healthcare workers therefore both facilitated and hindered healthcare worker availability. The aim of the programme, however, was to stop nosocomial transmission and protect those accessing healthcare from the harms caused by Covid-19.

326. SG also conducted analysis of data in this period, developing models of projected Covid-related NHS and social care staff absence over winter 2021. As a result of frequent testing of NHS and social care staff, rises in Covid-19 prevalence led to disproportionate impacts on these workforces, which placed additional strains on the system.

Workforce wellbeing

327. On 10 April 2020 advice provided to Ministers from Senior Civil Servants within the Health and Social Care Directorate recommended the decision to create a National Wellbeing Hub. This was scoped as an interactive website that would provide a range of resources to help the Health and Social Care Workforce as they responded to the Covid-19 pandemic. It was developed to meet the identified need for a single point of access to wellbeing support for the workforce. It officially launched on 11 May 2020. In the intervening time before the wellbeing hub was launched, work was undertaken on a digital inventory of general resources and materials using the existing Project Lift platform on a special Coronavirus Resources page. This was highlighted and shared in regular mailings and via social media channels.

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

329. On 1 May 2020, the Minister for Mental Health wrote to NHS Boards, IJBs, Local Authorities and Local Mental Health Service Leads to set out principles to support active local decision making, promote consistency, and ensure the provision of safe, person-centred and effective service responses during the pandemic. This

guidance built on existing Mental Health Act Principles, provided: [CL8/091 - INQ000470112].

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

331. Furthermore, on 10 August 2020, the CSH agreed to provide a suite of digital services including the National Wellbeing Hub which provided a range of resources designed to support the workforce. This included Stress Control and wellbeing apps such as Sleepio and Silver Cloud, and signposting to services designed to support the wellbeing and mental healthcare needs of the health and social care workforce during and beyond Covid-19.

332. The Minister for Mental Health approved on 14 September 2020 the decision for the SG to provide funding for the workforce development programme to increase Health Boards' capacity and capability to deliver psychological interventions and therapies to support the mental health and wellbeing of the workforce. The programme included national and local delivery of training and supervision in psychological interventions and therapies.

333. On 21 December 2020, the decision was made by the Minister for Mental Health to establish three wellbeing groups: an Oversight Group, a Programme Board and an Expert Advisory Group. These were established to discuss various programmes of work relating to supporting staff wellbeing and staff recovery, including the national initiatives. They also provided clinical and operational advice to support the mobilisation of the Workforce Specialist Service.

334. On 21 January 2021 CSH consented to £500,000 funding for practical support, including hot drinks, snacks and mobile catering to NHS Scotland staff, to support health and wellbeing.

335. On 27 June 2021 the CSH announced a £8 million package of wellbeing support for health and social care staff. The increased support was to help fund several immediate recovery actions and lead to the development of a National Wellbeing programme.

336. On 5 October 2021, the SG announced an additional £2 million wellbeing support fund to Health Boards for NHS staff's wellbeing to cover c.178,000 NHS staff in recognition of the importance of practical support, including access to fresh food, drink, and rest spaces, and the positive impact this has on the psychosocial wellbeing of staff for NHS Scotland during the pandemic. The funding was used for meeting practical needs over the winter including access to hot drinks, food, appropriate transport, rest facilities and other measures to aid rest and recuperation.

337. On 30 November 2020, the FM announced a £500 one-off payment for all health and care staff as a thank you for helping Scotland cope with Covid-19. The SG, employers and staff side worked in partnership through the Scottish Terms and Conditions Committee to agree the fairest way of allocating this payment to NHS Scotland staff. The one-off pro-rata non-consolidated £500 was payable to all directly employed NHS staff, as well as staff bank workers and locums paid through NHS Payrolls who had at least one month's continuous service in the NHS Scotland between 17 March and 30 November 2020.

338. The payment was also payable to contractor staff covered by the Two-Tier Agreement and staff working on honorary contracts with the same qualifying criteria as directly employed staff. The £500 thank you payment was further extended to "Hard FM", facilities management services to maintain the internal and external physical assets of NHS buildings, staff working within Public, Private & Partnerships and private sector *PPP/PFI) hospitals, whether they were on Agenda for Change equivalent terms and conditions or not, provided they worked exclusively for the NHS.

339. Removal of the NHS Surcharge for non-UK healthcare staff also provided financial benefits to those within the scheme. That is, however, a matter reserved to the UK Government. SG were not involved in the discussions to remove the surcharge, but it has always been the SG's position that the Immigration Health Surcharge should be abolished for the entire migrant population. NHS Scotland would be best placed to respond on what they considered the impact of NHS Surcharge removal.

340. Additionally, Nursing and Midwifery students who entered employment were paid their salary in addition to bursary, £8,100 increased to £10,000 in September 2020. The bursary was not deducted from their salary.

341. Staff experience within NHS Scotland is measured annually via the National iMatter Staff Experience Continuous Improvement Programme. However, in recognition of the changing priorities in responding to the Covid-19 pandemic, it was agreed, in partnership with the Scottish Workforce and Staff Governance Committee, that this be paused for 2020. Extensive engagement was done with a variety of key stakeholder groups to explore options for implementing a national staff experience measure for 2020. This approach provided a meaningful opportunity for staff to express their views whilst still recognising the recovery work being undertaken across Health and Social Care.

342. A pulse survey development workshop was held on 22 June 2020 with key representatives from SG, Health and Social Care and National Staff Side. The aim of the session was to explore the detail in relation to the purpose and methodology for a wellbeing measurement. The principal consensus agreed by the group is summarised below:

- Clear priority for measuring holistic staff wellbeing. Validated wellbeing models were considered, and the Warwick-Edinburgh 7-item Mental Wellbeing Scale was a preferred approach;
- It is essential for the measurement to be meaningful and actionable within the context of the line manager and organisation;
- Qualitative, open questions would be beneficial and provide an enhanced opportunity for staff to be heard;
- Role and demographics should be captured in recognition of their impact on holistic well-being and ability to add greater organisational context.

343. The Scottish Workforce and Staff Governance Committee made recommendations on 16 July 2020 for next steps, a timetable for the 2020 staff experience pulse survey measurement, and the reinstatement of a full National iMatter Programme in 2021.

344. The NHS Scotland Pulse Survey for 2020 went live on 1 September. There were 22 NHS Scotland Health Boards and 30 Health and Social Care Partnerships who took part in the survey. Online survey invitations were sent from 1 September 2020, with

responses received through until 23 September 2020. Paper surveys were distributed to staff throughout September and returns were accepted until 2 October 2020 by which point 83,656 staff had taken part in the survey. Staff were asked 13 questions about overall wellbeing and staff experience of work during the Covid-19 pandemic. The survey also asked staff two qualitative questions inviting them to describe what was most worrying them and what was supporting them, two succinct questions about the work environment, and finally a suite of staff groupings and demographic questions. The staff experience pulse survey produced reports at National, Board and Directorate level.

345. This approach provided an appropriate and accessible avenue for staff to use their voice and provide feedback to Scottish Government and NHS Health Boards during a period of unprecedented pressure and change. This approach provided an appropriate and accessible avenue for staff to use their voice and provide feedback to Scottish Government and NHS Health Boards during a period of unprecedented pressure and change.

346. The National Report was published in November 2020, with outcomes being used to support and inform wider staff experience, health and well-being, culture, dignity at work and work on equalities, diversity, and inclusion programmes, provided: [CL8/092 - INQ000429295]. Support links to the National Wellbeing Hub, the National Wellbeing Helpline for Staff and the Samaritans were included in the survey to promote the help available to all health and social care staff through a range of resources to support physical and mental health. Analysis of the results enabled SG to understand, on a national scale, how staff felt their experiences at work were being impacted by the pandemic and support assurance of maintaining the Staff Governance Standard, a published framework that sets out expectations of NHSScotland employers and employees, forming a system of corporate accountability for the fair and effective management of all staff, details of the standard are made available on the NHS Scotland Staff Governance website. At local board level, a greater understanding was also gained on what was causing staff most concern about the workplace (patient care, safety at work and remote working) and on a personal level (contracting Covid, the prospect of a second wave and general personal health). These insights, along with qualitative information gained regarding support, allowed Health Boards, teams and managers to tailor staff engagement, discuss lessons learned and develop more robust action plans to

support staff in working through that time, particularly in relation to health and wellbeing support for the workforce.

347. In addition, the Workforce Senior Leadership Group met regularly. This enabled SG to capture first-hand information from Health Boards and Trade Union representatives on staff member mental health and wellbeing. Wellbeing was a regular topic on the agenda during meetings throughout the relevant period.

348. The Wellbeing Champions Network was formed in April 2020 with a membership created through nominations by Health Boards, Local Authorities, IJBs and from the Third and Care Sectors via personal contact. The role of the Champions was to be actively involved in the development, implementation and monitoring of their organisation's wellbeing plans, working in partnership with the appropriate staff governance committee or equivalent to ensure that workforce wellbeing featured at the centre of their planning activities. This includes ensuring that wellbeing resources were accessible to staff across the health and social care workforce.

349. Staff Wellbeing Champions are responsible for promoting and supporting the wellbeing of the health and social care workforce across Scotland. They are responsible for leading on the dissemination of good practice and information relating to the positive mental health and wellbeing of the workforce within their parent organisation. This includes practical support, both during the Covid-19 crisis and times of normal working.

350. The Wellbeing Champions provided first hand qualitative monitoring of mental health and wellbeing across health and social care during the Covid pandemic.

351. The National iMatter Continuous Improvement Model is a model for capturing staff experience and promoting NHS staff engagement, which was developed, pre-pandemic, by NHS Scotland staff. As a team-based tool, iMatter offers individual teams, managers, and organisations the facility to measure, understand, improve and evidence staff experience.

352. As noted above, the National iMatter Programme was paused in 2020 with the Pulse Survey being undertaken for that period. It was reinstated in 2021 and utilised as monitoring platform for mental health and wellbeing, amongst other aspects.

353. The 2021 iMatter questionnaire enabled staff the opportunity to feed back their experience within their team and at organisational level on a real-time basis. The iMatter results were then directly reported at all levels throughout the organisation. Once team results were delivered, teams were invited to collectively share responsibility for developing an action plan within an eight-week period and to review actions and progress made throughout the year. An integral part of the iMatter process is teams coming together to review the results and share thoughts and ideas to develop and implement action plans.

354. The iMatter process is supported by Team Stories, narratives that provide best practice examples of how to address challenges and provide inspiration and ideas for other teams and for the organisation as a whole. As a direct consequence of the Covid-19 pandemic and the ongoing situation faced by Health and Social Care, the decision was taken to not request Team Stories in 2021.

Medical Equipment

355. There was no pre-existing plan or contingency for the supply of ventilators and oxygen prior to the Covid-19 pandemic so the SG ICU Resilience and Support Group was established in March 2020. This included SG, ICU consultants, clinical engineers, estates / facilities staff and NSS NP staff. This group had senior clinical, technical, procurement and policy representation, able to make informed decisions on equipping, levels, and technical suitability of devices.

356. Throughout the period, there were challenges in obtaining intelligence and baseline information on what medical equipment was available within NHS Boards and how much of it there was. Each Health Board has its own medical equipment management system on which details of its medical equipment are recorded, for example, category of equipment, manufacturer, model, serial number. During the relevant period, there were a number of different systems in use with no national oversight of what equipment each board held. This therefore meant that medical equipment information had to be requested, manually collated and sorted into a meaningful format. Health Boards took time to respond, in many cases it took days, mainly owing to the competing priority of keeping clinical services functional under pressure against a backdrop of staff shortages as a result of illness throughout that time. This situation occurred each time SG requested information on ICU equipment held, ventilators, monitors, syringe pumps and infusion pumps. NHS Boards were

asked to set a flag within their medical equipment management systems (MEMS) to help track devices and aid management and inter-board co-operation if required. At all times, NHS Boards were consulted via the SG ICU Resilience Group on their ability to supply the ancillary equipment required to support ventilation. As part of post-Covid learning, NHS NSS, on behalf of NHS Scotland, is leading the development and implementation of a National Medical Equipment Management System which includes data harmonisation. This will mean that all relevant data held by local Health Boards will be available via a central platform and interrogated without delays.

357. The policy position in terms of the number of ICU beds was set by Ministers on advice from the SG Performance Directorate who were in turn supported by the SG ICU Resilience and Support Group to ensure that the ICU equipment needed to support the required number of ICU beds was available. Cabinet discussed the emerging capacity issues in the NHS and social care sectors on 10 March. It was noted there that the planning assumption was to double intensive care capacity. However, on 17 March 2020, the Cabinet Secretary for Health and Sport made a statement to the Scottish Parliament 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.

358. All anaesthetic machines with integral ventilators could potentially be used as ventilators. However, as some required oxygen to perform the mechanical operation of ventilation and oxygen supplies were thought to be an issue at the time, many were re-engineered to operate by medical air as an interim measure. 'Medical air' is a form of purified respirable air from compressors, which is made available via pipelines in clinical areas at wall outlets alongside oxygen supply outlets. It is safe to breathe and generally used to obtain a mix of air and oxygen during ventilation. This provided an additional layer of support to the ICU ventilators with the added benefit that the anaesthetic machines also came with integral patient monitoring. This allowed national procurement efforts to focus on obtaining ICU ventilators of greater suitability, quality, and familiarity to achieve max ICU surge levels and lessen the need to either purchase or use more exotic models not normally used in the UK.

359. There was regular and effective communication and collaboration between the DHSC and all the DAs. NHS Scotland was allocated access of up to an 8.2% share of all the equipment procured by the DHSC. Available ventilators were assessed by NHS Scotland clinical engineers and although the more familiar brands were accepted, this was in small numbers as it was felt that the resilience supplied by anaesthetic machines was less of a risk than introducing unfamiliar ICU ventilators.

360. For oxygen resilience in ICU, HFS were part of the SG ICU Resilience and Support Group so oxygen resilience in ICU was included in planning. As a result of these arrangements, NHS Boards therefore had on site the ICU ventilators they required with additional capacity available from the NSS central stockpile. We have been asked for details of any major incidents relating to portable oxygen supplies or medical gas pipeline systems in acute hospitals in Scotland during the relevant period, and can confirm that officials are not aware of any such incidents.

361. As part of the learning from Covid-19, a National Medical Equipment Management System (NMEMS) has been implemented, so going forward inventory management of medical equipment being held and used by NHS Boards can be quickly established.

362. In April 2021, the COO, CMO and CNO jointly commissioned a SLWG to consider ICU baseline capacity, uplift capacity, and associated factors in preparation for winter 2021/22. Following this work, the baseline figures for ICU beds was increased from 173 to 203 level 3 beds, with boards retaining the on-site ability to double this capacity (406 beds) and a central stockpile held by NSS to enable up to approximately quadruple capacity, subject to staffing.

363. A decision was taken by Ministers on 20 March 2020 to utilise private hospital capacity for the treatment of urgent elective procedures and urgent cancer cases as hospitals were limited and overrun with Covid-19 admissions. The utilisation of this resource enabled urgent surgical cancer procedures to continue during the pandemic in an environment where staff were not directly dealing with Covid-19 treatment.

364. The decision to utilise the private sector during Covid-19 was based on the clinical need to have a standalone facility to deliver healthcare to the most urgent patients, who were predominantly cancer patients.

365. This decision was also based on the fact it would be beneficial to have a collaborative arrangement between the NHS and the Independent Sector to ensure capacity was utilised in an optimal way.

366. Each hospital had their own contract. The total value of the contracts was circa £13 million. These were signed off by the then Cabinet Secretary for Health and Sport, Jeane Freeman.

367. The provision of elective care had been paused in NHS facilities to enable them to treat Covid-19 patients, and due to the pressures in the system, there was clearly a risk that urgent cancer patients would not be able to be treated in these facilities.

368. In relation to value for money, the arrangement with the private sector was based on SG covering the overhead costs of utilising these facilities, and no marginal cost was charged. This was verified by open book accounting, and represented the lowest cost at which these facilities could have been operated.

369. This represented a positive outcome for both the NHS, and the treatment of cancer patients, and the private sector, who otherwise would have been required to mothball their facilities and place their staff on furlough.

PPE

370. In the pre-Covid 19 pandemic planning phase, the pandemic flu stockpiles of PPE were primarily intended for provision to NHS acute services with some provision intended for social care and primary care. Notional amounts were intended for each of those sectors, but actual allocations would depend on the nature of the pandemic and the relative needs of the sectors.

371. NSS National Procurement (NP) is responsible for national PPE contracts in Scotland and was responsible for supplying PPE to the healthcare system during the pandemic through its National Distribution Centre (NDC).

372. The SG sought to learn from issues identified with PPE supply during the Covid-19 pandemic and methods of PPE provision developed throughout the pandemic. Prior

to the pandemic, PPE stock had been held in line with modelling of a reasonable worst-case pandemic influenza scenario.

373. In late 2020, in order to deal with the supply chain risks arising from the possible consequences of a no-deal or low deal Brexit scenario, there was a move to holding a minimum of 16 weeks' stock based on Covid-19 demand levels. This minimum was adjusted to 12 weeks during 2022 based on improvements to the supply and demand position by that time.

374. NSS NP now have a target to hold 12 weeks' worth of pandemic PPE stock at the high demand levels experienced during the Covid-19 pandemic. The stock levels and the types of PPE to be held will be reviewed as further guidance becomes available. Information on this is provided: [CL8/093 – INQ000469944].

375. NSS NP actively manage stocks of pandemic PPE, ensuring that business as usual demand is used to rotate stock. NSS is also tasked with setting up a surge capacity element as part of future inbound supply frameworks to lessen the risk of PPE shortage during future pandemic scenarios. Work has begun in relation to stockpile access proposals for different sectors and this will be developed as plans in relation to a collaborative procurement with a section of public sector bodies are progressed.

376. The PPE Policy Team have also drafted sectoral pandemic PPE preparedness guidance for HSC providers to assist them to improve preparedness for a future pandemic. Stand-up guidance for use in SG is in the initial stages of development and will be taken forward by other policy teams as pandemic preparedness planning work progresses.

377. In the initial stages of the pandemic, the focus for PPE was on procuring appropriate quantities of excellent quality PPE, as defined in IPC guidance, to provide protection for healthcare workers. Employers are responsible for sourcing and providing PPE for their staff and Health Boards were able to source further items where there was a particular need for a model not catered for by the central suite provided by NHS NSS NP. For instance, there was no national contract in place for the provision of powered air purifying respirators and the NDC confirmed they did not hold stock for powered air purifying respirators on the national pandemic stockpile; as such NHS boards were required to source these items locally. This is

because the particular products were not used nationally and were bought by individual Health Boards to best suit their local situation. Other Health Boards used similar, but not identical items, which were also managed locally by those Boards. Close liaison with local Health and Safety and infection control was expected to be undertaken to work out other solutions that were possible and that would still maintain the required levels of staff safety.

378. The Scottish Government, in its PPE Action Plan, published in October 2020, recognised the challenges that had been expressed by some women and BAME individuals who rely on PPE. The Action plan detailed that work was ongoing to improve users' comfort. Contact was made with Health Protection Scotland and the Deputy Chief Nursing Officer – NHS England and NHS Improvement by the PPE Unit in order to better understand the challenges in relation to PPE fit for ethnic minorities and in relation to gender. The PPE Unit also carried out a literature review in relation to this subject. Where there were a range of sizing options available for PPE items NHS National Services Scotland's National Procurement bought and made available a wide range, making it easier to ensure that the majority of HSC workers could get items that fit ted. For example, NSS were providing at least 8 different models of FFP3 by March 2021 and were issuing four sizes of nitrile gloves from pandemic stocks. Where available, products were bought with adjustable attributes.

379. In 2020, NSS agreed a contract for a Scottish based company flowing from collaborative work involving Scottish Government, NSS and Scottish Enterprise to support the supply of vital Type IIR masks, visors, and FFP3 masks for Scotland's health and social care until summer 2021. This partnership with a domestic manufacturer led to NHS Scotland receiving FFP3 masks to a specification that recognises the staff demographic within the Health Sector. A small scale study carried out in late 2020, in which 90% of the participants were female, showed that the overall 'fit pass rate' for this new range of masks was 81.5%. The pass rate for comparable models was understood to sit between 55%–63%. The NHS Scotland supplier also provided teams of expert fit testers to help hospitals introduce the new products quickly.

380. No specific Equality Impact Assessment (EQIA) was produced for the PPE Action Plan as it was an overarching plan, and so it was deemed to be more apt for PPE Division / Unit Policy Officials to carry out impact assessments in relation to the

different workstreams which were formed following on from publication of the Action Plan. These workstreams formed strands of the PPE Futures Programme.

381. Once equality assessment work had begun in the different PPE policy workstreams from late 2021 as part of the PPE Futures Programme, it was found that there were similar issues being highlighted across workstreams. The specific equalities issues being highlighted across the Future Supply, Primary Care, Innovation and Manufacturing workstreams were as follows:

- The communications issues arising from mask wearing. The action taken was to support the development, production and provision of transparent masks, as described below in paragraph 568;
- The issue of finding PPE that fitted, particularly PPE that fitted women. Action taken was to support the development, production and provision of an FFP3 mask more suitable to the demographic of the NHS in Scotland, as described above in paragraph 379. In addition to this, PPE was made available from NSS in a range of sizes, or with adjustable fitting where available;
- The issue of close-fitting masks being unsuitable for those with facial hair. This particularly affects those for whom this is a religious observance. Action could be taken at a local level to provide powered air purifiers as required.

382. This assessment led to further work on a combined EQIA for the PPE Futures Programme in April 2022. Work on this EQIA was continued as part of the PPE Supply Implementation Project, details of which are provided: [CL8/094 – INQ000469945]. It has not yet been published and is currently in draft form.

383. Another specific issue identified during this work considering equality impacts was the effect of face mask use on those who used lip reading as a means of communication. In December 2021, a transparent face mask was approved for use in health settings in Scotland. The mask was developed in accordance with the transparent face mask specification originally published on 1 April 2021. This specification was produced by the NHS Transparent Face Mask Working group brought together by NHS England and NHS Improvement (NHSE/I) which included SG representation. The mask features a clear anti-fog front panel, positioned to prevent reflection, and make lip reading easier and can be worn in healthcare settings where a Type IIR surgical face mask would be worn. The product was introduced to make communication easier and help reduce the challenges the

pandemic created for those with communication needs following feedback about the challenges which facemask use posed for a proportion of disabled people. Further detail can be found in the news item 'Transparent face masks introduced to NHS Scotland' published on the Scottish Government website, provided: [CL8/095 – INQ000398869] [CL8/096 – INQ000369744].

384. The PPE Directorate/Division/Unit worked with several groups including some led by SG, NSS and UKG. Bodies represented in those groups included NHS Scotland, DHSC, Welsh Government and the Northern Ireland Executive. An outline of the groups in which the PPE Directorate/Division/Unit participated is provided: [CL8/097 – INQ000469948].

385. The main SG-led groups include the PPE Strategy and Governance Board and the Primary Care PPE Steering Group. The main NSS-led groups were the Single Point of Contact Strategic PPE Oversight Group (SPOC) and the PPE Clinical Oversight Group (and its subgroups), while the main four nations group was the PPE Four Nations Strategic Board and its subgroups.

386. The Primary Care PPE Steering Group was established in May 2020 and consisted of policy representatives and clinicians to consider PPE issues for Primary Care Independent Contractors. Membership consisted of representatives from General Medical Services, Community Optometry, Community Pharmacy, General Dental Services and the PPE Division / Unit as well as NHS staff. It ceased regularly meeting in early 2023 on the basis that the group could be convened if anything arose which necessitated doing so.

387. The Chair of the Primary Care PPE Steering Group was as follows:

- May 2020 – July 2020: Associate Medical Director NHS NSS/ Covid-19 Primary Care Cell Lead
- July 2020 onwards – Co-chaired by Practice Manager Lead, HPS and NSS Director of Dentistry, and then solely by NSS Director of Dentistry.

388. The Group was an advisory group feeding into the SpoC oversight group and SG Primary Care policy. Meetings were held weekly via virtual meetings, moving to fortnightly, then monthly. There was direct contact between policy officials and

steering group members as and when required for information sharing purposes outwith the formal meetings.

389. The Single Point of Contact Strategic Oversight group was an NHS-run group. It followed on from an initial Single Point of Contact (SpoC) group which was established at the start of April 2020 with the following remit:

- Act as a senior point of contact within their board in matters related to PPE
- To resolve issues locally, escalating as required
- To communicate internally to their board
- To work collaboratively on practical solutions to emerging issues.

390. The SpoC oversight group met virtually on a fortnightly basis. The group had an information and advisory role, feeding into policy officials, Board Chief Executives and the Chief Nursing Officer. There was direct contact between officials and SpoCs for information sharing purposes and to address individual reports of localised PPE supply issues.

391. As the provision of PPE broadly stabilised and systems were in place to manage the operational aspects of continuing good supply the content of the SpoC meetings became more operational in focus. It was identified that there was a need to ensure strategic matters were properly considered with operational aspects being dealt with by an appropriate forum.

392. As the response to Covid-19 moved into a recovery phase the purpose of the SpoC oversight group developed and became refocused on the wider strategic issues for procurement and supply for the remobilisation of acute services (one aspect of which continued to be PPE).

393. The PPE SpoC group was, therefore, amended to become the Strategic SpoC Group for Remobilisation Supplies (of which PPE was still part) in June 2020. The agenda was to focus on consideration of the impact / enabling work procurement services could do to support remobilisation and the ongoing Covid response. A separate PPE operational supplies group was established and was to meet weekly to deal with operational issues.

394. The Strategic SpoC group was to receive updates from the PPE operational supplies group and from the NSS National Procurement (NP) Elective Recovery workstream on supply status and matters requiring escalation. DG HSC family representatives attended but did not set up nor formally seek advice from the group. It was very active throughout the pandemic (and supported by an Operational Group), but our records suggest it stood down in March 2022.

395. The Chair of the Single Point of Contact Strategic PPE Oversight Group was NHS NSS – Director of National Procurement succeeded by Head of Strategic Sourcing & Commercial, National Procurement.

396. The PPE Clinical Oversight Group (COG) was originally set up as a short life working group (Covid-19 National PPE Clinical Short Life Working Group) by NHS Scotland, chaired by Executive Nurse Directors, and latterly by an NSS Medical Director on an interim basis. This group operated throughout the pandemic, offering clinical and staff-side expert input on PPE issues and supporting the NHS's decision making.

397. It was renamed Expert and Clinical Oversight Group (ECOG) latterly but without significant membership or activity changes (prior to which it was briefly called the Expert Advisory Group (EAG) per remit below). Its members agreed to stand the group down at a meeting on 14 April 2022.

398. The COG/ECOG was supported by a PPE Clinical Advisory Panel (CAP). The Chair of the PPE Clinical Oversight Group was as follows:

- Chair Alex McMahon, Exec Nurse Director & Chair of Scottish Executive Nurse Director Group (SEND)
- Jacqui Reilly, NSS Nurse Director
- Anna Lamont (interim Chair as she covered the position at a time when the group's remit and membership were under review), Medical Director, NSS Procurement, Commissioning and Facilities (PCF).

399. The PPE group initially met weekly via virtual meetings, with frequency of meetings varying through the pandemic, eventually meeting on an ad hoc basis. The group reported to the Scottish Executive Nurse Group and Scottish Association of Medical Directors who reported progress to Board Chief Executive Group and to the CNO.

400. The remit of that Group (in March 2022) was to:

- advise on clinically related PPE matters but also matters related to the wider occupational use of PPE
- consider and advise on innovations in PPE and will advise on any necessary work to appraise them for adoption within clinical and non-clinical settings
- ensure staff / user perspectives are considered at every stage.

401. The aim of the EAG was to consider and advise the Scottish Government and PPE Strategy and Governance Board on emerging information and advice relating to PPE, where this was relevant to the work of the Board. In doing so the EAG was to interface with UK groups and organisations.

402. The EAG was also to act as a source of advice and support to the Scottish Government's PPE Futures Programme due to run to end-March 2022, and representatives were to attend meetings of workstreams under that Programme as appropriate. They would attend on behalf of the whole EAG and take issues arising back to the EAG for consideration.

403. On policy issues which were for a Scotland-specific decision, but where they had been discussed at UK level and a position reached for Scotland to adopt or not, the EAG would support NHS and Scottish Government in its consideration of the issues.

Communication and Engagement

404. The remit of the HSCMB is to be collectively and individually accountable for the strategy and performance of the NHS and the DG HSC family, ensuring that resources are best used to respond to the priorities and deliver the best services possible for the people of Scotland. This is covered earlier in this statement and further information on the governance arrangements of HSCMB which evolved during the pandemic can be found in the "Governance and Decision Making" section of the Module 2/2A statement submitted to the UK Covid-19 Inquiry by the DG HSC on 31 March 2020.

405. The HSCMB received regular reports from John Connaghan, Chief Operating Officer and Interim Chief Executive of NHS Scotland, on the ongoing impact of Covid-19 and progress towards the remobilisation of the health and care system. One of the ways in which progress was monitored was through a regular Chief Executives meeting / teleconference, chaired by the Interim Chief Executive and attended by representatives from each of the Health Boards across Scotland.

406. During the initial phase of the Covid-19 response, March 2020 to May 2020, the Interim Chief Executive led meetings of the Health and Social Care Planning and Assurance Group (PAG) which temporarily replaced HSCMB. During this time, PAG was collectively and individually accountable for the strategy and performance of all NHS and the DG HSC family, ensuring that resources were best used to respond to Covid-19, to save lives, protect the health and social care system and support Ministers. It took decisions on the implementation of policy decisions and the management of financial commitments. It promoted robust assurance processes (risk management, financial and performance) for the NHS and DH HSC. It determined which matters were delegated to other relevant stakeholders and groups. It also commissioned and received relevant information, data and intelligence from the Military Planning Team and from the Covid-19 Response Division within SG, provided: [CL8/098 - INQ000468164], [CL8/099 - INQ000468165], [CL8/100 - INQ000468166]. The strategic command structure through PAG (established with support of military liaison colleagues) helped match provision to demand in the acute sector, ensure resilience and responsiveness in the community, and maintain critical areas of business. The final meeting of PAG was on 20 May 2020, at which point discussions at PAG had moved from the rapid decision-making processes required in response mode to greater considerations of recovery and renewal. This culminated in the publication, led by the Health Planning and Sponsorship Division, on 31 May 2020 of *Re-mobilise, Recover, Re-design – The Framework for NHS Scotland,* provided earlier in the statement [CL8/032 – INQ000147375].

407. Throughout the pandemic, Health Workforce Directorate continued to use established mechanisms for disseminating new policies and guidance to the health service. Typically, new policies or information that relate to staff governance, workforce practice, health, safety and wellbeing, workforce planning are set out in a Directors' letter, signed by a senior civil servant, using a prescribed format, and numbered. These letters are formally addressed to recipients 'For Action' and

copied to others 'For Information'. An 'Enquiries To' contact is also provided. They are issued by email.

408. Health Boards should pay due regard to the wishes of Ministers set out in published policies or strategies. These documents set out the commitment of the Government around the role played and services provided by NHS Scotland. Chief Executive Letters (CELs) and Directors' letters are viewed as "administrative instructions". While they do not have the legal underpinning of the Orders or Directions set out in the NHS (Scotland) Act 1978 ("the Act"), given the way in which boards are established and accountable, these instructions should be followed by the boards.

409. For workforce matters, a Directors' letter might typically be addressed to the HR Director and copied to the Chief Executive. It may be cross-copied (for information) to several recipients, including Employee Directors, Nurse Directors, CMO and / or Directors of Planning. Directors' letters are also published on 'NHS Scotland – Publications' website. The website holds a bank of historic letters that SG has issued. These include Directors' Letters, as well as CMO and CNO letters. Where new guidance or policy is superseding existing guidance or policy, older Directors' letters may be wholly or partially rescinded by a more recent Directors' Letter.

410. Instructions to Health Board(s) and / or specified officials need not be in a Directors' Letter format, nor published, but are typically provided in the form of a letter, directly addressed to intended recipients, and from an official on behalf of the SG. Where matters are urgent such instructions might simply be delivered by email.

411. Updates to terms and conditions of service are issued by way of a 'Circular'. These broadly speaking take a similar format to a Directors' Letter and are directly addressed to recipients for action, for information, though they are numbered differently. Circulars are published on the Scottish Terms and Conditions Committee (STAC) website.

412. In March 2020, it quickly became apparent that existing partnership working arrangements were insufficient to manage the volume and flow of information, particularly in relation to emerging issues and the development of new guidance in response to the evolving situation. Whilst SG have long-standing arrangements for developing new policies and guidance in partnership with trades union colleagues and NHS employers, the existing mechanisms were not responsive enough. As

such the Director of Health Workforce established the Workforce Senior Leadership Group, which met daily in the first instance (though meeting frequency altered over the course of the pandemic). It was a forum through which SG disseminated information produced by Directorates across the HSC DG including statistical and analytical information relating to the state of the pandemic, information about PPE supply and any SG Covid Daily Update. The forum was also used to debate planned policy documents and guidance and to review draft documents.

413. Outwith these formal mechanisms, the Health and Social Care Directorate would disseminate selected data and statistical information with stakeholder groups, including information emanating from within workforce and from the wider directorate. This included Health Workforce officials uploading key information into the Staff Governance website and endorsed guidance that was regularly updated and supplemented as relevant national guidance changed. This was principally to allow stakeholders to keep abreast of the changing nature of the pandemic and to support workforce planning responses. This was typically disseminated to established senior stakeholder groups, including:

- Workforce Senior Leadership Group
- NHS Board Chief Executives
- NHS Board Chairs
- NHS Human Resources Directors
- NHS Employee Directors
- Scottish Partnership Forum
- Scottish Workforce and Staff Governance committee
- Scottish Terms and Conditions Committee.

414. Examples of the type of information that was disseminated this way are:

- "Covid-19 Daily dashboard" – Public Health Scotland
- "PPE Supply update" – NSS
- "State of the pandemic presentation slides" – National Clinical Director.

415. Health Workforce Directorate shared vast amounts of information and guidance with NHS Scotland leads. These leads included NHS Chief Executives, Health Board Chairs, Human Resource Directors and Employee Directors. Distribution lists were

extensive and kept up-to-date to ensure information was available to Health Boards at the earliest opportunity. Across the specified period there were fifteen occasions where SG officials issued guidance on Friday afternoons rather than delaying to the following week. This was to ensure Health Boards were kept up-to-date with policy changes in real time in the context of the public health crisis, for example, by sharing guidance on isolation exemptions, lateral flow testing for staff, IPC measures, and terms and conditions. A table with a summary of the information/guidance provided to NHS Scotland leads on these fifteen occasions has been provided: [CL8/101 - INQ000468176].

416. Health Boards raised concerns through Chief Executives and Human Resource Directors groups regarding information being received late in the working week. They felt it was challenging to proactively implement guidance late on Friday afternoons. Health Workforce Directorate colleagues took the feedback on board and ensured all colleagues were aware. The Interim Chief Executive asked Health Workforce staff to minimise the amount of correspondence issued to Health Boards wherever possible and put in place a temporary process where all communications were to be distributed through the Office of the Chief Executive of NHS Scotland. This was for defined periods and was designed not to prevent issuing essential guidance, but to prevent Health Boards getting an onslaught of correspondence not related to managing their response to the pandemic, provided: [CL8/102 - INQ000469949]. DCOO already had a good, constructive and open relationship with NHS Scotland and all communications were issued using well-established and longstanding processes.

417. Another example of concerns being raised directly was upon receipt of a letter from the CMO on 31 December 2020 setting out the Health and Social Care staff who would be prioritised for vaccination in phase one of the vaccination programme. NHS 24 contacted the SG to query whether their staff should be included, given their role as the front door to NHS services and the impact any outbreak within their call centres would have on their ability to deliver services. In addition, the SAS also contacted SG with similar concerns, provided: [CL8/103 - INQ000470084]. Following further discussions with Trade Unions and Scottish Ministers, it was agreed that NHS 24 call centre staff and SAS staff would be vaccinated.

418. The Health Workforce Directorate stepped up to a seven-day working week at the start of the pandemic. This was to make sure cover was available to assist NHS Scotland when working at such pace.

419. While the UK Government and subsequently ARHAI Scotland held and maintained IPC guidance for Scotland, SG played a role in communicating updates and changes in IPC guidance to NHS Boards and other stakeholders, including unions. In the early stages of the pandemic, guidance was evolving rapidly in line with what was being learned about SARS-CoV-2. This did lead on occasion to confusion and miscommunication. An example of this was when the PPE guidance in the context of Covid-19 was jointly published by Department of Health and Social Care, Health Protection Scotland (HPS), Public Health Wales, Public Health Agency Northern Ireland, Public Health England (PHE) and NHS England on 2 April 2020. The SG initially sent out a communication to update the workforce stating that social care workers did not have to wear a fluid resistant surgical facemask (FRSM) if the person for whom they were caring was not displaying symptoms of Covid-19. This was contrary to what was stated in the newly-published PPE guidance and was based on earlier guidance. It was necessary to issue a joint statement from SG, COSLA and trade unions on 9 April 2020 to clarify that social care workers could wear a FRSM along with other appropriate PPE if the person for whom they were caring was neither confirmed nor suspected of having Covid-19..

420. While there was regular communication with all stakeholders, there was no central mechanism in place to monitor the efficiency of communications.

421. DCOO already had a good, constructive and open relationship with NHS Scotland and all communications were issued using well-established and long-standing processes.

Expert Advisory Groups

Covid-19 Nosocomial Review Group (CNRG)

422. The CNO and CMO in consultation with SG officials and ARHAI Scotland within NHS NSS identified the need to better understand healthcare-associated Covid-19 epidemiology and emerging evidence. This was in order to identify any additional Infection Prevention Control (IPC) measures which could be considered for

implementation in health and social care settings to reduce the risk of hospital associated Covid-19 infection in Scotland. The CNRG was an advisory group.

423. The CNRG supported Scottish Government, and senior clinical advisers to:

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

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

425. The CNRG was a time-limited expert group chaired by Professor Jacqui Reilly, Nurse Director, and Healthcare Associated Infection (HAI) Executive Lead. It met 40 times between 7 May 2020 and 17 November 2022. CNRG was formally closed at that point because it was felt that the group had fulfilled its purpose as set out in the ToR.

426. The group was accountable to the SG through the CNO, to whom it provided advice. At the request of the SG, HPS submitted a paper on 22 April 2020, provided: [CL8/104 - INQ000322609] setting out a number of recommendations in relation to reducing nosocomial transmission in hospitals. In this paper (written for the then CNO, Fiona McQueen), Professor Jacqui Reilly stated that there was an identified need to better understand the healthcare-associated Covid-19 epidemiology and emerging evidence in order to identify any additional IPC measures which could be considered for implementation in health and social care settings to reduce risk of HAI. The paper highlighted five key evidence gaps and made nine recommendations, one of which was to establish an HAI Covid-19 group in Scotland, with key ARHAI, public health microbiology, virology/PHS and wider SAGE stakeholders from Scotland to review all the intelligence and make recommendations for national surveillance, research, guidance and policy in Scotland. It was the recommendations made within this paper that led to the establishment of the CNRG.

427. The eight other recommendations were considered by the CNRG and other relevant organisations as part of associated programmes of work, such as ARHAI Scotland. An account of the actions carried out in response to these eight recommendations follows:

- *Adopt the ECDC COVID-19 HAI case definition in Scotland:* This definition was adopted at the earliest opportunity.
- *Scope all the existing HAI data and wider national datasets in Scotland, and consider use of local NHS board data (which is more timely although not quality assured for record linkage) to determine the proportion of COVID-19 cases meeting the agreed case definition and examine epidemiology of deaths associated with HAI in patients, residents in care homes and HCWs involved in identified clusters:* As members of CNRG, ARHAI Scotland were responsible for providing nosocomial data and intelligence to inform the advice provided by CNRG to the Scottish Government. ARHAI worked with colleagues in PHS and Scottish Government to supply the required intelligence to inform CNRG advice. ARHAI Scotland was required to develop new surveillance and monitoring systems at pace as SARS-CoV-2 was a new pathogen. The rapid implementation of these systems provided epidemiological intelligence from

very early on in the pandemic which was able to support the work of CNRG from the outset. Data were collated on patient and/or staff clusters of Covid-19 in non-Covid wards; staff clusters in Covid-19 wards; cases of hospital onset Covid-19 including nosocomial Covid-19; a limited number of infection prevention and control structure and process indicators; and analyses to inform development of testing policy. ARHAI developed an cluster/ incident monitoring tool on 'COVID-19 cluster and outbreak intelligence' which allowed for electronic reporting and analysis and improved the epidemiological intelligence relating to clusters. Scotland was the only UK country to implement such a critical real-time outbreak monitoring system for nosocomial intelligence. Hospital onset COVID-19 intelligence was developed using ECDC definitions.

- *Scope WGS merits in understanding the transmission within clusters and incidents reported in health and care settings and consider implementing this in pilot sites (connecting to the SAGE nosocomial work to date on this matter being led by public health microbiology colleagues in PHS in Scotland):* Intelligence from whole genome sequencing of nosocomial outbreaks was also shared with CNRG for their consideration alongside wider intelligence from WGS (provided by PHS). CNRG gave advice early on about the importance of WGS data to supplement other data sources. The results from outbreak investigations were presented to CNRG alongside essential epidemiological data for context. The results provided evidence about multi-directional cross transmission in hospital settings and flagged the complexity of interpretation of direction of transmission between patients, HCW and visitors, particularly in high prevalence situations. The advice and feedback from the group also helped develop the SARS-CoV-2 sequencing service, which has included the setting up of a sequencing request service for outbreak detection and incident investigation, and the development and implementation of routine NHS Board level reporting of genomic clusters.
- *Consider piloting admission screening for COVID-19 in asymptomatic patients with follow-up during their inpatient stay (the testing of all admissions or admissions for some specific patients groups was being considered at a policy level):* CNRG considered various proposals relating to testing and a subgroup was convened to support CNRG advice. Specifically, the subgroup considered: asymptomatic admission testing policy; serial testing including in the over 70 age group; PCR confirmation of LumiraDX test results in the context of nosocomial infection; prioritisation of HCW testing; use of lateral flow testing

(LFT) for admissions, for incidents and outbreaks; and prior to planned aerosol generating procedures.

- *Consider piloting anonymously asymptomatic health and care worker to determine asymptomatic prevalence in hospitals and care homes:* The testing subgroup was chaired by a consultant healthcare scientist with expertise in admission screening programmes and consisted of members of CNRG inclusive of the chair of the Scottish Government Clinical Cell, an infectious diseases consultant, an infection control doctor, and a consultant microbiologist (who was the chair of the SMVN). Other CNRG members were co-opted onto the subgroup from CNRG when required and included a consultant virologist and a Director of Occupational Health Medicine. The inclusion of a OH was particularly important for HCW testing policy proposals. Where time permitted, the testing subgroup recommended wider consultation for some proposals and groups such as the SMVN and the Infection Control Doctors Group. The Lead Clinicians Group for Occupational Health provided further feedback that was included in the presentation to wider CNRG before policy advice was formulated. This mechanism for consideration by the multidisciplinary subgroup enabled focused discussion with the wider group at the regular meetings and supported the provision of consensus advice for policy.
- *Consider undertaking serial Point Prevalence studies for Covid-19 in hospital settings (and pave the way for collaboration with EU colleagues through ECDC):* There was a focus on incidence surveillance and outbreak reporting. These data systems provided epidemiological evidence to support the understanding and management of Covid-19 transmission in hospital settings.
- *Consider adopting the ECDC LTCF national surveillance of HAI COVID-19 protocol when available:* It should be noted here that this would not have been a recommendation for ARHAI as they have no routine role in LTCF surveillance. PHS may also have considered this.
- *Formally review the wider published evidence to inform any potential additional IPC measures to prevent HAI COVID-19:* A standalone rapid review, first published in March 2020 to assess the IPC requirements for the prevention and management of COVID-19, updated monthly, informed CNRG and formed the basis of Scottish Addendums for COVID-19 IPC guidance. This formed part of the inputs from all four UK countries to the UK IPC guidance documents. A rapid review of the evidence base to inform the UK AGP list for COVID-19 was also undertaken by ARHAI Scotland, in collaboration with NERVTAG, prior to the

establishment of CNRG. ARHAI were also represented at the UK IPC cell four-country meeting. This cell was the owner of the UK IPC guidance, which was important for connecting the UK work on IPC guidance to CNRG.

428. Members of the CNRG were IPC experts, clinicians and academics spanning the disciplines of epidemiology, virology, public health and statistical modelling. Ministers were not involved in the membership or ToR sign-off for CNRG, as it was an independent group, but were provided with a link to the ToR when they were informed that minutes of CNRG meetings had been published on SG website, or when the ToR was updated by the group.

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

430. The chair of CNRG was also a member of a sub-group of SAGE called the Hospital Onset COVID-19 Working Group (HOCWG). The Working Group was formed under instruction from SAGE to provide an overview of possible nosocomial transmission of Covid-19 and evaluate evidence from which to recommend actions and interventions to reduce nosocomial infection and risk of transmission. The chair attended the HOCWG for the month before it was stood down. Following the standing down of this group, the chair was invited to be an observer at Hospital Onset Covid-19 Infection Working Group (HOCI).

431. As noted, the CNRG provided advice to the CNO. Thereafter, the CNO and officials in the Healthcare Associated Infections and Antimicrobial Resistance (HCAI/AMR) Policy Unit considered the advice and used it to inform policy development. Submissions containing CNRG advice were provided by CNO and CMO Directorates to Ministers for consideration and decision. Advice was offered by the CNRG on the following topics:

- the evolving understanding of the nature of Covid-19, infection routes, potential consequences of infection, at risk groups, the risk of re-infection and death
- the impact of the Covid-19 pandemic and the countermeasures taken by the Scottish Government on those at risk or vulnerable, whether as a result of underlying medical conditions or protected characteristics in Scotland
- testing strategy and rollout
- NHS capacity, including the availability of staff, equipment, PPE and infrastructure and the management and significance of nosocomial infection;
- non-pharmaceutical interventions (NPIs)
- face coverings.

432. The CNO and HCAI/AMR Policy Unit also considered any cross-cutting policy impacts and consulted with the CMO, National Clinical Director and other Health and Social Care Directors where necessary.

433. Though not a formal sub-group of the C19AG, the CNRG provided regular updates on the work of the group at main C19AG meetings. This ensured two-way information and evidence sharing within Scotland and with wider UK groups, such as HOCI, the UK SAGE Nosocomial Group (via the CMO) and the UK IPC guidance cell.

434. These connections and information sharing enabled Ministerial updates to be made to the Cabinet Secretary for Health and Sport, the First Minister and other Ministers with a portfolio interest.

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

436. There was no official arrangement for SAGE to share any outputs with CNRG. As such, the outputs available to CNRG were those publicly available on the UK Government website.

437. The working relationship between CNRG and the advisory systems and other advisors was effective. The Chair, being a core member of the C19AG and the Care

Home Professional Advisory Group (CPAG), supported information and evidence sharing.

438. As noted earlier, the ARHAI provided scientific critiques of available published literature. A standalone rapid review, first published in March 2020 by ARHAI Scotland to assess the IPC requirements for the prevention and management of Covid-19, updated monthly, informed CNRG and formed the basis of Scottish Addendums to the COVID-19 IPC guidance (*National Infection Prevention and Control Manual: Scottish COVID-19 Infection Prevention and Control Addendum for Acute Settings*), provided: [CL8/105 - INQ000322610]. This work formed part of the inputs from all four UK countries to the UK IPC guidance documents (*COVID-19: infection prevention and control* (IPC), provided: [CL8/106 - INQ000322611]. A rapid review of the evidence base to inform the UK Aerosol Generating Procedures (AGP) list for Covid-19 was also undertaken by ARHAI Scotland, in collaboration with the New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG), prior to the establishment of CNRG. ARHAI was also represented at the UK IPC cell four nations meetings. This cell was the owner of the UK IPC guidance, which was important for connectedness of the UK work on IPC guidance to CNRG.

439. Individuals on wider UK SAGE sub-groups were invited to attend CNRG according to the specific needs of the agenda, such as the SAGE Environmental & Modelling Group (EMG) representation from Health Facilities Scotland (HFS) and modelling colleagues from PHE.

440. CNRG also invited international experts to present national lessons learned and guidance from across the globe. This was enabled via the CNRG members academic and professional connections. Connections were also made to colleagues in CDC, European Centre for Disease Prevention and Control (ECDC), WHO and Australia by correspondence. This was an important part of the CNRG remit as understanding the policy decisions made in other countries in the absence of evidence was helpful for context and advice. All the emerging evidence was considered in the context of the available Scottish nosocomial data and intelligence.

441. In relation to the Scottish Parliament, the CNRG was not subject to Parliamentary scrutiny, nor that of its Committees.

442. SG has not carried out or commissioned any internal or external reviews, lessons learned exercises and other reports on CNRG's role in SG decision making relating to the management of the Covid-19 pandemic.

443. However, CNRG did complete a Review of the CNRG response to Covid-19 to inform future preparedness in November 2022, provided: [CL8/107 - INQ000322605]. This review considered the delivery against the agreed remit and scope of CNRG, highlighting lessons learned for future preparedness in delivery of the CNRG objectives. Wider system learning, as part of the CNRG considerations, was also covered and recommendations made for wider future pandemic preparedness and IPC strategy.

Advisory Subgroup on Public Health Threat Assessment

444. The Advisory Sub-Group on Public Health Threat Assessment (PHTA) was established as a sub-group to the C19AG. The PHTA was an advisory group.

445. The PHTA was a time-limited group which provided advice to the CMO and to Scottish Ministers on:

- determining the likelihood and impact of significant and concurrent clinical risks to public health that may occur during the next 12 months
- identifying data that will be critical to signalling in advance this emerging risk and also monitoring the response of the health and social care system in addressing these
- identifying and describing high value and evidence-based interventions that healthcare systems can begin to plan and make contingency for should these threats arise.

446. The PHTA was established in summer 2020 and held five meetings in July and August 2020. The last meeting of the Group took place on 12 August 2020. The Group was always intended to be short-life, and its business concluded with the publication of two reports: Coronavirus *(COVID 19): Advisory Subgroup on Public Health Threat Assessment: seasonal influenza vaccination programme proposal,* provided: [CL8/108 - INQ000322821] and *Coronavirus (COVID 19): Advisory*

Subgroup on Public Health Threat Assessment: preparing for a winter emergency report, provided: [CL8/109 - INQ000322822].

447. The PHTA was chaired by Professor Sir Harry Burns. The membership of the group was drawn from the operational and academic public health structures across Scotland and was supplemented with relevant expertise to fulfil the intended function of the group. Members of the group included NHS Boards, PHS, SG, the BMA, local authorities and HSCPs. The membership of the group was agreed between the Chair and the CMO. The full membership was published as were the minutes, ToR, provided: [CL8/110 - INQ000322768] [CL8/110a – INQ000326469] [CL8/110b – INQ000326470] [CL8/110c – INQ000326471] [CL8/110d – INQ000440246], and reports.

448. The PHTA was a sub-group of the C19AG. There was no direct link between PHTA and SAGE; however, links were made via the C19AG.

449. The PHTA reported to and provided advice to the SG through the CMO. It did not directly advise PHS, NHS Boards or other organisations, though its membership included representatives from a number of these groups.

450. The PHTA did not provide advice to Cabinet, SGoRR or the Four Harms Group.

451. The PHTA was attended by a number of senior civil servants. Upon completion of the final report of the PHTA, the Chair met with the Cabinet Secretary for Health and Sport on 9 September 2020 to present the report. A note of the meeting is provided: [CL8/111 - INQ000322608].

452. No formal lessons learned or evaluation of the PHTA were carried out.

Scientific Advisory Group on Testing

453. This group was another sub-group of the C19AG. The group's name varied in practice, though it was most commonly referred to as the Scientific Advisory Board on Testing or sometimes the Scientific Strategic Advisory Board on Covid Testing. This was an advisory group. The ToR for the group is provided: [CL8/112 - INQ000324917].

454. The C19AG identified testing as a priority area on which it gave advice to the SG and CMO. As such, the SG and the C19AG agreed to establish a dedicated sub-group to provide additional scientific advice in relation to Covid-19 testing.

455. This group considered the scientific and technical concepts and processes key to supporting the delivery of Covid-19 testing; and informed the SG's strategic use of testing to manage the pandemic. The Group considered emerging scientific evidence and other appropriate sources of information to inform local decisions in Scotland during the pandemic. The Group provided expertise and advice to inform Scottish Ministers but did not have a role in policy decision making.

456. The Group's remit was to:

- provide an ongoing review of testing strategy within Scotland in light of emerging scientific evidence and changing prevalence of the disease
- recommend strategies for the delivery of testing, including the evaluation of different testing types, considering new methods of testing, and the need to have sufficient testing capacity to meet demand
- consider emerging evidence to inform current testing priorities and recommend which groups within the Scottish populace should be prioritised for testing
- provide an expert point of contact with and strategic input to C19AG
- evaluate the efficacy of Covid-19 testing strategy and practice across the UK and thereby provide advice to inform Scottish provision.

457. The Group was chaired by the Chief Scientist (Health), Professor David Crossman. The first meeting was on 1 April 2020 and the last was on 8 March 2022. The Group met three times per week.

458. The First Minister and Cabinet Secretary for Health and Social Care were made aware of the establishment of the Group by the Chief Scientist on 2 April 2020.

459. As a sub-group of the C19AG, all advice was provided through the CMO. The group did not directly provide advice to Cabinet, SGoRR or the Four Harms Group.

460. The sub-group did not carry out any formal lessons learned exercises.

Mobilisation Recovery Group

461. The Mobilisation Recovery Group (MRG) was established under the *Remobilise, Recover and Redesign: The Framework for NHS Scotland,* provided earlier in the statement [CL8/032- INQ000147375]. It provided input to decisions on resuming and supporting service provision but was not itself a decision-making group; its main role was stakeholder engagement and supporting the Cabinet Secretary for Health and Sport in the areas of policy and delivery. This was an advisory group.

462. The Health Planning and Sponsorship division supported the MRG. The MRG generated key expert, stakeholder, and system-wide input into decisions on resuming and supporting service provision in the context of the Covid-19 pandemic.

463. The Group:

- brought together stakeholders and decision makers to ensure that the delivery of health and social care services maintained a strong focus on quality, equity and person-centred care, within the necessary constraints of the Covid-19 response
- provided insight and advice in ensuring the safe and incremental resumption of paused services, whilst safeguarding resilience in health and social care and ensuring that the positive transformation that has taken place can be sustained into the future
- provided insight and advice on key interdependencies, risk factors and opportunities, and how these could be mitigated / addressed
- considered how we could collectively continue to offer enhanced and active support to ensure staff wellbeing and safety
- assisted initial thinking on longer term reform, feeding in to the wider Renew programme
- acted a forum for frank and open discussion, whilst maintaining a clear focus on securing resilience and recovery.

464. The MRG was chaired by Jeane Freeman, Cabinet Secretary for Health and Sport. It was also attended by the Minister for Public Health, Sport and Wellbeing. The Group met for the first time in June 2020, and held 13 meetings between June 2020 and April 2021.

465. The membership of the Group was published online and is provided: [CL8/113 - INQ000324470]. The Group was made up of external partners, service delivery partners, service users and the SG.

466. The Health and Social Care Alliance ("The Alliance") sat on the group and were commissioned to undertake community engagement work. This engagement work, called "People at the Centre", was delivered in partnership with Healthcare Improvement Scotland (HIS). The aim of this was to ensure that the diverse experience and a broad range of perspectives from patients and carers fed into the work of the MRG.

467. During this engagement work, short papers and updates were submitted to the MRG. These were published and an example of a published update is provided: [CL8/114 - INQ000324576]. A final report summarising the findings of "People at the Centre" was published by the Alliance on 18 February 2021, provided: [CL8/115 - INQ000224577].

468. The minutes of the Group were published online, as were the key reports produced by the Group.

469. The Group as a whole acted as a stakeholder engagement forum with an agenda set by the Cabinet Secretary for Health and Sport, so was itself the conduit for discussion between the Scottish Government, external partners and service users.

470. The final report cited above set out the findings of the Group's priority programme, the "People at the Centre" Programme, taking into account the views of a wide range of stakeholders.

471. A presentation on the future of the MRG was prepared in May 2021, taking into account views of members on its effectiveness. It was considered to have been a successful forum for engaging and informing stakeholders, with learning points identified as being the effect of the size of the group on its ability to hold full discussions, especially on policy matters, provided: [CL8/116 - INQ000322607].

Clinical and Professional Advisory Group (CPAG) for Adult Social Care

472. The Clinical and Professional Advisory Group for Social Care (CPAG) was established in April 2020. Its initial remit was to provide clinical and professional advice and guidance for protecting the care home sector during Covid-19. This remit was later expanded to include the wider adult social care sector. This was an advisory group.

473. CPAG met more than 80 times during the course of the pandemic. The first meeting was held on 23 April 2020 and the last in December 2022. The frequency of meetings varied at different phases of the pandemic from twice weekly to monthly.

474. The group, which was commissioned by the CMO and CNO, and chaired by a CMO and CNO representative, brought together clinicians and external stakeholders including care home providers, NHS and local authorities to provide professional and clinical advice to SG. The chairs were initially Senior Medical Officer, Professor Graham Ellis (who later became DCMO) and Anne Armstrong, Deputy CNO. Both chairs reported directly to CMO and CNO.

475. SG officials identified key stakeholders and invited them to join the group. Membership was designed to ensure advice was provided to SG and partners on clinical and professional support for the care home sector (and subsequently adult social care). Members reflected the care home and adult social care sector as well as national and local organisations that support the sector. Representatives attended from care homes, Scottish Care, CCPS, Directors of Public Health, PHS, Executive Nurse Directors, Chief Social Work Officers, IJB Chief Officers, Care Inspectorate, HIS, the RCN, the University of Glasgow, COSLA, Scottish Social Services Council, RCGP, BMA, Scottish Committee for GPs (SCGPs), Royal College of Physicians, SAS, Alzheimer Scotland, ARHAI Scotland, Social Work Scotland, NHS NES, NHS NSS, SG clinical and professional advisers (from nursing, medicine, social work and pharmacy) and policy officials.

476. The details of individual membership and minutes of CPAG meetings were not published by the SG, but minutes were disseminated to all members, including those external to Scottish Government.

477. When officials were developing policy, this group enabled consultation with a wide range of stakeholders, allowing appropriate solutions to be developed. Members also brought issues to the attention of the group for consideration. This approach

enabled a more significant degree of collaboration than would otherwise have been feasible under the circumstances.

478. The discussions at CPAG also influenced members approaches to developing advice and support for care homes and adult social care. For example, it supported the Care Inspectorate to develop appropriate communications to support the sector. The discussions also informed the development of Health Protection Scotland (now PHS) guidance for adult social care.

479. While the CPAG itself did not directly report to Ministers, advice and outputs from the group (for example, guidance) would be considered by the Adult Social Care pandemic policy team and shared with CMO, CNO and the National Clinical Director for review and approval before being shared by the Adult Social Care pandemic policy team with Scottish Ministers for final sign-off ahead of publication.

480. CPAG was not a decision-making forum. It provided advice and, where necessary, matters of importance were escalated to the CMO, CNO and Scottish Ministers. Advice provided by CPAG included clinical and visiting guidance for the care home sector. CPAG also provided advice to the sector on implementation of policies that it was not directly responsible for, so the development and rollout of testing to care homes, guidance on this and also training workshops for the sector. Other examples include the rollout of the vaccination programme within the social care sector.

481. Where work required deeper examination than a core CPAG meeting would allow, informal and sometimes more formal 'sub-groups' were established with a smaller number of members who then reported back to the core group. For example, when the first standalone visiting guidance was developed in May and June 2020, an informal writing group was established with members. The outputs from this writing group were then taken to the core CPAG group.

482. CPAG did not provide advice to Cabinet meetings or SGoRR but provided clinical and professional advice to the SG and the care sector leadership on ways to protect the sector through guidance and support. It worked closely with the Care Home Rapid Action Group (CHRAG) which then became the Pandemic Response in Adult and Social Care Group (PRASCG) to ensure that best practice and guidance was communicated promptly and effectively to the sector and the public.

483. Officials are not aware of any instances where advice provided by CPAG was not followed by SG.

484. There were no specific mechanisms put in place to ensure CPAG was scrutinised by the Scottish Parliament or its Committees. Ultimate accountability for CPAG was provided by the Cabinet Secretary for Health and Sport. If the Committee had called for her to give evidence, officials would have supported any appearance or request in the usual way.

485. Review of the Group's remit and functions was an ongoing process, and in September 2020 a decision was taken by the membership to widen the scope of the forum from care home to encompass wider adult social care. This was duly updated in the CPAG ToR.

486. Learning around advice being given to the SG was also an ongoing process.

487. In 2021 and 2022, surveys were undertaken of members to consider the role, remit and future of CPAG. The last survey undertaken particularly focused on the future of the CPAG, and the follow-up discussions with members led to a recommendation that the CPAG should end in December 2022.

The Pandemic Response in Adult and Social Care Group (PRASCG)

488. This Group was formerly known as the Care Home Rapid Action Group (CHRAG) and was a stakeholder group sitting within the Pandemic Response for Adult Social Care Responding to the Pandemic Division (now the Adult Social Care Oversight and Assurance Support Division). This was an advisory group.

489. A national CHRAG was established in April 2020 comprising key partners with operational oversight and delivery responsibility for care homes. The group received daily updates and was tasked with activating any local action needed to deal with issues as they emerged, as well as informing and co-ordinating a wider package of support to the sector. The CHRAG initially focused on care homes but in September 2020 was widened to cover adult social care under a new group, PRASCG.

490. PRASCG was set up to provide a multi-stakeholder focal point for the work being undertaken to support the effective delivery of adult social care provision during the continuing coronavirus pandemic.

491. The objectives of the group were to:

- enhance existing collaborative working across adult social care sector leaders
- share intelligence and identify key issues for resolution related to the pandemic (supported by relevant data / metrics / evidence as appropriate)
- share intelligence and identity key issues that continue to hamper recovery from Covid-19
- ensure learning from the pandemic shapes the future as the sector recovers.

492. CHRAG was co-chaired by the Director of Community Health and Social Care in the SG. When PRASCG took over from the CHRAG, a co-chair arrangement was put in place between Scottish Government and COSLA, with a rotational chair put in place from both organisations.

493. SG officials identified key stakeholders and membership was designed to ensure all core partners had input in the analysis of the current situation and identification of evolving risks and of actions to be taken. This was a collaborative multi-agency approach. Representatives attended from the COSLA and the Society of Local Authority Chief Executives (SOLACE), Scottish Care, the Care Inspectorate, PHS IJB Chief Officers, Directors of Public Health, RCGP, BMA, RCN, SSSC and the SG. PRASCG was jointly chaired by the Scottish Government and COSLA.

494. The details of individual membership and minutes of CHRAG/PRASCG meetings were not published by the Scottish Government, but minutes and actions were disseminated to all members, including external partners.

495. CHRAG/PRASCG did not provide advice to Cabinet meetings or SGoRR. However, it made proposals to Scottish Government and the care sector leadership for national level actions to drive good two-way communication within the whole system and with the public on care home and wider social care issues. This included communicating best practice and guidance from the clinical group or elsewhere promptly to the sector and the public. It sought to enhance local collaboration both by helping to tackle any obstacles and by spreading good practice.

496. While the forum was not a core decision-making body, CHRAG/PRASCG escalated matters of importance to the Cabinet Secretary and Ministers. CHRAG developed an *Action Plan* in late May 2020, provided: [CL8/117 - INQ000322940]. The aim of this action plan was to deliver whole-system support to care homes in Scotland and as such provide a safe and homely setting for their residents and staff throughout the Covid-19 pandemic and assure the public that residents and staff would be protected. The action plan was flexible, and the Group updated it on a regular basis to meet emerging and new issues. The plan was shared with Ministers but not published. It was a live document and was updated on an ongoing basis.

497. In addition, PRASCG played a role in drafting the *Adult Social Care - Winter Preparedness Plan: 2020 to 2021,* provided: [CL8/118 - INQ000324639]. The plan, which was published in October 2020, set out the measures already in place that should be retained and those that needed to be introduced across the adult social care sector over winter 2020 to 2021. This was signed off as a key output by Scottish Ministers. The intention was to work with partners to ensure strong local oversight that took account of and responded to delivery barriers and challenges. This was to be supported through the PRASCG.

498. Meetings with Ministers would be held regularly during the pandemic across a raft of portfolio social care issues alongside specific briefings and updates on the work of CHRAG including evolving action plans arising from the groups.

499. Officials are not aware of any advice provided by CHRAG/PRASCG that was not followed by the SG.

500. The groups included a broad range of key internal and external stakeholders across health and social care to ensure integrated working across several areas. CHRAG/PRASCG established links with senior colleagues and professional advisors in the SG through other advisory systems and sub-groups. PRASCG also established relationships with other groups like CPAG. These relationships were seen as effective but there was ongoing opportunity for members to reflect on the roles and remits of each group. There was no direct connection with SAGE or the C19AG.

501. There were no specific mechanisms put in place to ensure CHRAG/PRASCG was scrutinised by the Scottish Parliament or its Committees. Ultimate accountability for CHRAG/PRASCG was provided by the Cabinet Secretary for Health and Sport. If the Committee had called for her to give evidence, officials would have supported any appearance or request in the usual way.

502. Overall, the Adult Social Care PPE Steering Group played an important role in monitoring the provision of PPE to the social care sector, which was a critical issue in the wider response to the pandemic. It allowed a collaborative approach between SG, NSS, COSLA, HSCPs and care provider representatives in ensuring provision of PPE to the social care sector. It also provided reassurance throughout the sector and allowed the sector direct access to officials for any concerns to be raised and acted upon.

503. No formal lessons learned reviews were undertaken for this group.

Coronavirus (Covid-19): Mental Health Research Advisory Group (MHRAG)

504. Pre-pandemic, and as part of the Programme for Government, provided: [CL8/119 - INQ000322604], the SG established a mental health policy and research forum. However, in light of the pandemic, the work of the Group was refocused on to the effects of Covid-19. Instead of the planned thematic explorations of different topic areas and research in mental health involving various people, the Group had a tighter remit, acting as a central co-ordination point for translating Covid-19 mental health research findings into advice to the Government. This was an advisory group.

505. The Group published its Terms of Reference, provided: [CL8/120 - INQ000323488] in May 2020, alongside its membership. However, it had met for the first time in April 2020. It was planned that the Group would meet virtually every six weeks. The MHRAG met six times between April 2020 and January 2021, with SG representation at each meeting. SG officials took minutes of the meetings, which are published on the SG website. The Group is still active.

506. The membership of the MHRAG was consistent with that of the existing policy and research forum. It consisted of a wide range of mental health academics, stakeholders and experts, as well as with those leading and working in NHS Mental

Health services. The Group was chaired by Professor Andrew Gumley, Director of the NHS Research Scotland (NRS) Mental Health Network and Professor at the University of Glasgow.

507. The Group was tasked with identifying emerging evidence of how the pandemic and lockdown was affecting the population's mental health and wellbeing. The key emerging themes, agreed through discussion between MHRAG members, were summarised in the *Mental Health Transition and Recovery Plan,* provided: [CL8/121 - INQ000322603], which was published in October 2020, having been signed off by the Group. This Plan had targeted commitments to respond to where the MHRAG identified greatest need, or population groups at particular disadvantage.

508. The initial findings from the MHRAG were summarised into the themes listed below, with appropriate policy actions included. These were taken forward in the Transition and Recovery Plan. SG officials had worked with MHRAG members to agree the themes for inclusion in the Transition and Recovery Plan through discussion in meetings and circulation of drafts:

- Studies show that some groups in the population are at higher risk of experiencing negative mental health impacts due to Covid-19 including younger adults; women; those living on low incomes and individuals with pre-existing mental health conditions. There are other groups whose mental health seems to have been particularly affected by the impacts of Covid-19, for example people who have been requested to shield and those whose employment has been adversely affected
- A combination of social factors (such as loneliness and social networks / friendships) play a key role in the impacts on mental health and wellbeing, in addition to economic pressures (such as finances or employment). There is a relationship between increased mental distress and a range of factors related to spending more time at home, including loneliness, childcare, home schooling, working from home and receiving care from outside the home
- There is growing evidence that interventions, such as social distancing, stay at home guidance and school closures, have likely had an adverse effect on the mental health and wellbeing of children and young people. Loneliness has been a particular challenge. Some have reported benefits for their

mental health. Vulnerable children and young people, and those with challenging home environments, are more likely than others to have had experiences during the pandemic that are associated with a risk to mental health and wellbeing, such as disruptions to support. There also appears to have been a general worsening of mental wellbeing in older girls particularly

- The economic and employment impacts of Covid-19 are likely to have a significant effect on the public's mental health in the coming years, and these impacts are likely to be unevenly distributed. An Institute for Fiscal Studies briefing indicates that if the economic downturn is similar to that experienced after the 2008 financial crisis, the number of people of working age suffering poor mental health in the UK would rise by half a million
- Traumatic experiences of Covid-19 in hospitals and care homes could lead to mental health problems (including Post Traumatic Stress Disorder (PTSD)) for patients, residents and family members. Staff working in these settings may also experience negative mental health impacts. The circumstances associated with the pandemic may increase the numbers of those who experience prolonged and severe grief symptoms, which may require intervention. Normally around 7% of people experience a complex reaction but we may expect this to be higher
- There are indications of a potential widening in mental health inequalities as the impacts of Covid-19 interact with pre-existing risk and protective factors for mental health
- Pre-pandemic, rising public awareness and demand for mental health treatment and support was outstripping supply. There will be challenges in meeting new levels of demand, and in gearing back up, changing and reshaping services. However, there will also be opportunities for improved and more person-centred approaches to personal wellbeing and mental health service delivery. There have been many successes in terms of how services have been reshaped. Some of these changes will remain in place or will be further developed to better meet need in a person-centred way.

509. There were no specific lessons learned exercises undertaken for this Group. Feedback from members was primarily provided through dialogue in meetings, all of which were minuted.

NHS Scotland

510. NHS Scotland are required by legislation to promote the improvement of the physical and mental health and the prevention, diagnosis and treatment of illness.

511. Powers exercised around Health Boards can be described through three categories: engagement, instruction, and statute. Details of these are provided below.

512. The CSH has regular meetings with all Health Board Chairs, providing an opportunity to explore issues and to allow Ministers to ensure that the strategic leads of all Health Boards receive a clear view of priorities. Additionally, the annual reviews of Health Boards provide a further opportunity to engage Boards in a more public forum to challenge and instruct.

513. The powers given to Scottish Ministers through the National Health Service (Scotland) Act 1978 are quite extensive. A summary of these is set out below:

- General Power of Direction: Section 2(5) gives Ministers powers to direct Boards on any function conferred on them under the Act
- Default Powers: Section 77 of the Act allows that where a board has not carried out their functions in line with regulations or directions that Ministers may have given, after inquiry, the board would vacate their office and Ministers can then appoint others in their place
- Emergency Powers: Section 78 of the Act explains that if Ministers are of the opinion that an emergency exists and think it necessary to secure effective continuance of services, they can direct that functions can be carried out by another body or person for as long as they consider an emergency exists. This is a general power that is underpinned by:

    - Powers in the Case of Service Failure: Section 78A allows that where Ministers consider that a health body or individual is failing to provide a satisfactory service, they can direct that another body or individual takes on that role. This is the power used in relation to NHS Tayside
    - Health Board Members: Specifically, those whom Ministers appoint to Health Boards, Regulation 5(2) of the Health Boards (Membership and Procedure) (Scotland) Regulations 2001 may have their membership

terminated by Ministers in cases where it is considered that "it is not in the interests of the NHS" for someone to continue in that role.

514. Ministerial powers are not restricted to Health Boards and cover the direction of integration. Section 52 of the Public Bodies (Joint Working) (Scotland) Act 2014, which is the legislation covering integration, provides far-reaching direction-setting powers to Ministers in relation to Health Boards, Councils, and Integration Authorities.

515. The EPRR framework in Scotland as it applies to the healthcare system is set out in the document *NHS Scotland: Preparing for Emergencies: Guidance to health boards* (2013), provided earlier in the statement [CL8/030- INQ000102971].This describes the roles and responsibilities of government and Health Boards in preparedness and response, including those set out for relevant responders under the Civil Contingencies Act 2004. The NHS Standards for Organisational Resilience provided: [CL8/122 - INQ000148758], also help to underpin the roles and responsibilities under the health EPRR framework in Scotland. Pandemic strategy and guidance are also relevant to how government and frontline health services will operate in that kind of emergency.

516. The EPRR framework in Scotland is different to the one which applies in England. There were no formal levels of emergency as set out in the NHS England EPRR framework documents. Rather, the DG HSC family works in collaboration with the Health Board(s) to establish the scale of the emergency / incident and the resources, approaches and governance required to respond.

517. Various sections of this statement outline the legislative powers of Scottish Ministers to direct the NHS, including emergency powers and how they were used. More broadly, the statement also includes various examples of how the SG and DG HSC directed elements of the Covid-19 response.

518. The fundamentals of the EPRR framework in Scotland did not change during the relevant period.

Funding

519. Within the DG HSC family, the Directorate for Health Finance, Corporate Governance and Value ensured appropriate pandemic-related financial governance principles were implemented with effect from 13 March 2020. This was to support necessary decision making, often at short notice, while ensuring that pandemic response activity complied with revised SG financial policy in force at the time. These principles remained in place throughout the entire period of pandemic response from 13 March 2020 and through 2020 and 2021, and included:

- revision of delegated authority to allow Directors and Deputy Directors within the DG to approve spend up to £1 million
- agreement of all spending decisions above £1 million by the Planning and Assurance Group (while in existence) or HSCMB prior to formal approval by Ministers.

520. 2021–22 budgets were set with consideration given to additional financial need arising from Covid-19 response. However, the DG HSC family continued to operate financial governance principles regarding any additional funding requested.

521. All spending requests set out above were accompanied by an Accountable Officer template ("AO template") aligning to the wider corporate approach taken across DG Corporate and DG Scottish Exchequer for Covid-19 accountability across the whole of SG. The AO template required that the following matters were be taken into consideration prior to the approval and allocation of funding:

- whether proposed spend was novel or contentious
- under what statutory or budgetary powers the spend was to be directed
- cash availability, ensuring that the SG's Treasury and Banking team were cited on particularly significant outlay
- whether spend would have implications for procurement on either existing or pending contracts.

522. On 11 March 2020, a letter was issued by John Connaghan, who was titled Chief Performance Officer for NHS Scotland and Director of Delivery and Resilience at this time, asking Health Boards to set out their local mobilisation plans (LMPs) to scale up intensive care and bed capacity, alongside scaling back elective and day case activity. This was followed by a letter to all NHS Board Directors of Finance and

Integration Authority Chief Financial Officers by the Interim Director of Health Finance and Governance on 20 March 2020 requesting completion of a template to identify a financial baseline for additional costs of Covid-19 response. Further guidance on regular completion of financial reporting in respect of mobilisation was issued by the Interim Director on 30 March, ensuring consistency in information returned and setting out the anticipated categories of activity where additional costs may be incurred.

523. A further email to NHS Directors of Finance and Integration Authority Chief Financial Officers from the Interim Director of Health Finance on 3 April 2020 set out the financial governance arrangements to be implemented for the 2020-21 financial year and noted that:

additional spending in excess of the thresholds set out below should be shared with [SG] Mobilisation Team contact[s] at the earliest opportunity to request formal approval. For avoidance of doubt, this is referring to spending more than these thresholds (per annum) for additional staffing, equipment, or measures specifically for the purpose of responding to Covid-19, and for which you would be anticipating additional funding from the SG. This relates to both individual and packages of spending activity.

Board Baseline Budget	Threshold
More than £1bn	£1m
Between £750m and £1bn	£750k
Between £500m and £750m	£500k
Between £100m and £500m	£250k
Below £100m	£100k

524. Mobilisation plans were then updated by NHS Health Boards, setting out activity and associated additional costs incurred throughout 2020–21 and 2021–22, with quarterly allocations made reimbursing the same, following scrutiny by officials. During the initial response, a specific delegation was provided for NSS National Procurement of up to £2 million to support increasing stocks of consumables, including PPE.

525. The guidance was designed to ensure that financial and related activities were performed in accordance with SG policy at all times. This ensured the following key principles of managing public money: probity, accuracy, economy, efficiency, and effectiveness. Documentation relating to decision making (both within the DG HSC family and NHS Health Boards / Integration Authorities) during the period of the Covid-19 response has been retained by the Health Finance, Corporate Governance and Value Directorate, including those decisions which were not taken forward or approved by the HSCMB and / or Scottish Ministers.

526. An overview of the budgetary process including funding provided to the DG HSC family and how these flow to the relevant health bodies has been provided in the Module 1 DG Health and Social Care statement provided to the UK Covid-19 Inquiry on 9 May 2023.

527. Where additional funding is provided for devolved matters in England, this gives rise to Barnett consequentials which then flow to SG. Since 2010-11, consequentials associated with health funding have been protected for direct pass-through to the Health Portfolio and this continued to be the case for additional funding pertaining to the Covid-19 response. Budget documents relating to the specified period, and showing total funding allocated to DG HSC Directorates, are provided: [CL8/123 - INQ000147381] [CL8/124 - INQ000147382] [CL8/125 - INQ000147383] [CL8/126 - INQ000147384].

528. Additional consequentials were received during the pandemic and passed to the DG HSC family at the extraordinary Summer Budget Revision (May 2020), and at the routine Autumn (September 2020 and 2021), and Spring (February 2021 and 2022) Budget Revisions.

529. The table below has been populated based on:

- The list of Accountable Officer templates requesting additional funding from consequentials as received, logged and taken for decision making to senior officials and Ministers during the period 13 March 2020 (covering activity necessarily commenced before that date) to 31 March 2021
- Local Mobilisation Plans (LMPs) as submitted by NHS Boards during the period, setting out surge and reactive healthcare activity pertaining to Covid-19 in

respect of primary, secondary and other delegated functions, including the activity of HSCPs run jointly by the NHS Board and relevant local authority

- Annual budgets during the relevant period for specific Covid-19 activity.

530. LMPs were regularly submitted to the SG's HSC Directorates during the period of the pandemic response and set out a range of activities undertaken by NHS Boards through exercise of their statutory duties to support delivery of healthcare. Costs funded by SG through the LMPs included support for the additional demand on bed capacity, equipment, hospital and community prescribing, temporary staff and overtime, staff wellbeing, public health, and redesign of patient pathways and interactions (particularly in respect of primary care), amongst other activities. Plans were subject to internal scrutiny by SG Health Finance officials and allocations made on a quarterly basis in arrears.

531. Activities within the relevant records have been assessed against the core themes set out in the Provisional Scope of Module 3 of the UK Covid-19 Inquiry, and therefore activities pertaining to testing, contact tracing, vaccination roll-out and other broader compliance activity (e.g. marketing and stay at home guidance) have not been included.

532. In all activities, the organisation responsible for providing the additional funding is the SG, through the Directorate of Health Finance, Corporate Governance and Value. Funding was provided on the basis that it was used in delivery of the activity indicated in requests.

Activity	Action taken forward (Y/N)	Funding provided (Y/N)	Additional comments
1 March 2020 – 31 March 2021			
Changes to delivery of primary and secondary health care, as delegated to NHS Boards, and set out in Local	Y	Y	Spend was incurred by NHS Boards across the relevant period and set out in LMPs submitted to SG Health and Social Care Directorates. Following scrutiny, quarterly

Mobilisation Plans (LMPs)			allocations were made during the relevant period to appropriately fund NHS Boards for actions undertaken.
Recruitment of patients to Covid-19 research study	Y	Y	Funding was provided through the CMOD to fund research activity pertaining to Covid-19.
Governance costs associated with Covid-19 antiviral clinical trials	N	N	N/A
Scottish-specific Covid-19 research	N	N	Funding was provided through the Chief Medical Officer Directorate to fund the "Rapid Response Research Call".
Community Pharmacy - additional costs incurred in responding to the pandemic	Y	Y	Funding for Independent Contractors, including community pharmacies, is regularly incurred through non-cash limited spend, and provided monthly through NHS Board Payments on Behalf as administered by Practitioner Services Division (NSS). Additional funding was provided through CMOD to account for loss of income and ensure sustainability.
Scientific Writer - summarising evidence	Y	Y	Funding was provided through the CMOD for a

for CMO and Ministers			scientific writer to support the Covid-19 Advisory Group secretariat by producing evidence summaries and ensuring the latest scientific evidence was reflected in advice produced by the group for the CMO and Ministers.
Pre-reg Pharmacy training delay - costs to extend training	Y	Y	Funding was provided to NHS Education for Scotland, via an allocation from the CCMOD (Pharmacy Division) to reimburse costs of extending training for pre-registration pharmacy trainees.
IT Medicines reporting tools - stock management (12 month)	N	N	N/A
Scottish Medicines Consortium expansion to 2021-22	N	N	N/A
Coaching for wellbeing	Y	Y	Funding was provided through the Workforce, Leadership and Service Reform Directorate by allocation to NHS Education for Scotland to deliver additional support for staff wellbeing.
National wellbeing hub	Y	Y	Funding was provided through the Workforce,

			Leadership and Service Reform Directorate by allocation to NHS Lothian for development of a national wellbeing hub (Promis).
NHS 24 National Helpline	Y	Y	Funding was provided through the Workforce, Leadership and Service Reform Directorate by allocation to NHS 24 for delivery of a national helpline.
Nursing - additional bursary funding for i) students required to undertake further clinical placement hours; ii) increased student numbers following the Deputy First Minister's August 2020 announcement on secondary school student exam results.	Y	Y	Funding was provided through the Chief Nursing Officer Directorate for additionality in bursary. Payments were then made from the Directorate through the Student Awards Agency Scotland (SAAS) in the usual manner.
Increase Nursing and Midwifery discretionary fund	N	N	N/A
Alternative methods of placement for Nursing and Midwifery students	N	N	N/A
Additional Allied Health Professionals' Practice Education Leads	N	N	N/A

Bursary extension for Nursing and Midwifery students who could not complete studies due to placement disruption	N	N	N/A
Attend Anywhere - scale-up costs	Y	Y	Funding to scale up Attend Anywhere and Near Me was provided through Digital Health and Care Directorate to various NHS Boards, including NSS.
Procurement of PPE items (gloves, aprons, masks, googles, visors, sterile gowns and non-sterile Covid gowns)	Y	Y	Procurement of PPE was taken forward through a framework agreement by NSS and funded by SG.
Securing manufacturing capacity for FFP3 masks in Scotland (Don and Low - meltblown)	Y	Y	Capital funding was provided to Scottish Enterprise to secure meltblown production, through Don and Low. Meltblown is a material frequently used in the production of personal protective equipment (PPE) and was subject to significant scarcity in the initial stages of the pandemic due to global PPE demand. Funding was used to support PPE supply and capacity.
MRI recovery extension	Y	Y	Funding was provided to NHS Boards through

			Access Support Division, within the Healthcare Performance and Delivery Directorate, to support recovery of MRI activity including through mobile MRIs.
Dental services - additional costs incurred in responding to the pandemic (sustainability payments)	Y	Y	Funding for Independent Contractors, including general dental practitioners, is incurred through non-cash limited spend, and provided monthly through NHS Board Payments administered by Practitioner Services Division (NSS). Additional funding was provided through Primary Care Directorate to account for loss of patient charge income due to significant suppression of the sector due to IPC measures, and thereby ensure sustainability of providers.
Additional seasonal flu vaccinations for adult and children, anticipating a circa 10% surge in demand	Y	Y	Population Health Directorate provided additional funding to NSS for the procurement of additional (standard) seasonal flu vaccinations

			to cope with anticipated surge in uptake.
Alcohol and drug misuse – additional support measures	Y	Y	Funding was provided through Population Health Directorate to deliver substance abuse support measures through NHS Board allocation and direct spend with third party providers.
National Mission to tackle growing numbers of drug-related deaths in Scotland	Y	Y	In January 2021, additional funding was announced to support a National Mission to tackle growing numbers of drug-related deaths in Scotland. That Mission included an additional £5 million in funding for Health Boards for 2020/21 and an additional £50 million for 2021/22.
Collection of convalescent blood plasma from recovered Covid-19 patients	Y	Y	Funding was provided through the Population Health Directorate to NSS to support plasma collection by the Scottish National Blood Transfusion Service (SNBTS).
Procurement and delivery of Vitamin D for those on the shielding list (operating on an opt-in basis)	Y	Y	Funding was provided through Population Health Directorate (Shielding Division) to NSS by allocation, and supporting procurement of additional Vitamin D.

General Practice - additional costs incurred in responding to the pandemic	Y	Y	Funding was provided through Primary Care Directorate to NHS Boards by direct allocation.
Optometry - additional costs incurred in responding to the pandemic	Y	Y	Funding for Independent Contractors, including community optometrists, is incurred through non-cash limited spend, and provided monthly through NHS Board Payments on Behalf administered by Practitioner Services Division (NSS). Additional funding was provided through Primary Care Directorate to account for loss of income and ensure sustainability of providers.
Social Care Support Fund (self-isolation support)	Y	Y	Additional funding provided to sustain social care through Covid-19 initial response.
£500 thank you payment to social care staff	Y	Y	Funding provided to social care staff, through transfers to Local Government, for delivery of £500 “thank you” payments. This maintained parity with NHS staff.
Attend Anywhere/Near Me - accelerated rollout	Y	Y	Funding to scale up Attend Anywhere and Near Me was provided through Digital Health and Care

			Directorate to various NHS Boards, including NSS.
vCreate, including seizure service	Y	Y	Funding provided through Digital Health and Care Directorate to NHS Boards to fund vCreate (video messaging) activity.
Attend Anywhere - evaluation of Covid-19 response	Y	Y	Funding to evaluate the scale up of Attend Anywhere and NearMe was provided through Digital Health and Care Directorate to various NHS Boards, including NSS.
PFI Car-Parking Charges	Y	Y	Funding was provided to NHS Lothian, Tayside and Greater Glasgow and Clyde to ensure the provision of free parking in PFI hospital carparks for patients during the pandemic.
Temporary Healthcare Facility at SEC (Louisa Jordan)	Y	Y	Funding provided to build and establish the temporary hospital. Ongoing revenue costs of operation were incurred by NSS and funded through LMP allocations.
Infection Prevention and Control Centre of Excellence	Y	Y	Funding was provided by way of an allocation to NSS from Health Finance, Corporate Governance and Value Directorate for

			establishment of the centre of excellence.
Safer workplaces assurance scheme	Y	Y	Funding transferred to Local Government Portfolio by Health Finance, Corporate Governance and Value Directorate to fund additional Environmental Health Officer capacity.
PPE innovation project (Tayside)	Y	Y	Funding provided by Health Finance, Corporate Governance and Value Directorate through allocation to Golden Jubilee Foundation for delivery of an innovation project focused on reducing need for PPE through consideration of greater use of reusables, with necessary decontamination.
Clinical waste resilience	Y	Y	Funding provided by allocation to NSS from Health Finance, Corporate Governance and Value Directorate for clinical waste resilience during the pandemic.
Cancer Recovery Plan	Y	Y	Funding provided from Healthcare Quality and Improvement Directorate via NHS Board allocation to fund Cancer Recovery Plan. Cancer waiting times and core Detect Cancer

			Early (DCE) Programme funding from the Health Performance & Delivery Directorate (now Directorate of the Chief Operating Officer of NHS Scotland) also contributed to the delivery of actions within the Cancer Recovery Plan.
Chest, Heart and Stroke Scotland - Long Covid	Y	Y	Funding provided by Healthcare Quality and Improvement Directorate through direct payment to Chest, Heart and Stroke Scotland to part-fund a Long Covid support scheme.
1 April 2021 - 31 March 2022			
Changes to delivery of primary and secondary health care, as delegated to NHS Boards, and set out in Local Mobilisation Plans (LMPs)	Y	Y	Spend was incurred by NHS Boards across the relevant period and set out in LMPs submitted to SG Health and Social Care Directorates. Following scrutiny, quarterly allocations were made during the relevant period to appropriately fund NHS Boards for actions undertaken.
Dental services - additional costs incurred in responding to the pandemic	Y	Y	Funding for Independent Contractors, including general dental practitioners, is incurred through non-cash limited

(sustainability payments) Further funding for recovery of services - hand pieces and ventilation			spend, and provided monthly through NHS Board Payments on Behalf administered by Practitioner Services Division (NSS). Additional funding was provided through Primary Care Directorate to account for loss of patient charge income due to significant suppression of the sector due to infection prevention and control measures (IPC), and thereby ensure sustainability of providers. Recovery funds were provided by Primary Care Directorate to NHS Boards (for onward disbursal to individual practices).
Dental student bursaries	Y	Y	Additional funding provided to Dundee University by Primary Care Directorate for additional students recruited during pandemic.
Covid Delivery Service	Y	Y	Funding for Independent Contractors, including community pharmacies, is regularly incurred through non-cash limited spend, and provided monthly through NHS Board Payments on Behalf as administered by

			Practitioner Services Division (NHS NSS). Additional funding was provided by the CMOD, through this established payment route, for medicine delivery.
Additional healthcare students (nursing, paramedics) following DFM exam announcement, including further bursary funding required.	Y	Y	Funding was provided for additional student numbers, including additional bursary demand, following DFM announcement in August 2020. Funding was provided through the CNO Directorate to SAAS for additionality in bursary. Funding for increased student numbers was provided to the Scottish Funding Council.
Wellbeing programme	Y	Y	Funding provided through Health Workforce Directorate to NHS Boards to take forward a range of wellbeing measures with NHS staff, including those in Health and Social Care Partnerships.
ICU baseline bed capacity uplift	Y	Y	Funding was provided through the Health Performance and Delivery

			Directorate to NHS Territorial Boards.
Discharge without Delay	Y	Y	Funding was provided through the Health Performance and Delivery Directorate to NHS Territorial Boards.
Interface Care	Y	Y	Funding was provided through the Health Performance and Delivery Directorate to NHS Territorial Boards.
Summer unscheduled care funding	Y	Y	Funding was provided through the Health Performance and Delivery Directorate to NHS Territorial Boards.

533. During the period 1 April 2022 to 28 June 2022, no additional funding was received through consequentials from the UK Government, so Covid-related activities, to the extent they remained extant, were funded from budgets as allocated in the Scottish Budget.

Infection Prevention and Control (IPC)

534. The process by which IPC guidance, protocols or standards were formulated is outlined below:

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

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

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

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

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

539. During the pandemic, the Health Workforce Directorate's process regarding IPC guidance and protocols / standards consisted of engaging and communicating with stakeholders and supporting the implementation of relevant clinical guidance. The Health Workforce Directorate's role was to support the engagement between SG, NHS Scotland Boards, Trade Unions / Professional bodies and Health and Social Care partners. This was managed through the WSLG which was established to:

- inform, engage and take collective action on key issues identified that require national senior strategic leadership in the Health and Adult social care workforce response to Covid-19
- work in partnership to ensure that the healthcare system is as prepared as it can be to respond to the peak of the virus, during and post response
- ensure timely feedback from NHS Boards and Trade Union / Professional Organisations for the WSLG to address key issues.

540. Staff-side representatives and NHS Employers were able to work in partnership with SG through WSLG forum meetings. Draft guidance would be shared with members from the WSLG and then following engagement, SG submission(s) were made to the CSH with recommendations. With consent from the CSH, officials would action the guidance with Health Workforce ensuring it was shared with members of the WSLG at pace. This allowed the most up to date information to be available without delay. Key issues and topics that were raised and discussed at regular WSLG meetings include but were not limited to: PPE, self-isolation, staff testing and various other Health Workforce guidance.

541. The CNRG considered the scientific, technical concepts and processes that were vital to understanding the evolving Covid-19 situation and potential impacts on healthcare settings in Scotland. Details of this Group have been provided earlier in the statement. The advisory group applied the advice coming from the WHO, SAGE, the UK-wide IPC guidance cell and other appropriate sources of evidence and information and used it to inform the decision-making process in Scotland during the pandemic. IPC leads in other countries presented at CNRG meetings; for example, the group were presented with a rapid review of Australian IPC Task Force Covid-19 Guidance for Personal Protective Equipment (PPE) in June 2021.

542. SG worked collaboratively with the four nations to adopt IPC measures informed by the UK IPC Cell.

543. It is important to highlight that any change to IPC measures or Covid-19 guidance was, and is, in relation to the latest and emerging evidence. This evidence continues to be reviewed.

544. The emerging evidence was assessed via ARHAI Scotland's rapid reviews of literature. These rapid reviews were presented and discussed in relation to IPC measures at the UK IPC Cell, HOCI and the CNRG. At the start of the pandemic, SG aligned with the rest of the UK in relation to IPC measures to reduce Covid-19 transmission. This ensured a consistent approach until further scientific evidence was available. Covid-19 guidance was developed using a variety of sources such as the WHO, alongside other international and UK clinical expertise, research reviews and contextual considerations.

545. ARHAI Scotland has the required expertise internally to present findings from their rapid reviews of literature and enable other clinical experts to challenge and determine the validity of the scientific evidence presented. As a direct result of these rapid reviews, and the discussions that the reviews facilitated, IPC measures changed in line with the scientific evidence, which included but was not limited to the evidence on the mode of transmission of Covid-19.

546. Person-based IPC measures were incorporated into national guidance by ARHAI Scotland. IPC measures included respiratory protective equipment, physical distancing, and use of Fluid Resistant Surgical Mask (FRSMs). SG published national guidance for the use of face and face coverings, and for health care worker Covid-19 testing, as exceptions.

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

Date of changes	Version	Overview of change
14/07/2020	Version 1	DL (2020) 20 – Quarantine (self-isolation) for NHS Scotland Staff returning to the UK - first version: [CL8/127 - INQ000389185]
31/07/2020	Version 2	Changes to take account of changing position
14/08/2020	Version 3	Changes to take account of changing position
26/05/2021	Version 4	DL (2021) 13 – Quarantine (self-isolation) for NHS Scotland Staff returning to the UK: [CL8/128 - INQ000470086] 1) Advised NHS Scotland staff not to travel to an amber or red list country due to preventing new Covid variants from entering the UK.
23/07/2021	Version 5	DL (2021) 22 – Framework for the implementation of isolation exemptions for Health and Social care staff: [CL8/129 - INQ000469955] 1) New policy framework and accompanying staff fact sheet.
27/08/2021	Version 6	DL (2021) 24 – Update on isolation exemptions for Health and social care staff: [CL8/130 - INQ000469956] 1) No longer required to automatically self-isolate if double vaccinated with the second dose of Covid-19 vaccine.
05/11/2021	Version 7	DL (2021) 36 – Quarantine (Self-isolation) for NHS Scotland staff returning to the UK: [CL8/131- INQ000470087] 1) Staff traveling abroad are encouraged to check Covid-19 infections rates in any potential destination and should do this in the full awareness that the status of their destination may change at short notice either in the run up to or during their trip
24/12/2021	Version 8	DL (2021) 50 – Update on Self-isolation for Health and Social care staff: [CL8/132 - INQ000469957] Updated Policy Framework states that if a staff member declines daily LFD testing, they should not return to work in a physical setting and instead should work from home during the 10-day isolation period. This applies even if the member of staff cannot fulfil their role from home. 2) It also clarifies that staff are advised that they should also follow the SG guidance on isolating after the initial close contact, when they are not at work or carrying out work related activities

06/01/2022	Version 9	DL (2022) 01 Update on Self-isolation for Health and Social care staff: 1) All index (positive) Covid-19 cases can exit self-isolation on day 7 regardless of vaccination status if they have a negative Lateral Flow Device (LFD) test on day 6 and day 7 (taken 24 hours apart) and do not have a fever (for the previous 48 hours without the use of anything to reduce a fever). 2) Unvaccinated or partially vaccinated contacts (0-2 doses) will be asked to take a PCR test and regardless of result will be asked to isolate for 10 days, from exposure to the case.
17/01/2022	Version 10	DL (2022) 01 Update on Self-isolation for Health and Social care staff: [CL8/133 - INQ000469958] 1) Fully vaccinated staff (those who have had two doses and a booster 14 days prior to the last exposure to the case), identified as either household or non-household contacts will be expected to take daily LFD tests for seven days, from exposure to the case and if the LFD tests are negative and they remain well, will not have to isolate. They can also end further contact testing at the end of the 10-day period.
24/01/2022	Version 11	DL (2022) 01 Update on Self-isolation for Health and Social care staff, provided above [CL8/133-INQ000469958]. 1)The revised policy document sets out the conditions that allow Health and Social Care staff who are isolating as a Covid-19 index case to leave isolation in seven days, in line with the general population advice. Re-affirms the guidance that is in place which allowed Health and Care Staff who are close contacts (household and non-household) to return to work when certain conditions are met.
19/04/2022	Version 1	DL (2022) 10 Health and Social care worker access to FFP3 masks, based on staff preference during the transition period: No change: [CL8/134 - INQ000429256]

548. SG worked with NHS Boards to manage and reduce the number of hospital onset cases of Covid-19 through the implementation of robust IPC measures. These measures were aligned with the guidance set out in the Covid-19 addendum, then the Scottish Winter 2021–22 Respiratory Infections in Health and Care settings IPC Addendum, which was replaced by the National IPC Manual. This included measures such as the appropriate use of PPE, the extended use of face masks and face coverings, physical / social distancing, ensuring optimal ventilation, enhanced cleaning measures in high-risk pathways, systematic outbreak management, healthcare worker (HCW) testing and patient admission testing to ensure patients were placed in the appropriate pathway. The dates and reasons for changes are listed within the response above under the heading "IPC Guidance Timeline".

549. HFS provided evidence and guidance on ventilation to the CNRG. It was the responsibility of ARHAI Scotland to incorporate the evidence into national guidance.

550. Any change to IPC measures in Scotland was based on the best available scientific evidence, expert opinion and consensus at that time. The only exception to this is the offering of RPE because of a health or social care worker's personal preference. This was not based on the IPC evidence base and, as such, was not an IPC measure.

551. SG commissioned HIS to carry out Covid-19 specific inspections at healthcare facilities. During these inspections, HIS inspectors assessed the implementation of IPC measures with consideration of the guidance detailed within the IPC guidance in place at the time, be that the Covid-19 addendum, the winter respiratory guidance or the NIPCM.

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

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

554. Officials attended Infection Control Nurses / Infection Control Manager meetings where the practical application of IPC measures and current challenges were discussed. This group supported the discussion which led to the development of the IPC webinars and the "It's Kind to Remind" campaign.

555. At the beginning of the pandemic, healthcare settings in Scotland were provided with PHE guidance to follow, provided: [CL8/135 - INQ000469937], which was then superseded by Scottish national guidance with specific links to relevant sections of PHE guidance as the pandemic progressed. It was important for NHS Health Boards to facilitate their own risk assessments and operationalise the guidance locally to be of relevance to specific board functions, infrastructure and built environment, such as surgical pathways, scheduled and unscheduled care.

556. Having UK and nationwide guidance had a number of different impacts. It allowed for consistency and transparency in guidance across the UK. Where guidance was shared, there was a single message based on the available science and best practice. Decisions could be implemented quickly. One possible limitation of having nationwide guidance was that containment guidance in hospitals was escalated even in instances where there was no reason specific to that location to do so, e.g. by island boards in Scotland with very low or no cases of Covid-19. Hospitals within these boards still had to adopt universal containment levels and associated practices. In some instances, universal decisions led to challenges in supplies of appropriate levels of PPE and the logistics for supply across Scotland. An example of this would be smaller hospitals being unable to accept large orders of PPE owing to the size of their storage facilities.

557. The SG Pandemic PPE stockpile is based on expert advice and modelling of what will be required to deal with a pandemic event. Specifically, the stockpile was based on modelling of a reasonable worst-case pandemic influenza scenario.

558. The table below shows the stockpiled levels of PPE held at Quarter 1 2020 in the national pandemic flu stockpile and excludes any procurements made in response to the Covid-19 pandemic. It also excludes stock held by the NHS NSS National Distribution Centre for normal business. Stock held by individual Health Boards and other frontline parts of the healthcare system are not included either.

Type of PPE	Number of units held at Q1 of 2020
FFP3	1.6m
Facemasks	14.9m
Aprons	15.8m
Gloves	8.35m
Eyewear	2.56m

559. On 10 January 2020, UK Covid-19 IPC guidance was published on the UKG website. This set out the expected levels of PPE for healthcare workers and was followed in Scotland at that time. A copy of the archived guidance will be available from the UKG.

560. (ARHAI) Scotland contributed on a four nations basis to UK PPE guidance until it was incorporated into the Scottish Covid-19 IPC Addendum for Acute Settings, published in the National IPC Manual on 26 October 2020, both provided earlier in the statement [CL8/105 - INQ000322610], [CL8/106 - INQ000322611].

561. The HCAI/AMR Policy Unit within SG published guidance on the wearing of face masks in healthcare settings. The guidance referred to workers as providing "direct" or "indirect" care to patients, provided: [CL8/136 – INQ000470088]. The term 'direct care' is defined as a clinical, social or public health activity concerned with the prevention, investigation and treatment of illness and the alleviation of suffering of individuals (all activities that directly contribute to the diagnosis, care and treatment of an individual). The term 'indirect care' is defined as activities that contribute to the overall provision of services to a population as a whole or a group of patients with a particular condition, but which fall outside the scope of direct care. It covers health services management, preventative medicine, and medical research.

562. On 21 December 2021, the WHO updated recommendations on the use of Filtering Face Pieces (FFP3) respirators by health and care workers, taking into consideration the increased transmission of the Omicron variant. The guidance contained a conditional recommendation to allow access to FFP3s based on individual staff members' personal preferences.

563. The UK IPC cell reviewed the WHO recommendations on mask use by health and care workers, considering the Omicron variant of concern statement, and agreed that no

changes were required to the existing UK guidance on IPC for seasonal respiratory infections in health and care settings (including SARS-CoV2).

564. As a result of the WHO additional recommendation, SG wrote to Health Boards on 19 April 2022 advising that an individual risk assessment could be carried out by line managers in line with current guidance, taking into consideration staff members' overall health, safety, physical and psychological wellbeing, as well as any personal views/concerns about risks. This was in addition to the process and risk assessments already in place for the use of FFP3 masks for health and social care staff when performing an AGP. This included in the low-risk pathway, and when working in the respiratory pathway in a clinical area deemed as having an unacceptable risk of transmission following rigorous application of the Hierarchy of Controls and where there was no other suitable area for placement of these patients. The letter is provided earlier in this statement [CL8/134 - INQ000429256].

565. From the outset of the Covid-19 pandemic, the SG worked with the NHS, Scottish suppliers, and on a four-nation basis to ensure that Scotland had stocks of PPE. On 1 March 2020, use of the pre-existing pandemic (influenza) stockpile was formally delegated to NHS NSS so that this could be issued to frontline providers.

566. The DG HSC family worked with policy officials from the Economic Development Directorate, Scottish Enterprise, and NSS to develop supply chains and Scottish manufacturing as detailed in the PPE Demand and Supply Report, which was published on 4 June 2020.

567. Domestic manufacturing was developed for Type IIR masks, FFP3 masks, visors, aprons, gowns and hand sanitiser. PPE officials also worked with NSS to establish the levels of procurement required for stockpile maintenance and business as usual supplies through demand modelling and forward buy meetings. The work on agreeing demand models fed through to forward buy proposals being submitted to the PPE Directorate / Division / Unit which then fed back on any concerns with the proposals. The request for a forward buy was then provided to the Director of Health Finance Governance and Value for consideration and final approval.

568. Officials from the DG HSC family also worked with the PPE Clinical Oversight group, including in their efforts to gain approval for the use of transparent masks in healthcare

settings. As detailed in the response to earlier questions, Policy Officials from the PPE Division/Unit and from Primary Care and CMOD also contributed to supply decisions as members of the Primary Care PPE Steering Group.

569. The paragraphs below contain references to 'push' and 'pull' bases. A push basis is one whereby the issuing organisation determines the amount of provision (in these cases after consultation with relevant SG Policy Officials) and sends it out to organisations without them specifying the amount or mix of items required. A pull basis is one by which the recipient indicates the amount required.

570. NHS NSS NP is the procurement centre of expertise for all NHS Scotland organisations.

571. For provision to Primary Care on a pull basis for some contractors, Health Boards reviewed orders for some contractors and were able to act if they deemed orders to be excessive. NHS NSS NP monitored use levels and communicated with Health Boards to reduce over-ordering and lower the risk of PPE being used for non-NHS service provision. A narrative description of PPE distribution follows.

<u>January 2020</u>

- 24 January 2020: First distribution of Fluid Resistant Surgical Face Masks (FRSM) to GP practices in Scotland. As a precautionary measure, SG issued facemasks to all GP surgeries in Scotland. This was the first issuing of any PPE from the pandemic (influenza) stockpile and consisted solely of surgical facemasks. As policy lead for the pandemic PPE stockpile, EPRR organised the distribution with NSS and after approval by the Cabinet Secretary for Health and Sport.

<u>March 2020</u>

- 1 March 2020: SG, via Health EPRR and Health Finance, issued NHS NSS with a formal letter delegating full use and deployment of the national pandemic stockpiles. The delegation document also provided significant initial procurement delegation in relation to PPE
- PPE was supplied to Health Boards for use in acute care prior to the Covid-19 pandemic, and supplies were increased in the weeks before cases were confirmed in Scotland.
- NSS's usual role is in supply of PPE to Health Boards and the change to provision to Primary Care ICs did not begin until the Covid-19 pandemic began

- 11 March 2020: Second distribution of FRSM to GP practices in Scotland, this time including other PPE such as aprons and eye wear
- PPE was supplied to GP surgeries on a 'push' basis. Prior to the Covid-19 pandemic, GPs sourced their own PPE, but with the changes to guidance that resulted in greater demand for PPE, along with a reduced global supply, GPs were supplied from the national stockpile.

April 2020

- The Ministerial Briefing Note provided gives further detail on the methods of supply to Health Boards, SAS and GPs as of April 2020, provided: [CL8/137 - INQ000261832].
- PPE was supplied to Emergency Eyecare Treatment Centres (EETCs) to manage patients with emergency eye problems face-to-face
- PPE was supplied to community pharmacies on a 'push' basis.

June 2020

- PPE was supplied to dentists on a 'push' basis.

July 2020

- PPE was supplied to optometrists on a 'push' basis.

February 2021

- The process began to transfer most Primary Care contractors in to a 'pull' model with practices utilising online ordering of pandemic PPE. This change was brought in to allow practices to identify how much and what mix of PPE items were required rather than this being determined centrally. This was done to minimise the risk of overstocks or short supply at a contractor level
- The members of the Primary Care PPE Steering Group worked together and consulted with external organisations to consider the options for supply of PPE to Primary Care Independent Contractors. Recommendations as to the options were then submitted, after approval from relevant DG HSC family Directors to the Cabinet Secretary for Health to obtain a Ministerial decision in relation to supply for Primary Care. There were submissions on the 31 July 2020, 14 December 2020, 1 June 2021, 15 December 2021, and 23 February 2023.

572. The following tables set out the chronology of face mask guidance and extended use of Respiratory Protective Equipment (RPE).

Face Masks and Face Coverings Timeline

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

		areas in adult care homes as well as long stay / overnight visitors; and clarification around the need for outpatients, to wear face coverings, as well as encouraging individuals being cared for at home and their household to wear face coverings.	
June 2021	23/6 - The use of face masks and face coverings in social care settings was published.	A new guidance published to separate the use of face masks from healthcare settings and social care settings	Separation of guidance to support sector understanding and awareness
July 2021	Guidance for hospital staff to support visitors	Questions and answers added to guidance on the extended use of face masks and face coverings	Guidance for hospital staff and how to support visitors.
October 2021	Guidance sections updated to reflect latest position on the extended use of face masks and face coverings.	Change to physical distance requirements, waste disposal of face masks, update to the Health Protection (Coronavirus) (Requirements) (Scotland) Regulations 2021.	The Scottish Covid-19 addendums had been amended.
April 2022	Face mask guidance updated to reflect latest position.		Guidance was updated to reflect the change from legislation to guidance.

June 2023	Guidance was withdrawn and recommended to revert to pre-pandemic and the NIPCM.		Based on the evidence provided by ARHAI Scotland's rapid review of literature.

Respiratory Protective Equipment (RPE) Timeline

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

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

April 2021	An update to the Scottish Covid- 19 IPC Addendum.	The change highlighted that the transmission of Covid-19 is mainly droplet or contact. However, recognised that some over-crowded and poorly ventilated areas may generate a risk of aerosol transmission of Covid-19 if used to care for cohorts of suspected and / or confirmed Covid-19 cases (environmental risk assessment).	Following the publication of interim WHO guidance *Covid-19 - Occupational health and safety for health workers*, (Feb 2021), a SAGE paper *Masks for HCW to mitigate airborne transmission of SARS-COV-2* and subsequent advice from the CNRG. [CL8/138 - INQ000075022]
July 2021	Framework for the implementation of isolation exemptions for health and social care staff	For those staff who are willing to return to work to relieve service pressures, they may be supported to do so through the additional provision of FFP3 masks, where this assists with allaying concerns that the staff member might have.	This was a workforce policy introduced as a result of Ministerial decision making and did not follow a change in evidence. This was a Scotland only policy and was not replicated in the rest of the UK.
March 2022	Personal preference access to FFP3s	Workforce policy introduced which offered health and social care staff access to FFP3 respirators if they wanted to wear one.	This was a workforce policy introduced because of Ministerial decision making and did not follow a change in evidence. This was a Scotland only policy and was not replicated in the rest of the UK.

The supply of PPE to the healthcare system.

Date	Guidance	Exhibit Reference
26/05/2020	CNO letter to NHS Board Executives on re- use of PPE	[CL8/139 - INQ000398868]
23/06/2020	Interim guidance on the wider use of facemasks	Provided earlier in the statement [CL8/136 - INQ000470088]
09/12/2020	Expansion of twice weekly Covid-19 testing	[CL8/140 - INQ000413478]
08/03/2021	A Director's letter on continuing to reduce the risk of Covid-19 transmission.	[CL8/141 - INQ000469954]
23/07/2021	Framework for the implementation of isolation exemptions for health and social care staff	Provided earlier in the statement [CL8/129 - INQ000469955]
27/08/2021	Update on isolation exemptions for Health and Social Care staff	Provided earlier in the statement [CL8/130 - INQ000469956]
24/12/2021	Asymptomatic testing guidance for patient testing; adult care home staff testing; extended use of face masks	Provided earlier in the statement [CL8/132 - INQ000469957]
24/01/2022	Updated Policy Framework on the self-isolation exemption for health and social care staff	Provided earlier in the statement [CL8/133 - INQ000469958]

09/05/2023	Withdrawal of the coronavirus (Covid-19): extended use of face masks and face coverings guidance across health and social care, and the unpausing of ventilator associated pneumonia (VAP) and bacteraemia surveillance	[CL8/142 - INQ000469959]

573. NSS National Procurement (NP) is responsible for national PPE contracts in Scotland and has stringent and robust procurement systems, including appropriate due diligence. Although the normal pre-tendering procedure, where NSS will work with stakeholders through a Commodity Advisory Panel to define the correct product specification, was suspended during the pandemic, the specifications and product requirements were maintained from previous processes.

574. PPE must conform to essential health and safety standards, as stipulated by the Health and Safety Executive (HSE), before being sold within Scotland. To ensure that these standards are met, PPE undergoes a conformity assessment process before it can be marked with a "CE mark" (or now the UKCA mark as appropriate). However, in March 2020 a European Commission Recommendation allowed EU nations to suspend this requirement to facilitate the swift supply of PPE during the Covid-19 pandemic, a process known as "easement".

575. The PPE (Temporary Arrangements) (Coronavirus) (Scotland) Regulations 2021 came into force on 1 February 2021 to allow easement to occur in Scotland until the Regulations expired on the 30 June 2021. Under the Regulations, PPE still had to comply with the essential health and safety standards required by the HSE. Easement of PPE instead of CE marking did not represent any reduction in PPE standards for use when dealing with Covid-19; it was simply a different way of approving PPE for use. NSS never made use of the PPE easement arrangements.

576. NSS, through National Procurement, only buys PPE that meets CE (or now UKCA) standards. NSS have a dedicated Quality Team who ensure that all products meet the required standard set out at the time of tender and point of ordering.

577. Specifications and guidance on the type and uses of products changed as the pandemic progressed. Before transparent masks were introduced for use in NHS Scotland, the Commodities Advisory Panel carried out clinical acceptability testing.

578. Some of the PPE stock in the pre-Covid pandemic influenza flu stockpile had been revalidated to extend its shelf-life. This was generally carried out by the manufacturer and the activity was coordinated by PHE on behalf of the four nations. Some additional revalidation was carried out early in the Covid- 19 response, again largely coordinated by PHE, though NSS NP also organised some revalidation. The testing carried out, which was not done through the original manufacturer, was guided by the HSE.

579. As illustration, the March 2020 results of a revalidation exercise on three models of 3M FFP3 masks are provided: [CL8/143 - INQ000470089]. NHS NP also arranged for other FFP3 masks to be revalidated to the same standard through the same testing house. In February 2020, a company called Medline revalidated stocks of their FFP3 masks in the pandemic stockpiles. Before the withdrawal of the Medline FFP3 respirators from NHS usage in Scotland, they had been in use within NHS Health Boards. These respirators were issued to NHS Boards in the week commencing 9 March 2020. Within days, SG's Emergency Preparedness, Resilience and Response Division was receiving reports from the NHS that the Medline masks had a high fit-test failure rate within territorial Health Boards in Scotland, and this was supported by experience in England which SG was informed of by PHE. On 18 March 2020, the SG was informed by PHE that these masks had failed testing that would have extended their shelf-life from that point by an additional five years. PHE also informed SG on the same day that HSE were content that masks already issued to the frontline could remain there and be used, but that no further Medline FFP3s should be issued until independent quality assurance testing had been carried out. This view from HSE took account of the fact that the masks had had already passed testing to extend their shelf-lives by three years from that point.

580. Given the increasing concerns around the high fit-test failure rate and the failed testing – and despite the HSE advice that issued stock could still be used – the SG asked NHS National Services Scotland (NSS) on the same day (18 March 2020) to make arrangements with NHS Boards to withdraw the masks from use. SG does not hold information on when the masks were actually withdrawn from use, although NHS NSS may have this. The SG was informed by NHS NSS that they had told Health Boards to quarantine the stock locally and is not aware of any use of the masks after that point. Although subsequently informed by PHE on 6 April 2020 that the Medline stock had passed independent quality assurance testing, the SG did not issue permission for the masks to be used.

581. In May 2020, after goggles issued from the four nations' pandemic stockpiles were subject to some complaints in England, HSE carried out additional tests which found that the product failed to meet the standard for splash protection required. Complaints in relation to the goggles, which led to their being testing by HSE, were received in England only as far as the SG are aware. PHE, who informed the SG about the complaints in England, did not provide the SG with the details and numbers of complaints. Neither does the SG have any record or awareness of such complaints having been made by

stakeholders in Scotland. The SG was informed about the concerns over the goggles, the testing of the goggles by HSE, and the failure of those tests, all at the same time on Saturday 9 May 2020. NHS Boards and other health and social care organisations in Scotland were instructed on the same day to quarantine any stock held. They were not subsequently re-introduced.

582. NSS hold the evidence on standards of PPE procured and any clinical acceptability testing carried out.

583. During the period covered by this module, pandemic PPE was distributed on behalf of SG the Scottish Government by NHS NSS. Pandemic stockpile PPE holdings were released to NHS NSS who provided this PPE to Health Boards and Primary Care ICs providing NHS services free of charge. These stocks were augmented by procurement of further pandemic PPE, principally carried out by NHS NSS using funds provided by the SG for that purpose.

584. As noted in earlier responses relating to financial provision, Health Boards including the SAS were also able to procure their own PPE for use in the pandemic where the central offering did not fully meet the needs of their workforce. This was managed via their local mobilisation plans.

585. Prior to the pandemic, Primary Care Independent Contractors sourced PPE via their own supply routes. On 24 January 2020, the Scottish Government issued limited supplies of surgical facemasks (FRSM) to all GP practices in Scotland, as a precautionary measure. On 11 March 2020, all GP practices in Scotland were issued with PPE supplies consisting of fluid resistant surgical face masks (FRSM), disposable gloves, disposable plastic aprons and eye protection. The stocks were issued on a 'push' basis (i.e. practices did not have to request the PPE) from NSS and distributed to GP practices via territorial Health Boards. Access was expanded to cover community pharmacies in early April 2020, with supply to dentists commencing in June 2020, and optometrists the following month. By early 2021, Primary Care contractors in many Health Board areas had transferred to a 'pull' model with practices utilising online ordering of pandemic PPE.

586. After this initial period, supply reverted to a 'pull' model whereby NHS boards placed orders with NHS NSS based on their own particular needs. Further details on the mechanisms of distribution of PPE will be held by NSS as the issuing body.

587. In early April 2020, SG set up and managed a dedicated PPE helpline mailbox for HSC staff to contact if they did not have access to the PPE that they needed, or if they had other concerns regarding PPE supply. This covered Acute, Primary Care, Social Care, and members of the public. At the same time, each Health Board nominated a Single Point of Contact (SPOC) for PPE.

588. Correspondence received in the mailbox was triaged by officials within the PPE Directorate and actioned depending on the content and the correspondent. Each email was categorised for a response and / or further action as required. The process document is provided: [CL8/144 - INQ000470090]. The ministerial correspondence spreadsheets referred to in this document are also provided: [CL8/145- **INQ000474231** [CL8/146 - INQ000468146]. Within the first spreadsheet, which covers the most intense period of correspondence, the correspondence is categorised as described in the process document.

589. In the first instance, staff or members of the public enquiring about availability of PPE were directed to their local Health Board PPE SPOC. Where there were supply or distribution issues that could not be resolved at NHS Health Board level, the Health Board PPE SPOC engaged with NSS National Procurement for action and resolution.

590. Advanced PPE (FFP3s and non-sterile gowns) were not available to Primary Care Independent Contractors other than dentists through the 'pull' ordering model owing to these items not being routinely required by the other contractor groups. In situations where access was needed contractors were advised to contact their local Health Boards for supply.

Medical Equipment

591. Details of equipment provision have been set out earlier in this statement and the following information should be read in conjunction with that text.

592. As part of the learning from Covid-19, a national Medical Equipment Management System (NMEMS) has now been implemented so that in future NHS Scotland inventory management of medical equipment being held and used by NHS Boards can be quickly established.

593. As of 15 March 2020, there were 363 ICU ventilators available across NHS Scotland. As of 28 March 2020, there were 693 anaesthetic machines with integral ventilators available which could be utilised to supplement ICU ventilation, if required. It was considered important not to introduce equipment that NHS Scotland staff were not familiar with while they were under extreme pressure. In total, approximately 1056 machines with ICU ventilation capability were available but with the caveat that most planned surgery was suspended and did not require these.

594. The agreed maximum surge position was for 714 ICU beds, a position of quadruple the baseline ICU capacity, but with the constraining factor of trained staff availability.

595. In addition, there were also 124 sub-ICU ventilators that incorporated limited modalities of invasive mode ventilation. However, these were not included in ICU resilience planning because of their limited functionality in invasive modes. To support the increase in ICU capacity and build future resilience, 527 ventilators were procured by NSS National Procurement and ordered in March 2020 with deliveries in tranches and with long lead times owing to the global demand.

596. As of September 2022, there were 592 ICU ventilators in NHS Boards and 148 in the central stockpile held by NSS, totalling 740.

597. Following a revision, the baseline figure for ICU beds was increased from 173 to 203 level three beds, with boards retaining the on-site ability to double this capacity (i.e. to 406 beds).

598. The SG ICU Resilience and Support Group was established in March 2020, including SG, ICU consultants, clinical engineers, estates / facilities staff and National Procurement staff. This group had senior clinical, technical, procurement and policy members who were able to make informed decisions on equipping, levels, and technical suitability of devices.

599. 5,182 infusion pumps, 93 Renal Replacement Therapy and 34 Haemodialysis machines were procured by NSS NP in August 2020 with deliveries in tranches.

600. ICU ventilators are made to order without large stocks held by manufacturers. There is no manufacturing base for ICU ventilators in the UK. This meant all stock had to be sourced from abroad with the more familiar brands coming from the EU. As Covid was worldwide,

many countries were vying for limited stock which resulted in several issues: long lead times and pop-up vendors who offered access to Far East-manufactured machines at increased prices. Some did not actually have the stock or access to the machines as they claimed. These processes were managed by NSS NP who vetted all potential suppliers as far as possible with the preference being to use known suppliers.

601. On 26 March 2020, critical care workforce guidance was published by SG, provided: [CL8/147 - INQ000228364]. This followed a joint statement on developing critical care nursing capacity made on 25 March 2020, provided: [CL8/148 - INQ000227427]. This was updated throughout the pandemic, and updates are provided: [CL8/149 - **INQ000469966** [CL8/150 - **INQ000469968**

602. In general, as NHS Boards were stopping many clinical functions to deal with Covid-19, there was some re-distribution of equipment that was common to general ward areas and ICU such as infusion devices. At Board level, NHS Boards used their Medical Equipment Asset Management Systems to ascertain what equipment they held and what could be redeployed., including anaesthetic machines which could be used as ventilators if required. They had access if required to the central ICU stockpile being held by NSS. However, some supplementary ICU equipment had to be obtained by National Procurement and was also required as services started to re-open.

603. A summary of medical equipment categories held in central store and obtained by National Procurement either directly from the supplier or from DHSC is shown below. All devices listed were acquired and held in sufficient numbers to support the Health Boards. A number of measures were in place to monitor this.

604. Ensuring that all Boards had access at all times to their ICU equipment was overseen by the SG ICU Resilience Group who monitored intelligence on ICU equipment using ongoing engagement with all Boards and utilising regular reports from the Scottish Intensive Care Society Audit Group on ICU occupancy.

605. Stock held in the central store was available to Health Boards on request. All requests made to National Procurement were discussed with the SG ICU Resilience Group and managed on an equitable basis.

- Blood Gas Analysers
- Blood Pressure Monitor

- Bronchoscopes- video
- Haemodialysis Machine
- Hemofiltration Machine
- Humidifier – heater
- Laryngoscope – Video
- Monitors – patient
- Syringe Pump - Ambulatory
- Syringe Pump – General
- Infusion Pump – Enteral
- Infusion Pump – Volumetric
- Suction Pump
- Ultrasound Scanner
- Ventilator – ICU
- Ventilator – Sub ICU
- Ventilator – Transport
- Ventilator – Non-Invasive (including CPAP)
- Warmer – Patient.

606. National Procurement obtained adequate stocks of the consumables required to be used with the equipment, including Renal Replacement Therapy fluids and ventilator circuits.

607. Clinicians' guidance on the use of pulse oximeters was included in the Covid-19 Remote Monitoring Pathway and took into account the potential effect of differing skin pigmentation levels, noting that clinicians should "be aware that in people with dark skin tone saturations may be up to 2% lower than recorded", provided: [CL8/151 - INQ000469969]. The monitoring was aimed solely at patients with an initial threshold above 95%, therefore risk was minimal within that range. The pathway included other symptom questions to avoid sole dependency on a "number". The SG is not aware of any related consequences for patient care having arisen in Scottish settings. Officials in the DG HSC family had access to the papers for a roundtable organised by the Department of Health on 19 January 2022, which included a rapid review of open-access literature on the subject, supplier and manufacturer data and insights, an account of clinical pathways and guidance, and operational and patient safety data, provided: [CL8/152 - INQ000468147], [CL8/153 - INQ000468148], [CL8/154 - INQ000468149], [CL8/155 - INQ000468150], [CL8/156 - INQ000468151], [CL8/157 - INQ000283537]. This roundtable was attended by HIS representatives, who were also cited as partners in the Department of Health and Social Care consensus statement issued on this subject.

608. Several evaluations and rapid assessments of the remote monitoring COVID pathway are provided: [CL8/158 - INQ000469970] [CL8/159 - INQ000469971] [CL8/160 - INQ000469972] [CL8/161 - INQ000469973].

NHS Scotland Capacity

609. The average number of available inpatient and critical care beds (acute beds) between January and March 2020 was 13,478. Occupancy of acute beds at this time was at 83.4% on average and decreased to 61.6% in quarter ending June 2020. The statistics are published by PHS and provided: [CL8/162 - INQ000469960].

Average number of available staffed acute (Inpatient and critical care) beds, and the percentage occupied from Quarter 1, 2020 to Quarter 2, 2022

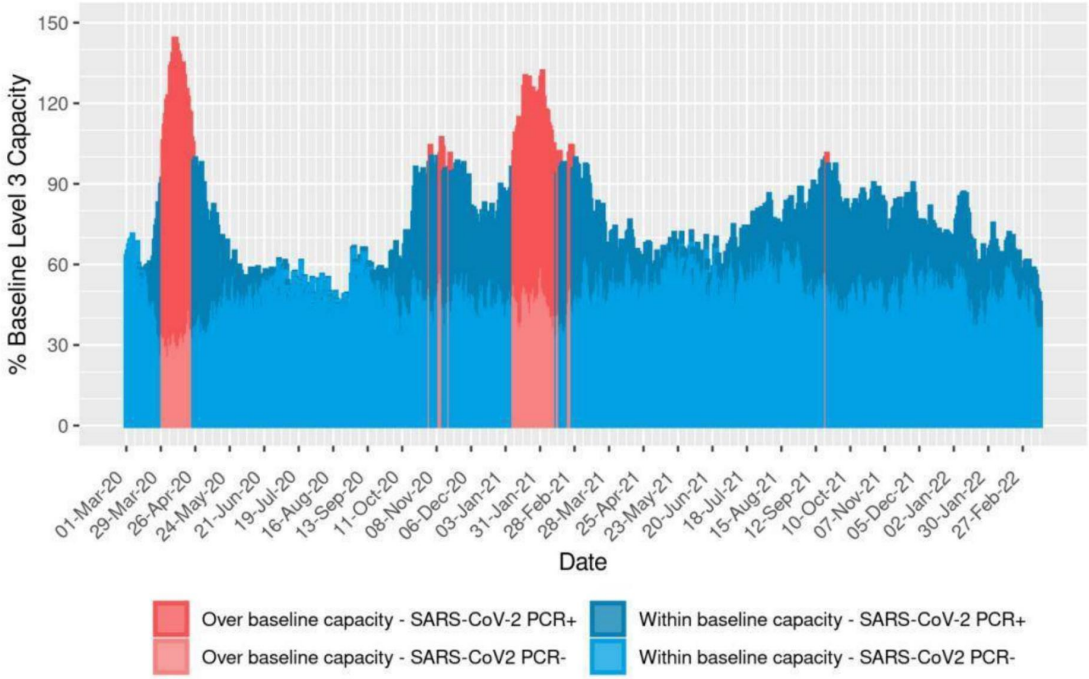
Quarter	Average	Available Staffed Bed Percentage Occupied
Jan - Mar-20	13,478	83.4%
Apr - Jun-20	12,706	61.6%
Jul - Sep-20	12,638	76.7%
Oct - Dec-20	12,941	79.7%
Jan - Mar-21	13,083	81.0%
Apr - Jun-21	13,041	82.2%
Jul - Sep-21	13,199	84.1%
Oct - Dec-21	13,406	85.1%
Jan - Mar-22	13,546	86.2%
Apr - Jun-22	13,583	87.2%

Data source: PHS Published data.

610. Data was available on the baseline pre pandemic ICU capacity (173 as published), and on the numbers of patients in ICU beds (expressed as a percentage of the baseline). Local systems were flexing ICU capacity on an ongoing basis. Further to this, the *Scottish Intensive Care Society Audit Group on Covid-19,* provided: [CL8/163 - INQ000470091] describes the details of the critical care bed capacity and occupancy levels in Scotland during the relevant period.

611. 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.

Figure 5. Patients receiving level 3 care as a percentage of baseline capacity



612. National baseline capacity was exceeded on 8 occasions between 1 March 2020 and 15 March 2022. The highest peak was 44% above baseline on 10 April 2020. Patients with a positive PCR test for SARS-CoV-2 comprised 76.7% of all those in ICU during the period of peak capacity (as of 10 April 2020), which reduced to approximately 56% during other episodes of activity exceeding baseline capacity later during the pandemic. During these periods, care was often delivered in areas of the hospital re-purposed to provide intensive care, with separate units for Covid-19 and non-Covid-19 patients, resulting in additional stress on staffing.

613. In April 2021, John Connaghan (COO, NHS Scotland), CMO and CNO jointly commissioned a short-life working group to consider ICU baseline capacity, uplift capacity and associated factors in preparation for winter 2021/22. The SLWG on ICU Baseline Bed Provision provided advice to COO, CMO and CNO and then to the CSH on what the bed uplift should be, including the financial implications. The CSH took the final decision to

implement an additional 30 level 3 intensive care beds (for patients requiring highest levels of clinical support) across Scotland on a permanent basis.

614. In May 2021, the SLWG committed to a second phase report to provide further detail to support boards with the implementation phase. The membership sought to understand how SG could support Health Boards to implement the uplift of 30 beds, including the provision of appropriate facilities.

615. In June 2021 letters were issued by the COO to inform the mainland Health Boards to implement the ICU uplift in time for winter 2021–2022, including specific provisions to support island Boards, provided: [CL8/164 - INQ000414537] [CL8/165 - INQ000470093] [CL8/166 - INQ000470094] [CL8/167 - INQ000470095] [CL8/168 - INQ000470096] [CL8/169 - INQ000470097] [CL8/170- INQ000470098] [CL8/171 - INQ000470099] [CL8/172 - INQ000470100] [CL8/173 - INQ000470101] [CL8/174 - INQ000470102].

616. In April 2020, as Covid-19 admissions rose, the decision was made within a West Health Board forum to keep NHS Golden Jubilee as a "Green Site" responsive to the situation and to support the West Health Boards. This was to minimise the risks to patients undergoing complex surgery. Contractual agreements were handled within the Health Boards and capacity at the NHS Golden Jubilee was directly funded in full and allocated to NHS Boards by the SG. Governance sign-off was actioned by the DCMO and the COO.

617. Regarding unscheduled care, all the Health Boards intended to retain red / green pathways for patients. They also noted the need to balance Covid-19 and non-Covid-19 capacity, and the need to focus on a complete system approach to service delivery. Most boards also intended to develop pre-hospital triage and hospital-at-home services, although the level of detail set out in the remobilisation plans at this point was variable.

618. The need for new ways of delivering services during Covid-19 broadened understanding of what could be achieved to keep people safe, demonstrating that there are a range of alternative ways to access NHS services available in addition to traditional face-to-face care. The Redesign of Urgent Care programme sought to build on these opportunities to support the public to access the Right Care in the Right Place at the Right Time.

619. Since the programme launched in winter 2020, Flow Navigation Centres (FNCs) have been established in every mainland Health Board to offer rapid access to virtual clinical

assessment or arrange a scheduled appointment in person. This service is accessed by patients calling the NHS 24 service, who refer patients to the FNC for access to Minor Injury Units, Assessment Areas and clinics where appropriate. The overall aim of the programme is to reduce self-presenting attendances at A&E by 15% to 20% and ensure faster access for those who do require to attend. Through the Redesign of Urgent Care programme, capacity has been bolstered at NHS24, which has seen staffing levels increase by 65% since 2007 and now operates as a 24/7 service. More hospital alternatives are being provided to prevent unnecessary attendances to A&E. The combination of services have significantly contributed to reduced attendance at Emergency Departments (EDs), with self-presentations between February 2023 and January 2024 down by over 90,000 (around 11%) compared to pre-Covid levels.

GP Capacity

620. The relationship between GPs and Health Boards is set out at paragraphs 70-71, which should therefore be read in conjunction with the following text.

621. As a result of the delegated nature of the GP model, the SG did not centrally hold data at the beginning of the relevant period about how many GP appointments were being regularly offered in March 2020 or what the levels of utilisation were. The pandemic highlighted the need for consistent, quality data which could be made available to practices, GP clusters, HSCPs and Health Boards and collated nationally to support sustainability and future planning of services.

622. The primary purpose of data recording in GP practices is to record information on patients' health accurately. However, there are many ways the clinical information can be recorded in the IT systems, which means that extracts of data from different practices are not necessarily compatible.

623. The initial phase of the GP In-Hours project focused on a data extract from practices to allow exploratory analysis of the data currently held. This helped inform subsequent phases to analyse further the accuracy of the data being recorded and agree revised encounter recording guidelines (an encounter is anything from a face-to-face appointment with a GP to a medication review conducted without the patient present). Data extracts were initiated during the relevant period at the start of February 2022 for those practices which had not requested to be excluded from the project, and work

continues to develop national encounter recording guidelines for practices and work towards higher quality data nationally.

624. Since February 2022, several extracts of aggregated data have been taken from practices, including information on the number of encounters. The project team worked with a small number of GPs to process the encounter data into meaningful categories. The preliminary in-hours GP activity data was then shared with NHS Board Chief Executives and HSCP Chief Officers on 12 September 2022 to illustrate the type of analyses possible. As this work was exploratory in nature, NHS Board and HSCP data were anonymised at that time.

625. Following further consultation with the SGPC and the RCGP, it was agreed that this data would be published and made available as experimental statistics at an NHS Board and HSCP level. The data was first published in December 2022 and demonstrated that activity fell sharply at the start of the pandemic to around 1.2m encounters per month, but by March 2021 had recovered to pre-pandemic levels, typically between 1.5m and 1.8m per month.

626. As discussed above, general practice is provided in Scotland under a delegated model and the activity data we have is experimental. Nonetheless, it is understood from this data and routine conversations with Health Boards throughout the period that the levels of appointments changed during the relevant period. The general reason for those changes was guidance from PHS about IPC to reduce the incidence of Covid-19 infections in community health settings including general practice, with GP practices looking to avoid face-to-face contact unless clinically necessary. This meant some appointments were given remotely and others were not provided at all. As an example, the Cervical Screening programme was suspended between March 2020 and June 2020 for non-routine screenings with routine screenings being resumed in September 2020.

627. The data published in December 2022 suggests that pre pandemic, around 84% of GP encounters were physical (in person). This percentage dropped to around 49% in April 2020 before steadily increasing to 66% by October 2022. However, it is worth noting that these percentages are likely to be an overestimate due to GP IT systems having in person encounters as the default setting for encounter type.

<u>Community Pathway for managing Covid-19</u>

628. SG wrote to Health Boards in March 2020 setting out the rationale and policy intent for a community pathway for managing Covid-19 in Scotland, provided: [CL8/175-INQ000470117]. The letter recognised that the main burden of managing any significant outbreak would lie within primary and community care. A strong and well-functioning integrated system in local communities would help ensure better flow for those people waiting to be discharged from hospital, early intervention and proactive management of those at potential increased risk of serious outcome, and good local communication and education to support and enable community resilience. This approach was developed with the input of SG clinical colleagues and approved by Scottish Ministers. During the relevant period, the SG's intention was to protect GP capacity.

629. To enable this approach, local systems were asked to consider urgently how they could ensure a comprehensive and expansive front line community response to help alleviate the surge in demand for hospital beds and use of critical care facilities, enabling rapid pathways for those affected or concerned about Covid-19, but also how the system could connect to more of itself to mitigate the likely consequence of staff absences.

630. The letter provided above [CL8/175 - INQ000470117], suggested pathways as part of a national "once for Scotland" approach. In this model, NHS 24, rather than GP practices, would provide a single point of entry for all people with respiratory symptoms or concern about Covid-19 through use of the national 111 phone number and the national website, NHS Inform, using existing Interactive Voice Response (IVR) telephony to stream people appropriately. This approach was intended to keep Covid-19-related activity and the threat of infection away from general practice as far as was practicable.

631. At the beginning of the relevant period, the SG advised Health Boards to implement Covid-19 escalation frameworks to make sure that where GP practices had to stop certain activities, either owing to the constraints of Covid-19 related illness or to avoid infection, Health Boards were made aware. This was so that the contract between them and practices would not be breached. Health Boards provided regular updates on their local frameworks to the SG throughout the relevant period and this provided broad intelligence about the capacity of general practice.

632. There were 1,680 Health Board-employed multidisciplinary team members working in support of General Practice at the beginning of the relevant period and 3,320 employed by March 2022 through the Primary Care Improvement Fund. These staff were employed to enhance overall general practice capacity and capability under the 2018 GP Contract.

633. In March 2020, the Coronavirus Act 2020 amended the National Health Service (Primary Medical Services Performers Lists) (Scotland) Regulations 2004, the National Health Service (General Medical Services Contracts (Scotland) Regulations 2018, and the National Health Service (Primary Medical Services Section 17C Arrangements) (Scotland) Regulations 2018 to allow GPs to begin performing in a Health Board area while their application to join a Health Board's Performers List was still pending. This allowed Boards to postpone administration and deploy new or returning GPs sooner that would have otherwise been the case. This measure expired with the bulk of the Coronavirus Act 2020 in 2022.

Ambulance capacity

634. The emergency ambulance service in Scotland is provided by the Scottish Ambulance Service (SAS). The SAS was established in 1999 under The SAS Board Order 1999, which amended the National Health Service (Scotland) Act 1978.

635. The SAS is responsible for a range of services for the people of Scotland, from accident and emergency response, to delivering primary care, providing patient transport, dispatching rapid air ambulance and SCOTSTAR support for critical patients, to being a Category 1 responder for national emergencies. Independent ambulance services do operate in Scotland; however, the SG does not hold information on these organisations regardless of whether they operate emergency ambulances. SG does not hold data on the number of emergency ambulances available across NHS Scotland as of 1 March 2020, this data is held by SAS.

636. The SAS receives 999 calls for ambulances from across NHS Scotland and processes and retains relevant data on 999 calls. SG does not hold data on the number of 999 calls made across NHS Scotland in the full week up to 1 March 2020.

637. In early March 2020, SAS was asked to provide SG with both daily and weekly information, which showed the number of attended incidents (both non-Covid-19 and suspected Covid-19). These also showed the number of patients that were conveyed to hospital. This information was provided from 18 March 2020. This does not include the number of 999 calls which will have been handled by the SAS without attending the patient.

638. The SAS attended 1,538 incidents (of which 292 were suspected Covid-19) on 18 March 2020, and 11,199 for the week commencing 23 March 2020, the first full available week's figures since the reporting noted above started. The data that is held and published on the SG website does not provide sufficient information to show whether response times were met.

639. Whilst the SG does not have data on the number of emergency ambulances available during the relevant period, the SG did support the SAS to implement steps to increase availability of ambulances. Since 2010/11, SAS' resource budget has increased by 26.9% in real terms. The Budget takes their overall funding for 2023-24 to £334.2m. This has helped to boost staff numbers by 50% between September 2006 and September 2023, with the workforce standing at 5,543.2 Whole Time Equivalent (WTE) in September 2023.

640. In 2019 the Scottish Ambulance Service commissioned an independent Demand and Capacity review as demand was exceeding capacity, which was impacting response times for patients, causing shift overruns for staff and impacting the ability to rest staff in accordance with agreed procedures. Th review provided detailed analysis and modelling which identified where the greatest demand was and allowed SAS through re-rostering of staffing resource to match to the demand need. It also highlighted the requirement for an additional 458 staff (these were new posts and not filling existing vacancies). In addition, the Demand and Capacity Review assessed the additional demand requirements and the supporting additional fleet. This was modelled as an extra 52 additional A&E response vehicles.

641. In September 2021, SAS faced extraordinary pressures as a result of the pandemic. To assist SAS to cope with such high demand, the Scottish Government, as part of the £1bn NHS Recovery Plan, gave SAS an additional £20m funding. This helped SAS to facilitate, as a short term measure, the assistance over 100 military personnel, who assisted as drivers and support to the mobile testing units across Scotland, as well as allowing SAS to enlist around 100 2nd year paramedic students to assist the Service in ambulance control rooms. In addition, the number of Hospital Ambulance Liaison Officers was raised from 11 to 20.

642. In addition to this, SAS worked with Loganair to temporarily increase their capacity to respond to requests to transport suspected or COVID-19+ patients from remote, rural and island communities in Scotland. This was required as there were significant infection

control measures in place, which made some of the existing fleet of air ambulances unsuitable for such transfers at the time.

643. In 2022 SAS launched their integrated clinical hub. Located within the SAS ambulance control centres in the west, north and east of Scotland, the hub is made up of a multidisciplinary team of clinical advisors, advanced practitioners and GPs. It provides assessments for all patients who are initially triaged as non-immediately life threatening and may benefit from a further virtual consultation and referral to other services in the community, rather than unnecessary trips to A&E. Data shows that since its launch, nearly 50% of patients do not require a transfer to A&E and can be better treated in other ways, such as in the home, in the community or through specialist services.

644. These operational service-derived requirements combined to form the Demand and Capacity Programme which was implemented during the relevant period and supported by £40 million SG funding over the phases of work.

645. The SG also provided, following requests from SAS, an additional £20 million of investment, to facilitate the following measures for the winter period of 2021. The outputs of this investment are detailed below:

- Assistance via a Military Aid to Civil Authority request, initiated in September 2021, which initially drafted in 114 military staff between October 2021 and March 2022. This was primarily made up of those able to drive SAS vehicles
- Additional drivers from Scottish Fire and Rescue Service and Red Cross
- The use of taxis for lower acuity calls
- The recruitment of nine additional Hospital Ambulance Liaison Officers began in September 2021
- Contract extension with Loganair to provide emergency air support, particularly to the rural and island communities, to be able to safely transport patients with Covid-19, considering the significant extra infection control measures.

646. The following table shows headline performance for 2020/21 against response time key performance indicators:

Performance summary: health improvement, efficiency, access to treatment and treatment

Index	Performance Indicator	2020/21	2020/21 Improvement Aim	2021/22
SAS2.1	Critically Unwell Patients Survival Rate	**42.7%**	Aim to be agreed %	**51%***
SAS2.2	Cardiac Arrest Survival Return of Spontaneous Circulation (ROSC) in people experiencing VF/VT arrest	**48.1%**	>46 %	**52.3%**
	Critically Unwell Incident Response Times Median time Purple incidents responded to	**07:11**	≤6:20	**07:24**
SAS2.5	Critically Unwell Incident Response Times Purple incidents responded to within 8 minutes	**57.1%**	67%	**54.7%**
SAS2.6	Critically Unwell Incident Response Times Purple incidents responded to within 15 minutes	**89.1%**	90%	**87.1%**
SAS3.4	High Risk Incident Response Times Median time Red incidents responded to	**08:21**	≤7:30	**08:53**
SAS3.5	High Risk Incident Response Times Red incidents responded to within 18 minutes	**89.9%**	90%	**86.4%**
SAS4.3	Stroke Stroke care bundle compliance	**96.0%**	≥ 95%	**95.5%**
SAS4.5	SAS Amber Incident Response Times Median time Amber incidents responded to	**15:25**	≤15.00	**18:19**
SAS4.6	SAS Amber Incident Response Times Amber Incidents responded to within 30 minutes	**85.5%**	90%	**76.5%**
SAS5.1	Shifting the Balance of Care Emergency patients referred to non-emergency dept. care pathway	**41.0%**	40%	**43.3%**
SAS5.4	SAS Yellow Incident Response Times Median time Yellow incidents responded to	**23:37**	≤22.00	**39:52**
SAS5.5	SAS Yellow Incident Response Times Yellow incidents responded to within 60 minutes	**79.5%**	86.5%	**61.9%**
SAS7.1	Patient Safety Peripheral Vascular Catheter (PVC) bundle compliance	**96.3%**	≥ 95%	**96.6%**

* figure to January 2

Data source: Scottish Ambulance Service

647. Additionally, the following table shows information from 1 October 2020 to 30 September 2021, and 1 October 2021 to 30 September 2022 respectively. The third column shows the aims that SAS set to improve their performance against the KPIs.

Purple 30 Day Survival Rate	47.5%	55.3%	40.0%
Purple Incidents Attended	17,864	21,145	-
Purple Response Time - Median	00:07:31	00:07:20	00:07:05
Purple Response Time - 95th Percentile	00:19:57	00:20:31	00:20:30
Red Incidents Attended	87,874	96,114	-
Red Response Time - Median	00:08:39	00:08:48	00:08:45
Red Response Time - 95th Percentile	00:23:39	00:25:41	00:30:30
Amber Incidents Attended	205,951	211,852	-
Amber Response Time - Median	00:16:31	00:17:55	00:18:30
Amber Response Time - 95th Percentile	00:49:47	01:02:40	01:31:00
Yellow Incidents Attended	203,200	185,800	-
Yellow Response Time - Median	00:27:56	00:38:02	00:36:30
Yellow Response Time - 95th Percentile	03:02:59	04:47:29	04:18:00

648. The response time targets are as follows:

- Purple; High risk of cardiac arrest – patients in cardiac arrest or "peri-arrest" – e.g. ineffective breathing. Median response time target for SAS <06:00 (mm:ss)
- Red; High risk of serious deterioration – e.g., patients affected by major trauma. Median response time target for SAS <07:00 (mm:ss)

- Amber; Patients requiring definitive care – e.g. STEMI (the sort of heart attacks that go to specialist centres for immediate interventions or Stroke). Median response time target for SAS <15:00 (mm:ss)
- Yellow; Patients affected by a range of emergency presentations but with no immediately life-threatening symptoms. This group require a discrimination between those who need ED intervention and those who would be best supported within communities. Median response time target for SAS <20:00 (mm:ss)
- Teal; Patients with an identified range of presentations where remote consultation can provide either a definitive solution or referral or identify the optimal SAS response. There is no target for this category of patients.

NHS 24

649. The 111 service in Scotland is provided by NHS 24. NHS 24 was constituted on 6 April 2001 and under the National Health Service (Scotland) Act 1978 and the NHS 24 (Scotland) Order 2001, NHS 24 is responsible for the delivery of urgent care triage, and advice when GP, pharmacy or dental practices are closed. The Service also offers health and care information via its own digital services, NHS Inform and the NHS 24 online app.

650. The NHS 24 Board, including the Chair, normally consists of non-Executives appointed by Scottish Ministers in line with the Code of Practice for Ministerial Public Appointments in Scotland. The role of the Board is to provide leadership, direction, support, and guidance to ensure the Body delivers and is committed to delivering its functions effectively and efficiently and in accordance with the aims, polices and priorities of the Scottish Ministers. The Chief Executive of NHS 24 is employed and appointed by the Board with the approval of Scottish Ministers. They are the Board's principal adviser on the discharge of its functions and are accountable to the Board. Their role is to provide operational leadership to NHS 24 and ensure that the Board's aims and objectives are met through effective and properly controlled executive action. Their general responsibilities include the performance management and staffing of NHS 24.

651. As of 31 March 2020, NHS 24 had a total of 1,154.0 WTE (1,676 headcount) staff in post. This is the total staff in post within NHS 24 which includes call handlers, healthcare advisors, management staff and general services staff. Further details on the number of call assessors and healthcare advisors available on 1 March 2020 may be held by NHS 24.

652. Effective strategic engagement between the SG and NHS 24 is essential to work together as effectively as possible to maintain and improve public services and deliver improved outcomes. SG works closely with the NHS 24 Chief Executive and is answerable to the Portfolio Accountable Officer for maintaining and developing positive relationships with NHS 24 characterised by openness, trust, respect, and mutual support. The Portfolio Accountable Officer is also responsible for assessing the performance of the NHS 24 Chair at least annually.

653. Scottish Ministers are accountable to the Scottish Parliament for the activities of NHS 24 and its use of resources. They are not, however, responsible for the day-to-day operational matters (and founding legislation prevents them from directing NHS 24 in relation to specific statutory functions).

654. The SG does not hold data on the number of 111 calls made in the full week up to 1 March 2020. However, regular performance review data held by the SG shows that in the first 11 months of 2019/20 (excluding March 2020 Covid-related activity), NHS 24 recorded a call demand of 1,426,611 calls to 111. The table below details performance against key operating plan targets and services pre-Covid to end of 2019/20. For the avoidance of any doubt, the performance framework figures above are based on pre-Covid-19 activity and therefore exclude March 2020 performance.

NHS 24 Performance			
Framework	**Improvement activity/KPI**	**Target %**	**2019/20 pre-Covid-19 (%)**
Patient Experience	90% of service users surveyed recorded overall satisfaction with the service.	90%	90.8%
Level of complaints	90% of complaints are responded to within 20 working days	90%	94.4%
P1 calls responded to within 60 minutes	98% of P1 calls responded to in 60 minutes	98%	99.7%
P2 calls responded to within 120 minutes	90% of P2 calls responded to in 120 minutes	90%	99.9%
P3 calls responded to within 180 minutes	80% of P3 calls responded to in 180 minutes	80%	91.2%
Care delivered at first point of contact	70% of calls will result in direct access to the service at first point of contact, increasing to 75% by Q4	70%	74.8%
NHS inform calls	80% of NHS inform calls answered within 60 seconds	80%	93.2%
Provision of self-care advice	Provide at least 30% of patients with self-care advice	30%	30.7%
Employee engagement index	Demonstrate improvement in iMatter engagement score (77 in 2018)	>77%	77%
Category C calls transferred from SAS	Convert at least 75% of Category C calls transferred from SAS to primary care or home care outcomes.	75%	69.8%

Breathing Space	80% of Breathing Space Calls to be answered in 30 seconds.	80%	72.7%
Access Service Level	The proposal is to deliver 50% of calls answered within 30 seconds	50%	46.2%
Staff Attendance Rates	Achieve and maintain an average attendance rate of 94.75%	94.75%	90.6%
Average Time to Answer	Target is to answer calls within an average of 1 minute 30 seconds	1m 30s	3m 19s
Calls abandoned after threshold	Expressed as percentage of calls abandoned after threshold. Maintain the current measure of <5% after 30 seconds for the '111' service.	5%	9.2%

655. NHS 24's performance against their performance framework is routinely published via their Board and Account papers on the NHS 24 website.

656. NHS 24 expanded workforce and estate and complete system collaboration during the reporting period. This was in response to increased demand on NHS 24 services and the Redesign of Urgent Care (RUC). The service was required to accommodate a 40% increase in workforce at the same time as managing a 44% reduction in seating capacity.

657. As a result of increased demand and changes to service delivery, the SG increased NHS 24's funding by over £20 million for 2021/2022 to support the additional capacity and estate expansion. In August 2020, the CSH approved the proposal for NHS 24 to expand both their estate and their workforce. In delivering this, over 500 people were recruited in 2020/21 and two new sites in Glasgow and Dundee were opened.

658. In March 2020, the SG worked with NHS 24 to enhance the NHS 24 mental health hub and ensure this was available 24/7. Advice for the initial expansion in response to Covid issued to Ministers on 26 March 2020, with approval received the same day. Advice to increase capacity further through the Recovery and Renewal fund was issued on 22 June 2021, with approval received on 6 September 2021.

659. In 2020–21 an additional £2.6 million was issued to support the development and implementation of the Mental Health Hub in response to the Covid-19 Pandemic. The Mental Health Hub expanded to a 24/7 service in July 2020. In 2021/22, through the £120 million Recovery and Renewal Fund, NHS 24 were provided with additional funding of 4.9 million in 2021–22 to support the NHS 24 Mental Health Hub to provide a 24/7 service through their 111 service for anyone experiencing distress or seeking mental health and wellbeing support.

660. Demand for the NHS 24 Mental Health Hub has remained consistently high. Since NHS 24's Mental Health Hub started providing 24/7 support in July 2020, they responded to over 180,000 calls between March 2020 and June 2022, and they continue to receive approximately 2,500 calls a week. The performance of NHS 24's Mental Health Hub performance improved because of this additional investment. Average call waiting times peaked in February 2021 at 21 minutes and reduced to an average waiting time of 9 minutes in June 2022.

661. In December 2020, the Redesign of Urgent Care (RUC) Programme and the Flow Navigation Centre (FNC) model was implemented across Scotland in response to Covid-19, after NHS Ayrshire and Arran had tested out the key components of the RUC by acting as a pathfinder site to inform the national rollout. This approach had been approved by the Cabinet Secretary on 16 October 2020. To monitor the changes to urgent care on patient and staff care and to assess the impact on all parts of the system, a stringent monitoring and evaluation process was put in place including an evaluation group chaired by Sir Lewis Ritchie. Boards submitted regular readiness assessments to mitigate any potential risks and assess preparedness for December implementation.

662. The CSH confirmed the decision for national implementation on 1 December, which saw NHS 24 shift from being an out-of-hours service to a 24/7 service. This followed regular submission of Board readiness assessments, which for week ending 23 November 2020 included a formal sign-off from each Board Chief Executive and Unscheduled Care Lead to confirm the Board was ready to implement the requirements for a FNC on 1 December 2020.

663. The SG allocated £350,000 in 2019–2020 and a further £3,062,000 in 2021–2022 to strengthen capacity at NHS 24 and establish FNCs to offer rapid access to virtual clinical assessments or arrange scheduled appointments in person.

664. The NHS Recovery Plan update published on 4 October 2022 reflected NHS 24 data that showed that 10.1% of patients in July were referred to the FNC in their local Health Board, reducing attendances at A&E. The overall aim of the programme was to reduce self-presenting attendances at A&E by 15% to 20% and ensure faster access for those who did need to attend. Further detail on this was provided in paragraph 619.

665. The SG also worked with NHS 24 to look at how improvements could be made to call answering times for patients accessing 111. Engagement with NHS 24 and colleagues within SG looking at workforce modelling, staff absence management, potential system improvements and a peer review with the Welsh 111 Service.

666. As of June 2022, NHS 24 had a total of 1,381.2 WTE in post, an increase of 20% since March 2020. This represents the total staff in post within NHS 24 which includes, call handlers, healthcare advisors, management staff and general services staff.

667. During the relevant period, NHS 24 developed and established a range of Covid-19 specific channels and assets across the service as the forefront of digital access to self-

help advice, including Test and Protect and the National Covid-19 Helpline, and the establishment of Covid-19 hubs and community assessment centres in primary care to minimise referrals to hospitals.

668. NHS 24 also saw a significant increase in demand across NHS 24 services in 2020–21 with over 1.6 million calls made to the 111 service and over 77 million page views on NHS Inform. Increased call volumes can be attributed in part to Covid-19; however, the launch of the RUC in December 2020 also led to an expansion in NHS 24's services which in turn resulted in increased call volumes. Call demand continued to increase throughout 2021–22 with just over 2 million calls made to the service (2,060,976). The months from April through to November 2021 were extremely busy and, in fact, each month received its highest ever volume of calls in 20 years of service history.

669. NHS 24 also enhanced the provision of information and advice for a range of Covid-19 issues through new pathways, including testing and vaccinations and delivered a consistent access route for those with symptoms of Covid-19 through 111. There were 414,075 calls to the helpline during 2020–21.

670. In March 2020, a Covid Community Pathway proposal was developed by SG to provide local dedicated and consistent medical advice, triage, and treatment for people with coronavirus symptoms. The paper and pathway were further developed with the SG clinical cell which was a group set up to discuss and provide rapid advice, with representation of professionals both internal and external to government, including academics.

671. A letter was issued to all Health Boards on 13 March from the Chief Performance Officer, NHS Scotland and Director of Delivery and Resilience, instructing Boards to implement the pathway on 23 March 2020, provided above [CL8/175 - INQ000470117] The SG worked with NHS 24 to plan and set up a national Covid phone line as part of the community pathway.

672. Pre-pandemic, NHS 24's key performance indicators placed significant focus on the timeliness of response, both in answering the initial call and the subsequent call back where clinician input is required and is initially unavailable. NHS 24 accept the importance of answering calls as quickly as possible; however, the indicators do not always meaningfully measure either the effectiveness or appropriateness of the NHS 24 response or indeed the experience of callers, nor do they offer any insight into how effectively NHS 24 supports complete system integration and patient pathways.

673. At the NHS 24 Ministerial Annual Review of 2015–2016, NHS 24 was asked to bring forward proposals for a more fit-for-purpose performance framework and associated targets and the Service has worked since that time with the SG sponsor team to develop an enhanced performance framework to deliver against that request.

674. As a result of the Covid-19 pandemic, there was a requirement for NHS 24 to completely transform their service delivery model to cope with the additional pressures and asks which were placed on the service. The service has expanded from what was largely an out-of-hours service to 24/7 access to urgent care, dental advice, a dedicated Mental Health Hub and a national Covid pathway. In addition to this, the service also now plays a key role in the re-design of unscheduled care, with patients asked to use NHS 24 as the first point of contact if they feel they need to access A&E but their condition is not an immediate emergency. This has resulted in a significant increase in demand which has required a significant investment in estates, workforce and infrastructure.

675. In 2021, it was agreed with NHS 24 to change their KPI framework to support the organisation get to a stable position. The new framework is better suited to effectively measure patients' quality of care experience and is aligned to what patients have told NHS 24 they expect from the service. It will also assist NHS 24 in making improvements to the services they deliver wherever possible, which in turn will result in improved population health and equity for patients and will allow NHS 24 to build on their role as an essential part of the wider healthcare system. Performance against NHS 24's interim KPI framework is set out below:

NHS 24 Performance against interim KPI framework				
Framework	**Improvement activity/KPI**	**Target %**	**April 20/ March 21**	**April 21/March 22**
Patient Experience	90% of service users surveyed recorded overall satisfaction with the service.	90%	91.4%	85.6%
Complaints	90% of complaints are responded to within 20 working days	95%	96.2%	91.3%
Care Delivered at First Point of contact	90% of calls will result in direct access to the service at first point of contact	90%	91%	95.0%
% Calls Answered within Threshold	50% of calls responded to in under 5 minutes	50%	38.4%	25.9%
% Calls abandoned after Threshold	Expressed as percentage of calls abandoned after threshold. Maintain the current measure of <10% after 5 minutes for the '111' service.	10%	13.7%	15.1%
Median Time to Answer (mm:ss)	Median is the midpoint of time taken to answer calls. Target is to answer calls within 5 minutes	05:00	02:06	13:13

90th Percentile Time to Answer (mm:ss)	This measure focuses on the longer waits for patients to access service, with the longest 10% of times to answer not exceeding 30 minutes	30:00	30:43	48:41
NHS 24 Patient Journey	Measure focuses on a patients journey through the service – Target 30 minutes	30:00	29:48	33:59
NHS Inform – core service	These below measures relate to activity related to NHS 24's Digital Services through inform website and reports the number of unique page views across the NHS inform site	n/a	57,995,262	95,135,474
COVID Content		n/a	14,544,595	27,131,839
NHS Inform – Covid vaccinations Microsite		n/a	5,089,714	37,022,796
Staff Attendance Rates	Achieve and maintain an average attendance rate of 96%	96%	92.8%	91.6%

NHS Inform – core service	These below measures relate to activity related to NHS 24's Digital Services through inform website and reports the number of unique page views across the NHS inform site	n/a	57,995,262	95,135,474
COVID Content		n/a	14,544,595	27,131,839
NHS Inform – Covid vaccinations Microsite		n/a	5,089,714	37,022,796
Staff Attendance Rates	Achieve and maintain an average attendance rate of 96%	96%	92.8%	91.6%

676. The Chief Executive of NHS 24 and Executive Team of NHS regularly updated the SG through regular engagement including daily and weekly reporting against their KPIs. Pressures were escalated accordingly. During the relevant period, NHS 24 advised that rapid and unpredictable fluctuation in Covid-19 demand was at times challenging for the service and impacted on their performance. NHS 24 also flagged challenging staff absence levels within the Service, particularly at weekends when call demand was higher, resulting in increased call waiting times. The SG worked with NHS 24 to monitor performance and staff absence levels as Covid-19 special leave exacerbated an already challenging sickness absence baseline for NHS 24 which in turn had a significant impact on NHS 24's performance.

677. All annual NHS 24 reports against their performance framework are routinely published via their Board and Account papers on the NHS 24 website.

Discharge of patients

678. In the early stages of the pandemic, understanding of the Covid-19 virus and the associated population health risks was developing rapidly. The European health systems, particularly in Italy, were already feeling the impact of large numbers of Covid-19 cases as healthcare systems started to become overwhelmed. The international advice at the time indicated that in-hospital capacity was clearly going to be crucial in any country's response, and moving fit-for-discharge patients out of areas that would inevitably be receiving Covid-19 patients was crucial for patient safety and for capacity.

679. As a general principle, it is accepted across the health and social care sector that delays to the transfer of people assessed clinically as fit for discharge into the community, including transfers to care homes, are not in the best interests of those people and may also have an effect on a hospital's capacity to treat other patients. Reducing the rates of delayed transfers from hospitals to the community for patients assessed as clinically fit for discharge has therefore been a priority across health and social care over many years, including the period in the run up to and during the pandemic.

680. Early on in the pandemic, it was recognised that people who had already been assessed as ready for discharge should, for their own wellbeing and to maximise hospital capacity for people who were likely to require inpatient care because of

Covid-19 infection, be discharged safely and quickly. On 6 March 2020, then DG Health and Social Care, Malcolm Wright, wrote to stakeholders across the health and social care sector to set new targets for transferring patients from hospitals into the community, including care homes, provided: [CL8/176 - INQ000470123]. The target was to reduce the overall Scottish delayed discharge position by 400 (from 1650 to 1250) by 9 April. Another letter was also issued on 27 March 2020 seeking a further reduction in delays, provided: [CL8/177 - INQ000470124]. This letter noted that the first target had been achieved (delayed discharges had been reduced by more than 400). The new target was to reduce overall Scottish delayed discharge position by a further 500 by the end of April. Both letters applied specifically to patients who had been clinically assessed as ready for discharge. The key reasons for issuing these targets were to ensure vulnerable patients who had been clinically assessed as ready for discharge were not put at risk of acquiring Covid-19 in hospital, as well as to free up capacity to treat new admissions.

681. Social care partners – in local government and in the third and independent sectors represented primarily by organisations like the CCPS and Scottish Care – agreed that it was important that people who were ready for discharge should not be delayed in hospital, and that hospital capacity should be maximised to support people who were seriously unwell with Covid-19. However, it became clear through wider engagement with the sector that SG would need to provide additional support across a range of issues to support the sector in its management of the effects of Covid-19.

682. From 12 March 2020, the SG held teleconferences with IJB Chief Officers across Scotland to discuss issues relating to the impact of Covid-19 on the sector, including issues relating to hospital discharge and care home admissions.

683. On 13 March 2020, the SG provided detailed *Clinical Guidance for Nursing Home and Residential Care Residents and COVID-19* (hereafter referred to as the SG Clinical Guidance) directly to IJB Chief Officers, Local Authority Chief Executives, IJB Chief Social Work Officers, Scottish Care, Coalition of Care and Support Providers in Scotland, Care Inspectorate and Scottish Social Services Council, provided: [CL8/178 - INQ000147440]. This reflected IPC advice published by HPS the previous day, provided: [CL8/179 - INQ000189302].

684. The SG Clinical Guidance was aimed at providing both advice and reassurance to the sector and was subsequently updated on 26 March 2020 and 15 May 2020 to reflect both updated HPS advice on IPC and also wider developments in understanding the nature of the virus and its likely impact on care homes and the wider social care sector.

685. Each individual decision about whether, and when, a patient was ready for discharge was a clinical one, made by the clinician in charge of that patient's treatment, typically once the patient has met particular clinical criteria agreed in advance by their consultant. This remained the case throughout the pandemic. Where someone was most appropriately cared for after discharge was (and is) based on a multi-disciplinary assessment involving the individual and their family carers. In cases where a patient lacks capacity, an appointed guardian or carer with power of attorney will be involved. If somebody is discharged to a care home, it is because that has been assessed as the best place to meet their needs.

686. The guidance issued on 13 March stated that prior to people being admitted to a care home whether from hospital or the community, clinical screening of patients should be undertaken alongside a risk assessment to ensure sufficient resources including appropriate isolation facilities were available within the care home to support social distancing and isolation. At this time, there was not sufficient testing capacity to test asymptomatic patients prior to discharge from hospital. The guidance recommended all admissions be isolated for 7 days and, if known to have contact with Covid-19 patients, for 14 days. Both clinical decisions around discharge and risk assessments were undertaken locally by health and social care professionals and paid particular attention to the needs and rights of the patients. There was no involvement of Scottish Ministers in individual decisions in relation to the discharge of people from hospital.

687. Guidance to aid clinical decision-making in Scotland was developed through the Clinical Guidance Cell. The Cell began as a group of Infectious Diseases physicians discussing how to deal with cases of Covid-19. The main purpose of the Cell was to produce guidance rapidly to support clinical decision making throughout the pandemic about the management of Covid-19. Membership was drawn from key organisations and professional communities across Scotland and included representation from the Academy of Medical Royal Colleges and Faculties in Scotland. This group of senior clinicians worked to produce guidance rapidly to

support clinical decision-making on the management of Covid-19. SG facilitated this group by providing secretariat support, and the DCMO and Deputy National Clinical Director attended. On the subject of hospital discharges, group members shared their own Health Board's checklists setting out discharge criteria as examples for their peers and to support what the Cell described as a "person-centred […] individualised approach" based on "good discharge planning", provided: [CL8/180 - INQ000468153].

688. On 21 April 2020, in a statement to Parliament, CSH announced that all admissions to care homes from hospital should have a negative test for Covid-19 prior to admission to the home, regardless of symptoms unless it was in the clinical interests of the patient to be moved, and then only after a full risk assessment. Where a patient tested positive for Covid-19, two negative tests were required prior to their discharge from hospital. This policy was reflected in both SG and HPS guidance for care homes. Two specific sets of HPS guidance were updated: (i) Version 1.1 of '*Guidance for stepdown of infection control precautions and* discharging *COVID-19 patients from hospital to residential settings',* provided: [CL8/181 - INQ000189405] on 22 April 2020; and (ii) Version 1.1 of '*COVID-19: Information and Guidance for Care Home Settings',* provided: [CL8/182 - INQ000189332], on 28 April.

689. Around the same time, on 24 April 2020 three information leaflets on being discharged from hospital with possible or suspected Covid-19 for adult patients, pregnant patients and, in the case of children, the parents or caregivers of younger patients were issued. These outlined what signs of developing illness should be monitored and how to seek further assistance if symptoms got worse.

690. As the national response to the pandemic changed in response to emerging findings and scientific advice, it became clear that the safeguarding measures introduced to protect care home residents, including recently transferred patients, were not as effective as anticipated, and rates of infection and fatalities continued to rise. In the early stages of the pandemic, test and protect measures were not established across the UK, as noted in the Module 2A corporate statement provided by DG Health and Social Care, science at that stage also advised that only symptomatic patients could transmit the virus, all of which contributed to the increased infections.

691. In response to increased infections, the SG Clinical Guidance was updated on 15 May 2020 to recommend tighter measures and limits on the numbers and types of direct contact between patients, visitors and staff, provided: [CL8/183 - INQ000383486].

692. The Covid-19 pandemic had significant and wide-ranging impacts across the health and social care system, significantly affecting the flow of patients throughout the acute sector, including the ability to discharge patients from hospital. There were various reasons for this, including limited capacity due to redesigned pathways for Covid-19; suspended pathways such as surgical assessment units; ambulatory care to accommodate Covid footprint; allowing only one patient per cubicle; limited assessment capacity; high volume of staff absent from work owing to shielding and other Covid related issues, as well as shortages of home care staff owing to recruitment and retention difficulties, along with increased staff absences.

693. Through the Unscheduled Care team, who engaged with Boards regularly through meetings and funding letters requesting descriptions of priorities, NHS Boards were encouraged to implement the following actions to support improvements including:

- Adherence to the six essential actions (6EA) to optimise flow through the hospital without delay;
- Focus on optimising safe and effective patient flow and improving capacity by ensuring the right care is provided in the right place at the right time;
- Discharge rather than admission to ensure patient safety;
- Implementation of the RUC which aims to ensure the public access the right care in the right place at the right time;
- Ensure all patients remain safe to prevent nosocomial spread – this means no "corridor care".

694. As an example, funding letters were issued to Health Boards on 27 October 2020 detailing the steps they should take in using the additional funding to implement the Redesign of Urgent Care and to build on the foundations of the six essential actions, namely reducing the need for attendance to acute services wherever possible, building capacity across the whole system, optimising early discharges at every opportunity, avoiding admission supported by a focus on optimising same-day emergency care and ambulatory care to provide rapid acute assessment, improving

pathways of care for high volume and complex pathways, improving technology and continuing to roll out the Mental Health hubs.

Temporary hospitals

695. The agreement to build the new healthcare facility followed similar plans in NHS England and Wales and aligned to a key Ministerial priority in force at the time to ensure sufficient bed capacity to manage an increase in patients associated with the pandemic. To meet the deficit in bed availability, SG explored options of additional capacity across private hospitals, predominantly for surgical care, and within private hotels, predominantly to provide care for delayed discharge patients and those who may require step-down care or rehabilitation. On balance and for a variety of reasons, including ease of staffing and difficulty in retrofitting hotels with medical gases and other services, whilst these facilities may have been helpful for overflow, it was considered that they would not provide an effective whole system response to the expected rapid increase in cases.

696. With the establishment of the Excel unit in London, there was agreement to explore an analogous option for NHS Scotland, in collaboration with on-site military colleagues. The military assessed the Scottish Exhibition Centre (SEC) as a suitable location for the build of a medical treatment facility, as the site offered accessibility, close proximity to hospitals in the West of Scotland, security, established infrastructure and transport links. The decision to create one temporary hospital, the NHS Louisa Jordan, situated at the SEC in Glasgow was therefore taken as a contingency to ensure adequate hospital provision for Covid-19 patients if NHS Scotland's existing estate was fully utilised.

697. 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. Officials explored what the facility in London would provide and looked at how this could be translated to a Scottish setting. It became clear that the Excel Unit was not a traditional field hospital, and the concept of a field hospital would not be appropriate for the envisaged pathways of care in the Covid-19 context. A field hospital provides rapid flow and throughput of patients with a low-bed base and a limited length of stay (< 2 days). Moreover, while it was understood that the Excel Unit focused on enhancing ITU capacity for NHS London,

it was judged that what was required in Scotland was a medical treatment facility for non-critical care patients (so with limited ITU capacity) with typical length of stay up to eight days.

698. 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 in the form of a submissions provided to the First Minister on 28 March 2020, on which basis agreement to proceed with commissioning was reached, provided: [CL8/184 - INQ000261872]. After the decision had been made by Ministers to progress with the hospital and commit the funding set out in the submission, a request was received from the NSS Chief Executive for written confirmation that the funding should go ahead. This enabled him to sign the necessary contracts with the companies who were due to commence the fit-out on the Tuesday morning.

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

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

700. In relation to staffing the temporary hospital, Heath Workforce were aware from the national staffing picture and from the data available from the TURAS portal that there would have been difficulties with fully staffing a large field hospital like the Louisa Jordan alongside the existing estate. The facility was never fully utilised, so no conclusive data on providing a full staff complement is available. Staff were deployed from West of Scotland Health Boards initially and from other Health Boards across Scotland as required. The Louisa Jordan was not an employing authority, so staff flowed from and through the NHS Boards where the employment contract was held. The Louisa Jordan also had access to staffing via the Accelerated Recruitment Portal commissioned by the CSH and operated by NHS

Education for Scotland. Staff recruited through the portal nationally included returning retirees and students. Health Workforce supported calls for clinically trained staff (not working in clinical roles) to be released to the Louisa Jordan.

701. As noted above, there were concerns about the potential difficulty in fully staffing a large field hospital like the Louisa Jordan alongside the existing estate. For example, at any given point there are only a finite number of appropriately trained and registered clinicians living and/or working in Scotland; as such workforce supply is limited in absolute terms. The two biggest determinants of workforce requirements for any clinical service are 1) total demand for the service, and 2) the design of the service being provided, which includes many factors such as days and hours of operation, planned activity, and team/rota composition.

702. Operational workforce planning for service delivery is a matter that is devolved to Health Boards, and in the case of the Louisa Jordan, would have been a matter for the Louisa Jordan Board, which made use of the expertise of officers from other NHS Scotland Health Boards.

703. As noted, the Louisa Jordan hospital was never fully utilised as a step-down care facility for Covid-19 so there is no conclusive data on what a full staff complement would have looked like. The hospital had an initial capacity of 300 beds, with physical capacity to increase up to 1,000 patients; including a high-dependency area with up to 90 beds. As has been indicated, it is assumed (on the basis of available national workforce data) that there would have been challenges with securing a sufficient number of registered clinicians (such as, but not limited to, nurses and medical practitioners) to support the hospital operating as a step-down facility at maximum expanded capacity of 1,000 beds.

704. However, it is important to note that it was always intended that any expansion of the facility beyond the initial 300-bed capacity would be taken on a phased basis, with the availability of workforce being a key consideration in any phased expansion of capacity. The national Accelerated Recruitment Portal was put in place to maximise the availability of qualified personnel to all Health Boards across Scotland, including the Louisa Jordan (which did not operate as an independent legal entity and therefore relied on the supply of staff from other Health Boards). The portal also facilitated the deployment of healthcare students on pre-registration programmes on paid placement. The redeployment of students on paid placement

could and would have been considered had significant expansion of the hospital been required to supplement the total complement of available staffing.

705. Additionally, there would have been other mitigation measures that the Louisa Jordan board and/or SG could have considered, including guidance on the dilution of staffing ratios, and the use of non-clinical staff to provide supervised care (such as feeding and washing activities) to maximise the availability of registered clinicians' time to deliver treatment within the Louisa Jordan facility. As a measure of last resort, a request for Military Aid to Civilian Authorities could have been made to support staffing needs within the facility.

706. Following the opening of the Louisa Jordan Hospital, it was used initially to support the delivery of outpatient orthopaedic and plastic surgery consultations, with some 315 patients having been seen by 27 July 2020. Subsequently the Louisa Jordan expanded its activity, seeing some 18,000 patients across 14 specialties, by 07 January 2021. The hospital then became a mass vaccination facility. For the Covid-19 stand-up phase of the work there were 36 staff working at NHS Louisa Jordan, although in the very early days when the facility was being developed there were many more people who were volunteers from other Boards and volunteers from the cohort of people who had retired from NHS Scotland with specific knowledge and expertise required for the development of the facility. For the elective and mass vaccination facility there were 22 staff working at NHS Louisa Jordan. As noted above, all of these staff were employed by other NHS Scotland Boards.

707. In advance of its use as a Covid vaccination centre, the Louisa Jordan also received Health Workforce Directorate support as part of the national programme to recruit the vaccination workforce.

708. A press release on 1 April 2020 by the CSH confirmed that the temporary facility would be named the NHS Louisa Jordan. The hospital was operationally ready from 19 April 2020, and officially opened on 30 April 2020, provided: [CL8/185 - INQ000470113] [CL8/186 - INQ000470114].

709. Following the agreement to proceed and media announcements, regular updates were provided on capital and associated revenue costs for the NHS Louisa Jordan to both the Cabinet Secretary for Finance and the CSH. The costs of commissioning / build were incurred through NSS contracts and using existing

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

710. On 18 March 2021 it was announced that the NHS Louisa Jordan would close on 31 March 2021, with ongoing activity pertaining to mass vaccination clinics relocated to the nearby SSE Hydro. The decision to close the facility recognised the work undertaken by the 14 NHS Territorial Boards to remobilise following the initial disruption caused by the pandemic, as well as the need to release capacity within SEC to operate as a working events and conference centre. This was important given SEC's expected role during COP26 which ran from 31 October to 13 November 2021. A briefing was provided to the Cabinet Secretary outlining the basis for decision: [CL8/187 - INQ000469991].

711. The NHS Louisa Jordan provided a number of services to support NHS Scotland, including outpatient services across 14 specialties and from three Health Boards: NHS Lanarkshire, NHS Greater Glasgow and Clyde and NHS Ayrshire and Arran. These services included orthopaedics, diagnostic imaging such as CT scanning and general x-ray, dermatology, oral medicine, plastics, rheumatology, breast clinics and occupational health services. In addition, the National Skills Education Hub established at the NHS Louisa Jordan accommodated training for approximately 4,000 individuals from NHS Boards, the Royal Colleges, universities and colleges, all of whom used the healthcare facilities and simulation opportunities onsite.

712. As NHS boards looked to re-establish non-Covid services in their home location, workforce availability for NHS Louisa Jordan became a significant concern. Health Boards were planning remobilisation, delivery of services over winter, wash-up of flu immunisation as well as planning population-wide Covid-19 vaccination. There was also a risk in an increase of staff lost to self-isolation owing to the roll out of HCW testing. NHS Louisa Jordan saw a number of cancellations of potential elective work as a result of staff needing to support services at host board.

713. This cost, married with a reduced patient number, called into question whether the Louisa Jordan would be necessary for delivery of NHS Scotland services and was offering value for money.

714. Under the initial licence, NHS Louisa Jordan was due to close operationally on 31 January 2021 with decommissioning up to 30 April 2021.

715. Agreement was reached to extend the licence to allow ongoing review of the need for the hospital for Covid stand-up, should it be required, and for the operation of the hospital to 31 March 2021 (which was when it closed), with decommissioning starting on 1 April 2021.

Private healthcare sector

716. On 20 March 2020 there was a decision to utilise private hospital capacity for the treatment of urgent elective procedures and urgent cancer cases as hospital capacity was limited and overrun with Covid-19 admissions. This decision to utilise the private sector during Covid was based on the clinical need to have a standalone facility to deliver healthcare to the most urgent patients, predominantly cancer patients. The virus necessitated the reduction and cessation nationally of non-urgent elective procedures to provide appropriate capacity to treat Covid-19 patients within the NHS. The utilisation of this resource enabled urgent surgical cancer procedures to continue during the pandemic in an environment not directly involved in the treatment of Covid-19. Owing to the pressures in the system, there was otherwise clearly a risk that urgent cancer patients would not be able to be treated in these facilities.

717. This decision was also based on the fact it would be beneficial to have a collaborative arrangement between the NHS and the independent sector to ensure capacity was utilised in an optimal way.

718. The National Clinical Director wrote to the independent sector on 1 June 2020 detailing that the implementation of these changes was undertaken on a phased timeline with cancer treatment being made available as soon as possible to support the reconfiguration ongoing in NHS Health Boards, provided: [CL8/188 - INQ000315558]. Each hospital had their own contract. The total value of the contracts was circa £13 million per quarter. These were signed off by the then CSH, Jeane Freeman.

719. On 18 June 2020 a request for funding was made, seeking an extension of agreement to enable NHS Scotland to continue utilisation of the private sector

hospitals in Scotland from 30 July to the end of September 2020. This request for this extension, which applies to the use of private sector capacity for diagnostics and particularly for cancer patients, is provided: [CL8/189 - INQ000468181].

720. During the first wave of the Covid-19 pandemic, NHS staff treated NHS patients undergoing urgent elective procedures, including urgent cancer cases, within four private hospital facilities which were procured for an initial period of three months (until the end of June 2020), although this was subsequently extended to 30 September 2020. Owing to increased winter and Covid-19 pressures, capacity within private hospitals has continued to be used in a more limited way since 18 January 2021. The timeline for use of private hospital capacity is set out below:

- On 9 December 2020 a funding letter was sent to the Chief Executive of NHS National Services Scotland to confirm an allocation of £10,391,701 would be made to NHS NSS to cover the costs of the use of independent healthcare providers' facilities during quarter two of 2020/21 (June to September 2020).

- On 20 December 2020 the Programme Director for Scheduled Care Performance and Delivery informed the National Clinical Director that he would be seeking to get an update on the capability of Boards (who previously utilised the private hospitals), to urge independent providers to cease all elective work and provide available capacity for urgent NHS patients. Additionally, he would follow up with the private sector to clearly establish their view and position. At this point he was unsure how willing private hospitals would be to provide this service.

- In early January 2021 Health Cabinet Secretary for Health and Sport (Jeane Freeman) confirmed that to support NHS Boards and to ensure that urgent elective and cancer patients continue to receive treatment, and following the arrangements set out in the NHS Winter Preparedness Plan 2020-21, stated that we had secured further capacity from the private healthcare sector in Scotland. Our strategy for using the private sector was to ensure that there was additional capacity for those patients who required vital planned care. The private sector hospitals provided support for breast surgery, urology, and gynaecology up to March 2021. This support came on top of the additional

capacity already provided by NHS Golden Jubilee and NHS Louisa Jordan for several elective treatments and outpatient appointments.

- For context, on 31 March 2020 an update had been provided to the Cabinet Secretary for Health and Sport stating that, 'Across Scotland, there are 5 private hospitals, with differing capabilities, offering varying services, and providing a total of 213 beds, 16 theatres, and with a nursing headcount of just over 300'. At that point, the outpatient facility at BMI Carrick Glen, in Ayr, formerly a hospital, was also in the process of being converted back to a 26 bed delayed discharge facility, thus providing a total of 239 beds across Scotland).

- On 23 March 2020, urgent surgical procedures for cancer patients commenced in the Nuffield Private Hospital in Glasgow. During that week, 20 breast cancer patients were treated. Two further hospitals were mobilized: BMI Albyn Hospital in Grampian and BMI Kings Park Hospital in Stirling to treat cancer patients. By 6 April, Spire Murrayfield in Edinburgh was treating urgent cancer patients. The NHS then made use of the theatres and other facilities for immunocompromised patients.

- In the week commencing 13 April, four private hospitals (BMI Albyn, BMI Kings Park, Nuffield Glasgow and Spire Murrayfield) began treating a variety of urgent cancers (Breast, Urology, Skin, Gynae, and Colorectal), supporting nine NHS Health Boards and equating to over 200 patients a week.

- Utilisation of BMI Albyn, BMI Kings Park, Nuffield Glasgow and Spire Murrayfield continued until the end of July, at which point it was recommended that that SG extended the existing three-month arrangement with these private hospitals for an additional three months, at a cost of £13m, and consideration was given to utilising Ross Hall, a private hospital in Glasgow. An extension of the arrangement was duly carried out. At this point, NHS hospitals were gradually resuming their elective activity. Officials then worked with NHS Boards to ensure in-house capacity was ringfenced for urgent and vital cancer treatments. This was done through local and regional mutual aid between Health Boards and national facilities such as the NHS Golden Jubilee. SG continued to work with all local Health Boards to support a gradual increase in activity, including through the National Treatment Centres (NTCs).

- From January 2021, two additional private hospitals were used for surgical day cases (i.e. planned surgical procedures where patients could return home the same day): BMI Ross Hall and BMI Carrick Glen.

721. As a result of the differences in bed base, theatres, service provision, staff, and the location of these private hospitals, the potential to maximise them, was determined by key local factors, including:

- the availability of local NHS surgeons and anaesthetists to form part of a surgical rota to take full advantage of theatre capacity. (Very few clinical staff are actually employed by private hospitals, with the vast majority holding NHS contracts);
- the degree to which the local need and demand for an urgent surgical specialty is greater than the established provision within a Board (i.e. does a Board have sufficient internal capacity to treat all their urgent surgical patients).

Local negotiations with private hospitals took place to ensure that available NHS surgical workforce was aligned to specific demand. To date, the most urgent surgical procedures required are related to cancer, as demonstrated in the activity undertaken or scheduled.

722. There have been long-standing arrangements for NHS Scotland to utilise private sector capacity to treat NHS patients through insourcing and outsourcing. This has been done in a structured and prioritised manner to provide capacity to manage to local health services where there are gaps in services or to ensure treatment is provided to avoid delays.

723. From the quarter ending 31 March 2019 to the quarter ending 31 March 2020 there were a total of 8,674 inpatient / day case spells for all specialities provided by non-NHS providers for NHS patients. From the 31 March 2019 to 31 March 2020 there were a total of 5,917 outpatient appointments for all specialties in non-NHS provider facilities.

724. The Treatment Time Guarantee (TTG) remained in place for inpatient/day case patients throughout the pandemic. This means that under the Patient Rights (Scotland) Act 2011, there is a 12 week legal guarantee for inpatient and day case

treatment. After a diagnosis is made and treatment is agreed, each Health Board must ensure that patients receive inpatient and day case treatment within 12 weeks.

Number of inpatient/day case spells for all specialities in non- NHS provider facilities between quarter ending March 2019 and quarter ending June 2022

Quarter Ending	Number of inpatient/day case spells
31/03/2019	2,140
30/06/2019	1,767
30/09/2019	2,098
31/12/2019	1,301
31/03/2020	1,368
30/06/2020	1,584
30/09/2020	1,621
31/12/2020	629
31/03/2021	1,774
30/06/2021	1,027
30/09/2021	922
31/12/2021	902
31/03/2022	1,196
30/06/2022	1,184

Data source: Inpatient, Day Case and Outpatient Stage of Treatment Waiting Times - Monthly and quarterly data to 30 September 2022, Public Health Scotland, provided: [CL8/190 - INQ000468172].

Number of outpatient appointments for all specialities in non-NHS provider facilities between quarter ending March 2019 and quarter ending June 2022

Quarter Ending	Number of outpatient appointments
31/03/2019	2,013
30/06/2019	1,294
30/09/2019	1,156
31/12/2019	759
31/03/2020	695
30/06/2020	557
30/09/2020	656
31/12/2020	290
31/03/2021	258
30/06/2021	904
30/09/2021	472
31/12/2021	373
31/03/2022	327
30/06/2022	472

Data source: Acute hospital activity and NHS beds information (quarterly) - Quarter ending 31 December 2022, Public Health Scotland, provided: [CL8/191 - INQ000468173].

725. From the quarter ending 31 March 2020 to the quarter ending 30 June 2022 there were 12,207 IPDC spells provided by non-NHS provider facilities for specialties including:

- Urology (1861)
- Trauma and Orthopaedic (1899)
- Plastic surgery (256)
- Palliative medicine (2902)
- Ophthalmology (600)
- Neurosurgery (30)
- Geriatric medicine (197)

- Geriatric surgery (3560)
- Gastroenterology (574)
- ENT (318)
- Cardiology (10).

726. From the quarter ending 31 March 2020 to the quarter ending 30 June 2022 there were 5,004 outpatient appointments provided by non-NHS provider facilities for specialties including:

- Urology (148)
- Trauma and Orthopaedic (167)
- Psychiatry of old age (1489)
- Plastic surgery (293)
- Palliative medicine (366)
- Ophthalmology (753)
- Learning Disability (871)
- General surgery (468)
- General psychiatry (mental illness) (5)
- Gastroenterology (10)
- Dermatology (434).

Number of outpatient appointments by speciality in non-NHS provider facilities between quarter ending March 2020 and quarter ending June 2022

Quarter Ending	All Specialities	Dermatology	Gastroenterology	General Psychiatry (Mental Illness)	General Surgery	Learning Disability	Ophthalmology	Palliative Medicine	Psychiatry of Old Age	Plastic Surgery	Trauma and Orthopaedic Surgery	Urology
31/03/2020	695		10	-	90	60	133	15		266		121
30/06/2020	557		-	-	89	76		10	132	115	135	
30/09/2020	656		-		66	93	40	46	161	218	32	
31/12/2020	290		-			93	25	27		145		
31/03/2021	258				41	81		51		75		10
30/06/2021	904	434			43	91	67	53		204		12
30/09/2021	472		-	-	39	83	172	53		125		
31/12/2021	373				40	116	74	31		112		
31/03/2022	327				25	86	88	26		97		
30/06/2022	472	-		-	35	92	154	54		132		5
Total	**5,004**	**434**	**10**		**468**	**871**	**753**	**366**	**293**	**1,489**	**167**	**148**

Data source: PHS Acute Beds Publication quarterly, Disclosure control methods have been applied to the data to protect patient confidentiality

727. The decision to utilise the private sector during Covid-19 was based on the clinical need to have a standalone facility to deliver healthcare to the most urgent patients, predominantly cancer patients.

728. As noted above, the provision of elective care had been paused in NHS facilities to enable them to treat Covid patients, and owing to the pressures in the system, there was clearly a risk that urgent cancer patients would not be able to be treated in these facilities.

729. There are five private hospitals across Scotland, with differing capabilities, offering varying services, and providing a total of 213 Beds, 16 theatres, and with a nursing headcount of just over 300. Utilising these hospitals therefore increased the capacity of the overall healthcare system in Scotland to provide urgent care.

730. The arrangement with the private sector was based on SG covering the overhead costs of utilising these facilities. No marginal cost was charged. This was verified by open book accounting, and represented the lowest cost at which these facilities could have been operated. Across four private hospital sites, a total overhead cost of £20,864,310 was spent on securing continued delivery of services between March and September 2020, provided: [CL8/192 - INQ000468158]. On 9 December 2020 a funding letter was sent to the Chief Executive of NHS National Services Scotland to confirm an allocation of £10,391,701 would be made to NHS NSS to cover the costs of the use of independent healthcare providers' facilities during quarter two of 2020/21 (June to September 2020) [CL8/333 – **INQ000485980]** Similarly, for quarter four (January to March 2021) an allocation of £10,017,560 was made available to NSS through the January 2021 allocation process to cover the costs of using independent healthcare providers' facilities during that period **[CL8/334 - INQ000485981]** **[CL8/334a - INQ000485982]** These are set out in the schedule of NSS core revenue allocations for 2020–2021 within the category 'Independent Sector Activity'.

731. Use of private hospital capacity through central arrangements ceased in March 2021, save apart from a small number of procedures carried out by arrangement between individual Health Boards and hospitals (and therefore funded through local arrangements, details of which would need to be sought from Health Boards). Direct funding from SG for use of private hospitals was provided during the period March 2020 to March 2021. The following table sets out the SG costs associated with the

utilisation of each of the six hospitals discussed above, together with an overall sum for this activity of £30,600,955:

Private Hospital	**Total cost – March 2020 to March 2021 (£)**
BMI Albyn	9,658,494
BMI Kings Park	1,865,851
BMI Ross Hall	4,085,116
BMI Carrick Glen	326,978
Nuffield Glasgow	6,090,789
Spire Murrayfield	8,573,727
Total cost for utilisation of private hospitals	30,600,955

732. This represented a positive outcome for the NHS as it facilitated the treatment of cancer patients, and for the private sector, who otherwise would have been required to mothball their facilities and place their staff on furlough. It was therefore considered to represent efficient use of resources.

Other healthcare services

733. Linda Pollock, interim Director of Healthcare Quality and Improvement, issued a letter to all Health Boards in February 2021, provided: [CL8/193 - INQ000469935] which confirmed that the Organisational Duty of Candour Regulations remained in place throughout the Covid-19 pandemic. However, recognising the significant impact that responding to the pandemic was having on the health service and that there might have been a need to prioritise immediate healthcare rather than carry out obligations under the legislation, it may not have been "reasonably practicable" for procedures to begin as quickly as they would have done previously.

734. This could have had an impact on healthcare for conditions as learning from organisational duty of candour incidents may not have been identified as soon as usual and policies and processes not amended as a result.

Sexual Health and Blood Borne Viruses

735. In the Programme for Government (PFG) 2020/21, the SG committed to support the delivery of health and care services to address inequalities by building on examples of innovation and best practice developed to address the impacts of the Covid-19 pandemic on sexual health services by developing a Recovery Framework for Sexual Health and Blood Borne Viruses.

736. The Scottish Health Protection Network Sexual and Reproductive Health Clinical Leads published a Triage policy document on 20 March 2020 to guide sexual health services during lockdown, provided: [CL8/194 - INQ000414605]. This document was in line with national guidance issued by the Faculty of Sexual and Reproductive Healthcare (FSRH) and British Association of Sexual Health and HIV (BASHH). In line with this guidance, from March 2020, SHBBV clinical care was restricted to only urgent and essential care, focusing on diagnosing serious and symptomatic sexually transmitted infections and blood-borne viruses, and on preventing unplanned pregnancies. In addition, measures to ensure the long-term viability of services, such as in-person undergraduate and postgraduate training, had to be limited because of Covid-19 mitigation requirements.

737. Face-to-face care in all instances was entirely removed, except for those urgent priorities. Technology and innovation (such as telephone and video consultation and posting of testing kits and prescriptions) were rapidly redeployed to fill the gaps, but these could not always substitute adequately, particularly given the complexities of the issues, the need for intimate or physical examination and testing, and the populations who needed support.

738. The 'Reset and Rebuild - sexual health and blood borne virus services: recovery plan', published in August 2021 as part of the SG PFG commitment, was produced in partnership with NHS and third sector partners, to take stock of the impacts of the Covid-19 pandemic on Sexual Health and Blood Borne Virus (SHBBV) services and people that use them, ahead of a more fundamental review of the SHBBV Framework, provided: [CL8/195 - INQ000480825].

Screening Services

739. Population health screening identifies people who appear healthy but may have a higher chance of developing a disease or condition. There are currently six national

screening programmes. These programmes are designed to detect early signs of a disease or condition and provide referral and treatment where necessary.

740. In March 2020, the five adult screening programmes, including cancer screening programmes, were paused due to the Covid-19 pandemic. The decision to pause was based on advice from the CMO and informed by a range of factors, including the need to facilitate social distancing and minimise the impact on essential NHS services as they responded to Covid-19. It involved carefully considering all the risks involved, including the risk of people attending any follow-up investigations needed and screening programme participants becoming infected with the virus.

741. NHS NSS produced the following modelling of the average numbers of screenings and positive results. The quarterly figures, based on data available to the NSS Information Services Division, were as follows:

- 248,177 patients received bowel screening, of which 220 were diagnosed with cancer
- 46,596 patients received breast screening, of which 291 were diagnosed with cancer and
- 101,963 patients received cervical screening, of which 341 were diagnosed with invasive cancer.

742. Programmes resumed in a staggered way in the summer of 2020, prioritising high-risk participants and those who had been affected by the pause. All programmes continue to recover from the effects of Covid-19, and most have returned to pre-Covid performance.

743. Scottish Ministers issued an approval in March 2020 to allow both abortion medications – mifepristone and misoprostol – to be taken at home in certain circumstances (previously only misoprostol could be taken at home). This enabled abortions to continue throughout lockdown and led to reduced numbers of patients requiring an in-person appointment. The CMO also asked Health Boards to make sure that patients needing later stage abortions were seen locally wherever possible to avoid patients needing to travel to England for treatment during lockdown, provided: [CL8/196 - INQ000469974].

Blood Transfusion

744. The SG supported the Scottish National Blood Transfusion Service (SNBTS) to minimise impacts of the pandemic on the blood supply and to ensure blood components remained available for any patients requiring a transfusion at any time. This included making sure that it was clear that travelling to give blood was considered essential travel (and subsequently blood donation was included in Regulations setting out exemptions to the restrictions on travel outwith a person's local authority area). The SG provided support to SNBTS in discussions with public sector partners to ask them to help facilitate blood donation sessions even when premises were closed (for example the Deputy First Minister's letter of 19 March 2020 to local authorities asked that schools continue to facilitate blood donor sessions), provided: [CL8/197 - INQ000470115].

745. The SG worked closely with NHS Blood and Transplant, the Scottish transplant units and National Services Division in NSS to monitor impacts of the pandemic on organ donation and transplantation and to agree where transplants should be prioritised to continue through the first wave of the pandemic. The SG worked with transplant units and NHSBT to ensure services could restart safely following the first lockdown and provided a Scottish transplant recovery plan to assist Health Boards in ensuring services resumed as quickly as possible.

746. The CNOD was primarily responsible for the reporting of and advising on nosocomial (hospital-associated) infection and transmission, which informed infection prevention and control measures and assisted with the placement of patients into the appropriate Covid-19 clinical pathways.

747. The CNO and CMO, in consultation with the HCAI/AMR Policy Unit and the ARHAI service within NSS, identified the need for additional analysis of nosocomial transmission of Covid-19 in Scotland.

748. The CNRG considered the scientific, technical concepts and processes that were key to understanding the evolving Covid-19 situation and potential impacts in hospitals in Scotland. The CNRG applied the advice coming from the WHO, SAGE, the UK-wide IPC guidance cell and other appropriate sources of evidence and information and used it to inform the decision-making process in Scotland during the pandemic.

749. The CNRG was accountable to the SG, through the CNO, and provided the CNO with advice. Thereafter, the CNO and the HCAI/AMR Policy Unit considered the advice and used it to inform policy development. The CNO and HCAI/AMR Policy Unit also considered any cross-cutting policy impacts and consulted with the CMO, NCD or other Health and Social Care Directors where necessary.

750. CNOD was responsible for communicating updates to infection prevention and control guidance to NHS Scotland Boards. However, CNOD did not provide this advice or guidance. The advice or guidance to reduce the risk of transmission of Covid-19 to patients receiving treatment for non-COVID conditions in healthcare settings was nationally developed and published by ARHAI Scotland. CNOD maintained the same advisory and reporting role throughout this period.

Cancer

751. Several guidance documents and frameworks were published to support the continued treatment and prioritisation of cancer patients during the pandemic. This included publishing the governance framework for cancer medicines in adults (28 April 2020), the framework for the recovery of cancer surgery (14 June 2020) and the guidance on restarting cancer treatment after an infection of Covid-19 (24 April 2020). Guidelines for cancer treatment during COVID 19 pandemic were first published on 20 March 2020, provided: [CL8/198 - INQ000414606], and revisions were made and published in April 2020 and December 2020.

752. During Covid-19, the British Society of Gastroenterology-Joint Advisory Group (BSG- JAG) circulated consensus guidance for UK Endoscopy (dating from 20 March 2020), recommending that all but emergency and essential endoscopy paused. Owing to reduced scoping capacity, a considerable backlog of patients requiring colonoscopy emerged. In response, clinical guidance on the use of faecal immunochemical testing (FIT) in the prioritisation of patients with colorectal symptoms was developed in NHS Scotland (published on 2 July 2020 and refreshed on 1 June 2022) provided: [CL8/199 - INQ000469992] [CL8/200 - INQ000469993].

753. Guidance was also published on the safety of Covid-19 vaccinations for those receiving cancer treatment (14 January 2021) and a new national Cancer Plan was

published on 9 December 2020 to support the recovery of cancer services in Scotland.

754. The number of urgent suspicions of cancer (USC) referrals into secondary care significantly reduced during the pandemic, by around 75%. There was strong concern, from both within primary and secondary care, that USC referrals for suspected lung cancer were being impacted, at least in part, due to the cross-over of symptoms with Covid-19; cough, breathlessness and fatigue. New clinical guidance, to ensure the effective management of USC lung patients during the pandemic was published on 15 July 2020, provided: [CL8/201 - INQ000469934].

755. During the pandemic, capacity pressures were closely monitored across Health Boards and where longer waits emerged, mutual aid or cross-Board arrangements were explored, including maximising capacity at NHS Golden Jubilee.

756. By the week ending 27 December 2020, compared to the same week in 2019, there were 584 fewer pathologically confirmed lung cancer diagnoses (a total fall of 20.6%), with urgent suspicion of lung cancer referrals remaining below pre-pandemic levels. Meanwhile, anecdotally, NHS Cancer Teams were reporting that people were delaying diagnostic tests or not attending hospital through fear of catching Covid-19.

757. In response, the National Cancer Plan, published December 2020, included a standalone section to support the recovery of lung cancer services. This included an additional £500,000 to invest in "developing a lung cancer awareness campaign that will launch in 2021, to highlight the importance of early detection and prompt people with possible symptoms to seek help as early as possible."

758. As an interim measure, while the new Detect Cancer Earlier campaign was being developed, a low-level DCE lung cancer campaign ran across social media channels, pharmacy posters and press in February 2021. The new campaign – Settling In – launched on 31 May 2021 and ran across several channels including TV, radio, print and digital, targeting those from areas of deprivation where lung cancer outcomes are poorer.

759. Campaign development involved undertaking independent research with the target audience and extensive stakeholder engagement across specialties and sectors,

manged by the SG's Marketing Department. These efforts were overseen by the National Cancer Recovery Group, which had responsibility for the successful delivery of the National Cancer Plan, with campaign creative and plans approved by CSH at the time. The submissions, feedback, approvals and brief are provided: [CL8/202 - INQ000469994], [CL8/203 - INQ000469996] [CL8/204 - INQ000244280], [CL8/205 - INQ000469998], [CL8/206 - INQ000469999].

760. Monitoring USC diagnostic demand and capacity was critical and, where bottlenecks emerged, solutions were explored including the commissioning of mobile imaging units, securing mutual aid between Boards and maximising capacity at NHS Golden Jubilee.

761. Health Boards were allocated their NHS Scotland Resource Allocation Committee (NRAC) share of £10 million (non-recurring) in July 2020 (and July 2021), to support cancer pathways. It was directed in many different ways across Scotland, dependent on local challenges, including supporting diagnostic pathways.

762. The Cancer Treatment Response Group (CTRG), along with PAG, Cancer Policy Team and Planned Care Policy Team, were involved in the decision to develop a Framework for the Recovery of Cancer Surgery. The decision was to produce a prioritisation framework to ensure Boards were working to the same guidance and patients would be treated based on their clinical priority rather than their home Board's capacity. The relevant Ministerial submission is provided: [CL8/208 - INQ000260796], as is the guidance published on 14 June 2020: [CL8/207 - INQ000470000] [CL8/209 - INQ000470002]. The email stating the Cabinet Secretary for Health and Sport's approval is also provided: [CL8/210 - INQ000470003].

763. CSH wrote to Health Board Chairs and chief executives on 24 March 2020 reinforcing the fact that cancer patients remained a priority and that vital cancer services must continue to be delivered, although some treatment plans may have to be changed owing to an individual's risk associated with Covid-19, provided: [CL8/211 - INQ000260935].

764. The letter continued: "Throughout this time, the recording and tracking of cancer waiting times standards will remain for this priority group. To suspend these targets would not be fair to patients and will aid us in measuring the impact of Covid-19".

765. PHS published quarterly cancer waiting times data throughout the pandemic.

766. NHS Scotland's cancer waiting times (CWT) Data and Definitions Group met on 24 March 2020, chaired by the Information Services Division (part of National Services Scotland), in response to the pandemic. Those in attendance included SG officials, NSS statisticians and Cancer Managers from across NHS Scotland. Here, there was a minuted discussion around the requirement for self-isolation impacting on cancer pathways and agreement to develop Covid scenarios to apply to existing CWT adjustments. With support from the National Cancer Recovery Group and Chief Operating Officer of NHS Scotland at the time, an appendix of the scenarios was published on Public Health Scotland's website on 23 April 2020, to support boards in tracking and monitoring CWTs during the pandemic.

767. The SG's Cancer Policy Team and Cancer Advisory Groups within the DG HSC family provided advice to the CMO and Ministers regarding new practice and guidance to allow for the care and treatment of cancer patients to continue. In the immediacy of the pandemic, the Cancer Treatment Response Group was established.

768. In June 2020, a new oversight committee, the National Cancer Recovery Group (NCRG) was established, which had oversight of the National Cancer Treatment Group (NCTG), National Cancer Data Programme Board and the National Cancer Quality Steering Group.

769. NCTG provided oversight of the established Systemic Anti-Cancer Therapy (SACT)/Radiotherapy (RT) sub-group and the Covid-19 National Cancer Medicines Advisory Group. Following a review completed by NHS National Services Division (NSD) in December 2020, and the publication of the National Cancer Plan that month, a new governance model was implemented and is largely still in place to date

770. The NCRG commissioned and approved various pieces of clinical guidance for use in cancer services across Scotland. This included the development and dissemination of the Cancer Surgical Prioritisation Framework (based on existing guidance by the Federation of Surgical Associations (FSSA), the Systemic Anti-Cancer Therapy (SACT) prioritisation framework and managing SACT RT for

Covid-19 positive cancer patients. This was based on clinical advice from governance groups, and wider clinical networks. In addition, NCRG received a new data source established through the Regional Cancer Networks on the delivery of cancer surgery.

771. The National Cancer Treatment Response Group met weekly from March 2020 to June 2020 with the National Cancer Recover Group replacing this and meeting weekly from June 2020. Both groups provided regular updates and intelligence on the impacts of Covid-19 on cancer services. Additionally, officials were in regular liaison with tumour-specific oncology networks to monitor any service impacts. There was also ad hoc contact between officials and clinical leads and service managers on a frequent basis. Existing data sources such as those around Cancer Waiting Time were regularly monitored, with new data sources established for the provision of cancer surgery, and a new national platform was developed to monitor the delivery of Systemic Anti-Cancer Treatments (SACT).

Long Covid

772. The SG's Covid-19 Clinical Cell supported the Scottish Intercollegiate Guidelines Network (SIGN) in the development of a rapid clinical guideline on managing the long-term effects of Covid-19, produced in partnership with the National Institute for Health and Care Excellence (NICE) and the Royal College of General Practitioners (RCGP) and published in December 2020. In May 2021, the SG published an "Implementation Support Note" on managing the long-term effects of Covid-19, to accompany and support delivery of the clinical guideline in Scotland, provided: [CL8/212 - INQ000232014]. The support note provided additional targeted information for clinicians and health care teams caring for those suffering from the long term effects of Covid-19, supplementary to the SIGN/NICE/RCGP Guideline recommendations.

773. In July 2021, the SG commissioned NHS National Services Scotland (NSS) to conduct a mapping exercise of NHS Boards to identify how they were supporting people with long Covid, resulting pressures and Boards' additional support needs. A short life working group was established by NSS to identify next steps required. This recommended the creation of a National Strategic Network for long Covid, which was established in March 2022.

774. The SG published the paper *Scotland's Long Covid Service* in September 2021, setting out the strategic approach to responding to the healthcare needs of people with long COVID, provided: [CL8/213 - INQ000320569]. The four key elements outlined in the paper were:

- Supported self-management. The main commitments in this area were to work with NHS 24 to increase the range of information available on NHS Inform, to work with NHS 24 and third sector partners to develop resources to help people with long Covid to access information on local community-based services, to commit £40,000 to a targeted long Covid marketing campaign in conjunction with community pharmacies across Scotland, to develop and distribute a communications toolkit for primary care teams, NHS Boards and other partners, and to support Chest, Heart and Stroke Scotland to raise awareness of their 'Long COVID Support Service'.
- Primary care and community-based support. Besides the Long COVID Support Fund, which is outlined below, the main commitments in this area were to establish an expert group to identify the capacity needs of NHS Boards and staff in delivering safe, effective and person-centred support for people with long COVID, to support future updates of the SIGN/NICE/RCGP joint Guideline and encourage clinicians to use the Implementation Support Note which provides key direction on identifying, assessing and supporting people with long COVID as required in line with clinical evidence, and to support and expand the range of professional roles in primary care that play a key role in the provision of services that can support people with long COVID through the Primary Care Improvement Fund.
- Rehabilitation support. The key commitments in this area were to build understanding of current rehab services being delivered across NHS Boards in Scotland, including ICU/Critical Care, primary care and community care (i.e. exit out of and entry into services), and to develop and implement a programme of work to deliver a 'Once for Scotland' rehabilitation pathway that will ensure everyone who requires rehabilitation will be able to access it.
- Secondary care investigation and support. The key commitments in this area were to support NHS Boards to develop and deliver a care co-ordination service model to enhance the way in which primary, community and secondary care services work together in order to meet the needs of people living with complex needs as a result of long COVID, to support NHS Boards to establish a service model for the delivery of clear, consistent and co-ordinated pathways across primary and secondary care to ensure that the person is at the centre of decision making and the pathway, to work with National Services Division to support NHS Boards to provide healthcare

staff with a clear understanding of the services and infrastructure available in their areas to support investigations related to long COVID, and to encourage the use of the SIGN Decision Support platform, which provides healthcare professionals with an integrated point of access to evidence-based information on supporting people with long COVID.

775. The strategic approach included the creation of a £10 million 'Long COVID Support Fund', which gave Health Boards additional financial resource to support local services in developing and delivering the best models of care appropriate for their populations. The paper stated that this could include strengthening and improving the co-ordination of existing services, or establishing dedicated services, potentially including dedicated 'long COVID clinics'. A total of £3 million was made available from the fund over the financial year 2022–23, with a further £3 million being made available over 2023–24.

Scottish Government support for people with long term health conditions

776. As stipulated under its terms of reference, CLAGS explored and considered the data and views from across Scotland, and beyond, about the best way to support those at Highest Clinical Risk and/or those with certain long-term conditions. They considered data on the effectiveness of measures and advised where changes should / could be made.

777. Regular meetings were held where topics related to healthcare provision were discussed by attendees and the advice forwarded to Deputy NCD John Harden as CLAGS chair.

778. The minutes from CLAGS meetings have previously been collated and submitted to the Inquiry.

779. SG provides core funding to the Neurological Alliance of Scotland (NAoS). In 2020 they published the report *Neurological Voices – Living through lockdown* charting the impact of the pandemic on people with neurological conditions in Scotland, provided: [CL8/214 - INQ000469975].

780. In 2021 the Neurological Alliance published a review of consultations in Scotland undertaken remotely using digital technology for people with neurological conditions, provided: [CL8/215 - INQ000469976].

781. This informed the guidance produced by SG for clinical staff to use virtual consulting in the most appropriate circumstances, provided: [CL8/216 - INQ000470051].

782. Clinical Priorities Unit officials met regularly with the Chair and Vice Chair of the Neurological Alliance throughout the pandemic. These kept officials informed about key impacts of the Covid-19 pandemic on the neurological community, highlighting issues around waiting times, repurposing of neurology specialist nurses, access to Covid-19 vaccination for people with neuro conditions, issues around shielding for vulnerable individuals with neuro conditions, and the use of NHS virtual consultations.

783. The SG has monitored the impact of the pandemic on people with neurological conditions through Public Health Scotland who gather data through the Scottish Multiple Sclerosis (MS) Register.

784. The main measures recorded are number of newly-diagnosed people, geographical spread of new diagnoses and gender split, percentage of newly diagnosed people contacted by a MS specialist nurse within 10 days of confirmed diagnosis, percentage contacted within 10 days from receipt of referral, number of Covid-19 PCR tests carried out on people who are on the MS register, and how many people on the MS register had received primary / booster Covid-19 vaccinations.

785. The Scottish Government funded the development of the Scottish Epilepsy Register. An as-yet-unpublished study has looked at the impact of Covid-19 on death rates of people with epilepsy during the pandemic.

786. The Scottish Government has also drawn intelligence on the impacts of Covid-19 upon people with neurological conditions from the many and varied pieces of correspondence it received from the public. For example, through this awareness was raised of disciplines or Health Boards where there were particularly long waits, such as waits for neurosurgical / spinal procedures and waits for neurology outpatient appointments in NHS Ayrshire and Arran. SG meetings with charity

stakeholders, such as the MS Society, also provided information on issues that affected condition-specific groups. This intelligence has informed the actions and strategic direction of the SG's five-year framework to improve neurology services, Neurological care and support: framework for action 2020-2025, provided: [CL8/217 -INQ000469978].

787. The SG established the Scottish Cardiac Audit Programme to monitor the delivery of interventional and surgical cardiac procedures. The first published reports are provided: [CL8/218 - INQ000469979].

788. PHS also established the Covid-19 Wider Impacts dashboard to provide an overview of the changes in health and healthcare during the Covid-19 pandemic. This included a section on cardiovascular disease which provided data on prescribing, A&E attendances, out-of-hours cases, SAS, Hospital Admissions, excess mortality and cardiac procedures.

789. Clinical Priorities Unit officials met regularly with the Chair of the Heart Disease Task Force, the Clinical Lead for the Heart Failure Hub and third sector partners (Chest, Heart and Stroke Scotland and BHF Scotland) throughout the pandemic, to inform officials about the impacts of the Covid-19 pandemic on the cardiology community. BHF Scotland developed and shared a consensus document, provided: [CL8/219 - INQ000469980]. Key outputs of this engagement work included the development of patient information resources, provided: [CL8/220 - INQ000414590].

790. The Heart Failure Hub is a subgroup of the National Heart Disease Task Force. It provided guidance on the delivery of Heart Failure services in Scotland during and in recovery from the pandemic, provided: [CL8/221 - INQ000469981] [CL8/222 - INQ000469982]

791. SG funds the Scottish Stroke Care Audit (SSCA). Appropriate care is measured through the SSCA using the stroke care bundle, which comprises four key components: admission to a stroke unit, swallow screen, brain scan and administration of aspirin. This was established in 2002 and includes all hospitals managing acute stroke in Scotland.

792. The result of the audit informs an improvement programme, with an annual report published. Monitoring of stroke services through the SSCA, and publication of the annual Scottish Stroke Improvement Programme report, continued throughout the pandemic.

793. The CMO Speciality Advisor – Stroke led on the production of NHS Scotland clinical guidance for TIA and stroke management during the Covid-19 pandemic. This document was approved by the Clinical Cell and PAG before publication. The document outlined that patients should be encouraged to seek emergency attention when experiencing symptoms of a stroke and that NHS Scotland would continue to provide access to stroke care for all patients.

794. The document offers guidance relating to organisational change, the provision of hyperacute stroke care, stroke units and rehabilitation services, TIA and outpatient clinics and maintenance of standards, provided: [CL8/223 - INQ000470106].

Shielding or Highest Risk

795. Shielding was a completely new strand of health policy which was established to assist in protecting people in Scotland at the greatest risk of severe illness if they contracted Covid-19.

796. Scottish Ministers were first approached to give authorisation to the broad approach to protecting and providing support for those considered most at risk from Covid-19 in our society by DG HSC family officials, based on clinical advice from the CMO, on 21 March 2020, three weeks after the first confirmed case of Covid-19 in Scotland, provided: [CL8/224- INQ000261358].

797. The four UK CMOs jointly identified certain health conditions which could mean someone was potentially at higher risk of negative outcomes if they contracted Covid-19. It was the clear and stated policy intent from that point onwards to identify, protect and support people considered to be at highest risk of severe illness or death from Covid-19. This led to the creation of the Shielding Programme within the DG HSC family, operated by a newly created Directorate.

798. The initial crisis response, the Shielding Programme (later Shielding/Covid Highest Risk Division), was a major exercise which ran from 26 March 2020 to 1 August 2020 involving collaboration between a range of stakeholders.

799. Based on clinical advice and four UK Chief Medical Officers' decisions, the shielding programme aimed to reduce the risk of infection, severe illness, and death. It sought to do this by:

- identifying those people at highest risk of Covid-19
- providing individuals with guidance to help minimise interaction between them and others
- providing individuals with the necessary support to enable them to follow the shielding guidance, including, for example, providing FIT notes in the form of Chief Medical Officer's letters for those who could not go to work due to Shielding, and priority access to online supermarket delivery slots.

800. From the outset, the SG recognised that following a completely new health policy by asking people to self-isolate for a lengthy period would present them with significant challenges. Deputy First Minister John Swinney announced on 24 March 2020 that support would be offered as soon as possible, through local Humanitarian Assistance Centres, to help people stay at home and to protect them from detrimental effects, including disruption of crucial health and social care, and social isolation and loneliness.

801. Further support included:

- Local services, led by Brakes and Bidfood, to supply groceries and medicines those most at risk from 8 April, provided: [CL8/225 - INQ000469983]. More than 50,000 individuals had registered for this service by 14 May 2020
- A national helpline established for those who did not have family or community support on 13 April 2020, provided: [CL8/226 - INQ000469984]
- Funding to connect the most vulnerable to online support on 7 May 2020, provided: [CL8/227 - INQ000469985]
- Community projects given £8 million to help combat isolation on 22 May 2020, provided: [CL8/228 - INQ000469986].

802. The Shielding List, which later became known as the Highest Risk List as Scottish Government policy moved away from the strict self-isolation of the first phase of the

pandemic, was a list of people identified as having those health conditions through their medical records or by their GP or clinician. In total, once the initial list had been established, approximately 185,000 people were on Scotland's Shielding List at any given time, with individuals continually added (in the event of the criteria being expanded or people newly diagnosed) and removed from the list (in the event of death or no longer meeting the criteria).

803. As the "pause" in the Shielding programme was approached, on 1 August 2020 the Shielding policy area became an established Division within the Directorate of Population Health within the DG HSC family. Policy in relation to people at highest risk from Covid-19 moved away from the concept of strict shielding from this point and over the course of the pandemic, given:

- The harms we knew prolonged strict self-isolation could cause, particularly regarding mental health and physical deterioration;
- The roll-out of an effective vaccination programme which prioritised those at highest risk;
- The emergence of evidence relating to the course and impacts of the virus, and the risks to certain groups;
- The development of new treatments to decrease the risk of severe illness and fatality.

804. The work for the shielding programme moved between different parts of the SG. When the Shielding Programme was established in March 2020, initial work to identify those who needed to be communicated to regarding being "on" the shielding list was led by Healthcare Quality and Improvement Directorate (with Linda Pollock as Deputy Director leading) but worked as a cross-NHS group.

805. Thereafter staff were drawn from several areas on an urgent basis, with Michael Chalmers as the Director, supported by Deputy Director Donald Henderson and Elizabeth Sadler, within the DG HSC family. Orlando Heijmer-Mason also provided Deputy Director support during this time. From July 2020, it formally became a division, sitting in the Directorate for Population Health and was led by Orlando Heijmer-Mason. John Froggatt also provided Deputy Director support during this time.

806. In August 2022, after the Covid Public Health Directorate merged with the Directorate for Population Health, the Division merged into the Covid Ready Society Division, led by Deputy Directors Elizabeth Sadler and Marion McCormack.

807. Decisions requiring Ministerial authorisation were split between portfolios:

- Health policy required sign-off by Jeanne Freeman, the Cabinet Secretary for Health and Sport (March 2020 – May 2021) and Humza Yousaf, Cabinet Secretary for Health and Social Care (May 2021 – May 2022, when the Shielding List ended)
- Wider support and resilience required sign-off by the then Deputy First Minister, John Swinney
- Overall strategy required sign-off by the then First Minister, Nicola Sturgeon.

808. Initially, all four Chief Medical Officers collaborated on and endorsed a four nations approach, including the joint development of shielding criteria.

809. Clinical advice was provided by the Scottish Chief Medical Officer, Catherine Calderwood, and her successor, Interim Chief Medical Officer, Gregor Smith.

810. Clinical advice, based on assessment of the risk to those with underlying health conditions, prompted the decision to establish a dedicated team to develop and deliver Shielding policy.

811. The CMO designated Dr John Harden, Deputy National Clinical Director, as the clinical advisor for Shielding.

812. Dr Harden put in place the CLAGS to support him in this work. The group had clinical representation for the health conditions included in shielding. The Strategic Liaison and Policy team within Healthcare Planning and Quality Division provided secretariate for all CLAGs meetings and held terms of reference, membership details and notes of all agendas and key notes of meeting. Key decisions were taken to the Clinical Cell and Professional Advisory Group for consideration, for example the timeline of changes to the shielding advice and guidance on return-to-work conversations. The CLAGS worked with a similar cross-UK clinical reference group.

813. Clinical advice generated was signed off by the CMO.

814. The Shielding Division is not aware of any clinical advice which was not followed in policy decisions.

815. From March 2020 to July 2020, work was undertaken to establish the shielding programme. A team was established, which was drawn across government including staff from the Directorate for Population Health, and working with NHS partners, to deliver the shielding programme. More detail is provided below. Functions of the programme included:

- identifying those people at highest risk of Covid-19;
- providing individuals with guidance to help minimise interaction between them and others through issued Chief Medical Officer letters;
- establishing a SMS service via a national SMS system for communicating with people in the highest risk categories;
- providing individuals with the necessary support to enable them to follow the shielding guidance, including, for example, providing FIT notes in the form of Chief Medical Officer's letters for those who could not go to work due to Shielding, and priority access to online supermarket delivery slot;
- liaising with Brakes and Bidfoods to enable people in the highest risk categories to order grocery packages, through the SMS system or phonelines, to be delivered directly to their door free of charge, provided earlier in the statement, provided: [CL8/225 - INQ000469983]
- establishing programme structures with local authorities and other partners such as Police Scotland, through regional resilience partners, facilitating frequent (initially daily) meetings to support coordinated working, regular monitoring and reporting (for example, ensuring individuals had been advised to Shield had been contacted and offered support), to achieve joint objectives and deliver important services for those in highest risk categories;
- maintaining and amending the list of highest risk categories based on developing clinical advice;
- reviewing social media to gain early insights into the general response, potential unintended consequences being experienced, to help resolve individual issues where possible / necessary.

- From July 2020 the Shielding Division, which was responsible for policy in relation to people at highest risk, continued working to support those in the highest risk group beyond the ending of the Highest Risk List on 31 May 2022.

816. Senior policy colleagues met regularly with counterparts from the UKG and other devolved administrations to discuss policy issues around shielding/highest risk, sharing information, research and insights, mirroring the clinical and scientific structures that had been established.

817. The Covid Highest Risk Division had six workstreams. These were:
- Risk Stratification
- Health Wellbeing and Support Policy
- Clinical Policy
- Engagement and Communications
- Briefing and Correspondence
- Delivery.

818. From the outset it was decided by the CMO that SG would follow the same identification process and communications as UK Government in order to maintain consistency across the four nations, with contextual adaptations where required.

819. Initially, the four UK Chief Medical Officers agreed the criteria for the cohorts that they assessed might be most at risk of severe illness or death should they contract Covid-19 on 18 March 2020. Confirmation of the final criteria for the shielding list was made to the SG by UKG DHSC on the same day. These initial groups were as follows:
- Group 1 – Solid organ transplant recipients
- Group 2 – People with specific cancers
- Group 3 – People with severe respiratory conditions
- Group 4 – People with rare diseases
- Group 5 – People on immunosuppression therapies which increased risk of infection
- Group 6 – People who were pregnant and had significant heart disease.

820. Some individuals met the criteria for inclusion in more than one group because of multiple health conditions. PHS worked to identify individuals falling into these

categories. Initially, approximately 136,000 individuals were identified and added to the Shielding list in March 2020.

821. On 26 March 2020, the CMO wrote to Nursing and Medical Directors for NHS Scotland Boards advising of the highest risk groups and asking for hospital clinicians and GPs to identify patients within these six groupings who may not have been identified through the national identification process, provided: [CL8/229 - INQ000351885]. Clinicians could also, based on their clinical judgement, add people to the Shielding/Highest Risk list if they were clinically at the highest risk from Covid-19 but were not included in the groups 1–6 above set by the four CMOs. A "Group 7 – clinician-identified" cohort was established. If someone thought that they were in the highest risk group but had not received a letter, the central list was updated to ensure people could be supported to shield.

822. The process of identifying individuals was complex and could involve both an analysis of healthcare and prescription records, some of which were held nationally and some locally, as well as clinical judgement. The initial Shielding/Highest Risk List therefore took some weeks to populate and would change as groups of patients were added (and in some cases, removed).

823. The number of people on the Highest Risk List fluctuated throughout its existence as a result of new conditions being added to the criteria at various stages of the pandemic, as listed above. However, for most of the list's existence, it stood at 180,000–185,000 people. At the time of the ending of the Highest Risk List on 31 May 2022, the number of individuals on the list stood at 175,193. In total 216,710 individuals have been on the Shielding/Highest Risk List.

824. In addition to the Shielding List, there had been consideration early in the pandemic to other people at risk: these were the "non-shielding at risk", a group comprising people over 70, disabled, requiring the support of mental health services, pregnant or receiving a flu jab for health reasons. People in this group were not individually identified but were encouraged to seek help via a helpline which channelled calls to local authority help services, should they not have family or existing community support or not have access to online support.

825. The initial crisis response Shielding Programme was a major exercise which ran from 26 March to 1 August 2020 involving collaboration among a range of stakeholders.

826. From a policy perspective, the internal stakeholders were the three clinical and scientific groups: the Clinical Guidance Cell, the CLAGS and the C19AG. Clinical links included the third sector.

827. Further engagement took place with Food Standards Scotland, GPs (both directly and through the BMA), Health Boards, local authorities, SOLAS, COSLA (primarily through Regional Resilience Partners) and the Royal College of Physicians, as well as Community Pharmacy Scotland, supermarkets (for food boxes and priority delivery slots) and with UKG partners.

828. Identifying the criteria for the shielding list was based on expert clinical opinion provided by the CLAGS, chaired by Dr John Harden, Deputy National Clinical Director. The group had clinical representation for the health conditions included in shielding. The Strategic Liaison and Policy team within Healthcare Planning and Quality Division provided secretariat for all CLAGS meetings and held terms of reference, membership details and notes of all agendas and key notes of meeting. Key decisions were taken to the Clinical Cell and Professional Advisory Group for consideration, for example the timeline of changes to the shielding advice and guidance on return-to-work conversations. The CLAGS worked with a similar cross-UK clinical reference groups.

829. CLAGS was an expert group, set up for a limited time to provide advice, information, data, proposals and outline approach to the CMO Scotland Advisory Group for:

- Consideration and discussion to support the four nation Quint/UK CMO discussions regarding the shielding population, alignment and next steps.
- Development of position for the First Minister's Framework for Decision Making in relation to shielding.
- Provision of clinical expertise and advice to Dr Harden in his capacity as SG Clinical Lead for shielding; and in his capacity as Clinical Lead for the UK Review Panel.

- Explorations and consideration of the data and views from across Scotland to inform policy-makers on the best way to support those shielding, post the initial 12-week period (26 March to 18 June 2020).
- Consideration of the data on the effectiveness of shielding measures and advise policy-makers where changes should be made.
- Consideration of the wider harms, practical and policy implications that the challenge of shielding may cause – including mental health.
- Reflection on user feedback from across Scotland explore and consider what matters to those who are in the shielding group and what information would help individuals who are shielding make informed decisions.
- Maintenance of links between the data group, COVID-19 CMO Advisory Group and Professional Advisory Group.

830. The first meeting of CLAGS was 14 May 2020 and the group met weekly until 28 July 2020, and then fortnightly until 15 December 2020, at which point frequency moved to monthly until March 2021. Subsequently the group met on an ad hoc basis. Its membership grew to include and reflect the changing clinical criteria for inclusion in the shielding list and highest risk group over time.

831. All the information and action points discussed at the meetings was summarised in an Action Tracker. Advice was provided to Scottish Ministers. In addition to this key advice there were ongoing discussions between Dr John Harden and policy officials. A summary of the key advice follows:

832. The work of CLAGS informed a submission made on 12 June 2020 from the Shielding Policy Team to the FM, DFM and the Cabinet Secretary for Health & Sport providing an update on shielding. This submission noted it was likely that a UKG announcement would advise that shielding would be paused in England, and asked that the views of the four advisory groups be sought on whether the evidence provided by UKG required a change to advice for Scotland. The advisory groups were to be asked to work with policy officials to map out how changes to the advice for the shielding group should be phased in coming weeks.

833. The advice from the Clinical Leads Advisory Group was that the shielding group could be advised that the risk of catching Covid-19 was low enough that they could meet people from another household if doing so outdoors and complying with other

public health measures such as strict physical distancing. CLAGS produced two documents, with the following advice:

- Before we can remove any groups, we need more evidence on the response of certain groups to the vaccine, as well as whether the vaccine will be effective against new variants;
- For some groups within the highest risk group, manual review by GPs and clinicians may be required to determine if they can be removed. This is likely to be time consuming and may not have a significant impact on numbers;
- Immunosuppressed patients are a group which members believe should be considered separately;
- Vaccinations of household members and plasma donors is key to those who are immunosuppressed;
- Advice, guidance and communications should be person centred and take into account individual needs, risks and the prevalence of the virus in the area;
- Members feel strongly that individuals need to be involved in their own decision making, with some input from other groups;
- There may be some sub-groups who could be removed from the shielding list, but more discussions on who they are and how to identify them are needed;
- Members agree there would be a need to weigh up the pros and cons of shielding before asking anyone on the list to shield in future.

834. On 16 June 2020, a further submission from the Shielding Policy Team noted that as prevalence of Covid-19 had remained at very low levels, the changes scheduled to happen on 24 July were confirmed to go ahead, as per the advice of CLAGS and other advisory groups. The Clinical Leads Advisory Group on Shielding remained supportive of pausing shielding advice after 31 July and committed to continuing to review the state of the pandemic to inform the shielding advice provided through guidance.

835. On 16 July 2021, CLAGS informed the advice on baseline measures to move beyond Level 0. The First Minister had announced on Tuesday 21 June 2021 that all of Scotland was expected to move to Level 0 on 19 July 2021, as long as the data continued to support this. The intention was then to move beyond Level 0 on 9 August 2021. The key conclusions drawn from the feedback received from CLAGS are listed below:

- Most of the measures are common sense, but self-isolation was the main theme running throughout the feedback from members. Members feel this has become unsustainable and has had a huge impact in both education and workforce settings. Members suggest there may be alternatives to be considered such as only isolating immediate household contacts.
- There should be a separate policy considering COVID and education, to avoid the disruption of the last 15 months.
- Members are supportive of continued use of face masks in August and beyond and believe much of the general public will be supportive of this too.
- Consistent messaging and guidance is needed, including communicating expectations of live "beyond level 0" and clarity that this will not be a return to "normal".
- Members are in support of vaccinating children and young people, especially 12 years and over, but accept there are a number of questions and potential issues around this;
- Many people are already not following guidance such as self-isolating and testing;
- As more people are being vaccinated and fewer people are becoming seriously unwell if they do catch COVID, questions are raised on whether the measures being taken (again particularly considering self-isolation), are proportionate.

836. On 16 August 2021, CLAGS had been asked by Shielding Policy Team officials to respond to questions on the future of the Highest Risk List in Scotland via email. The responses to these questions were collated and the Deputy National Clinical Director confirmed they would be used to help develop Shielding policy going forward. The information provided by CLAGS was fed into a submission of 7 September 2021. The advice summarised via a list of recommendations from officials in the submission was as follows:
    - Due to timing and unknown trajectory of the pandemic for the coming winter months, Scotland should not mirror the UK's decision to end the HRL at this time.
    - The HRL would be reviewed as further clinical advice is presented, with an aim to eventually have only those who are immunosuppressed/Immuno-compromised and clinician identified individuals remaining on the HRL (if this continues to be backed up by evidence), with the long-term vision being that

clinicians advise individuals on their risks from Covid rather than communicating via a central list.

- It was also recommended to Ministers that the process of commissioning a delivery partner to deploy a third QCovid tool for population level assessment should begin.

837. On 16 September 2021 FM responded stating she was content with the recommendations as proposed in the submission.

838. The Shielding Programme aimed to provide individuals with guidance to help minimise interaction between them and others, and to reduce the risk of infection, severe illness and death. Subsequently, this aim broadened out to include reducing a broader defined harm. The initial programme sought to provide individuals with the necessary support to enable them to follow the Shielding guidance, including, for example, grocery deliveries through Brakes and Bidfood, and priority access to online supermarket delivery slots.

- Between 15 May 2020 and 18 June 2020, a phased approach to agree the way forward was developed. On 15 May, a deep dive was presented by the C19AG to explore the policy detail and its implications and discuss the future direction for shielding. The emerging consensus was then tested with First Minister, Deputy First Minister, and CSH to allow policy implications to be worked through. The specific implications considered when developing the new approach were as follows:
- It was recognised this new approach may have significant medicolegal implications for clinicians.
- Sufficiency of transition period to enable establishment of robust Scottish evidence base, and recognition of limitations of that evidence base, to support individual decision making.
- Sufficiency of transition period to enable range of supports to be put in place, potentially including new digital capability. Flowing from this would be primary care readiness and willingness to provide advice on a person-centred basis.
- Potential divergence from the other UK nations on policy, whether that be the advice and/or the support put in place (including guidance). It was acknowledged that there would be a converse risk associated with a continued lockstep approach, should other nations take differing views of the emerging

evidence on Covid risks and health outcomes and/or the supports they would provide.

- It was noted that socio-economic inequalities may reduce people's capacities to develop a person-centred approach to risk, or to safely put them into practice in their localities.
- The international advice suggested that it would be very difficult to deliver a shielding strategy, as there were no international models to draw on which had been successful. The greatest dependency was the need to reduce the prevalence of the virus in the community.

839. An initial submission was made on 20 May 2020 to check the Shielding Policy team had captured Ministers' desired direction of travel, provided: [CL8/230 - INQ000261982]. The advice before the 20 May 2020 submission had been developed exclusively on the basis of likely harm for people with certain clinical conditions and in the context of increasing community transmission. It did not aim to take into account the harms arising from shielding itself over a long period of time, or other individual factors which may influence the risk of contracting Covid, such as the make-up of a household or risks arising from the local physical environment linked to deprivation.

840. The 20 May submission stated it was worth widening the criteria for assessing risk and harm since some degree of shielding advice was likely to be necessary for many months to come, if not longer. It outlined a need to test the assumption that the harms from the virus outweigh the harms from shielding, stating that "the ask to shield must be aligned to the evidence of risk, and, if possible, evidence from the Scottish context". It identified the need to move to a model where people could make informed decisions that balanced their individual risk with quality of life. It further set out the responsibilities of SG to give people the information and tools to allow them to make informed decisions about what matters to them about living with the threat of Covid-19, including not only refined clinical advice, but also local health surveillance data on Covid-19, if possible. Beyond information, it outlined the practical support required to be provided, going beyond food and pharmacy deliveries to include measures to reduce social isolation, to support education, work, digital connectivity and the provision of accommodation.

841. The submission further stated that officials would explore with clinical groups whether there were any modifications of the advice which could be considered for

the transition period. It was recognised that during transition SG would need to be able to support shielding individuals in making decisions about their risks of exposure, and tailoring their behaviour accordingly. Some individuals would need more support than others, so a mix of approaches would need to be provided to meet requirements. Specifically, it would be necessary to take into account considerations such as cognitive ability, including conditions such as dementia, health literacy and deprivation/health inequalities. It was stated that the main way to do this was by giving clear advice and sharing the evidence to support advice and decisions.

842. A subsequent formal submission on 29 May 2020 set out how the approach would be achieved, outlining an innovative approach to personal decision making rather than "blanket" advice, provided: [CL8/231 - INQ000261395].

843. Early shielding policy, in which people were advised to strictly self-isolate, was an example of a precautionary approach, which was based on the very limited evidence available at the time. The evidence as to who was at risk from Covid-19 evolved from the time of the initial advice to shield, and decisions were being made based on the best knowledge available.

844. More broadly, it was recognised early in the Shielding/Highest Risk programme that the policy of strict self-isolation for those on the shielding list could negatively affect people's mental health and physical wellbeing. This was informed by a user research team embedded in the Shielding/Covid Highest Risk Division, who conducted a high level of engagement with people asked to shield throughout the period April 2020 to April 2022. The purpose of this team was to inform policy design and support packages and embed a deeper understanding of lived experiences of shielding in the division. This produced insights from early May 2020 into the realities of shielding, provided: [CL8/232 - INQ000147410].

845. On 29 May 2020 it was agreed to extend the shielding period beyond the initial 12 weeks in principle due to prevalence levels, but it was agreed that a new approach to shielding should involve moving towards a more individual assessment of risk.

846. A larger online survey was conducted in early July (2020) to find out more about:
- People's experiences of shielding as measures eased;
- Mental health of people who are shielding;

- Information needs for people shielding as measures eased.

847. 3,033 survey responses were received from people who were shielding, and the very high response rate – over 72% of those contacted underlines people's needs to communicate their experience. Key findings from this survey indicated continued high levels of anxiety and fear about catching Covid-19, concern that guidelines were not being followed by the rest of society, and that the shielding group felt forgotten.

848. In addition to the mental health impacts of shielding, the insights gathered via this survey highlighted the practical challenges in following the advice, especially if people lived in multi-generational households, with people who were key workers, had school age children, or who required or provided care.

849. These insights significantly shaped SG policy, and were shared with UKG and other devolved administrations. Later, research was also undertaken with service users to inform the design and delivery of the shielding text alert service, a personal risk information booklet, and to provide LFD tests to adult contacts of people on the shielding/highest risk list.

850. This shaped SG's ongoing communications strategy to continue to support this group beyond the initial shielding period and after the advice to shield strictly was lifted, providing timely and helpful information and advice for as long as it was necessary.

851. The removal of the strict self-isolation advice was done on an incremental basis informed by prevalence of the virus in Scotland and bearing in mind the detrimental impacts of shielding. On 4 June 2020 it was agreed to change the shielding advice from 18 June to recommend people resume outdoor exercise as a first step in transitioning out of strict self-isolation.

852. The criteria for the shielding list were identified based on expert clinical opinion provided by the Clinical Advisory Group for Scotland, chaired by Dr John Harden, Deputy National Clinical Director. Clinical evidence was still developing and suggested that there were broader risk factors not reflected within the advice to shield, including: age, ethnicity, obesity, and diabetes. These other risk factors were identified mainly from those eligible for flu vaccine for medical reasons. As noted

above, there was a clinical decision taken that, in Scotland, a seventh group would be created in the shielding categories to allow clinicians to add individuals they felt were at the highest risk but who were not otherwise captured by the six health condition groups.

853. Conversely, the policy team became aware that some groups had been asked to shield when the evidence no longer supported it, whilst others had a heightened risk and had not met the formal shielding criteria. The main instances of SG becoming aware that evidence no longer supported the need for certain groups to shield are set out in the following paragraphs.

854. In May 2020 SG began to uncover some cases where mis-keying of data had led to people being on the list erroneously. SG wrote to them between mid and late May 2020 to apologise for the mistake and say they no longer needed to shield, but where they were in receipt of food parcels, these would continue for two weeks. They also retained their places in priority lists run by the supermarkets for home deliveries.

855. On 16 June 2020, a review of children and young people on the list was published in light of evidence showing low risk of poor outcomes from Covid. The Royal College of Paediatrics and Child Health (RCPCH), along with specialist clinical expert groups, reviewed new evidence. The CMO wrote to clinicians asking them to carry out a case-by-case review of approximately 3,940 children (under 16) on the shielding list. The CMO asked that individual discussions must take place with the patient, and where appropriate their family or care givers. Once discussions had taken place, and where appropriate, a letter was issued on 13 July 2020 to advise them that they no longer had to be on the shielding list.

856. On 29 January 2021, a response was issued from the UK CMOs to Diabetes UK to confirm that there was insufficient evidence to support inclusion of people with diabetes on the shielding list. Clinicians could, however, add people with diabetes to the highest risk list on a case-by-case basis where they judged it to be in the best interest of the patient. For the purposes of vaccination, people with diabetes were included in the JCVI group 6.

857. On 13 August 2021, there were CLAGS discussions regarding removing those people from the highest risk list who no longer met the criteria, specifically in Group

2 (certain cancers), because they were no longer receiving the treatment which would increase their susceptibility to infection. Challenges were identified with the practicalities of identifying said individuals and eventually this topic was subsumed into the wider decisions made about the future of the highest risk list in September 2021.

858. On 14 September 2021, there was a decision to refresh data in group 1 (transplant patients) as people identified for vaccination who should be on the list. There was also a decision to refresh or remove group 6 from the shielding list (pregnant with heart condition). As noted, there was an awareness that there were some people who did not meet the formal shielding criteria but who nonetheless had a heightened risk. The four CMOs, through expert consensus, had initially agreed the groups at highest clinical risk. Groups were added after 26 March (splenectomy and renal dialysis - both 29 April 2020), but the clinical evidence, while still developing, suggested that there were broader risk factors which were not considered in the initial advice to shield, including age, ethnicity, obesity, diabetes.

859. There were therefore some inconsistencies between who had been asked to shield and who was at risk – the over 80 age group, for example. This inconsistency was masked at first owing to the wider lockdown coinciding with the 12-week shielding period. It was recognised that when those lockdown conditions eased, it would again become apparent that the advice to shield does not wholly align with the emerging clinical evidence.

860. In March 2020 there was a clinical decision taken that, in Scotland, a seventh group would be created in the shielding categories that allowed clinicians to add individuals they felt were at the highest risk but were not captured by the six health condition groups. This was then a message used in response to queries from people that wanted to know why they were not included. As an example, many people with MND were added by their clinicians through this route.

861. In addition to the shielding list, there had been consideration early in the pandemic to other people at risk: these were the “non-shielding at risk”, a group comprising people over 70, disabled, requiring the support of mental health services, pregnant or receiving a flu jab for health reasons. People in this group were not individually identified but were encouraged to seek help via a helpline which channelled calls to

local authority help services, should they not have family or existing community support, or not have access to online support.

862. By May 2020, the threat of Covid-19 continued to be significant. However, the SG anticipated that extending shielding beyond 18 June, particularly with no end date, would increase the anxiety of individuals and their families as it could signal that shielding would need to continue until such time as a vaccine for Covid-19 became available. Early user research by PHS Shielding Team had found some common themes from the lived experience of shielding:

- Shielding was perceived to be impacting on mental and physical health, households and personal finances. Individual household situations made advice hard to follow;
- The advice was not tailored to individual circumstances, and some people were already adapting the advice to suit their circumstances;
- There was anxiety about what follows the initial 12 weeks, and about household circumstances becoming more complex when lockdown ease;
- People were experiencing a sense of loss, a desire to retain independence, and a feeling of disempowerment.

863. The Shielding policy team was aware that any easing of restrictions for family and household members could make it harder for people who were shielding to protect themselves, and the added complexity / nuances of change could make it harder to comply with shielding advice.

864. Between the period of 19 June 2020 and 31 July 2020, it was clear that substantial work was first needed to foster the conditions in communities which could support personal choice. This highlighted the need to extend the shielding period beyond the initial 12 weeks, i.e. which had been due to end on 18 June.

865. The CMO endorsed that position, and the team recommended a transition period to Ministers until 31 July 2020, with the significant caveat that this depended on the community infection rates continuing to improve and so could be delayed if necessary.

866. A transition phase from 19 June until end of July was recommended, during which:

- levels of community infection and the impact of lifting lockdown restrictions for the public would be monitored before any changes were recommended for the shielding population;
- people would be asked to continue to shield, with a gradual increase in the day-to-day activities they were advised to consider, starting with access to outdoor exercise;
- further support mechanisms were developed and put in place to allow people to make informed decisions, based on their individual clinical risk and their local environmental risk;
- support with food and employment continued to be in place for those who needed or chose it.

867. The Shielding Division recommended the new personalised approach from the beginning of August 2020, with an evolving set of measures in place to support people in their choices, including structures in place to allow as many of the shielding population access to education and employment as possible. This was contingent on clinical advice continuing to support shielding.

868. The policy team was also conscious of the timing of extending shielding in line with the end of the UK Government's first furlough phase. It was considered difficult to ask people to shield beyond that date without being able to offer reassurance about jobs and financial security.

869. Ministers agreed and the announcement was made on 8 June, when a Chief Medical Officer's letter was issued, provided: [CL8/233 - INQ000470010]. A paper, called 'Shielding - A way forward for Scotland' was published on 8 June, provided: [CL8/234 - INQ000480821]. Shielding was paused on 1 August.

870. Throughout the pandemic, new criteria were added to the original six groups making up the Shielding/Highest Risk List based on emerging evidence, data, and clinical consensus. To decide the new criteria, work and discussion was undertaken by the four nations' CMOs.

871. Health and Social Care Analysis (HSCA) undertook in-house qualitative research on how local authorities were supporting people at higher risk. This identified concerns about sustainability of support going forward and made useful suggestions

about how national and local government could work together in the future. This was published in November 2020, provided: [CL8/235 - INQ000414595].

872. Between July and August 2020, HSCA also carried out a survey of third sector organisations on support to people at higher risk. Respondents highlighted a range of issues requiring ongoing attention as Scotland emerged from the lockdown, such as access to practical supplies, mental health, the needs of certain groups (e.g., those shielding, carers and those cared for, children and older people), longer-term health harms and unemployment, provided: [CL8/236 - INQ000414596].

873. HSCA commissioned PHS to conduct an evaluation of the Covid-19 Shielding Programme over the period March–July 2020. This looked at the effectiveness of the advice to shield, the value of the support offer and lessons learned. Initially, SG asked PHS for rapid survey data on 19 May 2020 and a survey was developed and issued with initial findings shared with us on 12 June 2020. Further research included reviewing existing literature, data linkage and stakeholder research. The findings informed the development of the shielding programme and were published in January 2021. Key findings were as follows:

- A comprehensive programme was set up, at speed, despite the logistical challenges involved. Substantial effort and dedication were invested by those involved in the programme.
- There is evidence that the shielding programme correctly targeted people who (as a group) were at higher risk of negative COVID-19 outcomes. However, other risk factors, including older age and some other clinical conditions, also increased an individual's risk of negative COVID-19 outcomes.
- There is evidence that the shielding guidance resulted in a change in behaviour. It is, however, not the case that the guidance was always necessary or sufficient to change behaviour.
- Shielding was challenging and at times impossible for people. Many shielding individuals appear to have tried to follow the guidance to the best of their ability, but practical constraints, caring duties and quality of life considerations made this difficult at times. This holds lessons around the support offer that is necessary to enable people to shield, but also raises questions around what is and is not feasible in terms of 'shielding' those at the highest risk.

- Conclusive statements about the effectiveness or otherwise of shielding are not possible. Any additional protective impact of shielding in the period being evaluated may have remained relatively modest: shielding coincided with other population-wide restrictions. The impact and duration of those population-wide 66 restrictions could not have been predicted at the time. Possible benefits of shielding need to be set against the negative impacts of the shielding programme.
- The shielding support programme reached a large proportion of the shielding group and there is evidence to suggest that the support, including the national free food box scheme, addressed real needs. Some questions were raised about logistical challenges, the content of the boxes, whether all recipients needed the boxes and whether a national free food box scheme was the best approach. The support offer could not address all needs.
- With the benefit of hindsight, questions can be raised about some aspects of the programme rationale and implementation. Most important, however, are the conclusions that can be drawn from this in terms of lessons for the future. In the short term, the immediate priority is a review of the strengths and limitations of the current shielding list and how it should and should not be used. This should include an open debate about the data protection issues involved, which should involve those with lived experience of shielding.
- In terms of wider lessons learnt for future pandemic planning, a repeat of the shielding programme, in its initial format, is not recommended. The principle of protecting those at higher risk remains valid.
- It is recommended that future programmes consider more fully the risk of COVID-19 infection during a hospital admission and the support needs of the wider shielding household.
- There are opportunities to build on co-production approaches to programme development, as used in the shielding programme. There is also scope to explore future approaches to resilience planning that allow for more local flexibility. More generally, there are opportunities to further enhance collaboration between local authorities and the local public health function. Finally, some of the wider resilience issues that have been unearthed by shielding and COVID-19 more generally relating to health, care and therapy provision, including the role of unpaid carers, may benefit from further review.

874. The evaluation found clear evidence that the shielding advice changed people's behaviour and that the shielding support addressed real need. It also found that the shielding guidance was neither necessary nor sufficient to change behaviour in all instances. For example, shielding support did not address all needs such as the need to move around due to caring responsibilities.

875. The evaluation also found that the programme correctly targeted people at higher clinical risk of negative COVID-19 outcomes, but that some others, not included on the shielding list, were also at higher risk.

876. It was not possible to assess whether shielding had a protective effect over and above population-wide restrictions, as we could not know what might have happened had people not been asked to shield.

877. The report's final conclusion was that the shielding programme had been a major exercise involving collaboration among a range of partners. The programme had made a difference: the report summarised clear evidence that shielding advice had changed people's behaviour and that the shielding support had addressed real need. However, it also noted that the shielding guidance was neither necessary nor sufficient to change behaviour in all instances, and the shielding support could not address all needs. There was evidence to suggest that the people targeted by the shielding programme were at higher risk of negative COVID-19 outcomes than the population at large. Others, not included on the shielding list, were also at higher risk. Assessing whether shielding had a protective effect, over and above the protection offered by population-wide restrictions, was (and is) challenging.

878. Following the publication of the January 2021 report, the SG asked PHS to also evaluate the guidance and support offered to the highest risk group following the pause in shielding. PHS ran a second survey of the highest risk group and the findings of this second survey were published in March 2022, provided: [CL8/237 – INQ000202564]. These findings can be summarised as follows:

- There is evidence of ongoing negative impacts on the lives of people in the highest risk group. A total of 76% of respondents who had already been advised that they were in the highest risk group at the time of the initial (March–July 2020) shielding period, report an ongoing negative impact on their quality of life. Ongoing negative impacts are more pronounced among respondents who are

socioeconomically more vulnerable, who have an impairment or who provide unpaid care. Respondents who are severely immunosuppressed or severely immunocompromised are also more likely to report ongoing negative impacts. Socioeconomic vulnerability has the strongest association with ongoing negative impacts.

- There is evidence of ongoing worry and caution among the highest risk group. In total, 81% of respondents still make decisions that are mainly influenced by fear of COVID-19 infection, and 36% of respondents still try to minimise all physical contact with other households. Evidence of ongoing caution is more pronounced among respondents who are socioeconomically more vulnerable, who have an impairment or who provide unpaid care. Respondents who are severely immunosuppressed or severely immunocompromised are also more likely to continue to be cautious. Socioeconomic vulnerability has the strongest association with ongoing caution.
- There is evidence to suggest that the advice and support offered to the highest risk group has made a difference. For example, 85% of respondents report that the letters of the CMO have influenced some of their actions. The 'Clear your head' leaflet to support individuals' mental health is less often reported to have made a difference.
- A large proportion of respondents (77%) agree that having been included on the highest risk list has made them feel supported. Socioeconomically vulnerable respondents are less likely to have felt supported. Respondents who are younger than 65 years, who have an impairment, who provide unpaid care or who have children in their household are also less likely to have felt supported. Respondents who have been advised that they are severely immunosuppressed or severely immunocompromised similarly are less likely to have felt supported. Socioeconomic vulnerability has the strongest association with not having felt supported. Unmet needs are diverse and include issues relating to COVID-19 advice, COVID-19 vaccination, health and social care support, and financial and employment support.
- There is evidence of ongoing advice and support needs. A total of 88% of respondents think that it is very or quite important that there continues to be a separate highest risk group. Practical examples of requests for ongoing support include access to antibody testing, additional employment protection and public awareness-raising around the continued vulnerability of the highest risk group.

879. The following chronology shows shielding decisions and guidance, and details of groups placed on the shielding list in Scotland throughout the relevant period:

Date	Summary of Advice for Highest Risk List
18 March 2020	Shielding approach agreed between the four UK CMOs (Catherine Calderwood in Scotland) Initial groups considered highest risk from COVID-19 are as follows: Group 1 – Solid organ transplant recipients Group 2 – People with specific cancers Group 3 – People with severe respiratory conditions Group 4 – People with rare diseases Group 5 – People on immunosuppression therapies which increased risk of infection Group 6 – People who are pregnant and have significant heart disease Aware of concerns of others not falling within these categorisations but still 'at risk' due to individual health conditions, clinicians in the community are given the ability to identify patients who they think are at highest risk but do not fall into the existing six groups of people identified by the Chief Medical Officers, and a 'Group 7 – Clinician-identified' cohort is established.
24 March 2020	Decision to supply free grocery food boxes to people identified and asked to shield as part of a support package: [CL8/238 – INQ000244353]

26 March 2020	Shielding list created (circa. 136,000 people). The first CMO letter was sent to the c. 100,000 people initially identified for the Shielding/Highest Risk List asking them to self-isolate for the next 12 weeks as they were deemed to be at extremely high risk from Covid-19. The letter was based on, and consistent with the letter provided across the other three nations. The stated aims of asking people to stringently self-isolate for at least 12 weeks, or to 'shield', were to protect people at highest risk from Covid-19 from serious illness, as well as taking pressure off the NHS providing the most acute care. It was recognised that asking people to shield would impact their access to healthcare systems, specifically access to prescriptions and medicines, as well as their access to supermarkets/shops. Therefore, in the week commencing 23 March 2020, officials begin working with Local Resilience Partnerships, multiple retailers and others to put in place a package of support to help these people self-isolate. This programme of work aimed to rapidly establish and deploy: • a national helpline • a shielding page on NHS Inform • an SMS service for shielding • a shielding page on NHS Inform • a national food box service • a volunteer-led distribution service for people to access their prescriptions and medicines. • a variety of other services provided by local authorities and Local Resilience partners, according to need. The CMO letter to the Shielding/Highest Risk List of the 26 March 2020 also advised people they should either work from home, or not attend work if working from home was not possible. Letters were sent to people as they were identified in the course of the following weeks. Individuals could use this CMO letter which was called a 'shielding notification' to show employers they cannot go into the workplace. This letter acted as a FIT Note.

	Those shielding were told they should either work from home, or not attend work – CMO letter similar to fit note People on the Shielding list were offered grocery delivery and priority access to online supermarket delivery slots.
3 April 2020	First free food packages delivered to people on Shielding List.
5 April 2020	Agreement to fund National Assistance Helpline to be run by local authorities. The helpline is established to help people on the Shielding list access food, medicines and other support services.
9 April 2020	SMS issued to 21,000 people registered (at this time) informing of access to priority supermarket deliveries–everyone offered priority access to supermarket slots for home delivery up to 30 September 2021 (around 53,000 people were registered)
29 April 2020	SMS sent advising local authorities would help with access to medications or to phone the National Assistance Helpline on 0800 111 4000.
21 May 2020	Scotland's Route map out of Lockdown published. (It signals that SG are aware how hard shielding is and are talking and listening to people with lived experience, and will publish bespoke guidance in the coming weeks).
28 May 2020	Agreement to extend support – including food boxes – to people on the Shielding List to 31 July 2020.
29 May 2020	Shielding extended for a further four-week period (as of 8 June 2020, shielding list now at 180,017). CMO letter issued to shielding individuals advising of extension to original shielding period.

16 June 2020	Review of children and young people on the list in light of evidence showing low risk of poor outcomes from Covid. Royal College of Paediatrics and Child Health (RCPCH), along with specialist clinical expert groups, review new evidence. CMO writes to clinicians asking them to carry out a case-by-case review of children (under 16) on the shielding list. The CMO asks that individual discussions must take place with the patient, and where appropriate their family or care givers. Once discussions have taken place, and where appropriate, a letter is issued on 13 July 2020 to advise them that they no longer have to be on the shielding list.
18 June 2020	Change in shielding advice – outdoor exercise now allowed if 2 metre distance maintained, and can meet people from one other household.
3 July 2020	Bespoke guidance developed for employees on the shielding list returning to work, and potential to consider financial support with UKG.
10 July 2020	Advice changed for people on the Shielding List. CMO letter (and SMS) sent confirming this advice, with key message that low infection rate in Scotland means it is safe to further ease shielding advice. People could meet more people outdoors, and can meet indoors with up to 8 people from 2 other households. No longer need to keep 2m distance from the people you live with, but advised to continue to keep 2m distance outside of the home and avoid crowded places. Wear a face covering when going into shops and using public transport. Sit outside if going to pubs or restaurants.
17 July 2020	People on the Shielding List are allowed to stay in holiday accommodation and visit outdoor markets and gardens – allowing people to get out more, and for couples who do not live together to meet up without distancing.
31 July 2020	Pause to Shielding: [CL8/239 – INQ000470014] [CL8/240 – INQ000470015]
1 August 2020	People on shielding list should follow the general population advice. Recommendation that people on the shielding list should continue to work from home but can now attend work, if they cannot work from home.
7 Sep 2020	Decision to offer vitamin D to all on the Shielding List. CMO advice is that it is not clinically necessary, however Minister keen to offer based on having asked people to stay indoors and consequent lack of sunlight during summer months.

11 Sep 2020	Current guidance communicated to Shielding list via letter, SMS and mygov.
22 Sep 2020	People on the Shielding list advised that numbers of confirmed Covid-19 cases were increasing across Scotland, and that they should be extra careful and follow the updated guidance. Emphasised that they were not being asked to go back into shielding and suggested that they might want to reduce the number of people they have contact with.
30 Sep 2020	Four UK CMOs' agreement to the addition of adults with Downs Syndrome and people with Chronic Kidney Disease stage 5 to the shielding list as per UK Clinical Review Panel Recommendations informed by the interim data from the QCOVID model which was based on the application of a risk prediction model from Oxford University. This model takes into account a wide range of risk factors now–known to increase the risk of infection and serious outcomes from COVID-19 and provides an estimate of absolute and relative risk of catching and dying from COVID-19 during the 97-day period of the first wave in England.
21 Oct 2020	Advice to (shielding) care home residents on vitamin D includes taking an individual approach to the supplement and that shielding residents of care homes should discuss this offer with their nurse or carer.
23 Oct 2020	Scotland's Strategic Framework, with five protection levels published: [CL8/241 - INQ000339830]. Advice set out in a table developed to reflect extra advice at each of the protection levels for people on the Shielding List in relation to shopping, working, distancing and meeting with other households. Advised not to attend work/school/college in Level 4 or above. Advice on taking care of mental health and promotion of mental health support and services included in CMO letter and SMS: [CL8/242 – INQ000327757].

30 Oct 2020	Adults with Down Syndrome were added to Group 4 of the Shielding/Highest Risk List. People with Chronic Kidney Disease Stage 5 (CKD5) were added to group 5 of the Shielding/Highest Risk List. Letters from CMO were sent to these identified individuals (including easy read versions) advising them that they were being added to the Shielding list but that this did not mean we were asking them to shield: [CL8/243 – INQ000470017].
2 Nov 2020	New protection levels apply from this date 6am. This includes extra advice for people at highest risk in higher protection levels. Segmented SMS sent to advise people which protection level their area is in and pointing them to online guidance as to what this means.
9 Nov 2020	Free supply of vitamin D offered to everyone on the Highest Risk List for four months over winter, primarily as there is an assumption levels will be low due to staying indoors during the summer months, to help with bone and muscle health.
11 Nov 2020	Advice on shielding prisoners gaining access to the free vitamin D offer December 2020, and advice for GPs on prescribing vitamin D to shielding cohorts: [CL8/244 – INQ000470018].
24 Nov 2020	SG officials supporting clinical advice for those previously shielding including for shopping. Clinical advice – 'can go to shops but less often'; personal decision making; advice on how to shop more safely.
7 Dec 2020	Everyday activities booklet issued to everyone on the shielding list: [CL8/245 – INQ000327747]. This booklet included information on risks, support and protection levels. Covering letter gave details on priority shopping: [CL8/246 – INQ000470019].
10 Dec 2020	£15m Flexible Fund established to support Local Authorities on Level 4 areas to provide support to people at highest risk.

11 Dec 2020	Christmas card with personal message from FM and household bubbling advice sent to all on the Shielding list: [CL8/247 – INQ000240604]. The advice from 23 to 27 December is that people will be able to form a festive household bubble with up to 8 others (not including children under 12) from up to 3 households. This means that people can meet indoors. The card includes wording to ensure people feel empowered NOT to do this and not to feel pressured simply because it is Christmas. There is also advice on how best to stay safe if they do choose to meet others. The Christmas advice changed on 19 December 2020.
16 Dec 2020	Decision to add people with liver cirrhosis (Child-Pugh class B and C) to the Shielding/Highest Risk list: [CL8/248 – INQ000470020]. This decision was taken by the CMO for Scotland following a recommendation from the UK Clinical Review panel for Shielding Patients that patients with liver cirrhosis (Child-Pugh class B & C) should be included in the Shielding/Highest Risk List.
21 Dec 2020	Following a change in the advice due to rising case numbers, a letter is sent from CMO advising that all of mainland Scotland will be placed in Level 4 from 12.01am on Boxing Day: [CL8/249 – INQ000470021]. The letter acts as a fit note. At Level 4, the general advice is that children and young people who are on the shielding list should not attend school, college or regulated childcare services such as nurseries. However, parents and carers are advised to consult their child's secondary care (hospital) clinical team who may advise that an individualised risk assessment could be undertaken with the school, college or nursery and arrangements put in place which may allow their child to continue to attend.
5 Jan 2021	Mainland Scotland re-enters full lockdown to reduce the opportunity of infection from the new, more transmissible strain. Those on the shielding list strongly advised to work from home or not attend work. CMO letter acting as a fit note issued: [CL8/250 – INQ000470022].
20 Jan 2021	Communications sent about vaccination: as someone who is on the shielding list, you were offered your first coronavirus vaccine dose by mid-February. Your NHS Health Board or GP would contact you soon. You do not need to do anything in the meantime. We are prioritising people for the vaccine based on their risk of serious illness if they catch coronavirus. If you are 80 or over, you will be offered the vaccine by 5 February.

22 Jan 2021	Clarification and apology SMS sent to follow up 20 January message, and clarify this does not apply to children and young people under 16 on the shielding list, who can only be vaccinated under exceptional circumstances after an individual risk assessment by their clinician.
29 Jan 2021	Response from CMO to Diabetes UK to confirm insufficient evidence to support inclusion of people with diabetes on the shielding list: [CL8/251 – INQ000470023]. Clinicians can add people with diabetes to the shielding list on a case by case basis where they judge it to be in the best interest of the patient. For the purposes of vaccination, people with diabetes are included in the JCVI group 6.
31 Jan 2021	Additional support with transportation to vacation for people on the shielding list is arranged and communicated – to support safety by avoiding use of public transport (especially at Level 4) and access to vaccination clinics.
1 Feb 2021	New medicine delivery service launched to provide support to clinically extremely vulnerable – and will run until 31 March 2021.
8 Feb 2021	An additional £15m funding for Las is added to the original £15m flexible fund and paid as a grant: [CL8/252 – INQ000245164]. This is as a result of more areas being in Level 4 than anticipated, LA feedback on bureaucracy and complexity of funding and in order to provide additional flexibility to Las moving in and out of Level 4. The fund was targeted at people at highest and higher clinical risk, older people or disabled people.
19 Feb 2021	Advice for people on the Shielding list on voting safely in May's Scottish Parliamentary Elections. Letter sent to everyone on the list from the Electoral Commission on voting options, including postal and by proxy. Two letter versions sent – one to over 16s and one to under 16s: [CL8/253 – INQ000470025] [CL8/254 – INQ000470026].

10 March 2021	Reminder SMS issued – "our advice for you at the moment is to keep following the guidance for people on the shielding list, even if you've had both doses of the coronavirus vaccine. As you live in an area that's in lockdown, our advice is that you should not go to work if you cannot work from home, even if you've had the vaccine. Find the latest guidance for you at www.mygov.scot/shielding or check the letter the Chief Medical Officer sent you with advice about lockdown. The Chief Medical Officer will send you a new letter with updated advice soon."
20 March 2021	Support available to people on the Shielding list to help them access their medicines promoted during first quarter of 2021 via SMS, CMO letter and online.
22 March 2021	CMO letter issued which acts as a fit note to 30 June 2021: [CL8/255 – INQ000470027]. Encourages people to continue to follow the extra advice at each protection level, and indicates that from 26 April, it is expected that people on the shielding list who are currently at Level 4 will be able to return to the workplace, if they cannot work from home. College and university students and young people at school should also be able to return at this time. This is because, from this date, all areas now in Level 4 are anticipated to move down to Level 3 or lower.
24 March 2021	People on the shielding list are prioritised for PCR testing.
2 April 2021	'Stay at home' advice moves to 'Stay Local'
22 April 2021	Promotion of Lateral Flow Device (LFD) tests to adult contacts of those on the Shielding List. Universal offer had potential benefits for shielding households including reducing transmission and providing reassurance. This information is shared with the Shielding/Highest Risk list by CMO letter: [CL8/256 – INQ000470028]

26 April 2021	People on the shielding list who are currently at Level 4 advised they can return to the workplace, if they cannot work from home. College and university students and young people at school are also able to return. A new section of guidance added to the website to support people on the Shielding List to return to the workplace after the Level 4 lockdown from January–April 2021. To add to employer responsibilities and individual risk assessments, additional steps that people can take.
06 May 2021	CMO letter issued to shielding cohort to let them know that their adult household contacts are being asked to come forward for their vaccination: [CL8/257 – INQ000470029].
08 June 2021	Decision to remove those on the shielding list who no longer live in Scotland and to update addresses on the shielding list to align with CHI: [CL8/258 – INQ000470030].
28 June 2021	Agreement with proposal to move the narrative around shielding to 'People at Highest Risk from Covid' and to change the Shielding List to the Highest Risk List. Shielding paused close to a year previously, and no return to that very restrictive form of shielding again, largely because of the detrimental impact to mental and physical health of shielding: [CL8/259 – INQ000243054]. User research and PHS survey work showed large numbers continued to 'self-shield' and using this terminology was confusing and a contributor to people who no longer needed to shield doing so.
08 July 2021	Communication issued advising of new, no-appointment-needed drop in clinics for people over 16 who have not received their first or second dose of the vaccine.
15 July 2021	A decision is taken by the four CMOs to remove children from the Shielding list: [CL8/260 – INQ000470032].

19 July 2021	Scotland move to Level 0. People on the Shielding list asked to follow general population advice unless advised otherwise by their GP or specialist clinician, including in relation to work. CMO letter – issued to shielding cohort on 15 July – sets out strong clinical evidence for this move – primarily as a result of vaccination, which measures will remain in place, and that people on the Shielding list should now follow the same advice as everyone else in Scotland: [CL8/261 – INQ000470033]
09 August 2021	Scotland moved beyond Level 0. Everyone on the highest risk list asked to follow the general population advice from 9 August 2021 when Scotland moves beyond Level 0. CMO letter – issued 6 Aug: [CL8/262 – INQ000470034] to shielding cohort – advising of move from 9 August beyond Level 0 and the precautionary measures that remain in place. The letter acknowledges this might be difficult for some people who have been at highest risk but there is solid evidence behind the decision. Promotion of mental health support organisations and services, including promotion of the Clear Your Head campaign through a specially adapted leaflet sent out with the CMO letter. This leaflet provides advice and information about how to deal with mental health issues including anxiety and loneliness as we moved beyond Level 0, and information on where to get support.
23 August 2021	Decision by CMO to pause the decision to remove children from Scotland's shielding list: [CL8/263 – INQ000470035].
31 August 2021	Q&A with National Clinical Director Professor Jason Leitch published online video. This focuses on questions submitted by people on the Shielding List themselves and aims to address the common concerns shared by many. The Q&A is communicated via social media, SMS, earlier CMO letter.
14 Sep 2021	Decision to refresh data in group 1 (transplant patients) as people identified for vaccination who should be on the list. Decision to refresh or remove group 6 from the shielding list – pregnant with heart condition.

27 Sep 2021	In the week commencing 27 September 2021, third primary dose of the vaccine is offered to severely immuno-suppressed people as per JCVI criteria and advice agreed by CMO. Some, but by no means all, of this group are on the HRL. No specific letter was issued given the overlap between the Highest Risk List and the severely immuno-suppressed list meant there was a risk in issuing a letter when a large proportion of people would not be eligible. The website and new additions letter were updated with this information.
1 Oct 2021	Communications issued regarding the British Red Cross's Connecting with You service which aims to support people who may be feeling isolated and lonely. The service is available to all but targeted at people on the Shielding list. SG funds the service. The text messages are staggered to ensure there is not an overwhelming response and calls to the helpline.
7 Oct 2021	Decision to enact earlier CMO recommendation to remove children and young people from the list: [CL8/264 – INQ000470036].
23 Oct 2021	A CMO letter is sent to the highest risk list to inform them of the autumn/winter 2021 booster vaccination campaign and that they will be contacted by their Health Board and invited for either a booster or third dose of the vaccine.
26 Oct 2021	Decision to delay removing children and young people from the list due to current context: [CL8/265 – INQ000470037].
Nov 2021	Update to Strategic Framework. Protective measures for general public remain in place: [CL8/266 – INQ000353777].
9 Dec 2021	A Christmas card reflecting the 'Stay Safe This Winter' campaign messaging was sent to the List and included a message from FM, recognising the continuing challenges that those on the Highest Risk list face, particularly with the emergence of Omicron. Communications to the List encourage more to get the third dose or winter booster. "There are only a small number of people who can't get the vaccine so please, if you are able, make sure you get vaccinated as soon as possible, and please take up the booster or third dose offer as soon as you can. If you are unsure, please speak to your clinician."

14 Dec 2021	CMO letter to the Shielding List issued with updates/information on the Omicron variant: [CL8/267 – INQ000470038]. The letter also reiterated advice on vaccinations, lateral flow testing, PCR testing, mental health and wellbeing, socialising.
17 Dec 2021	Decision to add c. 9,000 people identified as severely immunosuppressed on the Chemo Care database to the Shielding/Highest Risk List (group 5): [CL8/268 – INQ000470039]. Chemo Care was a new data source which identified people that have received cancer therapy recently and meet the criteria for the Scottish Government Highest Risk List.
22 Dec 2021	Access to antivirals and monoclonal antibodies to treat Covid-19 begins for those people who remain at a higher risk due to certain health conditions. A letter is sent out on the 31 December 2021 from the CMO to those who are eligible. Adults and children (aged 12 or over) who are a member of one of the patient groups considered at high risk from coronavirus with a clinical condition prioritised for treatment are eligible and are sent a letter advising them of this. These treatments are in addition to Covid-19 vaccinations – including boosters – and not a replacement but we hope they will help reduce the severity of illness in people who may fall ill even if they have been vaccinated. Individuals who may be eligible to access these new treatments upon confirmation of a positive PCR result are sent a letter. If recommended for treatment, individuals may be invited to attend a day clinic at a hospital to receive a monoclonal antibody which is normally given by intravenous infusion. Alternatively, the assessing clinician may recommend an antiviral treatment to be taken orally.
17 Jan 2022	Decision for PHS to routinely remove invalid CHIs in risk-based approach rather than write out to them first.

25 Jan 2022	Distance Aware scheme is launched: [CL8/269 – INQ000470040]. CMO writes to people on the HRL on the 25 January to let them know about the scheme: [CL8/270 – INQ000470041]. Libraries and Asda stores across Scotland offer badges and lanyards for people to pick up and wear and these are also available online. Organisations are invited to support and promote the scheme. The First Minister promotes the scheme in her regular press conference. This CMO letter also includes information on free sources of support for job skills and job seeking including Fair Start Scotland, No One Left Behind, Skills Development Scotland (SDS) and Access to Work. This information was also shared on gov.scot.
22 Feb 2022	Update to Strategic Framework published with content relating to current guidance for people on the shielding/highest risk list as legal restrictions came to an end, and pointing to the list being reviewed and potentially coming to an end: [CL8/271 – INQ000147446]. Health measures and adaptations to be Scotland's primary means of managing Covid-19.
1 March 2022	Decision not to send new additions letters to those added to the Shielding list in March and April, prior to announcement on ending the list: [CL8/272 – INQ000470042].
4 March 2022	Scotland removed some protective measures. Legal requirements to wear face coverings in public places remained in place. CMO letter sent to the Highest Risk cohort with updates including, the intention to undertake a review of who still needs to be on the Shielding/Highest Risk List, updates to Covid-19 legal restrictions, vaccinations, PCR and Lateral flow tests: [CL8/273-INQ000470043].
7 March 2022	Spring/Summer boosters start, beginning in care homes. Appointments for those aged 75 and over begin w/c 21 March. People aged 12 years and over who are immunosuppressed, are offered a vaccine dose at least 24 weeks after their last dose. This is a precautionary measure which will help protect the most vulnerable, whose protection from the booster vaccine may wane with time.

15 March 2022	Anyone who is going into the workplace is asked to do lateral flow tests twice a week and a legal requirement is put on those running businesses or services to minimise the risk of transmission to help protect those at highest risk. Specific guidance is also published online covering employer responsibilities to make the workplace safer, as well as additional steps people can take themselves to make work safer. CMO advises that people on the Highest Risk List can still use public transport.
April 2022	Scotland removed final legal measures.
12 April 2022	Decision to allocate £120,000 to extend British Red Cross – Connecting with You service until 31 December 2022: [CL8/274 – INQ000244943].
27 April 2022	Evidence Review – bringing together data of the efficacy of vaccination for people with conditions which meant they were on the shielding list, and which underpinned advice to them is published – along with two sets of guidance – the first for people who are no longer considered to be at higher risk as a result of vaccination, and the second for people who do remain at higher risk – primarily people who are immunosuppressed: [CL8/275 - INQ000470045]. Developing online content for Children and Young people on mental health including the Aye Feel hub created by Young Scot to provide information on mental health and emotional wellbeing to support young people. Also promote access to counsellors now available through secondary schools across Scotland.
6 May 2022	CMO approval of the final letters confirming the end of the List on 31 May 2022. Letters sent to c. 170,000 people who had remained on the shielding/highest risk list. Two versions of the letter were issued, a general version and an immunosuppressed version: [CL8/276 – INQ000470046] [CL8/277 – INQ000470047]
9 May 2022	CMO letters sent to those people added to the list in March and April 2022 to confirm that the highest risk list was ending on the 31 May 2022.

31 May 2022	Retiring of Shielding/Highest Risk List in Scotland. Identification process to be stood up. Guidance for people who are severely immuno-suppressed published: [CL8/278 – INQ000470011]. Highest Risk List in Scotland ends. It was agreed that the SMS service would end once the List did as PHS no longer had a legal reason to hold onto people's data.

880. The Shielding Division reflected that various parts of the UK were ready sooner than others to support personal shielding decisions. It was not considered justifiable to ask people to remain alone inside if there was not a good reason for it. There was concern that if England took a different approach, the Scottish consumers of UK-wide media would potentially pick up English shielding advice. The challenge was how to get messaging out, clearly, to avoid confusion.

881. Shielding advice and guidance was disseminated to those on the Shielding/Highest Risk List and to the general public by the DG HSC family in several ways. The main ways of disseminating information directly to those on the Shielding/Highest Risk List were:

- Letters from the CMO sent to the Shielding/Highest risk cohort. The letters were initially drafted by the Shielding/Covid Highest Risk Division, with relevant clinical input from CLAGS and the Deputy National Clinical Director, John Harden. The final draft of the letter was approved by the Chief Medical Officer's office. Once agreed the letter was sent to NHS NSS for printing and issuing to those on the Shielding/Covid Highest Risk List;
- An SMS alert service to the shielding/highest risk list (for those who signed up for it). This service was operated by NHS NES and the content of the messages created by the Shielding/Covid Highest Risk Division. People on the Shielding/Covid Highest Risk List were made aware of the advantages of registering for the SMS alert service in a CMO letter issued on 7 April 2020. The SMS alert service was deactivated on 31 May 2022 and the data has not been retained.

882. A full record of all public health messaging/communications in the form of CMO letters and SMS alerts is provided: [CL8/279 – INQ000469987].

883. More generally, information about Shielding/Highest Risk was disseminated via regular updates to the guidance on the relevant Gov.scot pages, which were maintained by the Covid Highest Risk division within the DG HSC family and are provided: [CL8/280– INQ000117028].

884. Changes to advice and guidance were often announced by the SG either in Parliament or during the Government's regular Covid-19 update broadcast on TV/online. In these instances, the Covid Highest Risk division proactively engaged with First Minister's speechwriter to ensure content relevant to people on the Shielding/Highest Risk List was regularly included. The Covid Highest Risk Division also provided the First Minister's office with the most recent advice and guidance to inform announcements made through First Minister's Questions documents. For example, the ending of the Shielding/Highest Risk list was announced by a Government Inspired Question in Parliament, the drafted answer to which was provided to Ministers by the Covid Highest Risk Division.

885. Throughout the period the Shielding/Highest Risk Division liaised with other policy areas, Health Boards and local authorities to ensure that those people deemed at elevated risk of Covid-19 were considered and given sufficient support to access health care systems.

886. The SG, via the Pharmacy and Medicine Division, worked with pharmacies to support the delivery of prescriptions to those who needed support, including those who were shielding, prioritising those who were not able to leave the house. Those who did not have existing support to collect prescriptions and were without support of family, neighbours or friends were able to contact the National Assistance Helpline so that local assistance centres could find someone (who was ID checked) to make a delivery, provided earlier in the statement [CL8/264 – INQ000470036]. Hospital care teams made separate delivery arrangements for those receiving medicines or equipment from a hospital care team.

887. On 23 March 2020, a submission around wider support including pharmacy provision was sent to the First Minister, Deputy First Minister, Cabinet Secretary for Health and Sport, Cabinet Secretary for Justice, Cabinet Secretary for Finance, Cabinet Secretary for Communities and Local Government, provided earlier in the statement [CL8/238 – INQ000244353].

888. A letter was issued to the Highest Risk List patients in March 2020 with details of pharmacy support available, provided earlier in the statement [CL8/280 – INQ000117028].

889. On 14 April 2020, an SMS was sent to people who had opted into the service advising that Local Authorities would help with access to medications. They were advised that they could also phone the National Assistance Helpline.

890. In January 2021, the Highest Risk Division worked with Vaccination officials, Health Boards, and local authorities to arrange and communicate additional support with transport to vaccination for people on the shielding list, to support safety by avoiding use of public transport (especially at Level 4) and access to vaccination clinics.

891. In January 2021, the Chief Pharmaceutical Officer issued a circular setting out the introduction of a time limited delivery service, via community pharmacy, to help support those individuals most at risk as well as to alleviate the pressures on the pharmacy network and wider NHS services, provided: [CL8/281 – INQ000328676]. The cohort to benefit includes persons shielding, all people deemed to be at elevated risk (as per the NHS influenza vaccination criteria but excluding those aged 55–64), those self-isolating and those whom in pharmacists' professional judgement would warrant such a service.

892. The early Shielding policy, in which people were advised to self-isolate strictly, was an example of a precautionary approach, which was based on the limited evidence available at the time. The evidence as to who was at risk from Covid-19 developed from the time of the initial advice to shield, and decisions were made based on the best available evidence.

893. More broadly, it was recognised early in the Shielding/Highest Risk programme that the policy of strict self-isolation for those on the Shielding List could negatively affect people's mental health and physical wellbeing. This was informed by a user research team embedded in the Shielding/Covid Highest Risk Division, who conducted a high-level of engagement with people asked to shield throughout the period April 2020 – April 2022. The purpose of this team was to inform policy design, support packages, and embed a deeper understanding of lived experience

of shielding in the division. This produced insights from early May 2020 into the realities of shielding and is provided: [CL8/282 – INQ000147411].

894. On 29 May 2020, it was agreed to extend the shielding period beyond the initial 12 weeks in principle owing to prevalence levels, but it was agreed that an innovative approach to shielding should involve moving towards a more individual assessment of risk.

895. A larger online survey was conducted in early July to find out about:
- People's experiences of shielding as measures eased;
- The mental health of people who were shielding;
- Information needs for people shielding as measures eased.

896. 3,033 survey responses were received from people who were shielding, and the very high response rate – over 72% of those contacted – underlined people's need to communicate their experience.

897. Key findings from this survey indicated continued high levels of anxiety and fear about catching Covid-19, concern that guidelines were not being followed by the rest of society, and that the shielding group felt forgotten.

898. In addition to the mental health impacts of shielding, the insights gathered via this survey highlighted the practical challenges in following the advice, especially if people lived in multi-generational households, with people who were key workers, with school age children, or required or provided care.

899. These insights significantly shaped SG policy and were shared with UK Government and other devolved administrations. Later, research was also undertaken with service users to inform the design and delivery of the Shielding text alert service, a personal risk information booklet, and to provide LFD tests to adult contacts of people on the shielding/highest risk list.

900. This shaped the SG's ongoing communications strategy to continue to support this group beyond the initial shielding period and after the advice of strict shielding was lifted, providing timely and helpful information and advice for as long as it was necessary.

901. The removal of the strict self-isolation advice was done on an incremental basis, informed by prevalence of the virus in Scotland and bearing in mind the detrimental impacts of Shielding. On 4 June 2020, it was agreed to change the Shielding advice from 18 June to recommend people resume outdoor exercise as a first step in transitioning out of strict self-isolation.

902. A decision was taken to 'pause' shielding in Scotland from 31 July 2020 if low case numbers continued, owing to the emerging evidence of the detrimental impacts on mental health and physical wellbeing of being asked to shield. The timing of this diverged from the UKG approach in England and from that of other devolved administrations.

903. The Covid Highest Risk Division also worked with PHS to make sure the first and second phases of the shielding programme were robustly evaluated.

904. PHS published a report in January 2021, showing results from a survey conducted between December 2020 and January 2021, which explored areas such as the impact of services and support provided by the SG's Shielding Division, thoughts on vaccination, and how pausing shielding in Scotland had impacted various aspects of life.

905. User research and feedback also highlighted the detrimental affect Shielding had on mental health and wellbeing and contributed to the end of the strict shielding policy (self-isolation). It also identified an appetite for a voluntary social distancing programme which resulted in the development and launch of the Distance Aware scheme.

906. As additional support, guidance on 'Balancing the risks of everyday living during coronavirus' was published on 7 December 2020 to help people at highest risk start to make their own risk-based decisions. This was based on feedback from research that people felt abandoned, scared and continued to self-shield, so this was an intervention designed to encourage people to regain a better quality of life.

907. In December 2020 and January 2021, the Covid Highest Risk division carried out a survey among people at highest risk (then known as the Shielding List) in Scotland. It explored areas such as: the impact of services and support provided by the SG's

Shielding Division, the vaccination programme, and the effects of pausing shielding in Scotland, provided: [CL8/232 - INQ000147410].

908. Survey feedback highlighted that 15% of respondents felt there was not enough communication about the pausing of shielding, and expressed feelings of being unsupported once shielding was paused.

909. On 28 June 2021 an agreement was made with a proposal to move the narrative around Shielding to 'People at Highest Risk from Covid' and to change the Shielding List to the Highest Risk List. Shielding had paused close to a year previously, and no return was made to that very restrictive form of shielding again. This was largely because of the associated detrimental impact to mental and physical health relative to the protective benefits of shielding. User research and PHS survey work showed large numbers continued to 'self-shield' and using this terminology was confusing and a contributor to people who no longer needed to shield doing so.

910. Since the Shielding/Highest Risk List ended, SG has had no insight into the ongoing challenges and situation for the approximately 185,000 people who were on the list. However, SG are aware of a considerable number of people who may continue to restrict contact with others and the outside world and, therefore, may not feel supported by the SG. Several of whom have a high profile on social media and who also actively engage with Parliament. Currently, the SG has no means of understanding the scale of this issue and how we might be able to support those individuals so they can start to regain a better quality of life.

911. A user research directory was created within the Shielding/Covid Highest Risk Division which details all user research carried out during the period of the Shielding/Highest Risk List which informed our communications and policies throughout the Shielding/Covid Highest Risk timeline, provided above [CL8/282 – INQ000147411], [CL8/284 – INQ000285950] [CL8/232 - INQ000147410] [CL8/285 – INQ000326400] [CL8/286 – INQ000147409].

912. Regional Resilience Partnerships (RRP group) meetings brought Local Resilience Partnerships (LRPs) and SG together on a regular basis. These meetings allowed operational issues relating to shielding support programmes to be addressed and to exchange information, and for questions to be raised and resolved, provided:

[CL8/287- INQ000468161]. RRP and LRP are multi-agency partnerships made up of representatives from local authorities, NHS, emergency services and voluntary sectors.

913. Health and Wellbeing Reference Group (HWRG) had representation from LAs, Community Health Partnerships, the third sector, Resilience Partners and SG. The group considered, discussed and advised on support needed by the Shielding community to maintain their physical and mental health during the pandemic. The terms of reference are provided: [CL8/288 - INQ000468162].

914. Additionally, regular, if ad hoc, meetings with charities and organisations representing people at highest risk were held from the outset (examples include British Red Cross, Blood Cancer UK and Kidney Care UK).

915. From a policy perspective, there was clarity about who internal stakeholders were: Ministers, Covid groups and three clinical and scientific groups (the Clinical Guidance Cell, CLAGS and the C19AG).

916. Further engagement took place with Food Standards Scotland, GPs, both direct and through BMA (British Medical Association), Health Boards, local authorities SOLACE and COSLA (primarily through Regional Resilience Partners) and Royal College of Physicians, as well as Community Pharmacy Scotland, and supermarkets (for food boxes and priority delivery slots) and also with UK government partners.

Use of technology in the response to Covid-19

917. The use of digital technologies was critical in the SG's response to Covid-19. In Digital Health and Care these included initiatives tailored to patients and support to the health and social care workforce. This included the NHS Near Me Programme, national rollout of Microsoft Office Teams and working with Health Boards and local authorities to provide laptops, Wi-Fi and connectivity for staff. This required detailed guidance to be issued in a timely manner, with robust support and engagement from all delivery partners of Digital Health and Care. This enabled delivery at pace and scale and ensured appropriate levels of ongoing support.

918. The rapid scale up of NHS Near Me is an example of the type of support given by SG through use of technology. NHS Near Me (Scotland's public-facing name for the Attend Anywhere platform) was an existing video consulting platform which was rapidly rolled out for use once social distancing and restricted travel came into effect. Prior to the pandemic, NHS Near Me was already in use across 11 of the 14 territorial Health Boards, along with a range of third sector organisations. Approximately 1,000 video calls per month were undertaken in early 2020. Guidance notes are provided: [CL8/289 – INQ000470048] [CL8/290 – INQ000470049] [CL8/291 – INQ000470050] [CL8/216 - INQ000470051] [CL8/293 – INQ000470052] [CL8/294 – INQ000470053] [CL8/295 – INQ000470054] [CL8/296 – INQ000470055] [CL8/297 – INQ000470056] [CL8/298 – INQ000470057] [CL8/299 – INQ000470058] [CL8/300 – INQ000470059] [CL8/301 – INQ000470060] [CL8/302 – INQ000470061].

919. Detailed guidance was issued from March 2020 supporting the accelerated scale-up of NHS Near Me within primary and secondary care, provided: [CL8/303 – INQ000470062]. This support was issued to all Health Boards with the support of NHS Healthcare Improvement Scotland (NHS HIS). Guidance was followed up with status reporting and follow up briefings with Digital IT Leads to ensure issues and challenges were identified and addressed swiftly.

920. There were also two national media releases to raise awareness of NHS Near Me (in April and June 2020) which included national coverage on TV and press and were accompanied by bespoke briefings for Health Boards and patients. An in-depth evaluation of the video consulting service during Covid-19 was published in March 2021, provided: [CL8/303 – INQ000470062]. It showed that between March and June 2020, at the start of the pandemic, there was a fifty-fold increase in video consultations, from 330 per week to just under 17,000.

921. The rapid scale-up of a 2018 commitment to upgrade and roll out Microsoft Office 365 and Teams applications took place across NHS Scotland as an immediate priority to support business continuity challenges during Covid-19.

922. This digital technology allowed staff to leverage collaboration and communication opportunities across teams, departments, and boards, as well as significantly improving staff ability to work remotely. Prior to the rollout of Microsoft Teams there was a reliance on teleconferencing through the Skype for Business platform, which

was not enabled for cross organisation working, and a poor level of connectivity was experienced by all users.

923. Microsoft Office 365 and Teams were fully configured to be a safe and secure platform for messaging, calls and video. The Microsoft platform also provided ability to share, view and edit files across multidisciplinary teams which was invaluable to support the pandemic response. The initiative was led by NHS NSS and was completed by end of March 2020.

924. SG applies a people-centred and human rights-based approach to assessing the equality and inclusion impacts of innovative technology and platforms. SG carries out impact assessments in line with the Equality Act 2010 and The Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 which set out protected characteristics. Robust stakeholder engagement took place through existing equality and diversity groups to inform decision making and capture concerns and issues to then identify appropriate mitigations. Further details of this stakeholder engagement follow.

925. An example of the people-centred approach was the launch of the Protect Scotland app which was designed to support proximity alerts and to share the Protect Scotland Equalities Impact Assessment (EQIA). This clearly addressed the accessibility of the new technology introduced by SG during the Covid-19 response in relation to protected characteristics, provided: [CL8/304 - INQ000414602].

926. A Children's Impact Assessment for Protect Scotland was carried out to assess any potential impact for children and young adults, provided: [CL8/305 - INQ000414603].

927. To support accessibility of the Impact Assessments, easy read and translated versions of all key documents were published.

928. Protect Scotland had a dedicated website Protect.scot which was promoted by marketing providing supporting information and video demonstrations of the app. There was also robust engagement from SG which provided stakeholders with access toguidance on how and when to use the app to support those with specific needs. Protect.scot was promoted by and connected to the NHS Inform website.

929. The app design for Protect Scotland met Apple and Google's requirements and the Web Content Accessibility Guidelines (WCAG), provided: [CL8/306 - INQ000469988], which reference accessibility standards / guidelines for mobile accessibility. This includes the need for responsive design, multiple interaction methods and designing for assistive technologies, allowing Protect Scotland to be used with their App readers to make it more accessible on devices.

930. Throughout the Covid-19 response supporting documentation for services such as vaccination and certification were issued in over 30 languages, including Braille and British Sign Language (BSL).

931. SG Digital Health and Care directorate also made data available across local government and Health Boards to enable key initiatives including shielding, vaccinations, housing, and food initiatives.

932. Prior to the Covid pandemic, SG Digital Health and Care had established an Equalities Board to be a lead stakeholder group offering advice and direction on new technology and systems. The Board continued to meet (virtually) during the Covid-19 pandemic to provide advice and direction for this work from a citizen or protected group perspective. The Equalities Board had a wide representation from third sector organisations including the Royal Institute for the Blind (RNIB) and Deaf Scotland.

933. The SG led "Connecting Scotland" programme focused on providing laptops, devices and Wi-Fi to facilitate greater access to digital services during Covid-19. The Connecting Scotland programme initially focused on those who were asked to shield or to avoid any outside contact, recognising the importance of enabling access to this key group. Digital Health and Care also targeted greater access to technology, devices, training and support in Care Homes across Scotland, and support for Care Homes was discussed at all Digital Health and Care Silver Command group meetings during the Covid-19 response. Digital skills and increasing confidence in using the new devices was also delivered including the rollout of digital champions and support. The impact of the programme has been evaluated and is provided: [CL8/307 – INQ000469989].

934. The Scottish Government commissioned the National Vaccination Helpline, operated by the National Contact Centre at NSS. This allowed people to phone and enquire about vaccination appointments. The contact centre would also take details of patients and feed them back to Health Boards for assessment, e.g. to request a vaccination letter if someone believed they were in an immunosuppressed or at-risk group and had not been invited forward for vaccination, or to request a home vaccination visit if they were housebound but not noted on Boards systems as such. The contact centre was also able to rearrange people's appointments for them where they were unable to so do online.

935. The SG also commissioned the national online booking portal so that people could book online, offering a choice of location, date and time of appointment.

936. There has been continual analysis, upgrade and development of the online portal, the national vaccination helpline and NHS Inform by SG, PHS and NSS. Some examples are noted below (many more are detailed in the programme EQIAs):

- **disabled patients and in particular those with sensory impairments:** invitation letters were reviewed by RNIB for reader software compatibility; BSL content was included on the NHS Inform NCC call handler script; easy read and large print materials were produced and disseminated; NHS Inform information was made available in audio format; location filters were included on the portal for facilities such as parking, wheelchair access and a hearing loop;
- **older patients:** analysis shows this group are less inclined to use the portal/digital methods and are likely to use the helpline. All those who do not have a digital preference were sent a conventional letter of appointment;
- **patients whose first language is not English:** translators were available at NCC, and leaflets/materials on NHS Inform were produced in 38 languages.
- **patients with literacy issues:** easy read, large print and audio versions of materials were made available on NHS Inform and at clinics;
- **patients living in areas with poor, or no, internet connectivity:** those without a digital preference were sent lettered appointments with information leaflets and could call NCC free of charge to reschedule, book or cancel;
- **patients without permanent homes:** a policy steer and guidance were given to Boards for transient populations e.g. the gypsy traveller community, the homeless and those engaging with drug and alcohol services who may not have had permanent homes. The policy decision was made to note the homeless and

substance misuse groups as at 'clinical risk' due to the prevalence of complex co-morbidities;

- **patients in lower socio-economic groups:** in winter periods SG funded the SAS to provide additional outreach resource to the Health Boards focusing on communities residing in areas of high Scottish Index of Multiple Depravation and poorer rural areas. Continual refinement and developments to the scheduling system looked to schedule people as close to their home address as possible to minimise the cost and effort of travel for vaccination.

937. NHS Education for Scotland (NES) were commissioned to develop the Vaccination Management Tool (VMT) in September 2020 to improve the 'as is' approach that existed at the time. This relied on paper printouts for the Scottish Immunisation Recall System (SIRS) which were annotated, manually keyed back into SIRS and then posted as PDF records to General Practitioner Information Technology. As a solution it was designed to be a secure method of recording data at the point-of-care to a national database. It would provide a standardised clinical management and workflow and be accessible on different devices.

938. The first version of the tool was developed in approximately eight weeks and piloted from the end of October 2020 in flu clinics with Greater Glasgow and Clyde, before national rollout at the start of December ready for Covid-19 vaccination clinics. Key improvements that were made to the VMT from October 2020 to March 2022 are as follows:

- January 2021: Integrations with the National Vaccination Scheduling System
- March 2021: Retrospective keying of vaccination events
- April 2021: Incomplete vaccination sign out notifications
- June 2021: Incomplete vaccination sign in notifications
- July 2021: Addition of clinic statistics
- August 2021: Co-administration of vaccines supported
- September 2021: Product and batch number pre-selection
- October 2021: Assign a Community Health Index (CHI) number to a no CHI number vaccination record
- November 2021: Record outside Scotland vaccinations
- January 2022: Ability to lookup vaccination information held on National Clinical Data Store that was not recorded via VMT

- March 2022: Support for clinics to administer shingles and pneumococcal vaccines added.

Future Risks, Reviews, Reports and Lessons Learned Exercises

939. The Covid-19 pandemic presented, among other things, an opportunity to ensure that future risks, including pandemics, are better prepared for, as a result of the experiences and lessons learned, in Scotland and the rest of the UK. The SG is committed to ensuring that all appropriate steps are taken to ensure that lessons are learned and necessary changes are implemented to assist this. Further detail on relevant reviews, reports and lessons learned exercises relevant to the scope of Module 3 are detailed in the paragraphs below. In July 2020, the Directorate for Population Health asked PHS to review the Incident Management Guidance, provided earlier in the statement [CL8/050 - INQ000130954]. The guidance was lightly edited to reflect the country was in a pandemic.

940. The Directorate for Population Health helped to prepare the report, *Lessons identified from the initial health and social care response to Covid-19 in Scotland* [CL8/309 - INQ000147847], which covered the initial six months of the response to the pandemic and was published in August 2021. The report identified what had worked well, various opportunities for further resilience and key takeaways for leaders in reference to various topics. The key findings were as follows:
    - In relation to 'Capacity and Demand Modelling', the report highlighted the following opportunities for further resilience:
        - Further operationalisation of modelling outputs remain challenging due to uncertainty inherent to the data and a lack of integration across organisations. Dealing with many individual bodies to translate modelling figures into decision-making presents a challenge;
        - Skills and experience in modelling remain quite specialist, with limited support available to understand assumptions in the data. Leaders should ensure adequate support remains available to modelling teams to support wellbeing over the coming months and a pipeline of future resource is appropriately identified and monitored to cope with on-going demand;
        - Where physical adaptations are made to existing or new sites, consultation with patients, staff and trade unions remains crucial to

ensure both buy-in and all feedback given can be considered to provide the best possible care;
    - Communication with staff and patients about the process of zoning is important, particularly where redeployment is required across sites;
    - On-going reviews of the 'new normal' will be needed to embed aspects of redesigned services that can be maintained and embedded going forward.
- In relation to 'Primary Care', the report highlighted the following opportunities for further resilience:
    - Central source of guidance, tools and case studies available through Healthcare Improvement Scotland;
    - A wider range of services can support more effective primary care but needs close alignment with local government and Public Health teams to ensure consistent provision of care;
    - Continued uptake of digital consultations will be important but recognise there may be barriers around access and infrastructure in the community.
- In relation to 'Supply of PPE', the report highlighted the following opportunities for further resilience:
    - The ability to rely on stockpiles of PPE has been critical to the success of some organisations but can also negatively impact on the wider response if stockpiles are used inefficiently. Collaborative working across sectors and organisations should mitigate this risk;
    - Consideration into clear messaging so that less anxiety is felt by organisations in the delivery of services;
    - Access to accurate, real-time data across organisations will provide a basis for more effective decision-making.
- In relation to 'Tools, Infrastructure and ways of working', the report highlighted the following opportunities for further resilience:
    - Recognise that the rollout of digital tools will strain services if supporting infrastructure is not appropriately scaled up, particularly around integration of systems. In addition, service redesign, culture, leadership and skills are all important areas to evaluate alongside the integration of digital tools;

- Data has become central to the pandemic response. Leveraging this as part of the 'new normal' will provide opportunities to work more effectively and more closely with non-healthcare organisations.

- In relation to 'Access', the report highlighted the following opportunities for further resilience:
  - Recognise that digital will not come naturally to all and leaders must consider access issues, whether it be educationally or having the appropriate infrastructure, for certain stakeholder groups;
  - Digital is a key enabler for access in many respects and leaders must consider how to roll this out more widely beyond Covid-19 response.
- In relation to 'Internal and External Communication', the report highlighted the following opportunities for further resilience:
  - Guidance to organisations needs to be coordinated and consistent. Constant changing guidance has been problematic to some organisations with particular concerns around version control;
  - Consideration into keeping staff updated regularly throughout a changing landscape where staff are working flexibly across different organisations and at home. Consistency of message across digital and physical communications (i.e. in wards) will continue to be crucial.
- In relation to 'Shared Vision', the report highlighted the following opportunities for further resilience:
  - Ensure that there is an alignment between the new purpose and continuing with the core requirements/provision;
  - A clear mandate and well-defined vision can work effectively, especially in rapid-response environments.
- In relation to 'Workforce Supply', the report highlighted the following opportunities for further resilience:
  - Recognise the value of volunteer staff in freeing up clinical staff to focus on my value-added activities;
  - Consider the governance around rapid recruitment when trying to meet peaks in demand;
  - Increasing digital provision of care impacts of role automation in workforce plans. Scottish organisations should review workforce requirements over the next 5-10 years considering how the pandemic response may have accelerated this process;

- We can take learnings from the initial waves of Covid-19 around how we can rapidly reconfigure the workforce to direct more staff in service to frontline and emergency response, making use of retirees and returners to provide 'business as usual' services such as ward rounds, which would create additional capacity. Overall, future resilience in relation to workforce requires a holistic view on capacity, rather than filling specific gaps or roles with skills that are temporarily in short supply;
- Recognition is required that total clinical workforce capacity is predetermined and finite, it is therefore important to identify that limited additional productivity and/ outputs can be offered by the current workforce, without running risks related to workforce wellbeing, effectiveness and service recovery.

- In relation to 'Wellbeing', the report highlighted the following opportunities for further resilience:
  - Recognise that wellbeing response to the pandemic will be needed in the long-term. Leaders must consider how to transition this into business as usual and continue to support the physical and psychological wellbeing of staff;
  - Line managers continue to be a source of support to staff. Leaders should consider how to equip managers with the necessary training/resources on how to support staff remotely.
- In relation to 'Governance and Leadership', the report highlighted the following opportunities for further resilience:
  - It is important for leaders to understand has there always been existing strong leadership skills and approaches within organisations prior to the Covid-19 response;
  - Lessons identified around command and control highlights the ability of flexible governance structures that can prove pivotal in a rapid response environment;
  - Ensure there is enough representation to counteract unintended consequences of decisions could be considered going forward, for example increased clinical representation in operational decision-making.
- In relation to 'Service Redesign', the report highlighted the following opportunities for further resilience:

- Service redesign requires statutory consultation with the public and patients, and any organisations looking to embed changes from the Covid-19 response will need to ensure this is managed appropriately;
- Consistent themes across new models of care should be identified and kept in mind as services continue to transform. Regional hubs, targeted patient navigation and the use of digital will remain central to service provision going forward.

941. A submission to Ministers summarising the key findings from the draft report, which was received 10 December 2020, is provided: [CL8/308 - INQ000468178], as is the final report: [CL8/309 - INQ000147847].

942. The Directorate for Population Health leads on planning for, preparing for, managing Covid-19 and future pandemics, and providing advice to Ministers. To help provide that advice, the Standing Committee on Pandemic Preparedness (SCOPP) was established in or around August 2021. SCOPP's remit extends to:
- advice on preparedness for and response to future pandemics, but not to manage the response to future pandemics
- all aspects of preparedness in relation to public health and connected issues, but not to economic or wider aspects of preparedness not connected to public health.

943. Information about the Standing Committee is published on the SG website.

944. As well as supporting the DG HSC family, lessons learned exercises have been, and continue to be, carried out within the Directorate of the COO. This includes EPRR Division working with the four nations on reviewing a range of national countermeasures and reviewing our procurement and deployment arrangements with NSS. It is acknowledged that the pandemic is not over, and officials will continue to make changes or improvements to support the UK and Scotland's future pandemic preparedness.

945. At the level of individual teams, all key files and documents, such as desk instructions, relating to the DCOO pandemic response have been stored on the Scottish Government's electronic records and document management system, (eRDM), and are readily accessible if required again at a future point.

946. In June 2022, the UK and Devolved Administrations Board (UKDA), a four nations board attended by officials from the UKHSA, the SG, the Welsh Government and the Northern Ireland Executive, commissioned the SG to lead on four nations 'test, trace and isolate lessons learned' activity. The Directorate for Population Health has overseen and led the work on behalf of the four nations.

947. This report was not intended to be a clinical review, or to provide evidence of the absolute impact on transmission of delivery models across Test Trace and Isolate (TTI). Rather, it was intended to provide a review of lessons learned to date. The framing of this activity was to consider a potential response in relation to high case numbers of Covid-19 in future where the clinical view was that the risk of population wide health harm remained broadly similar to the assessment of the risks at that time.

948. The scope of this 'lessons learned' activity is to provide a collective view across the four nations on:

- the efficacy TTI delivery models and their suitability, considering constrained budgets currently and reduced population-wide health risks;
- an overview of the various aspects of TTI and a literature review of the evidence base;
- an assessment of aspects of TTI as part of winter preparedness/contingency and how its deployment might support resilience of key workforce groups.

949. To deliver this report, officials from Scotland, Northern Ireland, Wales, and England attended a weekly work group session between June 2022 and September 2022. Analytical input including the literature review activity and modelling was delivered by the Health and Social Care Analysis (HSCA) team within the SG, which led Covid-19 Test and Protect analysis throughout the pandemic.

950. The draft report remains in progress with officials continuing engagement and work to finalise it. In September 2022, UKHSA officials notified officials from Wales, Northern Ireland, and Scotland that their view was that the paper would not be put forward to the UK and Devolved Administrations Board, following the reconstitution of that board and revised governance from November 2022.

951. SG officials are participating in two key reviews which will feed into future pandemic policy/preparedness. These are the UKG-led reviews of pandemic/emergency planning countermeasures and the pandemic disease capabilities board

952. In 2019 the HCID subgroup provided a comprehensive set of recommendations to improve future resilience. Since then, it is acknowledged that significant learning has occurred because of Covid-19. The subgroup has now reformed, and work on the recommendations is once again being progressed.

953. *Scotland's national respiratory surveillance plan* provided: [CL8/310 - INQ000147522] and the *Plan for monitoring and responding to new SARS-CoV-2 variants and mutations (VAMs),* provided: [CL8/311 - INQ000147521] are two PHS planning documents that inform national health protection preparedness work.

954. The COVID Four Harms Group brings together the views from across the four harms which are defined in the Lessons identified from the initial health and social care response to Covid-19 in Scotland, provided above [CL8/309 - INQ000147847]. This incorporates the views of the CMO (either direct or via clinical colleagues) on the overall threat level of Covid-19 in Scotland; relevant data across Harms 1 and 2; and any information relating to the threat of potentially dangerous variants and mutations. The group provides governance, challenge, and scrutiny of the various legacy programmes. It forms the Programme Board to review plans, risks and issues and activity updates. It meets regularly and ensures that the SG can react to an outbreak, variant or mutation.

955. The Process Map attempts to map each individual phase of the Covid-19 threat level, moving to 'high' during the immediate period (Day 0 – Day 10). Included within these are the potential 'owners of actions' identified in each phase. Such preparatory work helps to step up the Covid-19 response at speed.

956. Desk instructions have been filled out by the key departments that mounted a Covid-19 response. As staff members move roles, and the Covid-19 dedicated teams reduce in size, the desk instructions ensure that any necessary restrictions, key files and documents are easily understood and accessible. Areas will regularly update their instructions.

957. A review has been carried out, commissioned by Public Health Scotland, of the Scottish Health Protection Network (SHPN), designed to ensure its form, structure and outputs remain fit for purpose, provided: [CL8/312 - INQ000414592]. The SG contributed to this and has responded to the report.

958. The SG has welcomed the recommendations of the review, whilst acknowledging that further work will need to be done to understand how they should be implemented.

959. The Directorate for Population Health, which is responsible for planning for Covid-19, has prepared for future threats from Covid 19 and any variants and mutations by developing the Variants and Mutations and Surveillance Plans Health Resilience and Protection Division work closely with Public Health Scotland (PHS) and other key stakeholders to ensure there is a comprehensive respiratory surveillance programme in place to monitor respiratory pathogens including SARS-CoV-2. Scotland's National Respiratory Surveillance Plan was published in September 2022.

960. The individual workstreams in Scotland's National Respiratory Surveillance Plan work together to inform the PHS Variants and Mutations Plan (which in turn sets out the processes needed to identify, investigate, risk assess and respond to Covid-19 VAMs in Scotland, provided above [CL8/311 - INQ000147521] [CL8/310-INQ000147522].

961. The Framework for Cancer Surgery, published July 2020, referenced within *Lessons identified from the initial health and social care response to Covid-19 in Scotland* are provided: [CL8/313 - INQ000343250]. The clinical prioritisation guidance is presented within this Framework (pages 7-18).

962. The 2011 UK */ Four Nations Influenza Pandemic Preparedness Strategy,* provided earlier in the statement [CL8/028 - INQ000102974], remains relevant in relation to future pandemic flu threats, albeit subject to current reviews in light of the Covid-19 pandemic experience.

963. In May 2020, the SG commissioned researchers at the University of Glasgow to undertake the Scottish Covid-19 (SCOVID) Mental Health Tracker Study. This was to help understand the impacts of the coronavirus pandemic on people's mental

health and wellbeing in Scotland, particularly the differential impacts on sub-groups of the population. The first wave of the study ran in May 2020, and surveyed a sample of adults (18 and over) in Scotland. There were four subsequent waves over the 12-month period with the final wave completing in July 2021, provided: [CL8/314 - INQ000414597] [CL8/315 - INQ000414598] [CL8/316 - INQ000414599] [CL8/317 - INQ000414600] [CL8/318 - INQ000414601].

964. The SG worked to identify the successes, challenges, and lessons to be learned relating to PPE supply during the Covid-19 pandemic. Several reviews and exercises have been carried out, which have been provided in the chronological list below. The key lessons to be learned from the Covid-19 pandemic in relation to healthcare systems are:

- We must ensure that effective mechanisms for collaboration and communication between the Scottish Government and stakeholders are in place in the event of a future pandemic. This is especially relevant in regard to real time data sharing, stockpile management and being able to effectively prioritise PPE supply where it is most needed
- Scotland's traditional PPE supply routes, just-in-time supply model and PPE stockpiling arrangements were not sufficient in pandemic circumstances. A reformed stockpiling and buying approach for pandemic PPE is required
- Long term and sustainable PPE supply arrangements are required for the primary care sector to ensure the challenges of any future pandemic can be met
- During the Covid-19 pandemic Scotland always had a sufficient supply of PPE. However, as the traditional routes of supply failed under worldwide demand pressures, new supply chains had to be set up quickly in order to meet demand, therefore, surge capacity needs to be available to ensure that anticipated PPE demand is met during the volatile early stages of any future pandemic

965. This progress report also refers to Audit Scotland's June 2021 review of Covid-19 PPE and details work done in response thereto. The main themes identified within this paper were communication, collaboration, and the fundamental inadequacy of the traditional just-in-time PPE supply system in the context of the Covid-19 pandemic.

966. This work has informed the development and implementation of the future pandemic PPE supply arrangements, to secure a resilient and robust supply of PPE

for the future. The main themes identified were further tested in a public consultation on future pandemic PPE supply. We consulted on the key lessons learned identified, whether any others should be considered, and for respondents' views on the proposed supply arrangements.

967. All but a few respondents who engaged with the lessons learned section of the consultation agreed with the key lessons learned found. Some respondents also proposed additional lessons for consideration within the free text element of the section. The key themes were:

- improved collaboration and communication
- criticism of PPE allocation
- importance of domestic supply
- prioritisation of quality and suitability of PPE
- addressing PPE cost inflation
- reducing PPE waste.

968. From December 2021 work to consider lessons learned and incorporate them into future PPE preparedness policy continued as part of the PPE Futures Programme.

969. The PPE Futures Programme closed in April 2022 and was superseded by the PPE Supply Implementation Project to develop and implement the new pandemic PPE supply arrangements through the remainder of 2022 and into 2023. This project has now ceased. Implementation of arrangements will be taken forward by NSS and remaining relevant Scottish Government policy teams.

970. The Implementation Project Board (IPB) was formed with the aim of delivering robust cross-sectoral pandemic PPE provision in Scotland and to ensure we have a resilient supply in place ahead of any future pandemic. The Board was made up of SG policy officials and NHS National Services Scotland. It was chaired by the Deputy Director, Health Infrastructure, Investment and PPE Division. Its remit was to deliver the aim above, by steering, directing, and providing challenge to the work of the PPE Supply Implementation Project throughout the financial year 2022-23.

971. Meetings were held virtually on a monthly basis, or as the project required. Meetings were attended by SG officials, and representatives from NHS National Services Scotland (NSS):

SG Board members:

- Deputy Director, Health Infrastructure (Chair)
- Head of SG Procurement Services
- Head of Emergency Preparedness, Resilience and Response.

Non-SG Board members:

- Director of National Procurement, Commissioning & Facilities, NSS.
- Members of the project implementation team, consisting of SG policy officials and representatives from NHS National Services Scotland, were also in attendance.

972. A chronological list of any internal or external reviews, lessons learned exercises or similar produced or commissioned by the Scottish Government relating to PPE as (relevant to the issues in the Provisional Outline of Scope for Module 3) since March 2020 is provided below:

Date	**Documentation**
July 2020	Covid-19 Health supply chain programme feedback [CL8/319 - INQ000470064]
August 2020	PPE Division survey results summary [CL8/320 - INQ000470065]
February 2021	PPE Single Procurement Framework Deep Dive Outcomes Paper [CL8/321 - INQ000470066]
June 2021	Lessons Identified from the initial health and social care response to Covid-19 in Scotland [CL8/322 - INQ000470067]
July 2021	National Clinical PPE Oversight Group: Lessons Learned July 2021 [CL8/323 - INQ000470068]
October 2021	Centre of Expertise Lessons learned exercise [CL8/324- INQ000470069] [CL8/325 - INQ000470070] [CL8/326 - INQ000470071]
December 2021	Lyreco PPE Framework Lesson Learned Document [CL8/327 - INQ000470072]
December 2022	A consultation on the future supply of pandemic Personal Protective Equipment in Scotland – Analysis of consultation responses – Final Report [CL8/328 - INQ000470073]
April 2023	Pandemic personal protective equipment (PPE) future supply: lessons learned [CL8/329 - INQ000470074] [CL8/330 - INQ000470075]

973. The SG played a significant role in directing the healthcare response to Covid-19 in Scotland and always tried to make the best decisions possible using the information that was accessible with the resources available. However, the SG recognises that there are areas where performance could have been improved and is committed to making the most of opportunities to learn from the experience of the pandemic and amend policies and processes accordingly. As such, the SG is grateful to the UK and Scottish Covid-19 public inquiries for the opportunity to draw upon their forthcoming conclusions and recommendations when making future further improvements to healthcare provision in Scotland.

Request for Chronologies

974. The requested chronologies are provided through a table, provided: [CL8/331 - INQ000469990].

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