Thursday, 14 November 2024

(10.00 am)

LADY HALLETT: Mr Mills.

MR MILLS: My Lady, may I please call Professor Colin McKay.

PROFESSOR COLIN MCKAY (affirmed)

Questions from COUNSEL TO THE INQUIRY

MR MILLS: Your full name, please.

A. Colin John McKay.

Q. Professor, you have provided a statement to the Inquiry. For reference that is INQ000478114.

You are currently the Deputy Medical Director of Corporate Services at the NHS Greater Glasgow and Clyde Health Board?

A. That's correct.

Q. And from 2019 to 2023 you were the Chief of Medicine at the Glasgow Royal Infirmary, which sits within the health board; is that right?

A. That's right. It's one of the four acute hospitals within the health board.

Q. First, please, background to the hospital. What can you tell the Inquiry about the age of its estate, and the characteristics of the population it serves?

A. Well, this will be the 300th anniversary of Glasgow Royal Infirmary. The oldest parts of the estate that are still functioning were built in the early part of

the century, opened in 1914, and much of the estate that houses our medical wards and older people's wards were built between the 1920s and 1930s, and those wards are still very much as they were at the early part of the century.

Q. And the demographics, please, about the population it serves?

A. Yes. The hospital sits in the east end of Glasgow, which is where many of the most deprived communities in Glasgow live, and just to give you a flavour of that, the life expectancy for men in that part of the city is maybe 10 to 14 years less than the parts of the city where many of the medical staff might live.

Q. The first topic, please, the efforts to increase capacity. At paragraph 43 of your statement you explain that pre-pandemic the GRI's ICU was a 20-bedded unit. That was comprised of twelve level 3 (that is ventilated) and eight level 2 (that is high dependency) beds. From that baseline, how did the GRI go about increasing its ICU capacity in March and April 2020?

A. So when we were given the directive to look to increase capacity, we examined our estate to look to the areas which would be suitable for flexible use for critical care patients. The first area was a small recovery area next to our obstetric theatres which we repurposed for

an additional six beds, I believe, in that area. And then we planned to move to the theatre reception area, where further beds could be made available. And beyond that we clearly had looked to the potential future of escalating the number of beds beyond that into our theatre recovery area and even into theatres themselves.

LADY HALLETT: Professor, you have a soft voice. If you could keep it up, I would be really grateful. It's probably my hearing, actually, rather than your voice but anyway.

MR MILLS: A soft voice but the pace is perfect.

In respect of efforts to provide the staff then for the increased number of beds, at your paragraph 57 you say the GRI asked nurses with previous critical care experience to bring this to the attention of their line managers so that they could be redeployed to ICU. How many nurses were identified as being able to assist via this route?

A. So, as you say, the first group of staff to be approached were those staff who had actual critical care experience, and those staff could be currently working within any part of the hospital. And I understand that at that point some 21 nursing staff were identified and asked to volunteer for deployment to intensive care.

Q. As well as that, anaesthetic consultants and trainees

were also asked to support ICU. Why were they chosen?

A. Well, anaesthetic staff in general were those who had the skills with airway management and ventilator management and as we started to wind down elective surgical care, so anaesthetic teams, both trainees and consultants, were redeployed into the intensive care unit.

Q. For those who were redeployed to ICU without the same levels of previous experience as those you have mentioned, can you help us with this, please, how did the GRI go about upskilling those members of staff so that the hospital could satisfy itself that they were ready to carry out ICU work effectively?

A. Yes, so this process was led by the senior nursing teams and medical teams within the intensive care unit and began in February 2020, and staff were taken for periods of time away from theatres or their normal place of work to spend time in the intensive care unit, under supervision of senior staff, and that process continued through February and into March, so that we had a cohort of staff who we felt were as comfortable as they could be, given the very limited time that we had available, to be able to work comfortably in that environment.

Q. You also explain -- this is at your paragraph 34 -- that the model in the first wave was for one ICU nurse to

supervise up to four non-ICU nurse who had been redeployed. Did any of those supervising ICU nurses, ie the "1s" in the 1:4 ratio, ever raise concerns that this ratio placed too great a burden on them?

A. Obviously this would primarily be an issue to look to ask the senior nursing teams, but what has been reported to me in my role was that there were times when the intensive-care-trained nurses felt that they were unable to deliver the -- if you like, the quality of care and supervision that they would normally expect to provide to patients under their care. And feeling responsible for the actions of staff who were less well skilled posed an additional stress on them at that time.

Q. At your paragraph 53 you say that, given the limitations of the GRI's estate, the availability of ventilators and the availability of staff, it was agreed that the maximum ICU expansion would be to 42 beds?

A. Yes, that's correct, that was what we set out in our expansion plan as an absolute maximum, given the limitations of the estate, and particularly staffing.

Q. Was that number achieved?

A. At no time did we need to extend to that number. I think the maximum number of beds that we ever needed was 31.

Q. Can you help with when you reached that 31?

A. I'm not sure I can give you the answer to that without looking through some notes but it was towards the end of the first wave, so that would have been in -- presumably in April/May 2020.

Q. Can you give the Inquiry a sense, please, of the feeling on the ground at the time that that 31-bed capacity was being reached. Was there a palpable fear amongst staff that the ICU would become overwhelmed?

A. In all honesty, I think I can say that that wasn't the primary concern of staff at that time. We had daily calls with the intensive care units across the west of Scotland, we had systems in place for transfers of patients out to maintain capacity, and we always knew that if the extreme situation called for it we would be in a position to expand our intensive care numbers. So I don't think that that was a concern that was openly expressed with me certainly.

Q. Let us consider those transfers, both in and out of the GRI's ICU.

Please can we go to INQ000412901. Thank you.

These are the transfers out of the GRI's ICU:

"Between March 2020 and June 2022, we sent 26 patients out for ICU care from [the] GRI."

And if we look to the second highlighted passage:

"Capacity transfers out totalled 11."

Do we understand from this that there were 11 occasions where patients could not be treated because the GRI's ICU didn't have a staff bed for them?

A. It's a little bit more nuanced than that because the primary reason for transfer of patients out would be to maintain non-Covid capacity, if that makes sense. Because clearly when most of the areas are being used for managing patients with Covid, with AGP restrictions and the need for full PPE, we needed to maintain at all times a small cohort of beds for patients who had other conditions because these obviously continued and so many of the capacity transfers were actually for non-Covid capacity into other intensive care units.

Q. Are you able to indicate when these capacity transfers took place? Were they at a particular time or period during the pandemic, or spread throughout that period March '20 to June '22?

A. I'm afraid I'm not, because the way in which these patients would have been identified for transfer would have come from the emergency department, or medical high dependency areas or other parts of the hospital, so it wasn't something that would be recorded. But it's important, I think, to understand that there are always transfers out for specialist care, for example to the neurosurgical institute or to -- for specialist dialysis

care, for example, in another hospital.

Q. To complete the picture let us consider the times when the GRI's ICU accepted transfers.

We have on screen INQ000412900.

First line, 40 patients received into the GRI's ICU. Again, that's the same period of time, March '20 to June '22.

And the second highlighted passage at the bottom of the screen, ICU capacity transfers in totalled 7.

Do we take from that that the GRI's ICU was able to assist other ICUs when they reached capacity on seven occasions?

A. Yes, that's correct, but again you will see that the majority of transfers in were for other reasons and for specialist care during that time, as happens all the time.

Q. Can we move, please, to IPC guidance. At paragraph 180 of your statement you say this:

"It was also clear on the ground that some of the advice about infection control early in the pandemic was incorrect and unhelpful. We were advised about droplet spread in a situation where airborne spread increasingly seemed possible."

First this, please. What were clinicians seeing on the ground that made them think airborne spread was

increasingly possible?
A. So I think this was first flagged to us by our infection control team who were seeing strange patterns of -- when I say strange, in other words not what we would have expected during non-Covid times. We were seeing spread patterns within our Nightingale wards which were indicative of airborne spread. So patients in a distant part of the ward, for example, would test positive without having had any known or obvious close contact with a patient who had tested positive earlier in another part of the ward.

So they, as the infection control team, raised that concern really quite early on.
Q. Are you able to give the Inquiry an indication of how early?
A. I'm not sure I could do that with accuracy but certainly by April 2020 that was something which we were concerned about.
Q. Those concerns having been raised by members of the IPC team, did that lead to the GRI treating Covid-19 as being airborne spread from that early stage, April 2020?
A. No, we were very careful to comply, as far as was possible, with the guidance that we were issued at a national level and, again, at board level. We had regular discussions through our, what we called the

acute tactical group which is where the governance of all of our guidance was held, and we sought to influence guidance where we possibly could but at no time did we feel that we could -- that we were in a position to deviate significantly from the national guidance that we were given.
Q. Did that create a certain level of tension within the hospital between trying to comply with national guidance at a time when there had been recognition of airborne spread?
A. Yes, it did at times. I certainly remember conversations where we discussed offering respiratory PPE to nursing staff who were managing patients on Covid wards, but there are many complexities to that, one being the availability of PPE early in the pandemic, but other -- but again, the messaging to staff, because by doing that we are, if you like, making -- we're introducing uncertainty to them and perhaps making them feel less safe in the workplace, when we were not in possession of strong evidence on which to overrule what we were being given as the national guidance.
Q. At your paragraph 179 you say:

"It became clear fairly quickly [that] across a range of areas ... NHS Scotland guidance would not be available within the timescale needed for definitive

action."

Can you share with the inquiry any examples of when local guidance was created in the absence of national guidance?
A. I think perhaps the most obvious of those was the cohorting guidance because clearly in a hospital where we had very few single rooms and many open wards, we were forced to cohort patients with similar risk profiles at different times, well in advance of structured Covid cohorting guidance coming out. And this particularly related to the management of patients who were identified as contacts of Covid-positive patients.

So we created our own cohorting guidance and adapted that through the different stages of the pandemic until formal guidance came in.
Q. Did you alert NHS Scotland to the fact that you had created local guidance where there was no national guidance?
A. Yes, my understanding is there were daily conversations with HPS and then ARHAI, as it became, with our deputy director of infection control but these conversations happened at a board level and not at a hospital to ARHAI or HPS level.
Q. Did those within the GRI ever perceive a difference

between guidance issued at a national level and guidance issued by the royal colleges?
A. Yes, there were several examples of that which I've set out in my evidence statement. I think the most obvious of those was the guidance on cardiopulmonary resuscitation and the national guidance was quite clear that chest compressions as a component of CPR was not an AGP but, if I recollect, the intubation component of it was. The medical teams on the ground who had obviously a lot of experience of managing CPR were concerned that that underestimated the risk of chest compressions to staff, and that was reinforced by guidance which was then issued by royal colleges and others, and led to some tension on the ground and many conversations, and led to us adapting that guidance within the Royal Infirmary to allow chest compressions to be considered as an AGP on advice and with the agreement of our senior medical teams.
Q. You refer to tensions on the ground. I wonder if I can ask you this. Given all that we have discussed on this subject, can you give the Inquiry an insight into the level of confidence that staff at the GRI had in national IPC guidance?
A. I think that that varied throughout the course of the pandemic. I met with my senior team on a daily basis

and we discussed the challenges of implementing guidance, but I think how we felt our role was to try to give that confidence to the teams on the ground, so that they felt comfortable understanding what current guidance was, what the expectations that they had -- that the expectations that they had were met and that they had PPE when they required it, and we, as I've said, tried very hard not to deviate from that national guidance because we did feel that bringing that uncertainty to staff would not be helpful in the midst of what was a deeply difficult crisis situation.

Q. Moving to PPE and starting, please, with fit testing.

At your paragraph 124, Professor, you say that by the second week of March 2020 the hospital had used the bulk of its FFP3 masks to fit test staff. Can you tell us, please, about the quality of the supplies of FFP3 masks that the hospital received later that month and their fit test failure rates?

A. Yes. We were assured there was a national stockpile of FFP3 masks which would be delivered and when that supply arrived and turned out to be a different mask and we started to fit test staff again, we were being reported failure rates of up to 75% with one of the masks which clearly meant that we stopped using those and looked for other supplies.

Q. At your 121, you say there was a small group of staff who could only be fit tested with one type of mask. Did this small group have any particular characteristics?

A. Yes, from memory, they were mainly women.

Q. Finally on fit testing, this, please. At paragraph 168 you refer to an equality impact assessment carried out at board level in respect of staff who, for religious reasons, preferred not to shave. The decision was made to ask those staff members to shave their beards so that masks would fit. Appreciating you were not working at board level at the time, I wonder, are you able to give the Inquiry an insight into the reasons for that decision and the staff reaction to that?

A. So I'm not sure I can give you an insight into the reasons for the decision but it was certainly a decision which we felt was appropriate. We felt it was appropriate for us to be able to ask staff to shave in order to be fit tested to allow them to work in a high risk environment, particularly if those staff had the very rare skill sets required for working, for example in critical care units. From memory, I don't think there were any members of staff who refused to shave in order to be fit tested. But any who did would have been deployed into non-patient-facing areas for their own safety at that time.

Q. At paragraph 181 you say:

"The lack of supply of approved powered respirators was difficult to understand."

Why do you say that, please?

A. Well, we had access to power respirators. One of our plastic surgery trainees had sourced a supply of powered respirators which she brought to our attention and I remember us all out in the hospital car park seeing if we could fit staff to these masks. But it transpired that there wasn't an approved method of filter cleaning or availability of filters to change for these masks. But for whatever reason, we were never allowed to deploy these masks into the workplace at that time and it was a source of ongoing frustration that it took many months for a supply of powered respirators to be made available to staff.

Q. Finally on PPE this, please. At your paragraph 126 you record that there was anxiety amongst staff that there might come a point when there was a critical shortage of PPE. You go on to say this.

"From an ethical point of view, we would never have asked staff to put themselves at risk, but it was always my belief that faced with this scenario many staff would have prioritised patient care over their own safety."

Do you mean to say here that staff would have been prepared to treat patients wearing inadequate PPE?

A. So this is very difficult and it was one of the questions in fact which we asked new consultant staff at interview, you know, what would you do if you were faced with, for example, having to intubate a patient who had arrested and you didn't have available PPE? And I think different staff may respond differently in that situation. But I think we have to look at this in the context of an environment where we knew, all of us knew that we were at risk, most staff caught Covid early in the pandemic through frontline patient care and continued to work in that environment, knowing that they were putting themselves and sometimes their families at risk.

So yes, I do believe that is the case.

Q. Did this scenario, in your view, ever, in fact, arise?

A. Well, there was never a scenario where we actually ran out of PPE as per national guidance but there were certainly weekends where we were looking at having no more than one or two days' supply which created a great deal of anxiety for those of us who were in charge of running the organisation.

Q. Can we move to consider the treatment escalation plan introduced in March 2020.

Please can we have on screen INQ000477554.
We read here the first highlighted piece of text:
"Due to the sheer numbers expected, the aim is to establish which patients are for further escalation or not at an early stage of their admission, ideally on admission."
The second highlight:
"These discussions can be difficult especially when the family are not present due to isolation measures."
Can I start by asking you about the genesis of this plan, please, Professor. Did it already exist in some form or was it created in March 2020 for Covid-19?
A. So the treatment escalation plan was already in place. The document that you refer to was an attempt by my senior medical team to pull together various components of guidance and signpost staff to the red map structure for handling difficult conversations with patients and to incorporate the treatment escalation plan within the patient record at the point of admission to hospital, because, as the Inquiry has heard, patients often deteriorated quickly and having the treatment escalation plan in place from the outset was thought to be helpful for managing decisions as they might emerge.
But the treatment escalation plan wasn't new. And

I think, in retrospect, looking at the documentation here, it's perhaps unfortunate that we called it the Covid-19 Treatment Escalation Plan because, of course, it's simply the treatment escalation plan and it is still in place and is considered best practice and is something that we encourage all staff to complete for patients even today.
Q. What effect do you think calling it the Covid-19 escalation plan had, then? What makes you say, "In retrospect, we would have just called it the treatment escalation plan"?
A. Yes, I think listening to some of the evidence to the Inquiry it's clear that there is sometimes a perception that we did things differently during the pandemic from the way in which we would have made decisions about escalation under normal day-to-day circumstances and I don't believe that in actual fact that was the case. So, yes, I think by calling it the Covid-19 Treatment Escalation Plan we have given the impression that this is something different or new.
Q. Considering then the decision-making process, please, if we look at page 34 briefly. This is the start of the suspected Covid-19 treatment proforma.
At page 37, please, within the proforma, we have the box here "COVID Treatment Escalation Plan --

Emergency Department decision", and under the section "Level of suitable escalation" we have four options.
Professor, please can you take us through each of these options and set out the factors that would have pointed towards their selection.
A. I'll do my best to do that.
So intensive care referral would be for those patients for whom it would be considered after a holistic evaluation and discussion with senior staff that it could be anticipated that a patient could survive prolonged ventilation and be able to resume a high quality of life or an acceptable quality of life following recovery.
There's very little difference between the suitability for ITU referral or HDU referral, in other words between level 2 and level 3, but certainly we would perhaps have a lower threshold for escalation to high dependency because mechanical ventilation would not be required.
I guess active ward-based care would include everything up to the point of requiring non-invasive ventilation.
And comfort care would be given to those patients who were, you know, perhaps patients who had advanced dementia or who were not expected to survive their

illness because of the severity of illness at presentation. But again, that was something which required two senior decision-makers to agree before that decision was made.
Q. And that's the note we see underlined there under "Comfort care"?
A. Yes, that's correct.
Q. If we look at the second point then within this box we have the question:
"Is this patient for CPR (complete DNACPR form if appropriate)."
Can I ask you this, please, were any concerns raised by staff that certain patients were arriving at the GRI with inappropriate DNACPR notices?
A. No, that was not something that was ever raised with me.
Q. Were you aware of any concerns raised by family members of patients that inappropriate DNACPR decisions had been made at the GRI?
A. No, I'm not aware of any concerns regarding inappropriate DNACPR decisions. We often -- or, I say "often". We sometimes receive complaints about failures in communication or sometimes in failures of documentation, but these are complaints that arise from time to time under normal circumstances. I'm not aware in the Royal Infirmary of any specific concerns during

the Covid pandemic relating to a DNACPR completion, communication or appropriateness.

Q. Turning to communication more broadly, we have in the next section response required across the top row: "Plan discussed with Patient", "Plan discussed with family".

Was it mandatory to discuss this plan with either the patient or their family or both?

A. We have a very clear policy. So the clear requirement is for us to discuss with patient and with family members with patient permission where that can be given. Clearly, the complexities during the pandemic were that family were often not present and so these conversations would have to take place by telephone, which is not ideal, and obviously that was a learning process for staff.

But, yes we did everything that we possibly could within the limitations of the visiting restrictions and other restrictions to make sure that families were informed and that these discussions were -- took place as they should always happen.

Q. Are you aware of any occasions where communication was not made?

A. I am not aware of any specific occasions but I am sure that there were situations where that communication was less than we would have hoped. I'm certain there will

be instances of it.

Q. If we look at page 42 we have a page entitled "Covid 19 treatment escalation plan". Can you help us, at what point in the process would this particular form be completed?

A. So the expectation would be that this was completed at the point of admission in the -- what we termed the SATA, so the medical admission unit, where patients with suspected Covid were taken when they first arrived at the hospital.

Q. On the following page we have the Clinical Frailty Scale. There appear, on the face of it, to be no instructions associated with how to use the Clinical Frailty Scale within the plan itself. What role did the scale play in the treatment escalation plan?

A. So if I can perhaps preface my response by saying I'm a pancreatic surgeon so this is not something that I have personal experience of using, but my understanding is that this was included as part of a holistic patient assessment at the point of admission to hospital. And while the Clinical Frailty Score is primarily validated for older patients, this is something which is used for and is encouraged to be used for assessing patient suitability for intensive care and other escalation.

Q. Was it made clear to staff that the scale was not appropriate for use on those under 65 or those with stable disabilities?

A. Well, I think although the scale is invalidated for use in under 65s and is less accurate in the patient cohorts that you describe, it is still recommended for use as part of that wider holistic assessment in patients of all ages, so I'm not sure that I completely agree with that characterisation of it. But the staff who were using this are staff who are trained and who manage patients with frailty on a day-to-day basis in their normal working lives.

Q. If we look at page 45, please. We find guidance on "Talking with people and families about planning care, death and dying". Is what we have looked at on screen the totality of the treatment escalation plan, or would there have been other guidance associated with it?

A. There is -- the document that you put up originally had a series of links so this was available on the hospital intranet site as a single place where all guidance -- up-to-date guidance for the management of patients, for the use of PPE and all other guidance was held in that one place. So this was part of that intranet site collection of guidance and information for staff.

Q. Do you have any reflections on the application of this

escalation plan, what worked well and what, if anything, worked less well?

A. Do you mean specifically with regard to the treatment escalation plan component of this?

Q. Yes.

A. So I think the completion of the treatment escalation plan at the point of admission worked very well because we had that documentation in place which assisted with the transfer of information as patients passed through the hospital. But it was supplemented by daily or even twice-daily escalation meetings which took place -- often I would attend or my deputy would attend -- so that the decision-making with complex patients, particularly around intensive care escalation, could be made with the intensivists, with the medical acute physicians, with -- you know, with care of the elderly staff, with palliative care consultants and others. So that multidisciplinary escalation meeting was something that I think we all found very helpful and gave us confidence that we had a consistency and an ethically-based, evidence-based approach to how we made these decisions on a day-to-day basis.

Q. If there were another pandemic next week would you change anything about this plan?

A. Apart from calling it the "treatment escalation plan"

and not the "Covid-19 treatment escalation plan", for sure. But I think what we've learned from this is the benefit of this approach in non-Covid times. So we are currently trying to encourage staff to continue to use treatment escalation plans at the point of hospital admission for all patients and certainly for those patients in whom critical care, level 2 care, is being considered. This is something we are keen to ensure is always in place.

Q. Would a national tool in respect of prioritisation have been of assistance to the GRI in adapting their plan for Covid-19?

A. I honestly think that these are decisions that senior clinicians make every single day and continue to make every single day, and I think the decision-making processes didn't change during the pandemic, and I honestly don't think that a national prioritisation plan would have been welcomed or have been helpful. It's difficult to see how that could have been implemented in practice, given that these are day-to-day clinical decisions made by senior staff.

Q. Visiting restrictions next.

Can we go to INQ000478112.

This is guidance established by the board to support compassionate visiting arrangements at the end

of life. First, please, can you help with when this guidance was introduced?

A. So my recollection is that this was brought in towards Christmas in 2020.

Q. If we look at page 2, please, we read that the guidance adopted the ethical framework suggested by the Academy of Medical Royal Colleges and Faculties of Scotland.

If we consider point 3 in the box, under "Minimising Harm" we read this:

"Harm from visiting can occur to the visitor, to those they subsequently come in contact with, or to others in the care facility. The patient themselves may experience harm if they feel guilt about exposing family visitors to the infection. That harm must however be balanced against harm to the dying person occasioned by absence of family, harm to family who are unable to be present (both immediate and longer term in bereavement), and harm caused to care staff who substitute themselves for absent family and undertake difficult telephone communication."

Does what we read here amount to a recognition that every participant in the visiting at end-of-life scenario is at risk of harm?

A. Yes, that's exactly what that says. In the complex environment that we're describing, where sometimes even

two or three individuals in an open ward which is full of patients can make infection control guidance almost impossible to follow, where we had numbers of instances of Covid being seeded into wards full of vulnerable patients and where sometimes we had relatives who refused to wear face masks for example, this was a very complex environment that we tried to manage as compassionately as we possibly could.

Q. If we move to page 3, please, we have a set of guiding principles. I'd like to look at principle 7. We read this:

"When patients are in the last days or weeks of life the number of people visiting (although the number at any given time will be in line with local guidelines) and the frequency of visits should not be limited as long as this is in accordance with the requirements described from the same/extended household."

Do you have any reflections, please, on how well this approach to visiting at the end of life worked?

A. This particular component of this guidance which is clearly set out as a framework, but this specific component of it led to significant concern from the senior clinicians, particularly those managing patients in our open Nightingale wards. And it was certainly something that I had anxiety about how we would actually

implement this in practice. There were -- at that time, as I recall, there was the tiered approach to Covid restrictions, so trying to -- even looking at that paragraph, trying to work out exactly how you would risk assess that on an individual basis at ward level, it's extremely difficult to see exactly how that would work.

Q. Would you take this particular approach in principle 7 in a future pandemic or not?

A. I think the answer to that is it depends. I think it depends on the environment. I do think that we could have been more flexible in our approach early on, in the first wave, but at that time there was a huge degree of uncertainty. But I think asking individual staff to manage that complex risk assessment is a step too far. I think we'd need to have something, maybe in between, if I can describe it like that.

Q. Finally, lessons and recommendations, please, Professor. Are there any lessons and recommendations that you would like to share with the Inquiry from the GRI's experience of responding to the pandemic?

A. Yes. The Inquiry has heard a lot about PPE and PPE resilience. I guess the first thing I would reiterate is that we understood there was a national stockpile of PPE and it certainly became quickly apparent that there either wasn't or that the PPE wasn't entirely what we

had expected. So I think we need a resilient supply of PPE at all times which is rotated and which is what the health boards are fit testing staff to in advance.

I do think particularly with regard to the Royal Infirmary that we have some of the oldest functioning hospital estate in the country and it's very clear that managing a respiratory pandemic in open wards without mechanical ventilation is extraordinarily difficult and we do need to look to, hopefully by the time we have another pandemic in 100 years, we hope, we will have a hospital estate which is more based around single-room accommodation and will allow us to prevent, as far as possible, hospital-acquired infection.

So I think those would be the two things.

But perhaps in a broader term, what we need to have is flexibility. What worked well was the flexibility of our staff to adapt to a rapidly changing situation on the ground. Our teams were the ones who knew how to adapt guidance to keep patients safe, and so I think the flexibility to make local adaptations as required by the specific situations in which people find themselves and for the estate to be adaptable to that purpose, as well, is, I think, going to be crucial.

MR MILLS: Professor, thank you.

My Lady, that's all I ask.

LADY HALLETT: Yes, and now it's some more questions from the core participants, Professor.

Ms Sivakumaran.

Questions from MS SIVAKUMARAN

MS SIVAKUMARAN: Good morning, Professor. I ask questions on behalf of the Long Covid groups.

I would like to ask you a few questions about the Glasgow Royal Infirmary's Long Covid service for staff. At paragraph 166 of your statement you state that the health board's occupational health department established a Long Covid service in May 2021 in response to the high numbers of staff absent from work with Long Covid, and you state that 454 staff members went on to use the service.

Why was it important that there was a Long Covid specific service for staff?

A. Well, I think it had become apparent that there were large numbers of staff who remained off work due to Long Covid and many of these staff I knew personally.

So the challenge for us as an organisation was to ensure that we maintained contact with those staff, which we did through our management teams. And in trying to encourage those staff or facilitate those staff back into the workplace we established that Long Covid service which, as you say, I think saw some

500 members of staff. At the beginning of that time there were maybe -- I think there were 25% of those staff were at work and after four months of support, that figure was 60%.

So it was clearly something that was beneficial to members of staff with Long Covid at that time.

Q. And you mentioned that it was apparent that there was a large number of staff. Did you have a system in place to monitor the number of staff reporting that they were suffering from Long Covid or was that through anecdotal experience?

A. No, we had -- certainly towards the mid to end of 2020, we were having regular weekly reports on Covid-related absence and although Long Covid wasn't initially identified within that, it subsequently became a specific reported criteria and I think was defined as an individual who had been off work for more than 10 days, I think was the criterion that was used.

Q. Are you able to assist us with when those weekly reports started including reports about Long Covid or long-term effects of Covid-19?

A. I think it was towards the end of 2020 but I would need to check and I'm happy to give you that information if that would help.

Q. Thank you, that would help.

Now, you mention the occupational health department provided the specific service. Were they provided with any support, financial guidance or otherwise, to establish the Long Covid service?

A. I'm afraid I cannot answer that with certainty but I understand that there was central funding made available to establish that service in 2021, yes.

Q. Okay. And when you say central funding, was that coming from the Scottish Government?

A. From the Scottish Government, yes. But I'm not certain. That's to the best of my recollection.

Q. And you've mentioned that you saw an improvement from 25% of staff in work to up to 60%. Can we take it, then, that the Long Covid service did improve staff retention rates and help staff with Long Covid who wanted to return to work to do so?

A. Again, I don't have a specific answer for you on the staff retention rate because that's not data that's been shared with me, but I've seen evidence on quality of life improvement and other parameters which suggest that it was beneficial to members of staff, yes.

Q. And finally, to your knowledge, was the initiative replicated by occupational health departments and other board or was it unique to your health board?

A. I'm afraid I can't answer that question, I'm sorry.

MS SIVAKUMARAN: Thank you.

Those are my questions, my Lady.

LADY HALLETT: Thank you.

Ms Mitchell.

That way, Professor.

Questions from MS MITCHELL KC

MS MITCHELL: Professor, I appear as instructed by Aamer Anwar on behalf of the Scottish Covid Bereaved.

In your evidence to my learned friend you spoke about staff being redeployed and the training that was given to them, and I have you noted as saying that -- and what happened when you were trying to redeploy people without the relevant training was that in February of 2020 staff were taken for periods of time away from theatres or not their normal place of work to spend time in intensive care units under supervision of senior staff, and that process continued through February and into March, so that we had a cohort of staff who felt as comfortable as they could be, given the very limited time that we had available to be able to work in that environment.

And I would just like to ask you a wee bit around that process and how it was done. Did it mean that people were in ICU units working or did it mean that people were in ICU units just observing whilst other

people worked and they were training them at the same time?

A. So, again, I wasn't directly involved in that process, but my understanding and recollection is that it would have been the latter, that they would have been observing and receiving instruction rather than actually working.

Q. And clearly, by the way that you have answered the question when you were asked it by my learned friend, that they were as comfortable as they could be given the very limited time that they had available, I take it that there was some discomfort, or at least to the understanding expressed, about the fact people were working in these conditions without having had the full training?

A. Yes, I think it would be fair to say that the impact on particularly theatre staff, who had to be redeployed into intensive care, was immense and very much working outside of their comfort zone, managing patients with severe critical illness, many of whom sadly died. These were conditions that these nursing staff would have had no experience of before and it must have been extraordinarily hard for them.

Q. And following up on that very point you make, you said when we have another pandemic, if it's 100 years, we

of course hope it will be, but if it's 100 days has there been anything done to address this sort of thing, for example, any ideas of training more broadly for people so that people can be deployed?

A. I think that's a very good question. We have a policy within our nursing teams and theatre to try to make sure that as many staff as possible are, if you like, anaesthetic and theatre scrub trained, and, you know, that's something that does continue, but you're right, we don't have a policy at the moment of ensuring that we are rotating staff through intensive care. Although we do rotate the staff who are working within level 2 units, so high dependency units within medicine and surgery, those staff do rotate through intensive care to maintain their skill set.

Q. I'm obliged.

I'd like to ask you about something else that arose from your written evidence to this Inquiry when you were talking about the guidance that you received and the fact that the guidance changed so many times, giving the opportunity for confusion.

What I'm wondering is, have you reflected upon the fast-moving, changing guidance so that when Disease X arrives on the next occasion there may be ways to better give that guidance or assist people with that guidance

so that such confusion is limited?

A. Clearly, I'm -- you know, I'm no expert in infection control or guidance and I would leave that to others, but I think my reflection would be that in the future, with resilient PPE supplies, if we were to adopt what we've heard described as the precautionary principle from the outset and then de-escalate PPE as it becomes apparent that it's not required or that we know more about the illness itself, then that's how I would hope that a future pandemic would be handled.

Q. So you're saying, in the practical sense, if we start with a higher protection level and work our way down, there would be less need for continuing changing guidance escalating?

A. There is nothing more alarming than escalating up, if you see what I mean, for staff on the ground. So I think that is my reflection on it. How practical that would be I'd need to leave to others to describe.

MS MITCHELL: I'm obliged.

My Lady, those are the questions.

LADY HALLETT: Thank you very much, Ms Mitchell.

Professor, I'm really grateful to you. It sounds as if you were too busy to actually serve on the front line using your skills as a pancreatic surgeon.

THE WITNESS: Yes, there wasn't much call for pancreatic

surgeons, particularly during the first wave, I'm afraid.

LADY HALLETT: Thank you so much for all that you did to try to ensure that the Glasgow Royal Infirmary continued to serve the people of Glasgow, very grateful to you. And thank you for your help to this Inquiry.

THE WITNESS: Thank you, my Lady.

(The witness withdrew)

LADY HALLETT: Right, Ms Price.

MS PRICE: My Lady, please may I call Caroline Lamb.

MS CAROLINE LAMB (affirmed)

Questions from COUNSEL TO THE INQUIRY

LADY HALLETT: Welcome back, Ms Lamb.

THE WITNESS: Hello.

MS PRICE: Could you give us your full name, please, Ms Lamb?

A. Yes, Caroline Sarah Lamb.

Q. I will be asking today about matters covered in two witness statements which you have provided for the purposes of Module 3 of the Inquiry, both dated 18 June 2024, the first running to 287 pages with the reference INQ000485979 and the second running to 89 pages with the reference INQ000485984.

I understand that you have copies of both statements in front of you and you are familiar with the

contents of them; is that right?

A. That's correct.

Q. I'd like it start, please, with your professional background and the roles you held during the pandemic and continue to hold.

You became Director General for Health and Social Care and Chief Executive of NHS Scotland in January 2021?

A. That's correct.

Q. Could you summarise, briefly please, your professional background prior to taking up that post.

A. Yes. So I am -- by background I'm a chartered accountant. I qualified as a chartered accountant with KPMG. Since qualification I've worked in a variety of sectors, so I've worked in housing and education and then latterly moving into the NHS.

I was chief executive of a health board -- one of our health boards in Scotland before going to Scottish Government first of all on secondment and then moving into the post that I hold today.

Q. As Director General, you are responsible for 11 health and social care director rates; is that correct?

A. That's correct, yes.

Q. In this role you are the accountable officer, meaning you are answerable to Parliament for the expenditure of

those directorates?

A. That's correct.

Q. Although the financial responsibility for budgets and expenditure incurred against these budgets were delegated, weren't they, to individual directors?

A. Yes, and to our health boards as well.

Q. You also line manage the health and social care directors and senior clinical advisers, including the CMO, the CNO and the National Clinical Director?

A. That's correct.

Q. Who do you report to?

A. I report to the Permanent Secretary in Scotland, and I'm also responsible to the Cabinet Secretary for Health and Social Care and to the ministers in the health portfolio.

Q. As Chief Executive of NHS Scotland, you had oversight of the health boards in Scotland; is that right?

A. That's correct.

Q. Is it right that there are 22 health boards, 14 of which are territorial health boards?

A. That's correct.

Q. Those health boards are accountable to the Scottish Government and Scottish Ministers?

A. Correct.

Q. And just so everyone is clear, is NHS Scotland itself

a legal entity or is it the health boards which collectively make up the NHS Scotland which are legal entities?

A. Yes, NHS Scotland is not a legal entity. We refer to NHS Scotland as being the collective of the health boards, yes.

Q. Is it right that there is no equivalent of NHS England in Scotland, that is, there is no national entity which leads the health boards?

A. So there is no NHS Scotland as a legal entity. However, I think that we perform a leadership role from Scottish Government both in terms of that relationship with ministers, and providing advice to ministers in relation to their setting of strategy and policy, and then through our planning guidance to boards, through our signing off the delivery plans of boards and our performance management of boards against those delivery plans, we, effectively, therefore, also manage the activity across our NHS Scotland boards.

Q. In terms of health and social care policy, is it right that the directorates and the health boards in Scotland have responsibility for putting Scottish Government policy into practice?

A. That's correct, yes.

Q. The NHS in Scotland was put on an emergency footing on

17 March 2020 and this remained the case until 30 April 2022; are those dates right?
A. Yes, that's correct.
Q. How, if at all, are the roles of DGHSC and Chief Executive of NHS Scotland different when the NHS in Scotland is on an emergency footing compared to when it is not?
A. When the NHS Scotland is on an emergency footing then, essentially, ministers are taking more direct control of activities and, therefore, I think we're probably more directive in terms of how we work, although we would always work in collaboration with our NHS boards. One of the advantages of a country the size of Scotland is that we are able to get everybody in a virtual room and quite often in a physical room to have those very, very regular discussions.

So I would say that there's a sort of more immediate relationship but, actually, that's maybe just a sort of enhancement on the way in which we would normally operate.
Q. Turning, please, to infection prevention and control and PPE issues. You deal with the Scottish Government's role in relation to IPC guidance at paragraph 419 onwards of your longer statement ending 979.

There you say that:

"[Whilst] the UK Government and subsequently ARHAI Scotland held and maintained IPC guidance for Scotland, [the Scottish Government] played a role in communicating updates and changes in IPC guidance to [the health] boards and other stakeholders, including [the] unions."

Before we come on to that communication role for Scottish Government, I'd like to deal, please, with the extent to which the Scottish Government was involved in the formulation of IPC guidance for healthcare settings.

Could we have on screen, please, paragraph 542 of INQ000485979 -- there we are.

At paragraph 542 of your statement you say Scottish Government:

"... worked collaboratively with the four nations to adopt IPC measures informed by the UK IPC cell."

And you highlight in the next paragraph that any change to measures or guidance would be in response to the latest and emerging evidence.

Over the page, please, paragraph 544, there is this:

"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."

That's the Covid-19 Nosocomial Review Group; is

that right?
A. That's correct.
Q. "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."

Is it right that the Covid-19 Nosocomial Review Group was accountable to the Scottish Government through the Chief Nursing Officer to whom it provided advice?
A. Yes. That group was established fairly early on in that the Scottish Government, through the chief nurse, had asked Health Protection Scotland, I think it was, for advice as to nosocomial infection. And their recommendation was that we should set up an expert group to provide advice on that, so that was set up and reported into the chief nurse, yes.
Q. And is it right that the Covid-19 nosocomial review group approved IPC guidance drawn up by ARHAI?
A. So the ARHAI is our expert group in relation to infection prevention control and management. So ARHAI were involved in both feeding in to the formation of

infection control -- infection prevention and control guidance at a UK level. The Covid Nosocomial Review Group were very interested in particularly the spread of infection within hospital and other healthcare settings, so they would provide advice depending on exactly what type of infection prevention and control measures were being considered.
Q. So whose decision was it as to what the IPC measures and guidance should be?
A. So, in general, Scotland would adopt the same measures that were being adopted by the rest of the UK and it was ARHAI who were predominantly feeding into that advice around infection prevention and control measures. However, we also took steps to contextualise some of those -- some of that advice and guidance to the Scottish context by producing an addendum to our National Infection Prevention and Control Manual and there were some occasions where Scotland took a slightly different approach around risk -- occupational risk assessment and personal preferences for people in terms of in relation to specific types of protective equipment.
Q. And when that was an IPC measure, or an IPC change, rather than the discretionary policy type of changes we'll come on to, whose decision was that? Was that

ARHAI or was that the nosocomial review group?
A. So, my recollection is that that was predominantly ARHAI who were making recommendations. The Covid-19 Nosocomial Review Group would particularly look at measures that related to spread within hospitals, but I think predominantly it was ARHAI providing that advice.
Q. Did the Scottish Government have any direct role in the final sign-off on IPC measures and guidance that were strict IPC measures and guidance as opposed to a Scottish Government policy for other reasons?
A. We would provide advice to ministers that indicated when IPC guidance and advice was changing and set out the reasons for those changes, and ministers were very keen to ensure that they were aware of that so that in their communications we could try, as far as possible, that that made -- that that remained aligned. But the advice, the actual guidance and advice, other than with the exception of some, I suppose, relaxations was absolutely based on the evidence that was available.
Q. Were you made aware, when you took up your role as DGHSC, that in December of 2020, so shortly before that, a representative of Public Health England at an IPC cell meeting, a UK IPC cell meeting, had proposed wider use of FFP3 masks in healthcare settings on a precautionary

basis in light of the evolving evidence on aerosol transmission of Covid-19, and that that was something that ARHAI did not support?
A. I cannot recall being specifically made aware of any recommendation for Public Health England. I was aware of the ongoing discussion between clinicians and others about the precise mechanisms by which Covid was spread.
Q. Do you think that that discussion is something that should have been reported up to Scottish Government so that senior civil servants and potentially ministers could be made aware of it?
A. My understanding is that the groups that we were using to feed into that formation of advice were all engaged in the UK conversations as well.
Q. Turning to communication of IPC guidance and changes to it. What was the Scottish Government's role in relation to communication?
A. So the Scottish Government's role was really to try to ensure that our communication was consistent and coherent. So we would, through our workforce senior leadership group, as an example, we would discuss with both representatives from our HR directors in boards, but also staff side, trade unions. Obviously, Scottish Government was also involved in the daily briefings and members of our team, particularly the Chief Medical

Officer, the Chief Nursing Officer, and the National Clinical Director were involved in very regular engagements with staff across NHS Scotland.

So the role was to try to ensure that we kept, in a situation where guidance was changing quite rapidly and where there were many differences of opinions around exactly what was happening with the virus, our role was to really try and keep all that advice aligned and to make sure that the most up-to-date guidance was available.
Q. Who was it who sent out updates to IPC guidance to NHS health boards and other stakeholders?
A. So my recollection is that that would generally have come from the chief nurse's office but there would also be occasions when health workforce colleagues were involved in issuing that guidance as well.
Q. You say at paragraph 420 of your longer statement that while there was regular communication with all stakeholders, there was no central mechanism in place to monitor the efficiency of communications. Why was that?
A. I think that certainly in the early days and when guidance was changing quite quickly, that was just -- that was part of the -- I suppose one of the issues that we were struggling with -- with keeping up with all of that.

We did have, through the workforce senior leadership group -- so we did have feedback mechanisms through that, through the regular meetings with all the directors of nursing in our health boards, through the regular meetings with all the chief executives, that we did have feedback mechanisms, but I would accept that there wasn't a sort of, you know, structured method of actually assessing how good those detailed communications were. We were carrying out surveys across the public in terms of how effective some of our broader communications were, but not to the same extent in terms of those very, I suppose, very specific communications.
Q. The Inquiry has heard evidence that difficulty was caused by updates to IPC guidance being sent out on Friday afternoons, which gave little time for dissemination and implementation of changes before the weekend. Was that something that you were aware of or received feedback on?
A. Yes, I think that we were aware of the challenges that were faced when we issued -- not just around IPC but other changes to guidance on the occasions where those were issued late in the week.

I think it was -- in most of those circumstances it wasn't our expectation that that guidance would be

immediately implemented and I suppose we also would hope that many of the people receiving those guidance would have -- through their own networks have an awareness of what was coming. But I would accept absolutely that late on a Friday is not the best time to issue updates. And that is something that, you know, we have moved to address going forwards.

Q. At the time was that changed or were any changes made when that feedback was received?

A. I can remember -- I can recall getting the feedback that it was unhelpful and that we did try to see what we could do to shift our timelines so that we were able to issue things, and sometimes, if it wasn't a particularly urgent piece of guidance, to actually hold off and issue it on a Monday rather than on a Friday.

MS PRICE: My Lady, I've reached the end of a topic, would that be a convenient moment for a break?

LADY HALLETT: Certainly. I shall be overly generous and give you until 11.32.

(11.16 am)

(A short break)

(11.32 am)

LADY HALLETT: Ms Price.

MS PRICE: Thank you, my Lady.

Ms Lamb, turning, please, to the approach to

protecting healthcare workers at greatest risk from Covid-19.

Concerns were raised in April 2020 by the BMA about increased risk associated with age, ethnicity, sex and comorbidities, and how healthcare workers at greatest risk were to be protected. In particular, an email sent by Jill Vickerman, the National Director (Scotland) of the BMA, to the DGHSC in Scotland at the time, appreciating that wasn't you, on 29 April 2020, asking what plans there were for risk profiling for healthcare workers in Scotland.

I think you've been provided with a copy of that email; do you know the email I'm referring to?

A. I do.

Q. Appreciating this was before your time, can you help, please, with what was done to ensure that healthcare workers were being appropriately risk assessed and protected, taking into account the particular concerns being raised by the BMA at that point?

A. Yes, I hope I can. So you are right, the email came in from Jill Vickerman and that followed a letter the BMA had written to NHS England, I think. What we did in Scotland is that we issued guidance around risk assessment, workplace risk assessment for healthcare workers and emergency staff, particularly those with

underlying health conditions, on 30 March 2020, and we issued interim guidance around black, Asian and minority ethnic staff on 21 May.

Those two pieces of guidance were then superseded by a further piece of guidance issued on 27 July 2020 which says that it supersedes those two initial pieces of guidance and brings together guidance which essentially was asking health boards as employers to make sure that they were carrying out local risk assessments for staff who may be particularly vulnerable for whatever reason.

Q. Did the guidance on risk assessments expressly cover the extent to which IPC or PPE guidance could or should be adapted to reflect an individual healthcare worker's risk?

A. Yes, yes absolutely.

Q. Could we have on screen, please, INQ000335968 and page 40 of that, please, paragraph 142.

This is a paragraph from a statement made by Paul Bassett of the Scottish Ambulance Service for this module of the Inquiry and he says this.

"Guidance was provided by Scottish Government to the service on 4 September 2020 in regard to vulnerable healthcare workers and to staff from some ethnic backgrounds. This guidance was adopted in its

totality ..."

And he goes on to talk about the specific steps that were taken by the Scottish Ambulance Service.

We have just looked at the -- well, you've just referred to the letter of July 2020 and those earlier bits of guidance from March and May, and that was disseminating guidance to the health boards; is that right?

A. That's correct.

Q. It's clear that that guidance was in place at that earlier stage. It appears from this evidence that the first time the Scottish Government provided equivalent guidance to the Scottish Ambulance Service on vulnerable healthcare workers and ethnic minority staff was in September 2020. Is that right?

A. I don't believe that to be correct, no. So the guidance that was issued in July and the guidance which that guidance superseded, so the guidance that was issued both in March and then in May, were DLs, so director letters, that went out to all health boards, including the ambulance service.

In preparation for this I've been trying to identify what guidance we did issue in September 2020 and all I've been able to identify is an update to the prior guidance which was -- and we were updating that to

add some additional information that was emerging about specific health conditions. So my assessment is that we did issue that guidance in July and the previous two bits of guidance, they went to the ambulance service as well, and I just wonder whether this statement was referring to a later piece of guidance.

Q. I see. A letter was sent by the BMA in January 2021 which went initially to Public Health England but was then sent to the CMO in Scotland by Jill Vickerman, who we've already referenced, raising concern that there should be wider use of respiratory protective equipment in healthcare settings outside of the procedures designated as aerosol generating. In light of the growing evidence of aerosol transmission, do you know the letter I'm referring to? I think the Inquiry has provided you with a copy?

A. I do, yes.

Q. Before we come on to the timeline for Scottish respiratory protective equipment guidance, I'd like to deal with a distinct issue which was raised by the BMA at around this time and that was that some female healthcare workers and some ethnic minority healthcare workers had experienced problems with ill-fitting PPE. You and the CMO for Scotland wrote to Jill Vickerman on January 2021 about that issue; is that right?

A. That's correct.

Q. Could you explain, please, what the concerns being raised by the BMA were and how you and the CMO responded to those concerns?

A. Yes. So there were a couple of concerns that were raised by the BMA with us in that email on 13 January. One of the concerns was around fit and the -- as I'm sure the Inquiry has already heard evidence about some of the challenges in fit testing FFP3 masks to women and to people from ethnic minorities as well, and the other was around, as you've said, around more widespread use of the FFP3 masks going beyond the aerosol-generating procedures.

And, again, looking back at the timeline around that, Jill Vickerman was due to meet with the cabinet secretary the day after that email was sent, so there was a meeting scheduled with the cabinet secretary on 14 January. That wasn't an unusual meeting, that was part of a regular routine of meetings that the cabinet secretary held with the BMA and it had been expected that those issues would be raised at that meeting. Unfortunately, the cabinet secretary had to reschedule that meeting at very short notice.

So the meeting went ahead, I think on the 21st -- the meeting, I think, with the cabinet secretary went

ahead about 21 January and in that intervening period the BMA wrote to the Cabinet Secretary to set out the range of concerns that they'd set out in the email.

So in response to that, the letter from Gregor and I -- sorry, the Chief Medical Officer and I, responds to the issues around fit testing and explains the process that we've been through or had been through, through National Services Scotland, to ensure that we were procuring a wider, broader range of masks that included entering into a contract with Alpha Solway in August 2020, whereby that was about trying to secure a more domestic supply of PPE but also a supply of PPE that was more customised to the demographics of people working in healthcare work services in Scotland.

So Gregor and I answered that bit of the question in our letter and then at the meeting with the cabinet secretary, she again listened to the concerns of the BMA around BMA arguing for wider use of FFP3 masks beyond aerosol-generating procedures.

She was clear that that wasn't what the evidence was suggesting at the time, that wasn't what the advice was, but she undertook to keep that under review, which indeed we did.

LADY HALLETT: Sorry, I should have done this long ago.

Ms Lamb, just for those who are following but are

not familiar with the Scottish structure --

A. Sorry.

LADY HALLETT: -- the cabinet secretary is the minister in charge of that department --

A. That's correct.

LADY HALLETT: -- as opposed to, in the UK Government, being an official?

A. Yes, my apologies for that.

LADY HALLETT: No, it's not your fault, I should have made it plain earlier. Thank you.

MS PRICE: Coming then, please, to the key changes set out in the Scottish respiratory protective equipment guidance timeline, which you very helpfully set out in your longer statement, ending 979. Could we have on screen, please, page 153 of the statement first and at paragraph 548 you explain that:

"[The Scottish Government] 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 201-22 Respiratory Infections in Health and Care settings IPC Addendum, which was replaced by the National IPC Manual. This included measures as much as the appropriate use of PPE, the extended use of face

masks and face coverings ..."

Et cetera, including ventilation.

You then refer to the timeline for that IPC guidance. In relation to -- if we go on to paragraph 550, please, you say here:

"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."

So is it right to summarise your evidence that in Scotland there were occasions on which guidance was provided to the health boards about discretionary provision of respiratory protective equipment for healthcare workers such as FFP3 masks outside of the strict IPC guidance circumstances where this was the healthcare worker's preference?

A. That's correct, yes.

Q. Could we go to page 162 of the statement, please. This is the table that you describe as a timeline, and it includes reference to some of the Scottish guidance which was issued on the discretionary use of FFP3 masks as well as some occasions when the Scottish IPC guidance

diverted from what the rest of the UK was doing.

The first date in the table is October 2020. Before we go to that entry, and for completeness, I'd just like to ask you about an earlier example of guidance on the discretionary use of FFP3 masks, please.

Could we have on screen, please, INQ000477445.

This is dated 20 May 2020, and it is a joint statement which was issued by the Chief Nursing Officer, the Chief Medical Officer and the National Clinical Director, dealing with PPE and aerosol-generating procedures. This was, I appreciate, before you took up your role, but in terms of that timeline.

Going to page 2 of the statement, the third paragraph on this page, there's a description -- apologies the one below that, under that heading.

This is the description of NERVTAG's decision saying:

"NERVTAG ... states ... it is biologically plausible that compressions could generate an aerosol, this is only in the same way exhalation breath would do."

And in bold:

"Based on this evidence review and NERVTAG's findings, UK IPC guidance will not add chest compressions or defibrillation to the list of AGPs."

And then underneath this:

"However, we are in unprecedented times and it is paramount that frontline healthcare professionals are supported to find a pragmatic solution to ensure their safety and that of their patience. NERVTAG recognises that the evidence-base is extremely weak and heavily confounded by an inability to separate out the specific procedures performed as part of CPR ..."

And then the paragraph below:

"Therefore, CPR within a hospital setting should be considered as a continuum which is likely to include an AGP as part of airway management. In this case, the precautionary principle should apply and the healthcare professional should be supported by their organisation to make a professional judgment about whether to apply airborne precautions; which would include FFP3 face mask, long-sleeved gown, gloves and eye/face protection. NHS Boards must ensure this PPE is available for these frontline staff."

Is it right that this applied to hospital settings but also to ambulance workers?

A. That's correct, yes.

Q. Is this another example, in addition to those listed in your table in May 2020, of the guidance on the discretionary use of FFP3 masks being issued in

Scotland?

A. Yes, that's correct.

Q. Going back, please, to the table at page 162 of Ms Lamb's statement.

You describe here a change in the guidance produced by ARHAI in October 2020, specifically the guidance contained within the Scottish Covid-19 IPC addendum upon its publication. The reason for the change was said to be to minimise staff anxieties during the pandemic, and the change was limited to healthcare workers conducting aerosol-generating procedures and the use of FFP3 masks.

Can you explain briefly, please, what the change was.

A. Yes. The change was to recognise that whilst the guidance was that in the low-risk pathways, so where people had not tested positive -- patients had not tested positive for Covid, that there wasn't need to use FFP3s when performing aerosol-generating procedures, but we recognised that staff may be anxious about doing that, albeit in a low-risk pathway, and therefore they could choose to wear an FFP3 respirator.

Q. The next change is said to be, going over the page, please, in April 2021, and it was made by way of an update to the Scottish Covid-19 IPC addendum.

In the right-hand column we see that it followed the publication of interim World Health Organisation guidance on occupational health and safety for health workers in February 2021, a SAGE paper on masks to mitigate airborne transmission of SARS-CoV-2, and advice from the Covid-19 Nosocomial Review Group; is that right?

A. That's correct, yes.

Q. Can we have on screen, please, INQ000410963.

This is the Scottish Covid-19 infection prevention and control addendum.

Going over the page, please, we can see this is version 2 in the highlight, 7 May 2021, and there is an addition here described as "Environmental risk assessment". Is that the addition you refer to in your table?

A. Yes, that's correct, yes.

Q. So it was in fact May 2021 rather than April 2021 that this change was reflected in guidance; is that right?

A. Yes. It looks like it, yes.

Q. The explanation under the table of this document, in general, is that:

"This addendum has been developed in collaboration with the NHS Boards to provide Scottish context to the UK Covid-19 IPC remobilisation guidance, some deviations

exist for Scotland and these have been agreed through consultation with NHS boards and approved by the CNO Nosocomial Review Group."

Then going, please, to page 30 of the document.

We see in yellow highlight the start of the amended section on hierarchy of controls.

And going to page 32, please, there is a section here on the obligation to conduct a risk assessment of the healthcare environment and the need to take account of environmental considerations.

Then over the page, please, at 5.11.2 there is a section on "Organisational Preparedness and COVID-19 Risk Assessment when determining appropriate location for High Risk Pathway". And it recognises that:

"Some clinical environments present a greater risk in terms of COVID-19 transmission if used to care for cohorts of suspected and/or confirmed COVID-19 cases. NHS Boards must seek to identify and prepare the most suitable clinical area for planned placement of patients requiring care on the high risk (red) pathway. This is not required for areas used for the medium and low risk pathways where sporadic cases of 'unexpected' positive COVID-19 cases may arise."

And just scrolling down there and going over the page, please -- apologies, if we can just go back one

page, please.

The requirement for a risk assessment is set out, and the following questions are required in that, including consideration of bed spacing and -- over the page, please -- as a minimum, whether the windows in the area can be opened and realistically remain open whilst the space is occupied.

And then, underneath that, having done that risk assessment:

"If the risk assessment concludes that an unacceptable risk of transmission remains within the environment after rigorous application of the hierarchy of controls (eg inadequate bed spacing AND natural ventilation where windows cannot be opened) and only if there are no other more optimal low risk clinical areas suitable for the high risk pathway cohort then the NHS Boards should consider utilising the area for this purpose with [the] provision of Respiratory Protective Equipment ... for the staff working in this area."

And then in bold in the box below:

"The evidence continues to support the most likely route of COVID-19 transmission being via the droplet and contact route. However, it is accepted that in some high risk environments housing COVID-19 cases where mitigations in line with the hierarchy of

controls cannot be applied, the level of risk is unknown and as a precautionary approach, the use of RPE by staff in the designated area may be considered by the organisation. This takes account of interim guidance issued by the World Health Organisation ... occupational health and saved for healthcare workers."

So this was not an exception for the discretionary use of FFP3 in defined circumstances based on healthcare worker preference, it's a change to the Scottish IPC guidance informed by the developing understanding of the role of long-range aerosol or airborne transmission; is that right?

A. That's correct, yes. And it's particularly recognising the increased risk in some of our environments.

Q. Going back to the table, please, that's page 162, I think it is, of the longer statement and on that page 163.

The next change in the table is said to be in July 2021. This was a workforce policy rather than a change in IPC guidance; is that right?

A. That's correct, yes.

Q. Did it apply across all health boards?

A. Yes, it applied all health boards in Scotland, yes.

Q. It was limited to Scotland and, as far as you're aware, not replicated in the rest of the United Kingdom; is

that right?
A. That's correct, to my knowledge, yes.
Q. Can you just explain, please, why this policy was introduced and the circumstances in which FFP3s could be offered to healthcare workers over and above the circumstances provided for by the IPC guidance?
A. So I think this was introduced in particular to support staff who may want to be back at work but who may have some underlying health conditions that would mean that they might be at a higher risk of Covid and, therefore, whilst they might be working in areas which wouldn't normally require that level of protection, we felt that it was important to be able to offer people that level of protection.
Q. And this is described as personal preference, access to FFP3.

The last change listed in this table introduced in March 2022. And here this is, again, described as a workforce policyholders and, again, personal preference access to FFP3. Did this apply across all health boards?
A. Yes, it did apply across all health boards, yes.
Q. Is it right that this policy was introduced in consequence of a December 2021 WHO update to recommendations on the use of FFP3 masks by healthcare

workers, taking into account the increased transmissibility of the Omicron variant?
A. Yes, that's correct, the WHO issued an update to their guidance and the UK infection prevention control structures decided that that didn't merit a change in the guidance around what infection prevention control measures were offered. If I recall correctly, our ministers asked for specific evidence in relation to that, and took a view, again, that we should offer that enhanced level of protection to staff who expressed a preference for that.
Q. Notification of this policy was given in a letter dated 19 April 2022, sent to the health boards.

Could we have that letter on screen, please. It's INQ000429256, and starting four paragraphs down.

"The UK IPC cell reviewed the WHO recommendations on mask use by health and care workers, in light of the Omicron variant of concern statement and agreed that no changes were required to the extant UK guidance for Infection Prevention and Control ... for seasonal respiratory infections in health and care settings (including SARS-CoV-2). Therefore, this letter does not reflect a change in the IPC guidance, but rather is in response to a conditional recommendation within the WHO updated

guidance (21 December) based on the individual staff member's personal preference.

"With this in mind, [IPC] managers do not have a role in the process to allow staff access to an FFP3 mask, if it is being done on the basis of their own personal choice. Rather, an individual risk assessment should be carried out by the line manager, in line with current guidance and with consideration of the staff member's overall health, safety, physical and psychological well-being, as well as personal views/concerns about risks."

So this was not a change in the IPC guidance; it was a policy decision taken by the Scottish Government. Is that right?
A. That's correct, yes.
Q. A policy decision which you say was not replicated in the rest of the UK?
A. That's my understanding, yeah.
Q. Why was the decision made to introduce this policy?
A. As I've said, my recollection is that after the WHO updated their guidance in relation to Omicron, ministers asked for additional evidence and to be given advice really about what further measures they could take. I think ministers were concerned to ensure that staff felt protected and as it says here, taken into account

their overall health and safety, but also psychological well-being of staff, as well, and it was on that basis that ministers made the decision that the staff should, if it was their preference, be offered access to an FFP3 mask.
Q. So WHO update to recommendations came in December 2021. Why did it take until April 2022 for this policy to be introduced?
A. I think, as I've said, the first step in that, so first of all, there was no update to the extant UK guidance so I think, first of all, we waited to see if there would be an update to that, which there wasn't. Ministers then asked for further evidence to consider, but effectively they were taking a decision that went beyond the IPC guidance so it was a process of working through that for them.
Q. If this was a decision that was a pure policy decision to do things differently over and above the IPC guidance, to make staff feel reassured, and you've referred to that psychological benefit, why could this policy that personal preference should be -- someone's personal preference to wear an FFP3 mask should mean they should have access to one, not be introduced sooner in the pandemic? And I don't mean just after December 2021. But if this is a policy decision

that you're going to do things differently for other reasons, other than the strict interpretation of evidence on transmissibility for example, why was that not done sooner?

A. I think as you've seen through the sort of development and the chronology of the decisions that were made around what IPC measures staff should use, Scotland very much took the position of adopting the same approach as the rest of the UK, and basing decisions on scientific advice. I think as we moved through the pandemic we, I guess, started to look at the particular concerns of staff, and whilst they might not have been backed by evidence, we were very -- I think ministers were very keen to ensure that staff did feel protected and that we were considering the psychological aspects as well.

So, I guess, it was an evolution, really, of looking, first of all, at these staff sort of in most risk, then it may be the areas where there was most risk and then moving towards more of being around personal preference.

Q. Was this policy -- or to put it in this way, were FFP3 supply constraints ever a factor in not introducing this policy sooner?

A. I don't -- I cannot recall any circumstances when supply constraints were part of the conversation about what PPE

should be available.

Q. We heard the evidence earlier of Professor McKay that in a future pandemic his view is that you should start with the precautionary principle of having the highest level of protection and then reducing it as things are known, applying that precautionary approach. What's your view on that?

A. I think it would depend on what the next pandemic brings us. But, yes, I would concur that taking a precautionary approach is -- would be a good place to be. I think you do have to balance that off against, you know, measures around -- some of this personal protection is not the most comfortable to be wearing all the time. So we do need to just think about balancing off all the issues that are associated with it.

I think we learnt a huge amount about PPE and about how to support people in wearing that and about how to mitigate against some of the, you know, some of the more negative consequences particularly around people who need to lip-read and not being able to see people's faces, and so we found ways through lots of that. So I think our approach to PPE is much improved from where we were pre-pandemic.

LADY HALLETT: Ms Price, I was thinking about Professor McKay's evidence during the break, I'm sorry,

I should have raised it with you earlier.

In fact, of course, we did in this case start with the higher degree of protection because it was initially classified as a high consequence infectious disease, and so what happened was the UK guidance went from the higher protection and reduced it, so I assume that Professor McKay's opinion, if we'd put that to him, would be: don't reduce it until you know more.

MS PRICE: That was my interpretation, my Lady. Sorry, I should have made that clear. My interpretation of his evidence was that you should stay at that higher level for longer until there is evidence to suggest it's not necessary as opposed to the chain of events that we know.

LADY HALLETT: It doesn't make any difference to Ms Lamb's evidence you would still say there are the other considerations.

THE WITNESS: Yeah.

MS PRICE: Thank you, my Lady.

Scotland was obviously thinking from a fairly early stage about whether it was necessary to give guidance about going above and beyond the strict IPC measures. We've been through the timeline of occasions on which that guidance was given. Has any analysis been done of whether the policy and guidance differences

relating to FFP3 masks in Scotland, when compared to the rest of the UK, reduced healthcare worker deaths or the level of infections by any appreciable margin?

A. I'm not aware that there has been any analysis or research into that. There may have been but I'm not aware of it.

Q. Is the data available -- and it may not be a question for you, you may not be able to answer, but is the data available in particular in relation to healthcare worker infections and deaths in Scotland to allow such an analysis to be done?

A. So, yes, I have the data in relation to healthcare worker deaths, and we also monitored absences related to Covid although I am not sure the extent to which they were absences where somebody might be isolating because of a family member or because they had Covid themselves, but we certainly have the number of deaths.

Q. Moving then, please, it a question about the location of ARHAI. ARHAI was separated from Public Health Scotland on its creation in April 2020. Can you help, please, with who was ultimately responsible for overseeing the governance of ARHAI from that point in April 2020?

A. Yes, so at the point where Public Health Scotland was created ARHAI was part of Health Protection Scotland. ARHAI is based in National Services Scotland and

a number of the functions of National Services Scotland moved to Public Health Scotland when Public Health Scotland was set up. ARHAI stayed in National Services Scotland. The rationale around not moving ARHAI into Public Health Scotland was linked to their role in ensuring infection protection and control measures in the built environment, so NHS Assure, who have that role in Scotland, also sit within National Services Scotland, so it was felt better at that point, and particularly because we had then and still have an ongoing public inquiry into a couple of our hospitals in Scotland, so it was felt better not to -- not to move them at that time but to keep them linked to that built -- the assurance of the built environment.

Q. At paragraph 134 of your longer statement you refer to the ARHAI Scotland location review, which was commenced in October 2023. Can you explain, please, what that review was, what it was considering and why.

A. Yes, so at the point where the decision was made not to move ARHAI into Public Health Scotland there was also a commitment that that position would be reviewed, and so the review that started in -- about a year ago, that was led by a couple of experts independent from Scottish Government, looked at the arguments for and

against moving ARHAI.

I think it's probably fair to say that they could see pros and cons in both of those, the options of moving it and the options of leaving it where it is. So, in the end, the conclusion was that ARHAI should remain where it is, in National Services Scotland. And we recognised as well that it was important, given that split of responsibilities, that there was maybe improved clarity around responsibilities, making sure that there isn't duplication between what Public Health Scotland are doing and what National Services Scotland and ARHAI are responsible for. And that's a bit of work that the two boards, National Services Scotland and Public Health Scotland, are taking forward at the moment. I think they are -- were due to report on that I think December of this year.

Q. And the conclusions of the review are set out in a letter from October of this year?

A. Yeah.

Q. And just in summary, what is the conclusion?

A. So the conclusion was that ARHAI would remain in National Services Scotland.

Q. Moving, please, to adherence to IPC measures in healthcare settings. You refer at paragraph 551 of your longer statement, if you need to refer to it, to the

Scottish Government commissioning Healthcare Improvement Scotland to carry out inspections at healthcare facilities, during which implementation of IPC measures was considered.

During your oral evidence given in Module 2A to this Inquiry, you highlighted the importance of adherence to IPC measures in non-patient-facing areas, not just in patient-facing areas, and the fact there was a campaign launched titled "It's Kind to Remind". Were concerns raised about adherence to IPC measures in non-patient-facing areas and if so, by whom?

A. I think so. My recollection is that there were concerns raised, I think probably through our networks, in terms of through nurse directors, through conversations with NHS boards, that whilst adherence to IPC measures in patient-facing areas was good, that there was -- that, you know, maybe inevitably, when people go for their breaks and they relax that adherence to those measures wasn't as high as it needed to be. And the campaign around "It's Kind to Remind" was developed through a suggestion from the officials within the chief nursing officers directorate, who were meeting regularly with the IPC -- infection prevention and control lead nurses boards, and they'd raised an opportunity maybe to just try and, I suppose, kindly reinforce with people the

need to keep vigilant around the potential of spreading infections not just in the patient-facing areas but in those areas, rest areas, where people went to take a break as well.

Q. Was there an evidence base for concerns or, to put it another way, was there evidence that healthcare worker to healthcare worker transmission was a particular problem or was this anecdotal?

A. I think it was more anecdotal than it was, you know, hard evidence based.

Q. Turning, please, to Scottish Ambulance Service access to suitable PPE.

Could we have on screen, please, INQ000335968, and it's page 14, please.

This is Paul Bassett's statement, which we looked at earlier, and in paragraph 56 he refers to:

"... regular meetings with Scottish Government across all service functions, including Chief Executives, Medical Directors, Workforce Directors and Finance Directors which ultimately fed back into the Scottish Government Resilience Room and the Scottish Government."

And included in the matters discussed at these meetings were PPE.

"Daily reports were provided relating to the

provision of PPE, number of staff fitted with Filtering Face Piece Level 3 (FFP3) marks, availability of resources, system wide challenges and vaccination numbers."

And then going to page 45, please, paragraph 163, he says:

"The logistics and supply chain within the SAS at the time of the pandemic was significantly tested as we rolled out PPE and other supplies at pace across the Service."

Mr Bassett then explains the model for the Scottish Ambulance Service's logistics and inventory management for PPE and RPE which was in place during the pandemic, or at least when it hit. And that was a locally-managed model for procurement.

He goes on to explain that a review led to a change in model to a centralised logistic service for each of the three regional areas in Scotland and that was rolled out in 2021-2022.

And then at 166, Mr Bassett says:

"The fragility of our operating model was highlighted during the initial months into 2020 when global demand was at its highest and securing supply from regular private providers was impossible for the Service. The private providers informed us that they

could not maintain this level of supply ..."

It appears from Mr Bassett's statement that assistance in procuring PPE was ultimately given by NHS NSS after the SAS procurement team took over responsibility for purchasing service supplies of PPE in February 2021.

You've seen Mr Bassett's reference to the regular meetings with Scottish Government which covered PPE issues. Can you help with anything else that the Scottish Government did to help address the PPE supply difficulties that were being experienced by the Scottish Ambulance Service?

A. Yes, so the position with regard to supply of PPE prior to the pandemic and indeed through the pandemic and as it stands today is that NSS, National Services Scotland, is the health board that is used within Scotland to buy -- to procure and then buy goods on national contracts and that includes PPE. NSS have a national distribution centre so they have well-established mechanisms for receiving large quantities of supplies and then distributing them around Scotland to health boards.

My understanding from this statement is that the Scottish Ambulance Service were not part of -- they may be part some of the national contracts for PPE but

certainly weren't part of all of the national contracts. I do understand that the Scottish Ambulance Service has some specific requirements, so, for example, given that ambulance operators are quite often outside I think having -- they need heavier aprons that don't blow up in the wind quite so much, but I think a lot of the PPE that they use was appropriate to be supplied through the national contract.

I think, as well, what this statement issues is -- indicates is that the Scottish Ambulance Service did recognise that in a situation where global demand was outstripping supply for PPE, that to be a single small procurer of that PPE was not the best position to be in. They, therefore, and I guess in terms of what the Scottish Government did, we were able to ensure that the NSS supply routes and their distribution mechanisms were able to support the Scottish Ambulance Service in the same way as they were supporting other boards and, indeed, primary care and social care providers. So that is the position that we moved into.

Q. Was there any additional help given prior to February 2021 before NHS NSS took on that assistance role?

A. Yes. So my understanding is from the beginning of the pandemic NSS would make supplies available to all health

boards, including the Scottish Ambulance Service where they required it, and, indeed, to other providers like primary care and social care organisations as well.

I think what's described in the statement is that obviously getting provisions into a board is one thing, but then they need to be distributed within that board and for the ambulance service that's a complex arrangement because it covers the whole of Scotland and there are multiple ambulance stations and I think what's being described in this is that SAS moved to set up a process of having hubs so that their PPE and, potentially other supplies, could be delivered into hubs within the ambulance service and then distributed out to the ambulance stations that needed it from there.

Q. You address PPE supply lessons learned at paragraphs 964 to 967 of your longer statement.

Could we start, please, on page 284 of that statement ending 979, please.

You set out in this paragraph some of the learning from lessons learned reviews and exercises carried out by the Scottish Government. Looking, in particular, from the second bullet point down, you say:

"... 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."

Can you help, please, with what the Scottish Government has done to develop and implement future pandemic PPE supply arrangements bearing in mind those particular lessons learned?

A. Yes. So, I think prior to the pandemic, the national stockpile in Scotland was based on assumptions around pandemic flu, and the pandemic that we got, the Covid-19 pandemic required significantly more items of PPE in order to manage that than would have been the case for the assumptions around pandemic flu.

So I think the first thing that we have done is

that we have significantly increased the amount of PPE that we hold in Scotland. Originally I think we went to 16 weeks' worth of PPE based on the quantities that we were using during Covid. That's been slightly scaled back so we're currently holding 12 weeks' based on -- again based on the amounts that we were using during Covid.

I think in terms of our supply routes, as well, I think what was an issue globally was the quantity and the proportion of PPE that was sourced from China and obviously China had its own issues in terms of being the first place hit by the pandemic, and therefore seeking to identify domestic supply routes was really important and we put in place that contract with Alpha Solway back in August 2020. So I think, in terms of broadening out supply routes and also moving away from that sort of just-in-time supply model, we've done a lot around that.

We've also recognised that having data and being able to share realtime data about the availability of PPE is really critical in terms of people being able to have confidence that there are supplies available in the system. We stood up a lot of additional data systems during the pandemic in order to do just that.

And I think -- you may come on to it, but we also went out and consulted with other organisations around

what was helpful, what wasn't helpful, and I think one of the things that emerged from that was around feeling there was inequitable access to PPE and I think that's part of that transparency and sharing of data about how the stockpile is being managed and how ongoing supply routes are being sourced.

Q. In what way inequitable?

A. I think that there was a view that there was insufficient supply for some of our social care organisations, for example, and I think we would recognise that prior to the pandemic we had focused very much on what was the -- what would be the requirement in healthcare settings. We're now much more -- we take much more cognisance of the PPE that's required across all of our health and social care settings.

Q. Coming, please, to PPE equality impact assessments and the learning from these.

Could we have on screen, please, page 98 of the longer statement.

And at paragraph 378 you deal with the Scottish Government PPE Action Plan, which was published in October 2020. And you explain towards the bottom of the page, at paragraph 380, that there was no specific equality impact assessment produced for the action plan. Instead, the PPE division and unit policy officials

carried out impact assessments in relation to the different work streams which flowed from the action plan. Is that right?

A. Yes, that's my understanding, yeah.

Q. You then set out the issues which were highlighted by the impact assessments done across the work streams. Can you explain, please, what the key specific equalities issues related to PPE were and what steps were taken by the Scottish Government to address them?

A. Yes, so the first one was around communications which I've already referred to around the difficulties of people not being able to see through the masks, and in response to that I think we approved a mask with a fog-proof transparent section in it for use from, I think, about December '21 onwards.

So this isn't -- the action to address the inequality impact assessments were being taken, sort of, in parallel, really, with those impact assessments being carried out.

The second issue was around fit and, again, we've heard the particular issues around, well, women for one, and as a result of that, two things; one, we expanded, or NSS expanded the range of masks that were available, so there were, I think, eight available by March '21 and we've also, as I've said, engaged with Alpha Solway to

set up a manufacturing base that would pay closer attention to the Scottish demographics.

Then the third issue was around the difficulty of fitting, close fitting masks to people with facial hair and the issues around that being a religious observance and we recognise there that actually what was needed there was a different form of PPE, so air purifiers.

Q. The next overarching topic I'd like to ask you about is NHS hospital capacity in Scotland and the response to hospital capacity issues.

Starting, please, with the hospital capacity data which was collected and presented to the Scottish Government and relevant NHS decision-makers during the pandemic.

The Inquiry has heard evidence from Dr Phin from Public Health Scotland that there were two types of daily reports produced, one for the Scottish Government, and that was considered at the daily huddle hosted by Public Health Scotland and attended by Scottish Ministers, and the second, a report that went to intensive care consultants and those responsible for co-ordination of intensive care across Scotland.

I'd like to look, please, at an example of each of these in turn to understand the type of data that was being produced in those reports and starting, please,

with the daily report for Scottish Government.

Could we have on screen, please, INQ000372596.

This spreadsheet provides figures for each hospital grouped by health board and then network. It's dated, we can see in the "Last updated" column toward the right of the page, 29 December 2020. And for the day it is dated and the previous day, so we can see "today" and "yesterday" in the table headings, it provides numbers of empty, full, and closed beds, the number of patients at each level of care, and the number of suspected or positive Covid cases.

The Inquiry understand that a closed bed is one which is closed due to a lack of staff or equipment to staff the bed. Is that also your understanding?

A. Yes, that's my understanding that that's the definition of it, yes.

Q. Is this the daily report which would have been discussed at the daily huddle with Scottish Government?

I should probably start by saying: did you attend those huddles?

A. So, I'm not entirely sure which huddles Dr Phin was referring to because there were multiple huddles. I was personally involved in the scale-up of ICU resilience in the early days of the pandemic and we had at least daily, sometimes twice-daily, meetings around our ICU

occupancy, which obviously this is very focused on and the programme of work to access increased and to scale up our ICU. And I recognise this as a summary of the data, that I was getting into my email box every morning in spreadsheet format, yes.

Q. So this report in this form was something that came to you?

A. Yes, and to others, I expect.

Q. What this report does not do is give any information about whether recommended staffing ratios were being maintained; would you agree?

A. Yes, I'd agree.

Q. It also does not give any information about, for example, how many patients were receiving mechanical ventilation or other respiratory support?

A. So if I look at this and look at the levels of care "today" and "yesterday", so level 3, level of care, I would -- my interpretation of level 3 is that those are people who are receiving mechanical ventilation support, and level 2 would be people who are requiring closer observation, perhaps receiving CPAP, as we moved into CPAP, but not requiring the same level of support as somebody who is mechanically ventilated.

Q. The report also does not make clear whether the empty beds were level 0, 1, 2, or 3 beds; would you agree?

A. Yeah, that's correct.

Q. And there don't appear to be any figures for bed occupancy as a percentage of baseline or surge capacity?

A. That's correct, although I think all of us who were looking at this report knew exactly what the baseline capacity was and where we were with the surge capacity as well. So looking at this, our baseline, this is 2020, so that's before we'd added 30, so our baseline level 3 was 173.

Q. Bearing in mind, in particular, that Dr Phin's evidence that these are the reports which would have been discussed at the daily huddle attended by Scottish ministers, so understanding you obviously had a very good understanding of things like the number of beds available, do you think it would have been helpful if these daily reports had contained further data on staffing ratios, the particular type of beds that were empty, the percentage occupancy against baseline figures?

A. So I would agree that a really helpful addition to this would have been the staffing ratios that were in place. I would also suggest, and obviously you'll have the opportunity to ask ministers, but I think ministers were pretty well aware of what our baseline was.

Q. Were you ever involved in discussions about what type of

data the Scottish Government would like to receive from Public Health Scotland?

A. Yeah, I was certainly involved, not so much around the critical care provision but as we started to really develop our data collection and as we moved through different phases in the pandemic, we were very keen to ensure that we were able to get a much more holistic view of what was happening with the system, and when I talk about the system, I'm talking not just about acute care but also what was happening in primary care, what was happening in social care, because none of these things exist as islands -- what's happening in one bit of the system absolutely impacts on the other bit of the system.

And we worked really closely with Public Health Scotland to produce what we call the, sort of, whole-systems intelligence which absolutely looked at where we were in terms of critical care, so how many beds we had occupied, how many of those beds were occupied by people with Covid, but also what our overall levels of occupancy across our hospitals were.

It also included any particular pressures in primary care. It included things like calls to NHS 24, ambulance turnaround times and ambulance performance, plus delays, so people who were in hospital who don't

need to be in hospital but whose discharge is delayed, and levels of unmet need in terms of social care in the community. So we were trying to pull together all those bits of data so that we were able to take a view and to understand where we needed to -- see if there were interventions that we needed to make in any bit of the system that would help to improve the way in which the system overall was working.

Q. The Inquiry has very recently been provided with some examples of the second type of daily report referred to by Dr Phin in his evidence, those reports being the ones going to intensive care consultants and those co-ordinating intensive care.

Could we have on screen, please, INQ000474554.

And this report is dated 2 February 2021. We can see "Table 1, Levels of care" with the date there.

And table 1 is similar to the table in the report for Scottish Government in that it provides figures for empty and full beds and different levels of care. It does not in fact give the figures for closed beds for some reason and it is, again, broken down by network, health board and hospital.

Table 2, towards the right-hand side, and both tables in the chart below are dated 2 February 2021, provides percentages for occupied beds against baseline

as well as level 3 beds against level 3 funded beds to the baseline. And level 2 and 3 beds against funded level 2 and 3 bed baseline.

We also have a chart underneath here which shows as a graph the percentages against baseline which are set out in that table 2 we've just looked at, and it's broken down by health board. And it's fairly easy to see at a glance, for example, that as at 2 February 2021, NHS Ayrshire and Arran were significantly over baseline capacity with overall bed occupancy against baseline being at 250%.

Did you ever see this type of daily report with a graph depiction of occupancy against baseline?

A. So I can't recall seeing it graphed like this, other than in the SICSAG, the PHS -- society of intensive care reports, more of a retrospective glance. What I would say is that I think all of those of us looking at these reports were very focused on what was happening at an individual board level but also particularly focused on where we were sitting against overall capacity and how -- and the reason why this is broken down into west, east and north networks is because there is, you know, long-standing arrangements of providing resilience and support against those networks. So, you know, it's then clear if you look at this that obviously the west

network was the one that was under most pressure in relation to their baseline capacity at this point. And Ayrshire and Arran is part of that network. But they were sitting at 139% of the level 3s overall and that was funded baseline so that was a -- at this point we had expanded to at least double that capacity.

Q. This type of report also didn't give any data for staffing ratios. Do you think it would have been helpful for intensive care consultants and those co-ordinating intensive care across Scotland to have had that information?

A. Yes, I agree that it would have been helpful to have understood exactly what those ratios were looking like in different boards because I think that would have -- at a national level -- I am sure that at a local level, because there are really strong networks -- the critical care network was having very, very regular meetings at this time -- I am sure that there was a lot of information sharing going on at a local level between critical care consultants, but at a national level it would have been helpful to have understood what that picture looked like.

Q. Did anyone ever ask Public Health Scotland for data relating to staffing ratios?

A. I'm not aware that we did. I think if I think around

the systems that we have in place, the -- our staffing data -- so we were able to pull from our staffing, our overall national staffing system, data around levels of sickness/absence, but that covered the totality of services, so I'm not sure whether we would have been able to break that down into individual staffing groups.

I suspect that perhaps part of the reason that we weren't collecting that data was because it would be -- we would have had to ask individual units to provide that, particularly around ratios, because it's not a question of sort of simply drawing -- pressing a button and getting it off a system. And I suspect that we were balancing off the desirability of having that data against putting additional pressure by having to ask the people who are running those services to provide that data on a very regular basis.

Q. Could we have on screen, please, page 174 of the longer of Ms Lamb's statements, please.

You've included in your statement this graph, which is taken from a report produced by SIGSAG, the Scottish Intensive Care Society Audit Group, and it shows in graph form patients receiving level 3 care in hospital as a percentage of baseline capacity.

And by reference to this and the data which underlies it, you say at paragraph 612, just scrolling

just go to that over the page briefly, please -- we can see that's the same figure, isn't it, that you reproduce in your statement as figure 5; is that right?

A. Yes, I think so, yes.

Q. And going back to 6.2.4, the paragraph the page before, there are these observations on the national baseline graph, and that figure highlights:

"... periods between 1 March 2020 and the end of June 2022, where the number of level 3 patients exceeded baseline capacity in critical care units. This means there were more patients than the number of funded beds available to the units. Funding is based on one nurse for each level 3 bed. Figure 21 shows in red where there were more patients than there were critical care staff to look after them on a 1:1 basis."

Should her Ladyship take from that that on any occasion when national level 3 baseline capacity was breached, it follows that staffing ratios were diluted from the prescribed ratio of 1:1?

A. So I don't think you can make that direct correlation. So what this shows is the actual occupancy levels compared to our baseline. So our baseline was 173 beds going into the pandemic. And that was the number of beds that boards were financed to staff, as well. However, I think you've heard already earlier this

down, please:

"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 56% during other episodes of activity exceeding baseline capacity later ... 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."

You're dealing here with the number of occasions on which the national baseline capacity was exceeded, and that takes into account capacity across the whole of Scotland and considers the demand across the whole of Scotland; is that right?

A. That's correct, yes.

Q. Could we have on screen, please, INQ000479816, page 47, please.

Paragraph 6.2.4, towards the end of the page here, this is a paragraph from a statement produced on behalf of Public Health Scotland which addresses data collected by SICSAG, and it explains that figure 21 -- which if we

morning about the measures that boards took to increase their staff -- the staffing available to them to staff critical care beds.

Scottish Government issued guidance to health boards in March 2020 about how to go about seeking to staff the increased numbers of ICU beds we were trying to stand up, and I think as you heard this morning, the first call was really on staff who already had some experience in critical care, and in staff who were working so for -- for example, staff who had worked in theatres, anaesthetists, and staff therefore who had some experience of the sort of procedures and arrangements that are necessary in intensive care. That was facilitated by the fact that we'd stood down elective surgery other than emergency and urgent work and therefore there were staff who were available to be deployed.

So whilst it's absolutely the case to say that this graph recognises that when you compare the actual numbers we had to the baseline we had, and I have no doubt that there was dilution of the ratios going on and we set out in our guidance ways in which to manage that, but actually there would have been staff available from other parts of the system as well.

MS PRICE: My Lady, might that be an appropriate time?

LADY HALLETT: Certainly. I shall return at 1.45.
(12.43 pm)
(The short adjournment)
(1.45 pm)
LADY HALLETT: Yes.
MS PRICE: Thank you, my Lady.

Can we please have on screen INQ0000470091.

Ms Lamb, this is a report published by SICSAG on 13 October 2021. On page 62 of that, please, it deals with nurse staffing levels in ICU. There is this explanation of the data gathered on this and it says:

"This is a new section which has been added in order to report nursing staffing levels in ICUs and combined units against agreed standards. These standards are defined in the Guidelines ... Data relating to nurse staffing are not part of the core dataset provided to SICSAG from units. For this reason, SICSAG undertook a survey on 23 September 2021, contacting charge nurses who were asked to report staffing levels and unit activity on a single day shift. All ICUs and combined units with patients admitted with COVID-19 were contacted. Of these 18 units, all 18 responded to the survey."

Does it follow from what is said here that beyond this single-shift, single-day survey snapshot, there is

no data available or held centrally about the extent to which ICU and combined unit staffing ratios were in fact maintained during the pandemic in Scotland?

A. That's correct, yes.

Q. Is that not less than satisfactory from the perspective of understanding the impact of the pandemic on the healthcare system in Scotland?

A. So I would agree that ideally it would have been really helpful to have access to that data. I think, you know, as you can see from this, the way in which SICSAG obtained that data was by directly contacting charge nurses and asking them to report on that particular day. I think that the burden of asking them to do that on a daily basis, when units were under such significant pressure, would have been disproportionate compared to benefit. But I do absolutely agree that I think there are a number of areas in which it would be helpful for us to have more accurate collection of staffing data going forward.

Q. The findings of the survey are set out on this single page here and, in headline:

"In 61% of hospitals patients requiring level 3 care were being looked after in at least one geographical area additional to the unit's usual footprint to allow separation of patients with and

without COVID-19. This required nurses and other healthcare staff to work across more than one area with level 3 patients.

"39% of units were able to maintain recommended nurse-to-patient staffing ratios with ICU-trained registered nurses from their own unit ... In the remaining 61% of units, staffing ratios could only be maintained with registered nursing staff who did not usually work in the ICU.

"67% of units required nurses to work in the unit who were not part of their usual nursing staff complement ...

"72% of units were able to retain a supernumerary senior nurse on duty ..."

"This snapshot ..."

At the bottom paragraph here:

"This snapshot survey describes nurse staffing on a single day in Scottish ICUs which will vary over time. However, it demonstrates that over half of ICUs and combined units in Scotland are currently unable to maintain recommended nurse staffing ratios from within their own staffing complement. Two thirds of units are relying on nurses who usually work in other areas of the hospital, or nurses recruited through agencies/staff banks. These findings should be considered when

interpreting data relating to the ICU bed capacity."

This is quite concerning, isn't it, that at this snapshot point in time over half of ICUs and combined units in Scotland were unable to maintain the recommended nurse staffing ratios?

A. So my reading of this is that they were unable to maintain the recommended staffing ratios using nurses from within their --

Q. ICU-trained nurses?

A. ICU-trained nurses from within their own unit, yes. So I think what they're reflecting here is the extent to which they've had to redeploy staff who would normally not work in that unit or staff who would not regularly work in ICU into that place. So, yes. And I think that absolutely reflects the fact that our baseline capacity was 173 and we were operating at beyond that baseline capacity.

Q. Were you made aware of the results of this survey at the time?

A. I can't recall being made aware of the results of this survey at the time. As I said before, we were seeking to monitor the levels of staffing available across all services in our hospitals, so we were gathering data around sickness absence levels particularly but also engaging regularly with the HR directors in boards to

understand what the level of workforce pressures was on a board by board area, and that was feeding into the whole-system intelligence work that I referred to earlier.

Q. This snapshot survey having been done, whose decision was it about who should know about the results of it?

A. So this is a Public Health Scotland publication, so that is -- obviously those publications are made available to Scottish Government, they're also made available on the Public Health Scotland website, so they're pretty widely available to people.

Q. Okay, so it's just you personally weren't aware of it --

A. I can't recall this being particularly drawn to my attention at the time, no.

Q. Had it been drawn to your attention, would it have required any action, in your view, on the part of Scottish Government?

A. So I think that our relationship with our NHS boards is that we rely on NHS boards as far as possible to do what they can in terms of the resource that they have available to them, particularly trained staffing resource locally, and the role of Scottish Government then has to be look and see what interventions would be helpful at a national level. So, as I've said, we did issue guidance in March 2020 around staffing levels in

critical care, recognising that that was likely to be a particular issue. We also put into place -- put in place sort of national mechanisms to try to support staffing. So an example would be the workforce portal, where we encouraged people who had may be recently retired from services to express an interest in coming back to work and streamlined the process for people to be able to do that, through disclosure checks and everything else that's required.

We also redeployed -- we also made arrangements to deploy both final year medical students and nursing students. Now I accept that they would have had limited experience around ICU and critical care but that was part of trying to make sure that we were able to I suppose backfill and support areas of the hospital from which those more experienced staff were being drawn.

So, yes, we -- I think we did what we could at a national level. It is and remains the situation that people who work in these units are highly skilled and it's very hard to create more bodies overnight.

Q. Given that hospitals were not reporting staffing ratio data to SICSAG, how did the Scottish Government monitor the extent to which the staffing ratios were being maintained to standards?

A. So that would be through the conversations that were happening with the critical care community, so through our sort of direct links into the critical care consultants who lead on a number of those units but also through conversations with chief executives around the particular pressures that their boards were facing and, as I've said, nurse directors, medical directors and others and, again, I think one the features about the system in Scotland is that we do have good, strong relationships and links into all those professional groups, so there would be -- where there are issues being highlighted, then the role of Scottish Government is either to see what we can do at a national basis or to try and broker an arrangement with neighbouring boards around providing support.

Q. Outside of the question of ratios being maintained to standard, that is an ICU-trained nurse as opposed to a non-ICU-trained nurse, to what extent were you aware of dilution of staffing ratios, that is 1:1 becoming one 1:3, for example?

A. I think, for start, we were aware that that would be a likely result of what we were expecting to experience in terms of the numbers of patients requiring ICU, so we had looked at, you know, together with senior nurses and others at what could be done, accepting that I don't

think anyone wanted to be in a position where those ratios were being diluted, but accepting there are choices to be made there around whether you're able to treat people or not.

Q. But were you receiving supports of staffing ratios being diluted?

A. I can't remember receiving specific -- I can't recall receiving specific reports around the extent to which ratios were or were not diluting. I think that relates back to your question around we didn't have a way of centrally gathering that data, which is why this is just a snapshot.

Q. Okay. So does it follow from that that even now you don't know the extent to which staffing ratios were diluted during the pandemic?

A. That's correct, yes.

Q. Is there anything that can be done about that state of affairs?

A. Well, I suppose there's two aspects here, isn't there? One is the collection of the data and seeking to do that in a way that is minimally disruptive, but the other bit is how much capacity you maintain in terms of that ability to scale up ICU very quickly. As I've said, these are highly-skilled roles and also roles where, if you're not regularly practising in that environment then

your skills inevitably will degrade and so I think there is a -- and it's back to the questions about how we would manage a future pandemic and the extent to which -- some of that is dependent on us having a bit more capacity and resilience in health services than we have at the moment.

Q. Is any consideration being given to how you could collect the data in a way that was less onerous for the particular units?

A. So we are, through a number of mechanisms, looking at how we can improve the data that we have around staffing levels in all areas of our provision. In Scotland we have the safe staffing legislation which was implemented on 1 April this year and we're also looking to roll out nationally an e-rostering system that will give boards much more granular information around the acuity of the patients they're looking after, not just in critical care units, and how that matches against staffing ratios available.

Q. Going back to the question of baseline capacity. Would you agree that looking at the baseline position across the whole of Scotland does not give any insight into variations across the country in terms of how well hospitals were coping with demand?

A. Yeah, absolutely, I think that's -- you know, that's one

of the challenges of looking at national level data is that it can hide things that are going across different parts of the country. And as part of that whole-system information modelling, we had the sort of national level picture. But also a map of Scotland that showed the different boards and BRAG, so black, red, amber, green, rated them according to a number of measures not just critical care.

Q. You will have seen from figure 22 in the PHS report we were looking at earlier, where there's a breakdown of patients receiving level care against baseline capacity broken down by network. Do you know the figure I'm talking about?

A. Yeah.

Q. We can put it up on screen, it INQ000479816.

A. Yes.

Q. And we can see here it's broken down with those red lines indicating over baseline capacity. And it's broken down into Covid-19 cases and other cases. And we can see at glance, can't we, that the west network struggled far more with capacity issues than the -- certainly more than the north network and more than the east network. Was that something you were aware of at the time?

A. Yeah, absolutely, and so we were aware of that because

obviously that -- the capacity issues linked very strongly to what we were seeing in terms of the proportion of Covid infections across the country and also links to some of the underlying demographics which differ across Scotland as well.

Q. I think you've had sight of a number of territorial health board statements providing data on the number of times between March 2020 and June 2022 that their critical care units reached 100% occupancy. The Inquiry has provided you with several of those. Have you had a chance to look at those?

A. I have, yes.

Q. It's right to recognise that the experience of the health boards is varied, as you might imagine, and there are statements from some territorial health boards that did not report significant capacity issues. But taking just one example of a territorial health board that did so struggle, could we have on screen, please, INQ000492651.

This is a statement provided on behalf of NHS Ayrshire and Arran, so that that was the health board we saw that high point on the graph for earlier.

A. Yes.

Q. And going to page 4 of this, please, under the heading of "Data Relating to Hospital Capacity", paragraph 11

explains that critical care services were provided by both of the board's acute receiving hospitals.

Going over the page, please. We see here recorded, in this top table, level 3 critical care beds and the number of times on which 100% occupancy was reached. Is it your understanding that this is 100% occupancy using surge capacity as well as baseline?

A. No, my understanding is that this is based on baseline and particularly if I look at the occupancy, so it's showing that on 8 March both of the hospitals were at 100% occupancy. That was before we had really triggered the full extent of the surge so this is -- my understanding is this --

Q. This is baseline?

A. -- measuring against baseline yeah.

Q. So in that table, on my count there are nine occasions when level 3 critical care beds in at least one hospital reached 100% occupancy. Two of these occasions were in March 2020 and on one date that was the case in both hospitals simultaneously. Five of these occasions were October 2020 and the two remaining were November 2020.

And then in respect of level 2 care, the table below, that table goes over three-and-a-half pages and on my count there were 179 occasions in the relevant period where level 2 critical care beds, so HDU, high

dependency unit beds, in at least one hospital reached 100% occupancy. And that happened on multiple occasions in each month during this period save for April to July 2020.

On 10 occasions both hospitals were in this position, and on two occasions both ICU and HDU in a hospital combined were at 100% occupancy.

What I'd like to ask, is how you, and the Scottish Government more widely, were kept informed of longer-term patterns like this of individual health boards struggling with capacity issues?

A. Okay. So I think the first thing to recognise in relation to this is, as I've said already, this is based on baseline rather than the surge capacity that was put in place. And also, and I think you've probably seen in the statement from NHS Lothian, that it is normal for our health boards to use the facilities that they've got across the whole entirety of their hospital network in order to manage demand particularly for level 3 and level 2 beds.

So, there are a number of occasions when there was one hospital, and I don't know whether it was University Hospital Ayr or Crosshouse, but -- one of them would be full but there are still facilities remaining. And the other hospital is about -- they're about 20 minutes

apart. So that's one thing to be clear about.

In terms of the trend data for hospitals and, indeed more broadly, so that was absolutely one of the things that we were monitoring in terms of seeing increases, particularly in utilisation of ICU. It's one of the things that we were monitoring in the early days where one of the challenges was not just staff but actually having the ventilator equipment in place and we were using that trend data really to assess when we had new ventilator equipment arriving, where that would best be distributed to in terms of where the highest likelihood of that being required was.

We also, when I talked about our BRAG rating, we did that on a trend basis as well, so we would use that to identify whether systems were trending up in terms of the amount of pressure on them or whether they were level or whether they were starting to trend down.

Q. When the data that was being monitored was showing a particular board or particular hospitals were under pressure, in that they were regularly at 100% occupancy in at least one type of an ICU unit, did that prompt any further investigation in relation to that particular health board, for example, sending someone out to see, on the ground, how the hospitals were coping?

Because it's not just about there being a bed to

put someone in or not, it's about whether staffing ratios were being maintained, it's about the pressures on the staff, it's about the working environment for those staff. So did it prompt any action like that?

A. So we didn't have a team or an individual who went out, and indeed I think we were quite thoughtful about not putting even more pressure on systems by arriving there, but, that said, a number of the clinical advisers who work in Scottish Government also still do clinical sessions, so we would hear direct reports from the front line, if you like, around what was happening in boards.

As Scottish Government, we would -- you know, I would hear from chief executives on -- in times when they felt they were particularly under pressure, and we would pick up conversations around, you know, what further support could be provided. And as I said, that -- you know, it's not just around the critical care bed, important as -- the beds, as important as they are, but about pressures more generally across the system. I think that our clinicians in Scotland are incredibly well networked in terms of, you know, being able to pick up the phone and support each other as well.

So, whilst we didn't have a specific team doing that, I'm -- I think I'm confident that we had really

good routes. And each of our boards had their bronze, silver, gold mechanisms of escalating issues within their own systems, including escalating to Scottish Government between all our regular engagement sessions.

Our cabinet secretary was still meeting with NHS board chairs on a regular basis as well, so chairs were in a position of being able to raise issues directly with the ministers as well.

Q. I'd like to deal, please, with the permanent ICU bed uplift which was decided upon in Scotland in 2021.

Could we have on screen, please, page 174 of INQ000485979.

At paragraph 613 of your statement you refer to an April 2021, John Connaghan (the COO NHS Scotland), the CMO and the CNO jointly commissioning a short-life working group to consider ICU baseline capacity, uplift capacity and associated factors in preparation for winter 2021/2022.

And you go on to explain what happened after that. What was the thinking behind the permanent uplift?

A. So I think the thinking behind the permanent uplift was recognising that whilst, you know, actually there were not that many occasions when we breached baseline capacity, as you've seen already, there was a sufficient amount of those that we should look to implement

a permanent increase to our baseline, and the short-life working group were an expert group looked at our experience through the pandemic, looked at how that had played out, and it was their recommendation that 30 was the number that we should seek to increase beds by and that -- the cabinet secretary accepted that and we then funded that increase so that we now have a permanent funded increase in terms of that baseline capacity.

Q. In the paragraphs which follow you deal with implementation support for NHS health boards. Were there any difficulties with the implementation of the uplift plan?

A. I can't recall there being specific difficulties, however I would imagine that locally there may well have been challenges and delays in recruiting to staff those beds. As I've said, you know, there are not spare intensive care consultants particularly sitting around, so there are -- that is about using the training pipelines that we've got in order to be able to recruit people and equivalent for ICU nurses, although I believe that board did put in place training arrangements locally as well.

Q. Coming then to third wave capacity issues and response to that.

When you gave evidence in Module 2A of this

Inquiry, you were asked about a period in the third wave from September 2021 when there were higher rates of Covid hospital admissions in Scotland, and is it right that this was linked to the Omicron variant?

A. That's correct, yes.

Q. You were asked about reports during this time that ambulances could not offload their patients when they got to hospitals because A&E wards were stretched past capacity. Do you recall there being reports of that at the time?

A. Yes, yes, I do. And I think, you know, that was part of the process that we have in place for monitoring what's happening in the system, so, yes, absolutely I recall that being the case as we went into winter 2021, yeah.

Q. There had been a permanent ICU bed uplift by this point; is that right?

A. Yeah, that's correct. However, the pressure was not just on ICU. So that what was preventing people from being moved through A&E, and therefore preventing ambulances from discharging people, was not the availability of critical care beds -- I can explain the context of that --

Q. Please do.

A. So the issues that we faced in winter 2021-2022 were around a significant increase in people in hospital with

Covid, not necessarily in ICU but people requiring hospital treatment for Covid, coupled with an increase in more general presentations at A&E. We'd seen a huge reduction in presentations at A&E during the early part of the pandemic and we'd got a bit more back to, sort of, business as usual around that. And also we had seen an increase, quite a gradual increase but a sustained increase, of the people who were in hospital who were delayed in their discharge. So people who no longer had a clinical need to be in our hospitals but whose discharge had been delayed largely because they were waiting on social care packages to enable them to return generally into their home.

And we'd done quite a lot trying to prepare for that going into the winter but I think the combination of the numbers in our hospitals -- and from memory, I think we were running at around about 1,000 people on average -- or 1,000 beds occupied by people with Covid, and then upwards of 1,500 people who actually didn't need to be in hospital any longer but were delayed there.

Q. During the pandemic did you receive any reports of critical care in Scotland being rationed as a result of lack of capacity or resources, whether officially as a policy or unofficially?

A. No.

Q. Could we have on screen, please, INQ000477554.

This is the guidance issued for the Glasgow Royal Infirmary respiratory unit in April 2020. Did you hear Professor McKay's evidence this morning?

A. I heard some of it, yes, not all of it.

Q. I'll take you to the key parts.

Going to page 8, please. And this is the section entitled "Treatment Escalation Plan and Frailty Assessment", and under the heading there is this guidance:

"The main complication of COVID-19 disease is hypoxaemic respiratory failure and it is likely that there will be many patients requiring oxygen some of whom may be considered for increased support such as CPAP or intubation with mechanical ventilation. Due to the sheer numbers expected, the aim is to establish which patients are for further escalation or not at an early stage of their admission, ideally on admission."

Do you read this as implying that it might not be possible to escalate treatment for all patients due to the sheer numbers anticipated in the respiratory unit?

A. I suppose that -- yeah, that could be an interpretation on this. I think as well that having these arrangements

in place are pretty much what we -- you know, what our clinicians do every day because being mechanically ventilated is not the best option for all people and obviously the earlier you can have those conversations the better. So I think I did hear from the evidence earlier this morning that maybe calling this a Covid-19-specific plan wasn't the best title for it, but -- yeah.

So, clearly we were -- I think, based on what had been happening in Italy, we were expecting very significant numbers. As you have seen from the data earlier, we didn't get to the point in Scotland where we breached our surge capacity.

Q. The instruction was that a decision should be made on whether patients were for further escalation or not at an early stage and ideally on admission and, further down, that the decision-making on this should be informed by an "objective assessment" of the patient's "overall frailty".

And that's the last sentence in that paragraph.

Going then, please, to page 34. This is the start of the GRI emergency department suspected Covid-19 treatment proforma.

Then on page 37, there's a section of the proforma dealing with the Covid treatment escalation plan, the

emergency department decision. So that earlier stage. And the four options there for level of suitable escalation are: ITU referral, HDU referral, active ward based care, and comfort care, and we heard from Professor McKay earlier for comfort care two senior decision-makers had to agree that and we see that underlined there.

Underneath that there is a box for communication and you've heard the evidence about that that there was a requirement to record whether the plan had been discussed with the patient or family.

And then going to page 42, please. This appears to be the treatment escalation plan to be completed on admission to the unit as opposed to at the emergency department. And the long box about a third of the way down there says "Covid classification and escalation plan", and then there are two options "For escalation", including "Diagnostic/Prognostic Uncertainty. Review escalation daily over the first phase of episode."

Then the other option, "Ward level ceiling of care".

Then the page after this in the guidance is the Clinical Frailty Scale and this scores patients 1 to 9. There's no guidance of how this frailty score should inform decision-making about escalation of care. There

is a requirement in that first paragraph we looked at, to be considering overall frailty and this is provided right next to the proforma but without any further guidance.

Given that this was called a Covid-19 escalation -- treatment escalation plan, and reference had been made to the sheer number of patients that were expected, do you have any concerns about the guidance in its totality?

A. So, I'm not a clinician so --

LADY HALLETT: I was about to say that, Ms Lamb.

I'm not sure it's a fair question, I'm afraid, Ms Price, I'm sorry.

MS PRICE: My Lady, understood.

There is here guidance that's been given by a particular health board. It's right, isn't it, that there was no national guidance issued to health boards in Scotland on escalation of care and clinical prioritisation? Is that right?

A. That's correct, yes.

Q. Appreciating that you did not take up the role of DGHSC until January 2021, so you may not able to speak to the first wave considerations, was there any discussion at Scottish Government level after you became DGHSC about whether there should be national guidance in Scotland on

escalation of care and clinical prioritisation?

A. I can't recall there being any discussion about whether we should produce or any intention to produce national guidance on escalation, no.

Q. Does it follow that you didn't receive any reports that there were health boards specifically requesting that?

A. I certainly wasn't aware that any health boards were looking for that national guidance and I think our view would generally be that actually it's the clinicians on the ground who are best placed to actually make those decisions based on the individual circumstances and, you know, and the wishes of the people they have in front of them.

Q. Turning, please, to the role and performance of NHS 24 and the response to ambulance capacity issues.

In December 2020 there was a redesign of urgent care pathways which saw NHS 24 go from being an out-of-hours service to a 24/7 service. Can you explain the reason behind that change, please, and the aim of the programme?

A. Yes, so our programme to redesign urgent care, actually the thinking around that pre-dated the pandemic and was based on some work we'd done to look at how urgent and unscheduled care was managed in other countries, particularly in Scandinavia where a number of countries

have a process of where blue light systems still operate but, actually, rather than individuals self-presenting to accident and emergency departments, you phone a number and then you can get appointed into be seen. And we so we'd been looking at that.

With the pandemic and with the need to try and, as far as possible, keep people away from our accident and emergency departments, both in terms of managing pressures and often, very often people who present at A&E, there are other routes through which they could be seen, but also trying to avoid overcrowding that would potentially expose people to risk, we accelerated the implementation of that programme. So we worked through all the pathways with NHS 24, as you said, taking the key role in terms of providing triage both in-hours and out-of-hours having moved from predominantly being an out-of-hours service previously, and also setting up what we call flow navigation centres in each of our NHS board areas.

That was a process that was tested first in one of our NHS boards and then rolled out to all of them. And the idea there being that, and it was accompanied by quite a large public information campaign around right place and right time for the right care, and that was about encouraging people rather than presenting

themselves to A&E, to first of all phone NHS 24 and to, providing it wasn't an immediately life-threatening situation and to get advice on what other options might be available. So that might include getting reassurance that they could wait and maybe present either at their pharmacist or GP. It might include being appointed into a minor injuries unit. Or it might mean being put through to the flow navigation centre where there would be senior clinicians who were able to advise and sometimes appoint people into A&E so that we were able to manage that flow of people through A&E and therefore deal with some of the social distancing requirements in a far easier way.

LADY HALLETT: For those of you who don't know, NHS 24 in Scotland is equivalent of 111?

A. Yes, that's correct.

MS PRICE: Written evidence from NHS 24 received by the Inquiry suggests NHS 24's additional workforce requirements equated to a 43% increase in staff and that around 2 million patients had accessed this pathway since it was launched. So this was a significant operational change for NHS 24, wasn't it?

A. Yes, it was very significant for them.

Q. And the intention behind it was, as you've said, to reduce emergency department self-presentation. How

successful was it, this change, in achieving this?

A. So we think that it has been extremely successful. We have, I think on average, we're looking -- we've got a reduction of around 10% in those presenting. It's always very hard to say whether you can attribute a change to being one bit of a shift in the system, but we have seen a reduction in the number of people self-presenting, and that's coupled with other changes as well.

So we also, the ambulance service have introduced a call before you convey, so that the ambulance services also, through having that access to senior clinical decision-makers, been able to reduce the number of people that they're conveying to A&E as well.

So -- and we're continuing -- that's a programme of work that we're continuing to promote, that we're continuing to look for improvements and continuing to develop the way in which we approach that.

Q. Looking at NHS 24 performance against targets, could we go, please, to page 191 of the longer statement.

And this is a table produced by you in your statement setting out performance for April 2020 to March 2021 and April 2021 to March 2022. And the target for percentage of calls responded to in under five minutes, we can see four rows down, there we are in

blue, the target, three columns in from the left, at 50%. And in '20 to '21, we have only 38.4% of calls being answered in this time. And the following year, 25.9%.

The target for percentage of calls abandoned after five minutes was up to 10%, so that's the row beneath there, and in 2021 -- 2020 to 2021, 13.7% of calls were abandoned in the time frame. And '21 to '22, it was 15.1% of calls.

Are these performance results reflective of NHS 24 being unable to cope with the very quick significant increase in demand which resulted from the pathway redesign or is it explained in another way?

A. So if you look at the performance statistics for the first period, so April '20 to March '21, that's the period in which we first implemented the redesign of urgent unscheduled care, and whilst a couple of the indicators aren't where we or NHS 24 would want them to be, they are obviously more positive then when you look at the following year.

So the following year, '21 to '22, that reflects the period when we had the Omicron wave and as I've said, services were under -- we had more people in hospital with Covid than we'd seen at any point at all and that was reflected in the number of calls that

NHS 24 were receiving as well. So I think that was really challenging for them.

What I would say is that, I think, one of the other statistics which is green, is the one just above there, so the care delivered at first point of contact, and that is important because we had shifted with NHS 24 from a performance indicator that was about how fast they answered the phone, so looking for them to respond to calls much more quickly, but what happened then was they would answer the phone but then they would arrange for somebody to get a call back and so that's not particularly efficient or, indeed, very person-centred. If somebody is phoning up then I think they want to be able to understand what they should do next.

So that measure there, about care delivered at first point of contact is really important because what that is, is that people are maybe waiting a bit longer than they would like to get the phone answered but once they are through and talking to somebody that person is able to deal with their question at first point rather than them having to wait on a call back.

Q. Turning please to ambulance capacity issues.

Could we have on screen, please, page 18 of INQ000335968.

It's paragraph 69, and this is the statement of

Paul Bassett again. He deals in this paragraph with staffing difficulties from early summer 2021, and he says:

"In early summer 2021 coverage of shifts became more challenging due to the compounding effect of a return to pre-pandemic sickness absence levels while Covid-19 absence remained. This coincided with an increase in demand and wider system pressures across Scotland, for example increased hospital turnaround times. Throughout Covid the Service used various levels of escalation to ensure that despite high levels of staff absence, high levels of demand, and increasing wider system pressures, it prioritised the resources it could generate to the sickest patients. And so, although it would be correct to say that there were no occasions when there were insufficient staff to meet demands on the Service that was only due the levels of escalation that were put in place to prioritise demand and the additional support received from the Military, Scottish Fire and Rescue, and British Red Cross. It was also not without risk to lower acuity patients."

How was the Scottish Government monitoring the impact of pressures on the Scottish Ambulance Service and what steps were taken to support the SAS to meet

demand?

A. So we monitor the performance of the ambulance service through the statistics that they return to us. I think probably at this period we were on daily statistics. We're -- I think we're on weekly statistics now. So we're monitoring their response times, but also things like ambulance -- hospital turnaround times, because clearly that's really important in terms of freeing up ambulances. So we were able to monitor all of that.

We had gone into that period having had discussions with the Scottish Ambulance Service about what further resources they needed and what further funding they needed in order to be able to extend their capacity.

There's a reference there to the military response there, so Scottish Government would have been involved in putting in the official request for what's called a MACA, the request for military assistance.

And in terms of hospital turnaround times, as I've explained earlier, the times that -- hospitals being unable to move people out -- sorry, ambulances being unable to move people into hospitals was all aggravated by the sheer occupancy levels in hospitals, some of which was driven by Covid and some of which was driven by delayed discharges. And in relation to both

of those features, we had funded the ambulance service to provide additional hospital liaison officers, so people who work with the hospitals to try to support those hospitals to be able to take folk from ambulances.

But we'd also, working with local government colleagues and as part of our winter plan for 2021, had provided an additional investment into social care for more care at home packages, for more step-down facilities, where people maybe go to a care home for a short period before being able to go home, and for more multidisciplinary teams to carry out the assessments of those in hospital.

So I think we were trying to support both that increase in resource that the ambulance service had identified that they needed, but also some of the underlying issues that were creating congestion for them in terms of how they run their service.

Q. You refer in your statement to the role of the Covid-19 helpline, the national Covid-19 helpline, Covid-19 hubs, and community assessment centres in primary care in reducing referrals to hospitals. You also refer to the launch by the SAS in 2022 of the Integrated Clinical Hub. How effective were these initiatives in reducing pressure on emergency departments, and what lessons have been learned from their use?

A. So I think I've already really covered that piece around trying to reduce the number of people self-presenting at A&E through offering other routes through which people --

Q. And these are the other routes?

A. -- can access services -- yeah, but the one that's -- the one I maybe haven't covered so much is the ambulance hubs. And -- I sort of touched on those earlier. So that was an initiative from the ambulance service to ensure that ambulance crews have access to expert clinical advice and support, and it's that that has enabled them to reduce -- I think we're on about 50% of call-outs now don't get conveyed into A&E departments because the paramedics and the crews are able to deal with the patients in their own homes and to, you know, provide support for them, but also link them into local community services.

And I think that's been a hugely valuable piece of work and one that we continue to pursue in terms of identifying whether there are other opportunities.

As far as possible we need to try to keep people who don't need to be in hospital away from our acute hospitals.

Q. Could we have on screen, please, INQ000335968, page 19, please.

This is Paul Bassett's statement again. Looking at paragraph 73 he says:

"One area which offered a potential pool of additional resource was private ambulance providers. Recognising the potential impact on service depend, the SAS undertook a voluntary review of private providers that indicated they would be willing to support the NHS if required. This review was conducted by a senior manager and primarily based upon the ... (CQC) Standards as laid down in England."

And he goes on that:

"However, Scotland does not have a legislative framework in place for the regulation of private ambulance providers. Consequently, there is no formal agreed governance mechanism by which NHS Scotland Health Boards, the SAS included, can be assured of the standard that private ambulance providers meet. This includes not only clinical standards, but also matters relating to financial probity, vetting ..."

Et cetera.

"75. The SAS therefore does not ordinarily contract the services of private providers. There were limited circumstances in which third sector organisations ... were asked to provide support ..."

Was any consideration given by the Scottish

Government to legislative or policy changes which might have allowed for the use of private ambulances to help meet demand on the Scottish Ambulance Service during the pandemic?

A. Yes. So Healthcare Improvement Scotland are responsible in Scotland for the regulation of private clinics, as an example. They do not currently regulate -- they're not regulated for private ambulances. My understanding is there is now provision for that in legislation but that hasn't yet been implemented and it is one of the things that we will look at in 2025/2026 in terms of the relative priority of starting to regulate and therefore be in a position for NHS services to access private ambulances should that be required.

I think though, as I've said, I think our actions in relation to pressures on ambulances has been more about trying to address the root causes of those pressures, particularly those turnaround times at our hospital front doors, rather than looking to, you know, maybe including unregulated providers in that provision.

Q. Coming now, please, to Long Covid. You explain in your shorter statement that, following a funding call from the Chief Scientist Office in October 2020, nine Long Covid research projects were funded with a total funding commitment of £2.5 million. Was that Scottish

Government funding?

A. Yes, it was, yeah.

Q. You say that in July 2021, the Scottish Government commissioned NHS National Services Scotland to conduct a mapping exercise of NHS boards to identify how services were being delivered across Scotland to support people with Long Covid.

The need for a clinical guideline for Long Covid had been identified back in September 2020, and there was a guideline in place, a clinical guideline, by December 2020. Can you help with why a mapping exercise didn't take place sooner than July 2021?

A. So I think what's important to recognise is that the clinical guidance was issued in December 2020 but then that was followed up by an implementation support note which I think was issued in May 2021. So that was really about providing boards with support and information based on the best evidence that there was around Long Covid at that point.

So, after having issued that implementation support guidance that was felt appropriate to actually then ask NSS to do the mapping and to identify how boards were in fact providing support to people with Long Covid.

Q. In September 2021, the Scottish Government introduced

a centrally funded Long Covid service in Scotland; is that right?
A. That's correct, yes.
Q. Could we have on screen, please, INQ000421758, page 13.
This is the expert report of Professor Brightling and Dr Evans on the treatment of Long Covid. And there is this observation at paragraph 28:
"The provision of Long Covid services in Scotland was left to the discretion of health boards for the first 18 months of the pandemic and therefore there was variation in access and quality."
Was it not foreseeable that leaving the provision of Long Covid services to the discretion of the health boards was likely to lead to a variation in access and quality?
A. So I suppose yes, but -- yes, but. And the "but" is that our health boards operate in very different geographical areas with very different local demographics, that range from really big urban settings to very small island settings. And therefore -- and I think the NICE and SIGN guidance issued in December 2020 recognised that there isn't a one-size-fits-all in relation to Long Covid provision and that it was really important -- we felt it was really important, therefore, that health boards be in

a position to work with their local partners, because, you know, a lot of these services need to be provided in the community, and that's where some of our health and social care partnerships and the way in which integration works in Scotland comes into play as well. So it was important for local systems to look to see what would be the best way of providing those services for them. I think after the work that was commissioned from NSS, it was recognised that some central funding would assist the boards in providing those services and that funding has continued and we've confirmed to boards that that funding will continue as well.
Q. Paragraph 29 below says that:
"A report funded by the Scottish Government Chief Scientist Office up to July 2022 indicated that once the public became aware of the one of the Long Covid services they were unable to meet demand and the service closed after 18 months due to a lack of funding, with the waiting list distributed to local community rehabilitation teams."
Can you help, please, with whether this report of the clinic being unable to cope with the level of referrals once it was set up related to the period prior to September 2021, that is prior to the introduction of centrally funded services, or after?

A. So it relates to the period prior to September 2021. I think the provision in question was in NHS Tayside, and so NHS Tayside had set up their Long Covid service and they then -- I don't have any data around the demand for that. But what did become clear to them was that they needed to work more closely with their health and social care partnerships to ensure that they were making best use of services available in the community and therefore they, you know, they reworked the way in which they were providing services.
So although, in one approach, the service stopped, they actually set up other approaches to the service and that then became part of that funded provision.
Q. The national strategic network for Long Covid was established in March 2022; is that right?
A. That's right. I think that the recommendation that a national strategic network be set up was made in, I think, either September or October 2021, and it was following on from that work that NSS did on mapping. There was a short-life working group.
That was then considered by -- as we would with any strategic network, it was considered by the NHS board of chief executives who agreed that that would be a helpful enhancement to the services that they were delivering locally. And NSS were tasked with setting

that up, and I think that became operational in March 2022.
Q. Can you help with why that was not established sooner? Was it simply a case of building on the work of what had gone before or do you think there was a delay?
A. I think it was a case of building on the work that had gone before and also ensuring that we had -- well, we had -- the NSS and the strategic network would have the best possible chance of success by ensuring that we had buy-in from all the NHS boards, which is the key part of actually having that process agreed by all the NHS board chief executives in one of their regular meetings.
Q. Could we have on screen, please, INQ000510079.
This is a response from the Minister for Public Health and Women's Health in Scotland to the Convener of the Covid-19 Recovery Committee, following recommendations that it had made. It's dated 16 June 2023.
Going, please, to page 10. Point 173, in the column on the left, from the committee was that:
"The Committee notes the evidence on the need for Long COVID clinical pathways across all health boards and is disappointed to hear that, to date, only six health boards have these in place and two more were aiming to have them in place by the end of March 2023.

The Committee recommends that the Scottish Government works with the National Strategic Network on implementing Long COVID pathways across all territorial health boards in Scotland."

And then the response to the right was that:

"At present ..."

The second paragraph there, in June 2023:

"... 9 Boards have Long COVID pathways in operation, and 5 remain in development."

It was noted that where pathways are in development people with Long Covid could receive assessment and input from existing services based on their symptoms and needs.

Were you aware that this was the position in June 2023?

A. Yes, I was, yes.

Q. Has there been a delay in creating dedicated pathways for Long Covid?

A. I think that there has been -- I think that certainly those dedicated pathways have been maybe more complex to set up, given the range of physical and mental symptoms that can present as part of Long Covid. I am pleased that we can confirm that all 14 territorial boards now have those pathways in place and operational but -- and yes, ideally I would have liked to have seen that happen

more quickly.

Q. Going, please, to page 14, point 226. In relation to comments about the National Strategic Network's workstream on children and young people, the response in the right-hand column was that:

"The Strategic Network's Children and Young People Group has been established and met for the first time on 17 April 2023. The group's membership includes lived experience representatives from Long Covid Scotland and Long Covid Kids. The group will continue to meet as part of the overall governance structure of the network, and the publication of a pathway for children and young people is in the network delivery plan for September 2023."

Do you consider that there was a delay in the setting up of a children and young people's group and, if so, to what do you attribute that delay?

A. So I would recognise that, given that the work was -- that work was already underway in relation to Long Covid more generally, that, yes, it does seem like there should have been work that was ongoing on that prior to April 2023.

I don't know exactly why there was that delay. I know that the pathway for children and young people has now been published.

My working assumption would be, again, around the complexity of understanding what the differences are in presentations around children and young people and also putting in place appropriate mechanisms to ensure that there is proper paediatric assessment as well, so things aren't being missed to an assumption this is a Long Covid issue.

Q. Moving to data collection on Long Covid.

Could we have on screen, please, INQ000468127.

This is a research project briefing from the Chief Scientist Office from the last quarter of 2023. It deals with deriving and validating a risk prediction model for Long Covid. And one of the key findings, the second bullet point under "part 1" was that:

"Clinical codes for Long Covid were rarely recorded in health records."

You've seen, I think, the letter that the CMO in Scotland wrote to NHS health boards in February 2022 making the strong recommendation that local primary care teams use these codes to enable development of a better understanding of prevalence over time and to inform the approach to supporting people with Long Covid. Given that that letter had gone out in February 2023 -- apologies, February 2022, why, in your view, was there still a problem with the use of clinical coding at this

point being reported on in the last quarter of 2023?

A. So my recollection of the CMO letter was that was addressed to primary care and that really, I suppose, the first point of recording Long Covid is by GPs, in primary care systems. We have -- GPs use two different sorts of primary care systems in Scotland, and I think an ongoing challenge for us is to ensure that across, I think, close to 1,000 GP practices that there is a consistent approach and understanding to the way in which codes are used in those systems.

So the letter from the CMO, I think was to encourage all primary care practitioners to ensure that their staff were aware of those codes and who knew how to appropriately use them. We continue to work with primary care to improve the quality of that data collection and data consistency.

Q. It's important, isn't it, because it is difficult to give an accurate assessment of prevalence and severity of Long Covid in the absence of that data. Is it something that is a priority for the Scottish Government?

A. So yes, there are a number of areas where we're working with GP practices to try and improve both the accuracy of recording and the consistency of recording because to get a national picture you need the data to be recorded

in the same fields consistently.
Q. And you say you're working with partners on this.
A. Yes.
Q. What is being done specifically?
A. So we have a programme for improvement in data, of the data in primary care, and this will be one of the elements that that programme of work is looking at. At the end of the day, though, this does rely on individuals being skilled and trained at a very local level.
Q. In terms of reflections and lessons learned in relation to Long Covid, it was the evidence of the CMO for Scotland to this Inquiry that for future pandemic preparedness, adequate surveillance mechanisms should be in place monitoring not just the pathogens but also the longer-term effects of those pathogens to enable planning for healthcare resources in the longer term. Do you agree with that?
A. Yes, I would agree with that, yes.
Q. Is work being done on that at the moment?
A. So as I've explained, we are working with primary care and others to try and improve the quality and consistency of our data.
Q. Forgive me. Setting aside the data, for a second, and just concentrating on should there be another situation

with a novel virus, is work being done on what could be put in place to monitor the longer-term effects from the outset?
A. So I think that's very difficult until you know what those -- what the implications are -- of that virus are. This is one of the challenges in trying to second-guess what a new virus might present us with. I think it's a bit of trap we fell into in terms of planning for an influenza pandemic and then what we got was something different. What we need is to have flexibility and capacity within our systems to be able to respond agilely to what is sent us. And to be honest, that's quite hard at the moment because the system is still under really immense pressure.
Q. And just having taken you away from data, presumably the accuracy of data recording in general terms is important to monitoring of any sort of --
A. Absolutely, yes.
Q. Was the potential for longer-term health consequences of Covid-19 given adequate consideration by the Scottish Government and the NHS in Scotland in your view?
A. I think that certainly clinicians and others were signalling the potential for longer-term implications. My understanding -- I think that during -- quite early, I think August 2020, the Cabinet Secretary was asked to

approve the development of a framework for -- we weren't using the expression Long Covid then, but the development of a framework to look at post-Covid rehabilitation and that would include people who'd perhaps been in intensive care during Covid but also people who maybe hadn't been so ill as to require intensive ventilation but who had -- were demonstrating other symptoms whether they be cardiovascular, pulmonary, musculoskeletal, psychological, a whole range.

I think we were alert to the possibility that that would need to be something that we looked at but this was a novel virus and I think people were still learning about exactly what the implications would be.

MS PRICE: My Lady, that brings me to the end of one topic. Might that be an appropriate moment for the afternoon break, please?
LADY HALLETT: Yes. I shall return at 3.10.

I promise you, we shall finish your evidence today.

THE WITNESS: Thank you.
(2.55 pm)
(A short break)
(3.10 pm)
LADY HALLETT: Ms Price.

MS PRICE: Thank you, my Lady.

I'd like to move, please, to shielding and the Highest Risk List. At paragraph 873 of your statement, in case it helps you to refer, you describe findings of a PHS evaluation of the shielding programme between March to July 2020. A key finding was that in terms of wider lessons learned 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 valued.

Is work ongoing now to consider how those at higher risk might be protected in a future pandemic?
A. So I think the things that we learnt from the work that was done around shielding, I think the PHS research also concluded that there were lots of good things around standing up support for people really quickly in terms of groceries and medications and other things like that, but I think, and I think the Chief Medical Officer indicated this, that maybe a blanket approach is not the most helpful one and I think in the future, and again this entirely depends what sort of future pandemic we have, and who are the most vulnerable in relation to that, but I think that the way in which we move towards more of a person-centred approach and trying to ensure that people had enough information to be able to make

their own decisions around their level of risk, I think that would be important.

I think the other thing we absolutely need to do is think much earlier around the -- supporting people's mental welfare. So if people are choosing or being asked to shield then that's quite -- it is quite isolating, I think it's very difficult, and the research also indicated for some people it was really challenging to be able to do that. So I think we'd want to put in more support earlier.

We also -- I mean, we relied on digital or semi-digital messages, text messages and things like that, so I think we need to make sure we're not excluding people from participating.

We did try, through our "connected" programme, to make sure that people had access to digital devices but I think we'd probably want to do more in relation to that in the future.

So I think that there's been quite a lot that the quick or the rapid research that we did around that shielded, high-risk group early on in the pandemic was helpful in terms of informing our next steps and then the further report that PHS produced that had -- could take a bit of, I suppose, a longer-term approach to that has been really useful as well.

I think one of the things that's quite difficult for us is that not now having that same contact with that group and so not being clear about what some of the ongoing issues might be.

Q. Before we come on to that, the PHS evaluation gave rise to a recommendation 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. What steps had been taken in relation to those two specific recommendations, so taking the first, the need to protect at risk groups from nosocomial infection? And more generally, that they can access healthcare without fear of nosocomial infection?

A. So I think I would need to come back to you on that one in terms of -- we have taken measures around and, obviously, and we took measures around having the low risk and the high risk pathways, the red and green areas of our hospital facilities, so that would definitely be part of that but I think I'd need to come back to you with any more detail on that.

Q. And in relation to the need to consider the support needs of those around the at-risk person, has any work been done thinking about that?

A. So in the generality, I think that applies both to the sort of practical support which we were pretty good at

standing up but I think we didn't give enough -- didn't pay enough attention to some of the mental and emotional support for people.

Q. A PHS survey of the highest risk group published in March 2022 found that there was ongoing worrying caution amongst the highest risk group with 81% of respondents still making decisions mainly influenced by reference to the risk of Covid-19 infection and 36% still trying to minimise all physical contact with other households.

What steps have been taken to act on that evidence?

A. I think that's really challenging because, as I said, we don't have the same links into those groups any longer. I think what we've tried to do is to, you know, general promotion about encouraging people and to, again, understand their own levels of risk and provide people with information about whatever it is in terms of their own underlying conditions that influences some of those decisions.

Q. On that particular difficulty in terms of contact, can we have on screen, please, paragraph 910 of the longer statement ending 979. And you say:

"Since the Shielding/Highest Risk List ended, SG has ... no insight into the ongoing challenges and

situation for the approximately 185,000 people who were on the list ... [Scottish Government] are aware of a considerable number of people who may continue to restrict contact with others in the outside world ..."

Is that a reference to that survey result we have just been to?

A. It is.

Q. And you say:

"Currently, the [Scottish Government] has no means of understanding the scale of this issue and how we might be able to support those individuals so that they can start to regain a better quality of life."

This is a real cause for concern, is it not, this limitation?

A. I think that's right. So there obviously are people who, I think, as it notes here, who have a high profile and who actively engage with policymakers, but we don't have a way of sort of systematically addressing all those who might be in this category.

Q. Could there be steps taken for, for example, targeted liaison with GPs and third-sector groups in furtherance of making contact with these individuals or at least more of them?

A. I think I would need to take advice from the original shielding division around just how much of that

information we retain, given that quite a lot of it was very personal information.

Q. Is that something which is being given consideration or will be?

A. I would -- again, I would need to check on that.

Q. I'd like to move, please, to non-Covid care and starting with maternity services.

You explain at paragraph 90 of your shorter statement that there are no NHS Scotland national level plans -- sorry, there were no NHS Scotland national level plans put in place specifically for antenatal care, maternity services, and postpartum care between notice of Covid-19 first being received and 1 March 2020, although there had been some discussion at UK level; is that right?

A. Yes, that's my understanding, yes.

Q. In your view should plans have been in place pre-pandemic to ensure maternity services were prioritised and maintained as an essential service?

A. So I think that we were always clear about the need to maintain maternity services and also some other essential and urgent services, for example, you know, cancer services, urgent unscheduled care services, so really clear, I think, again, it's down to, well, what is the nature of the pandemic you face and therefore

what are the adjustments that you need to try to make to the services that you're actually providing?

Q. But as between notice of Covid-19 and 1 March, for example, should steps not have been taken in Scotland to put a plan in place?

A. So I think as the statement recognises, that there were discussions ongoing at a UK level and I think the first guidance that was issued came out on 9 March. So I think that does indicate that there was work underway, just formal guidance hadn't issued at that point.

Q. You explain at paragraph 92 of your shorter statement that:

"On 9 June 2020, as part of remobilisation plans, the [Scottish Government's] Directorate for Children and Families wrote to all Scottish NHS [health] boards' Heads of Midwifery asking them to return a template outlining the current maternity service provision, including staffing levels, and service provision in antenatal, intrapartum and postnatal care. It was requested that that information be returned on a monthly basis."

It's right though, isn't it, that a decision was subsequently taken that in the summer of 2020 that those returns should be discontinued; is that right?

A. Yes, that's correct, that decision was taken in

consultation with heads of midwifery and heads of obstetrics in boards and was taken in light of the fact that boards were reporting that it had taken a considerable amount of effort to respond to that first return and therefore it was felt again that, in terms of the information that we got from that return, that wasn't adding much to what we already knew through direct engagement with all the services.

Q. Well, it may not have been adding very much to what you already knew in that moment for responding immediately to what was going on, but was any consideration given to the value of the collection of that data in the longer term, to understand what had happened?

A. So I can't recall at that point whether there were considerations around whether we should be collecting that data anyway, if you like, despite the burden that it placed on services, or whether we were in a position to actually document what we knew through the engagements that were happening and what we would then plan to do with that data.

A lot of the data that was collected was around the extent to which services were or weren't stood up to their full scale, so the data that we were looking at was really around the extent to which some of the minimum standards that we had set out were being

applied, or indeed were being exceeded, because in many cases services were running beyond the minimum level.

Q. Was any consideration given by the Scottish Government to whether support could have been provided to the services to assist them with the provision of that data to reduce the burden?

A. I think it would have been -- so I can't recall whether there were discussions at that point around what support could be provided. As I say, I think -- again, this was -- and perhaps what we should have done is to think about the template that we were issuing, and where it was possible for that to be pre-populated from existing sources of data, rather than a sort of, you know, starting-from-scratch data collection.

Q. In the absence of data on antenatal care, maternity services and postpartum care, what did the Scottish Government use to inform guidance and information provided to the public about what level of services was being provided?

A. So we had set out what were minimum standards for the provision of maternity services, and we also then supplemented that. So, for example, the general guidance around visiting was -- we supplemented that in terms of whilst, I think, one person would be regarded as an essential visitor, we recognised that in maternity

circumstances people need to be potentially supported by more than one person, and so we supplemented the guidance around visiting.

That was -- rather than being based on templates return, that was based on the feedback that we were getting from maternity units. As I said, really regular engagement between the Scottish Government teams and all the heads of midwifery and obstetrics, so they were listening to what were the issues on the ground, day to day, and considering where we needed to provide additional guidance to boards to support them, and we were always clear that those were minimum standards.

And in relation to maternity services, if boards were able to go above and beyond that and felt it was safe to do so, then we would expect them, absolutely, to do that.

Q. Is it right the result of the decision to discontinue returns is that, other than the incomplete set of returns completed before the decision was taken to discontinue, there is no systematically collected national data covering the delivery of maternity services?

A. That's correct.

Q. Does it follow that it's not possible now to assess how many women in Scotland were affected by, for example,

restrictions on birth location or whether there were changes in management of particular type of issues?

A. On a cross-Scotland basis, yes, I think that's correct.

Q. And also whether any specific groups were affected more than others?

A. Yes, although Public Health Scotland did do some research into the experiences of women who were giving birth during that period.

Q. We'll come on to that in a moment. Looking back, do you think it was the correct decision to discontinue returns?

A. I think it's really difficult to weigh up the value and to be really clear about the value that you get from returns against -- particularly when those returns are placing additional demands on hard-pressed staff. I think with the benefit of hindsight, I think that perhaps a way through that would have been to think about what was the minimum dataset we require, because the returns were quite lengthy, and to think about what were the things that we absolutely needed, why did we absolutely need those, and what we were going to do with them, and how, as far as possible, could we draw those returns -- or could staff locally draw those returns from systems rather than, you know, having to fill them out from scratch.

Q. It's right, isn't it --

LADY HALLETT: Sorry to interrupt, I think, too, one has to remember, and you said I think at the beginning of your evidence, or somebody has in relation to Scotland, one has to remember that with a smaller population and the group of people, as you said, around a table, whereas for England you may not find what is going on in Cornwall or Norfolk or Manchester, for you it's much easier to get the information without having the data returns.

A. Yeah, my Lady, I think that's absolutely the case. We are a small enough system that, as I've said, there were, I think, really regular, sometimes daily, meetings between the heads of midwifery, heads of obstetrics, with the Scottish Government team. So they were hearing what was happening on the ground. And one of the reasons for standing down the data collection was because they felt that it actually didn't add anything to what they were already hearing.

So whilst, technically I suppose, it means we don't have a nice suite of reports going through monthly, I don't think that means that we didn't have a good understanding about what the situation actually was.

LADY HALLETT: Sorry to interrupt, Ms Price.

MS PRICE: Not at all. Thank you, my Lady.

It's right, isn't it, that one the key changes in the provision of maternity services in Scotland was to limit face-to-face contact between expectant mothers and healthcare staff as much as possible to reduce transmission risks?

A. Yes, that's right. I think it meant that, as far as possible, we moved to using online means for consultations between pregnant women and staff. And also, you know, standard antenatal classes that would normally be face to face with groups of expectant women were stood down as well because of the risk of infection.

Q. Was any advice sought about the negative health impacts of a reduction in face-to-face care, including, for example, on the mental health of new mothers or those who had experienced baby loss?

A. I think that when we were looking -- when the team were looking at the relative benefits the concern around the spread of virus -- and the concerns of mothers themselves around the spread of virus -- outweighed the potentially negative risks.

I think that obviously we tried to ensure that mothers were provided with an equivalent level of support, so, for example, we used an online antenatal

class, but absolutely accept that that is not the same as being in -- able to be in a room with other people and to interact and to share experiences and form ongoing relationships through that.

So I think that, you know, we would all accept that those interpersonal relationships were impacted in many areas of healthcare but perhaps particularly in maternity services. And certainly I think for learning for the future is being able -- is how we can somehow -- whether that be running group sessions online or how we -- you know, how we can try to mitigate against some of those negative effects.

Q. The Inquiry has heard evidence that it was a case often of least bad decisions and that this was all a difficult balance in terms of making these decisions, but when the decision was made to reduce face-to-face contact, were those impacts actually considered at the time in that balancing exercise?

A. So I think wherever possible we were trying to balance off the negative impacts of decisions, and you'll already have heard about the four harms approach that we adopted in Scotland. But I think that quite often, because of the nature of the virus and the rate at which it was spreading, then the overwhelming concern was to put in place protections that would stop people from

catching the virus.

Q. You deal with guidance on visiting in maternity and neonatal settings at paragraphs 113-116 of your shorter statement. This guidance was initially included in the general Covid-19 hospital visiting guidance but in July 2020 service-specific guidance was issued to maternity and neonatal services on person-centred visiting in those services; is that right?

A. Yes, that is correct.

Q. And what prompted that change?

A. I think we were -- there was a concern, and no doubt that was coming from, as I've described, the regular meetings with people in the boards, that the guidance around visiting was being interpreted on a side of strictness as it applied to maternity and therefore the sort of "essential visitor" was being defined as people just being able to have one person with them and potentially not -- the guidelines on more general visiting not permitting somebody to be accompanied to antenatal appointments.

So we felt it was important that we clarify the expectations around people being able to -- women being able to be accompanied to antenatal appointments, to being able to have an essential visitor, a designated birth partner, but also someone else, and in certain

circumstances more than one person, and also then -- so in neonatal units, for example, parents not being defined as visitors but being able to access those units.

So that guidance was indicated I think to absolutely clarify that that was the position for all of our boards.

Q. Given the particular considerations which apply to maternity and neonatal services in particular, do you think that the guidance should have been service-specific from the outset?

A. Yes, I think if would have been helpful had we issued that guidance right at the beginning and had specific sections around visiting that applied to maternity and neonatal services.

Q. A report was published in April 2022 following the Covid experiences of pregnancy study; is that what you were referring to earlier?

A. Yes.

Q. And that was commissioned by the Scottish Government in 2021?

A. That's correct.

Q. A headline finding of that report was that Covid-related rules and restrictions for maternity services were perceived as poorly communicated and inconsistent across

different services and centres in the maternity pathway. And one rule in particular was highlighted as a major source of anxiety and that was women not being allowed to have a partner attend maternity services with them. Do you recall the section of the report I'm referring to?

A. Yes, I do.

Q. Has the Scottish Government implemented the recommendations made in that report?

A. I think that the recommendation around poor communication and also variation in what was permitted in different boards, the guidance we issued in July was intended to address that and to absolutely acknowledge that we expected that boards would permit pregnant women to be accompanied to antenatal appointments, and indeed the other things I've mentioned around having more than one essential visitor.

Q. What learning has been identified by the Scottish Government, whether from this study or more widely, about reduction in face-to-face contact in the context of antenatal maternity and postpartum services and visiting restrictions for maternity and neonatal services?

A. So I think, firstly, if we were in that position again, then we would want to ensure that we were issuing

guidance around visiting that was specific to maternity and neonatal services right at the beginning, when we're -- at the same time as we're issuing visiting guidance around anything else.

And I think that we would -- you know, I think that would help, in terms of that clear communication, being really clear with women what their expectations should be and also addressing some of the issues around variation. So we need to be really clear that this is an absolute minimum.

I think in terms of the face to face, I think we -- you know, we've all recognised that whilst digital solutions had a really important role to play, there are circumstances where actually that -- people being able to talk to others and to communicate and share experiences is really important so, as I've said, I think there are areas where if we were, again, in a position where it was very difficult to allow groups to come together in that way, face to face, as you would for a normal antenatal class, that we would want to look and see whether there were ways in which we could facilitate that online so it wasn't just one to one, we were able to do group sessions.

Q. Moving, please, to the clinical prioritisation framework for collective care which was introduced in

November 2020.

Could we have on screen, please, INQ000357276, page 56, please.

This is a section from a Public Health Scotland report on inpatient day case and outpatient stage of treatment waiting times. And the background to clinical prioritisation is provided here in the first paragraph.

So in November 2020, this clinical framework, Coronavirus Covid-19 supporting of elective care, clinical prioritisation framework was introduced.

It was an interim measure to provide NHS Scotland with clear guidance for prioritising elective care whilst ensuring appropriate Covid-19 safety and priority measures were in place. And it's explained that this was at a time when elective care capacity was severely constrained by the pandemic and the backlog of patients requiring treatment was beginning to grow.

The framework became no longer applicable on 22 July 2020 (sic) when it was stood down by the Scottish Government.

How was the framework used to prioritise elective care?

A. So the table that's on the --

Q. If we scroll down a little, please.

A. So the table there is essentially the prioritised

framework. So this is based on clinical judgment in terms of people, clinicians reviewing the lists of people who are waiting for treatment and categorising them in terms of the relative urgency of this.

You can see the P4s, priority level 4s, are down as being safely scheduled after 12 weeks, so that would be absolutely the non-urgent surgery and although it might be non-urgent in a clinical sense that doesn't mean that it isn't something that is impacting on somebody's quality of life.

So this framework, I think -- and you see it was developed by the Federation of Surgical Specialty Associations so it's looking across all specialties.

But we -- so this was introduced in terms of trying to ensure that the resources that we were able to stand up around elective care were focused on those with the greatest clinical need and then the framework was stood down in July 2022, I think, on the basis that recognising that although we had been dealing with those who were clinically most urgent, that had meant quite an increase in people waiting very long times and we wanted to ensure that clinicians had the flexibility to be able to both treat people who were immediately urgent but also to start to address some of those long waits where people were obviously experiencing detriment to

their quality of life.

Q. Just dealing with those timings. The introduction in November 2020, why was it not until November 2020 that this was introduced, appreciating it was before you were DG?

A. Yes, so I maybe can't be absolutely exact on this but I suspect that this was because, I think that we had maybe -- certainly, I think, when we came out of the initial wave of the pandemic I think we maybe overoptimistically thought we would be able to get services back to normal much more quickly than actually we were able to. So as we started to recognise that not only was Covid with us to stay, because we're still experiencing Covid right now, but also that if we were going to continue to experience waves of Covid, then we needed to think about how we were going to take a different and consistent approach across Scotland to elective care.

Q. You've referred to the reasons why it was stepped down in July 2022, did the decision to keep it in force until then remain under review?

A. Yes, I think all our decisions around this remain under review and it's -- again, it's one of -- these sort of decisions are the sort of things that are discussed regularly in terms of all those groups that we have

meetings, so this would regularly come up amongst the Scottish Association of Medical Directors, for example, in terms of, is this still an appropriate way to be looking at things. And it was as a result of some concerns about the number of long waits that we were building up, that ministers took the decision to actually step down this and to allow greater flexibility at local level.

Q. Has any work been done on what the longer-term impact of the framework was, whether positive or negative?

A. I'm not aware of any work on the impact of the framework. Clearly, waiting times and the categorisation, both of our lists against the priorities but also in terms of numbers of weeks waiting is ongoing work.

Q. You identify a number of lessons learned in relation to non-Covid care in your shorter statement, from paragraphs 255 to 258, if that helps you to refer to them.

Can you summarise, briefly, please, what those are and do refer to those paragraphs if you need to?

A. Thank you. It's right at the end, isn't it? So I think there are a number of things there. One is around -- and I think that's reflected in the prioritisation framework we've just seen, that we need to ensure that

we are taking advice from the royal colleges and other clinical experts in regard to how we prioritise tests and treatment.

We also talked about supporting shared aid across NHS health boards to maximise available capacity and to minimise backlog growth, and that's certainly something that we're actively pursuing or have been actively pursuing in terms of how we can best direct the capacity that we have available and how we can use our national treatment centres, for example, in order to make progress on waiting lists. That includes people travelling, so travelling out of area, as we would call it, so people may be treated at a hospital that is not in their board area but a hospital that has the capacity to do that.

And then we also talk about protected sites, so keeping, effectively, green sites for cancer treatment, and some of the issues around redeployment of staff.

So yes, I would recognise all of those.

Q. I'd like to ask you next, please, about the impact of the pandemic on the NHS workforce, and staff support and well-being.

You deal with pandemic-specific support in your longer statement at paragraphs 327 to 336. And you deal there with the various forms of support which were made

available to the health and social care workforce, the first of those forms of support, a national well-being hub being launched on 11 May 2020; is that right?

A. Yes, that's correct. Yes.

Q. A national helpline was launched at the same time?

A. Yeah.

Q. And in August 2020, a Workforce Specialist Service was established; is that right?

A. Yes, I think the -- I think actually the approval to establish that was in August 2020, but because it was a specialist service it took a little bit longer than that to be actually up and running.

Q. I see. What type of service was this, the Workforce Specialist Service?

A. The specialist service was designed to offer psychological support and counselling to staff who had been impacted particularly by the pandemic but who might feel uncomfortable seeking support from within their board area, so clinicians who might just feel a little bit uncomfortable seeking support in their own system essentially. So it was established to offer a service that was separate from the general NHS provisions.

Q. And in September 2020 the Scottish Government provided funding to assist health boards in delivering psychological interventions and therapies; is that

right?

A. That's right. So, as well as establishing that specialist service, we also provided funding to enable boards to increase their capacity to provide therapies to their own staff as well.

Q. Funding for practical support also followed. Can you give an example or some examples of what practical support looked like?

A. Yes. So, I mean, pretty basic practical things like ensuring that everybody had access to hot drinks, hot food, that there were rest and recuperation areas so that people could get away and get a bit of downtime when they were on pretty arduous shifts. So that was funding that we provided and have, you know, encouraged boards to continue, to make sure that staff are well supported in those sort of ways.

Q. Then in 2021 there were three separate injections of funding from the Scottish Government for practical and well-being support; is that right?

A. That's right, yes.

Q. You deal with measuring staff well-being starting at paragraph 342 of your longer statement.

A. Yeah.

Q. And one step that was taken was conducting the NHS Scotland pulse survey which was launched on

1 September 2020. What were the key themes arising from the results of the NHS Scotland pulse survey?

A. Okay, so it's maybe just, in context, worth saying that in Scotland we have a pretty well established staff survey called iMatter, which runs every year. The pulse survey was agreed in partnership with -- staff-side with our trade union representatives as a way of getting a, sort of, much quicker view on how things were with staff. So I think that there was a fairly short number, maybe about 8, I think, quantitative questions, and then staff were also asked to identify what they'd found particularly helpful and what had been most challenging for them.

In terms of the some of themes coming out of that -- first of all, I think we got a good response rate: 43% of staff took part in that, and it wasn't across our NHS boards, it was also extended our health and social care partnerships, so it covered social -- staff working in social care as well.

In terms of their concerns, largely staff were concerned about their ability to give -- deliver high-quality patient care. They were concerned about their safety, the safety of their families. And, almost surprisingly, their experience, their work experience at work didn't show a huge drop from the previous iMatter

scores.

They also acknowledged that they'd been through a significant amount of change and there was a lot of emphasis placed on the value of local support within boards.

Q. You refer in your longer statement to the directorate for population health's report published in August 2021, lessons learned from the initial health and social care response to Covid-19 in Scotland.

Could we have on screen, please, page 279 of that longer statement, and in the middle of the page these are the reports findings about opportunities for further resilience in the context of well-being, and is that healthcare staff well-being?

A. Yes, that is healthcare staff well-being, although I would say it applies equally across to social care staff as well.

Q. And the opportunities, which were recognised with ease:

"[Recognising] 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 and resources on how to support staff remotely."

What steps have been taken by the Scottish Government in furtherance of those recommendations?

A. So obviously what we put in that, we put in the original funding. We also worked with boards to appoint well-being champions across our board structures. And we have recently -- well, in the last year or so, we've stood up our leadership, culture and well-being board which looks at measures of leadership, culture, well-being across boards and brings forward recommendations for work that we should continue to do. Because I think, as this recognises, this isn't just about that immediate response to the pandemic, I think it's also very much about valuing our workforce, about having cultures in place that value and support our workforce. And that really is and will be important to us as a system going forwards.

Q. When the Chief Medical Officer for Scotland gave evidence to this module of the Inquiry, he told her Ladyship he considered the Scottish Government was too slow to provide support to the NHS workforce. In particular he thought that psychological support and safe spaces for staff to debrief should have been provided sooner. Do you agree with that assessment?

A. I think that we probably need to separate out the responsibilities of Scottish Government from the responsibilities of NHS boards who actually employ the staff and have that duty of care responsibility for staff.

What Scottish Government tried to do was to step in to provide funding support to ensure that boards were able to provide that sort of capacity, but I think there are lots of good examples of where boards themselves had already recognised that there was a need and were already providing that.

Scottish Government provided the funding for it and, you know, we continue to work with boards as part of our staff governance standard to ensure that they've got good strong leadership, good strong cultures of valuing and supporting staff.

Q. You have, at paragraph 940 of your longer statement, set out a range of other lessons learned identified in the Directorate for Population Health's August 2021 report. Those go much wider than the well-being questions. I don't intend to take you through all those now, although I would refer anyone who is interested to that paragraph in the statement.

Just this though: do you agree with the learning points identified in that report set out in your

statement?
A. Yes, I think there are a number of themes there. So that report was produced, I think, based on the first six months' experience in the pandemic. I think that we would recognise most of those points and it's clear that you can start to bring those recommendations together into themes.
Q. Finally, I'd like to ask for your views, please, on the reflections given to the Inquiry, again by the Chief Medical Officer for Scotland, about the impact of the structure of the NHS in Scotland on the healthcare response to the pandemic.

In his evidence, Professor Sir Gregor Smith highlighted the lack of an equivalent to NHS England in Scotland suggesting that a "once for Scotland approach" was made more difficult by the absence of a national entity to oversee the healthcare response to the pandemic. Do you agree with him?
A. On this occasion, no, I don't agree with the Chief Medical Officer. Very rare for me to disagree with him but on this occasion, no. I think, as I explained right at the outset today, we do not have a legal entity called NHS Scotland but what we do have is very, very close working relationships. So in my job I wear one hat as the Director General and I wear another hat as

Chief Executive of NHS Scotland.

Wearing my Chief Executive of NHS Scotland hat, I have a very direct relationship with all the chief executives of our NHS boards because I delegate their accountable officer status to them and, more generally, I meet with them on a monthly basis. We do our best to ensure that we are aligned in terms of planning and delivery so that they absolutely understand the priorities of ministers, and that they're then able to provide me and my colleagues with assurance about how they're going about delivering those priorities.

So I think we've got a really strong loop and feedback loop in terms of being able to advise ministers around some of the challenges and delivery that helps ministers in terms of their setting of strategy and policy and then leads back into ensuring that that strategy and policy can be implemented and delivered and the performance management that goes alongside that.

And as to "once for Scotland", so we do adopt "once for Scotland" approaches. When we do that, that is an approach that is agreed with the chief executives and therefore is an approach that we're all signing up to. We have been running an NHS Scotland planning and delivery board for about 18 months now with the express purpose of ensuring that where things are best taken

forward on a "one service for Scotland" approach, that is exactly what we're doing.

I think it's also important to note the roles of ministers here. So ministers -- the Cabinet Secretary for Health and Social Care meets with our chairs of NHS boards on a monthly basis.

As my Lady has indicated, we are of a size where those relationships can be very strong and we use those relationships a lot.

It's also the case that ministers have the power to direct NHS boards, so should we be in a situation where there is something that needs to be done on a "once for Scotland" basis and, for whatever reason, NHS boards aren't responding to that, ministers have the power to direct that.
MS PRICE: My Lady, those are all my questions.
LADY HALLETT: Thank you very much.

I think we now go to Ms Munroe.

Questions from MS MUNROE KC

MS MUNROE: Thank you. Good afternoon. My name is Allison Munroe. I ask questions on behalf of Covid-19 Bereaved families for Justice UK. I just have two very short questions, please.

During the course of your evidence, Mrs Lamb, you've told us about certain areas where Scotland

diverges from the UK in terms of the pathway you took during the pandemic. One of those areas was in relation to field hospitals.

In your statement of 18 June of this year, you explain how in Scotland you looked at what was happening with the Nightingale hospitals in England and, as you say at your paragraph 697 -- my Lady, for the record, it's INQ000485979 -- that the decision to establish NHS Louisa Jordan Hospital was based upon, not a decision to expand ITU capacity but to provide a facility for non-critical patients.

You also say at paragraph 700 of the same statement that there was an awareness quite early on that in terms of, and you looked at the staffing picture nationally in Scotland and also the data from the portal called Turas -- I think?
A. That's right, Turas.
Q. Turas. I knew I'd pronounce it incorrectly, which is NHS Scotland's digital platform, I understand?
A. That's right.
Q. That:

"There would be difficulties with fully staffing a large field hospital like the Louisa Jordan alongside the existing estate."

Now, that all said, what additional pressures did

the establishment of the Louisa Jordan Hospital place upon existing hospitals in the estate and health boards?

A. So the decision to establish the Louisa Jordan, as you've correctly identified, was not to set it up as an intensive care facility because I think, as we've already heard, the evidence around boards having to manage on a larger geographical footprint were already creating pressures and to have established yet another geographical facility somewhat remote from our existing hospitals would have exacerbated those pressures.

So our original plan for the Louisa Jordan was that it would be used for the care of people who were not critically ill, perhaps people who had been but who were recovering.

In actual fact, we never needed to use that. We had enough capacity within our general hospital base so the Louisa Jordan was never used for that.

We did use the Louisa Jordan for outpatient clinics, so we used it for outpatient clinics for orthopaedics, I think gynaecology as well, and we also used it as a training facility, so it was really helpful in terms of having that available. We used it for -- I think the Scottish National Blood Transfusion Service used it and we used it for a vaccination facility.

So because we never got into needing to use that

for very ill patients, albeit not critically ill, it didn't place pressure on our other hospital staffing complements and where we were using it for outpatient clinics, that was really around providing an environment that was Covid-free, so it was for -- staff were able to move their clinics, if you like, to a different location and obviously the vaccination programme was a huge use of it as well.

Q. Thank you. And the second question is this. Still on the field hospitals. There have been criticisms levelled at field hospitals some of which in the UK, in England, were very much under-used. The criticism levelled is effectively they were very expensive white elephants. And you in your statement, the second statement, at paragraph 713, you identify and recognise that there were question marks about the Louisa Jordan Hospital and whether or not it was delivering value for money and/or whether it was necessary in terms of provision of healthcare in Scotland.

So in terms of lessons learned, what is being done by the Scottish Government and the directorate to look at improving resilience and preparedness in the event of a future pandemic, to ensure that if these field hospitals aren't required again, that (a) they have a full complement of staff, and (b) that they actually

can be utilised effectively?

A. Thank you. So the decision to establish the Louisa Jordan in the first place was, I suppose, based on what we observed happening in other countries, and the modelling that we had available to us at that time.

So it's hard to say would we have made a different decision looking at that same modelling now, but with the benefit of hindsight, when we know that actually that modelling didn't play out to reality, then yes, you do think, well, had we known that that was the way the pandemic was going to develop, we might have made a different decision.

In terms of going forward, I think we need to be mindful that the NHS is not an organisation that has, you know, lots of spare capacity sitting around and therefore we need to make sure that the capacity that we have is being used as appropriately as possible.

So the measures that we've already been taking around redesign of urgent care, so that only those people who really need to go to hospital for urgent care arrive at urgent care, and the measures that Scottish Government have been taking to improve and enhance social care, so that people who don't need to be in hospital are not left in hospital when they have -- no longer have a clinical need for that. And also that our

social care services need to be strong enough because they have a real role in preventing people from being admitted to hospital in the first place.

So I think our focus at the moment is very much on how we best use the capacity that we have in the most appropriate way, in a way that enables people to be cared for in the right place for them rather than thinking about standing up facilities that we may or may not need.

MS MUNROE: Thank you very much, Ms Lamb.

Thank you, my Lady.

LADY HALLETT: Thank you, Ms Munroe.

Miss Sivakumaran.

Back there. If you can make sure your answers stay on the microphone, I'd be grateful.

Questions from MS SIVAKUMARAN

MS SIVAKUMARAN: Good afternoon, I represent the Long Covid groups. My first question touches on the impact of Long Covid on NHS Scotland healthcare workers.

At paragraph 51 of your witness statement and in your evidence this morning you have said that you have data on healthcare worker deaths and data on staff absences. You've also explained that there is -- whilst there's data on absences due to Covid-19, you don't know if that's because healthcare workers had Covid-19 or if

they were -- if it was because a family member was infected and they're quarantining.

Does it follow that there are no records of staff reporting the long-term effects of Covid-19, that is Long Covid.

A. That is my understand, yes, that the coding within our staff time system groups together the Covid absences and that those Covid absences could be as a result of Long Covid, could be as a result of people having Covid, but also, equally, could be as a result of family members having Covid and therefore people self-isolating. That is in the national statistics.

There may be intelligence available, more intelligence available at a NHS board level where our expectations would be that, and I think you heard some of this from Professor McKay this morning, that staff with Long Covid are being supported, ideally to return to work in the way that we would expect any member of staff on a long-term absence to be supported, but I don't have access to that data on a national level.

Q. And so it follows that you haven't requested from the health boards whether they hold data on the number of staff that have Long Covid?

A. I'm not aware that we have requested that, no.

Q. Do you agree that it would be useful to know nationally

how many healthcare workers are affected with Long Covid?

A. Yes, I do.

Q. And you've also mentioned this afternoon that Covid is with us to stay and because we're still experiencing Covid right now and are going to continue to experience waves of Covid-19, would it be fair to say that along with new waves of Covid-19, patients and healthcare workers continuing to be infected with Covid-19 may develop Long Covid?

A. Yes, that is my understanding. I'm not aware what the more recent research is in relation to the success of the vaccination programme particularly in terms of protecting people from Long Covid.

Q. But it follows that you're not taking steps to monitor any of those new cases of Long Covid?

A. So I think I would need to go back to NHS boards and establish whether -- the extent to which we're seeing new cases of Long Covid coming through.

Q. Thank you. My last topic is on support for healthcare workers with Long Covid. A CSO research project briefing that you have exhibited to your statement reported on the experience of healthcare workers with Long Covid in Scotland, that's the LoCH study.

The URN, for reference purposes only, is

INQ000468129.

Now, this study found that most participants were in work in NHS but managing complex and dynamic symptoms with periods of improvement and exacerbation. It also found that 17% of participating health workers were so severely disabled by Long Covid that they were not able to return to work. What support, if any, is there available for healthcare workers suffering from Long Covid?

A. So I think the support that is available will very much be at a local board level in regard to the board's responsibilities as employer of those staff and, again, we would expect all boards to be regularly engaging with staff who have been off work for any time or who are experiencing difficulties and perhaps having multiple experiences of absence as a result, but we don't have that data centrally.

Q. And there's been no review at a national level of consistency across the boards of support for healthcare workers?

A. Not that I'm aware of.

Q. Now, the CSO research report also refers to NHS Long Covid payments which ended in October 2022 and the report states that the NHS Long Covid payment had been fundamental in enabling participants to work in

a reduced capacity without reduced pay, but there were high levels of anxiety about when the payment would stop and the implications for them and their family financially. And it continues that the reduction in pay and job security would have resulted in additional stress and anxiety for those unable to meet their contractual obligations.

Was there any dedicated financial support for health workers with Long Covid after the NHS Long Covid payments ended?

A. I'm not aware that there were. I think the NHS Long Covid payments were an extension to our normal occupational sickness policy, so it enabled people who were unable to work to continue to enjoy their salary for longer than would normally be the case.

MS SIVAKUMARAN: Thank you.

Those are my questions, my Lady.

LADY HALLETT: Thank you.

Mr Wagner.

Mr Wagner is over there.

Questions from MR WAGNER

MR WAGNER: My name is Adam Wagner and I ask questions on behalf of the Clinically Vulnerable Families.

I want to ask you first, please, about the non-shielding at-risk category of people that you refer

to in your statement. I'm just looking at paragraph 824 of your longer statement where you say:

"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' ... People in this group were not individually identified but were encouraged to seek help via a helpline which channeled calls to local authority health services, should they not have family or existing community support or not have access to online support."

Do you recall that category?

A. Yes, so I recall the work that was done -- I think this was in -- this must have been early summer 2020, with -- in partnership with local government, recognising that there would be people who were not officially on the shielding list and therefore were not in receipt of the support, groceries, delivery, et cetera, but who might be vulnerable and might not have family members to support them, and therefore we worked with local government to try to ensure that those people had access, as it says, to a helpline and were able -- the local government colleagues were able to then support them.

Q. So we now know that a significant proportion of those

who ended up dying or suffered adverse effects from Covid-19 were part of that non-shielding at-risk group. It makes sense because they would be particularly at risk of Covid but not deemed to be clinically extremely vulnerable.

Do you think, looking back, was enough done to inform that group of their heightened level of risks and the steps that they could take, or others around them such as their family or employers, to mitigate the risk?

A. It's a difficult question to ask, isn't it: was there enough done? I mean, I guess in circumstances there's always more that can be done. I think what we tried to do was to ensure that people who understood themselves or felt themselves to be particularly at risk had access to support. And certainly what increasingly we tried to do was to make data available to people so that they could understand, for example, what the levels of Covid prevalency was in their local communities so they were able to make their own judgments about what was appropriate for them and, you know, how they wished to manage those circumstances.

Q. Well, I suppose you could always say there's always more that you could have done, but it's not really an answer to that question, is it?

Just in relation to what more could have been

done, do you accept the approach of essentially requiring that the non-shielding at-risk people self refer to local authority health services was insufficient given the heightened risk that they faced?

A. So I think that it was appropriate for people who felt that they were particularly at risk to make that decision for themselves. I think the Inquiry has heard from the Chief Medical Officer concerns that the blanket approach that was taken to shielding was not helpful for some people, and that -- I think, you know, I think there is this -- I'm not an expert in these matters but I do think that there are questions to be asked about whether in future we should take such a blanket approach to people or whether we should focus on ensuring that people have the information that they need to understand what level of risk they are exposed to and what level of risks they think is appropriate for them.

Q. Wouldn't that approach require a more targeted strategy for contacting those people? Because, if you see, the difference is, if you're going to be saying to people, "This is -- you're at risk and it's your choice what to do", and you know that they are at significant risk, isn't it very important that the government, as they did with shielded people, find out who those people are and contact them?

A. So I would agree that the more targeted we can get, the more helpful that is. And certainly, you know, with the shielded group we tried to take steps to get more targeted around different clinical conditions, for an example.

I think when you start to look at -- you know, at quite large groups around, for example, people over 70, there is a big difference in terms of the level of fitness and other issues that affect that group, and therefore I think some form of self identification is perhaps always going to be necessary and that we wouldn't necessarily hold all the details to enable that.

Q. You refer in your statement a number of times to an individualised or person-centred approach. What do you mean by that and how could that be better or more extensively implemented in a future pandemic?

A. So I think that is absolutely back to this point around ensuring that people are, if you like, equal partners in terms of some of the decisions that are being made, that we are giving people advice and guidance that helps them to make an assessment about what it is that they feel comfortable doing and what they don't feel comfortable doing, and that that is accompanied by appropriate support to enable people who do feel that they want to

absolutely minimise contact with others, that they are -- that they're able to be supported to manage their life in that way, whereas others who may be taking an account of all the risk factors, and indeed the impact on their own mental health by cutting off contact with others, are more prepared to take a different approach.

Q. So it's identification, contact, support, are the three sort of pillars of it?

A. Yes.

Q. Finally, a June 2020 framework for decision-making called "Shielding: A way Forward for Scotland" described the necessity of developing an evidence base about the virus so that the people who were shielding or had shielded could be provided access to support that could help them make informed choices about their lives and put their choices into practice.

Do you think those aims were achieved?

A. I think that those -- I think that we certainly partially achieved those aims. We certainly continued to provide people on the shielding list with -- as I've said already, with information as it related to their own individual health condition.

I think it's important also to recognise that we didn't, in June 2020, know everything that we know now about the Covid virus. I'm not sure we know everything

there is to be known about Covid virus right now, but as the Covid virus continued to develop, so as we went through the wave, the Omicron wave, and as vaccinations developed, then those things changed as well. I think that we did -- we tried to do what we could to make sure that we were providing personalised information and also that we were making information available to people so that they could understand what was happening in their local community and in their local environment, so what level of risk they would be exposed to, because that varied, again, from period to period.

MR WAGNER: Thank you.

LADY HALLETT: Thank you very much, Mr Wagner.

Ms Lamb, I think you've already helped us in relation to yet another module, haven't you, so I'm afraid you know -- three more modules. I was going to mention, as I've mentioned to other colleagues, I do understand the burden that this Inquiry -- and indeed other inquiries, because in Scotland you not only have a Scottish Covid Inquiry, I think you have other inquiries also making demands on you.

A. I have.

LADY HALLETT: So, I am extremely conscious of that, as I've said before, so I'd just like to thank you for the help you've given so far, and I'm sorry I can't say that

I won't be asking you to come back.

THE WITNESS: Thank you very much.

LADY HALLETT: Thank you, and safe journey back to Scotland.

THE WITNESS: Thank you.

(The witness withdrew)

LADY HALLETT: Very well, Monday 18 November at 10.30.

(4.16 pm)

(The hearing adjourned until 10.30 am on Monday, 18 November 2024)

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