

Thursday, 14 November 2024

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2 (10.00 am)  
3 **LADY HALLETT:** Mr Mills.  
4 **MR MILLS:** My Lady, may I please call Professor Colin McKay.  
5 **PROFESSOR COLIN MCKAY (affirmed)**  
6 **Questions from COUNSEL TO THE INQUIRY**  
7 **MR MILLS:** Your full name, please.  
8 **A.** Colin John McKay.  
9 **Q.** Professor, you have provided a statement to the Inquiry.  
10 For reference that is INQ000478114.  
11 You are currently the Deputy Medical Director of  
12 Corporate Services at the NHS Greater Glasgow and Clyde  
13 Health Board?  
14 **A.** That's correct.  
15 **Q.** And from 2019 to 2023 you were the Chief of Medicine at  
16 the Glasgow Royal Infirmary, which sits within the  
17 health board; is that right?  
18 **A.** That's right. It's one of the four acute hospitals  
19 within the health board.  
20 **Q.** First, please, background to the hospital. What can you  
21 tell the Inquiry about the age of its estate, and the  
22 characteristics of the population it serves?  
23 **A.** Well, this will be the 300th anniversary of Glasgow  
24 Royal Infirmary. The oldest parts of the estate that  
25 are still functioning were built in the early part of

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1 an additional six beds, I believe, in that area. And  
2 then we planned to move to the theatre reception area,  
3 where further beds could be made available. And beyond  
4 that we clearly had looked to the potential future of  
5 escalating the number of beds beyond that into our  
6 theatre recovery area and even into theatres themselves.  
7 **LADY HALLETT:** Professor, you have a soft voice. If you  
8 could keep it up, I would be really grateful. It's  
9 probably my hearing, actually, rather than your voice  
10 but anyway.  
11 **MR MILLS:** A soft voice but the pace is perfect.  
12 In respect of efforts to provide the staff then  
13 for the increased number of beds, at your paragraph 57  
14 you say the GRI asked nurses with previous critical care  
15 experience to bring this to the attention of their line  
16 managers so that they could be redeployed to ICU. How  
17 many nurses were identified as being able to assist via  
18 this route?  
19 **A.** So, as you say, the first group of staff to be  
20 approached were those staff who had actual critical care  
21 experience, and those staff could be currently working  
22 within any part of the hospital. And I understand that  
23 at that point some 21 nursing staff were identified and  
24 asked to volunteer for deployment to intensive care.  
25 **Q.** As well as that, anaesthetic consultants and trainees

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1 the century, opened in 1914, and much of the estate that  
2 houses our medical wards and older people's wards were  
3 built between the 1920s and 1930s, and those wards are  
4 still very much as they were at the early part of the  
5 century.  
6 **Q.** And the demographics, please, about the population it  
7 serves?  
8 **A.** Yes. The hospital sits in the east end of Glasgow,  
9 which is where many of the most deprived communities in  
10 Glasgow live, and just to give you a flavour of that,  
11 the life expectancy for men in that part of the city is  
12 maybe 10 to 14 years less than the parts of the city  
13 where many of the medical staff might live.  
14 **Q.** The first topic, please, the efforts to increase  
15 capacity. At paragraph 43 of your statement you explain  
16 that pre-pandemic the GRI's ICU was a 20-bedded unit.  
17 That was comprised of twelve level 3 (that is  
18 ventilated) and eight level 2 (that is high dependency)  
19 beds. From that baseline, how did the GRI go about  
20 increasing its ICU capacity in March and April 2020?  
21 **A.** So when we were given the directive to look to increase  
22 capacity, we examined our estate to look to the areas  
23 which would be suitable for flexible use for critical  
24 care patients. The first area was a small recovery area  
25 next to our obstetric theatres which we repurposed for

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1 were also asked to support ICU. Why were they chosen?  
2 **A.** Well, anaesthetic staff in general were those who had  
3 the skills with airway management and ventilator  
4 management and as we started to wind down elective  
5 surgical care, so anaesthetic teams, both trainees and  
6 consultants, were redeployed into the intensive care  
7 unit.  
8 **Q.** For those who were redeployed to ICU without the same  
9 levels of previous experience as those you have  
10 mentioned, can you help us with this, please, how did  
11 the GRI go about upskilling those members of staff so  
12 that the hospital could satisfy itself that they were  
13 ready to carry out ICU work effectively?  
14 **A.** Yes, so this process was led by the senior nursing teams  
15 and medical teams within the intensive care unit and  
16 began in February 2020, and staff were taken for periods  
17 of time away from theatres or their normal place of work  
18 to spend time in the intensive care unit, under  
19 supervision of senior staff, and that process continued  
20 through February and into March, so that we had a cohort  
21 of staff who we felt were as comfortable as they could  
22 be, given the very limited time that we had available,  
23 to be able to work comfortably in that environment.  
24 **Q.** You also explain -- this is at your paragraph 34 -- that  
25 the model in the first wave was for one ICU nurse to

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

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

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

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

21 **Q.** Was that number achieved?

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

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

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

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

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

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

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

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

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

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

20 Please can we go to INQ000412901. Thank you.  
 21 These are the transfers out of the GRI's ICU:  
 22 "Between March 2020 and June 2022, we sent 26  
 23 patients out for ICU care from [the] GRI."  
 24 And if we look to the second highlighted passage:  
 25 "Capacity transfers out totalled 11."

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1 care, for example, in another hospital.

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

4 We have on screen INQ000412900.  
 5 First line, 40 patients received into the GRI's  
 6 ICU. Again, that's the same period of time, March '20  
 7 to June '22.

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

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

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

17 **Q.** Can we move, please, to IPC guidance. At paragraph 180  
 18 of your statement you say this:  
 19 "It was also clear on the ground that some of  
 20 the advice about infection control early in the  
 21 pandemic was incorrect and unhelpful. We were advised  
 22 about droplet spread in a situation where airborne  
 23 spread increasingly seemed possible."  
 24 First this, please. What were clinicians seeing  
 25 on the ground that made them think airborne spread was

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1 increasingly possible?

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

12 So they, as the infection control team, raised  
13 that concern really quite early on.

14 **Q.** Are you able to give the Inquiry an indication of how  
15 early?

16 **A.** I'm not sure I could do that with accuracy but certainly  
17 by April 2020 that was something which we were concerned  
18 about.

19 **Q.** Those concerns having been raised by members of the IPC  
20 team, did that lead to the GRI treating Covid-19 as  
21 being airborne spread from that early stage, April 2020?

22 **A.** No, we were very careful to comply, as far as was  
23 possible, with the guidance that we were issued at  
24 a national level and, again, at board level. We had  
25 regular discussions through our, what we called the

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1 action."

2 Can you share with the inquiry any examples of  
3 when local guidance was created in the absence of  
4 national guidance?

5 **A.** I think perhaps the most obvious of those was the  
6 cohorting guidance because clearly in a hospital where  
7 we had very few single rooms and many open wards, we  
8 were forced to cohort patients with similar risk  
9 profiles at different times, well in advance of  
10 structured Covid cohorting guidance coming out. And  
11 this particularly related to the management of patients  
12 who were identified as contacts of Covid-positive  
13 patients.

14 So we created our own cohorting guidance and  
15 adapted that through the different stages of the  
16 pandemic until formal guidance came in.

17 **Q.** Did you alert NHS Scotland to the fact that you had  
18 created local guidance where there was no national  
19 guidance?

20 **A.** Yes, my understanding is there were daily conversations  
21 with HPS and then ARHAI, as it became, with our deputy  
22 director of infection control but these conversations  
23 happened at a board level and not at a hospital to ARHAI  
24 or HPS level.

25 **Q.** Did those within the GRI ever perceive a difference

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1 acute tactical group which is where the governance of  
2 all of our guidance was held, and we sought to influence  
3 guidance where we possibly could but at no time did we  
4 feel that we could -- that we were in a position to  
5 deviate significantly from the national guidance that we  
6 were given.

7 **Q.** Did that create a certain level of tension within the  
8 hospital between trying to comply with national guidance  
9 at a time when there had been recognition of airborne  
10 spread?

11 **A.** Yes, it did at times. I certainly remember  
12 conversations where we discussed offering respiratory  
13 PPE to nursing staff who were managing patients on Covid  
14 wards, but there are many complexities to that, one  
15 being the availability of PPE early in the pandemic, but  
16 other -- but again, the messaging to staff, because by  
17 doing that we are, if you like, making -- we're  
18 introducing uncertainty to them and perhaps making them  
19 feel less safe in the workplace, when we were not in  
20 possession of strong evidence on which to overrule what  
21 we were being given as the national guidance.

22 **Q.** At your paragraph 179 you say:  
23 "It became clear fairly quickly [that] across  
24 a range of areas ... NHS Scotland guidance would not be  
25 available within the timescale needed for definitive

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1 between guidance issued at a national level and guidance  
2 issued by the royal colleges?

3 **A.** Yes, there were several examples of that which I've set  
4 out in my evidence statement. I think the most obvious  
5 of those was the guidance on cardiopulmonary  
6 resuscitation and the national guidance was quite clear  
7 that chest compressions as a component of CPR was not  
8 an AGP but, if I recollect, the intubation component of  
9 it was. The medical teams on the ground who had  
10 obviously a lot of experience of managing CPR were  
11 concerned that that underestimated the risk of chest  
12 compressions to staff, and that was reinforced by  
13 guidance which was then issued by royal colleges and  
14 others, and led to some tension on the ground and many  
15 conversations, and led to us adapting that guidance  
16 within the Royal Infirmary to allow chest compressions  
17 to be considered as an AGP on advice and with the  
18 agreement of our senior medical teams.

19 **Q.** You refer to tensions on the ground. I wonder if I can  
20 ask you this. Given all that we have discussed on this  
21 subject, can you give the Inquiry an insight into the  
22 level of confidence that staff at the GRI had in  
23 national IPC guidance?

24 **A.** I think that that varied throughout the course of the  
25 pandemic. I met with my senior team on a daily basis

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

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

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

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

13

1 **Q.** At paragraph 181 you say:

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

4 Why do you say that, please?

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

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

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

15

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

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

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

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

14

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

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

16 So yes, I do believe that is the case.

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

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

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

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1 Please can we have on screen INQ000477554.  
 2 We read here the first highlighted piece of text:  
 3 "Due to the sheer numbers expected, the aim is  
 4 to establish which patients are for further escalation  
 5 or not at an early stage of their admission, ideally  
 6 on admission."  
 7 The second highlight:  
 8 "These discussions can be difficult especially  
 9 when the family are not present due to isolation  
 10 measures."  
 11 Can I start by asking you about the genesis of  
 12 this plan, please, Professor. Did it already exist in  
 13 some form or was it created in March 2020 for Covid-19?  
 14 **A.** So the treatment escalation plan was already in place.  
 15 The document that you refer to was an attempt by my  
 16 senior medical team to pull together various components  
 17 of guidance and signpost staff to the red map structure  
 18 for handling difficult conversations with patients and  
 19 to incorporate the treatment escalation plan within the  
 20 patient record at the point of admission to hospital,  
 21 because, as the Inquiry has heard, patients often  
 22 deteriorated quickly and having the treatment escalation  
 23 plan in place from the outset was thought to be helpful  
 24 for managing decisions as they might emerge.  
 25 But the treatment escalation plan wasn't new. And  
 17

1 Emergency Department decision", and under the section  
 2 "Level of suitable escalation" we have four options.  
 3 Professor, please can you take us through each of  
 4 these options and set out the factors that would have  
 5 pointed towards their selection.  
 6 **A.** I'll do my best to do that.  
 7 So intensive care referral would be for those  
 8 patients for whom it would be considered after  
 9 a holistic evaluation and discussion with senior staff  
 10 that it could be anticipated that a patient could  
 11 survive prolonged ventilation and be able to resume  
 12 a high quality of life or an acceptable quality of life  
 13 following recovery.  
 14 There's very little difference between the  
 15 suitability for ITU referral or HDU referral, in other  
 16 words between level 2 and level 3, but certainly we  
 17 would perhaps have a lower threshold for escalation to  
 18 high dependency because mechanical ventilation would not  
 19 be required.  
 20 I guess active ward-based care would include  
 21 everything up to the point of requiring non-invasive  
 22 ventilation.  
 23 And comfort care would be given to those patients  
 24 who were, you know, perhaps patients who had advanced  
 25 dementia or who were not expected to survive their  
 19

1 I think, in retrospect, looking at the documentation  
 2 here, it's perhaps unfortunate that we called it the  
 3 Covid-19 Treatment Escalation Plan because, of course,  
 4 it's simply the treatment escalation plan and it is  
 5 still in place and is considered best practice and is  
 6 something that we encourage all staff to complete for  
 7 patients even today.  
 8 **Q.** What effect do you think calling it the Covid-19  
 9 escalation plan had, then? What makes you say, "In  
 10 retrospect, we would have just called it the treatment  
 11 escalation plan"?  
 12 **A.** Yes, I think listening to some of the evidence to the  
 13 Inquiry it's clear that there is sometimes a perception  
 14 that we did things differently during the pandemic from  
 15 the way in which we would have made decisions about  
 16 escalation under normal day-to-day circumstances and  
 17 I don't believe that in actual fact that was the case.  
 18 So, yes, I think by calling it the Covid-19 Treatment  
 19 Escalation Plan we have given the impression that this  
 20 is something different or new.  
 21 **Q.** Considering then the decision-making process, please, if  
 22 we look at page 34 briefly. This is the start of the  
 23 suspected Covid-19 treatment proforma.  
 24 At page 37, please, within the proforma, we have  
 25 the box here "COVID Treatment Escalation Plan --  
 18

1 illness because of the severity of illness at  
 2 presentation. But again, that was something which  
 3 required two senior decision-makers to agree before that  
 4 decision was made.  
 5 **Q.** And that's the note we see underlined there under  
 6 "Comfort care"?  
 7 **A.** Yes, that's correct.  
 8 **Q.** If we look at the second point then within this box we  
 9 have the question:  
 10 "Is this patient for CPR (complete DNACPR form  
 11 if appropriate)."  
 12 Can I ask you this, please, were any concerns  
 13 raised by staff that certain patients were arriving at  
 14 the GRI with inappropriate DNACPR notices?  
 15 **A.** No, that was not something that was ever raised with me.  
 16 **Q.** Were you aware of any concerns raised by family members  
 17 of patients that inappropriate DNACPR decisions had been  
 18 made at the GRI?  
 19 **A.** No, I'm not aware of any concerns regarding  
 20 inappropriate DNACPR decisions. We often -- or, I say  
 21 "often". We sometimes receive complaints about failures  
 22 in communication or sometimes in failures of  
 23 documentation, but these are complaints that arise from  
 24 time to time under normal circumstances. I'm not aware  
 25 in the Royal Infirmary of any specific concerns during  
 20

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

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

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

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

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

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

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

21

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

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

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

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

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

23

1 be instances of it.

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

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

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

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

22

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

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

5 **Q.** Yes.

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

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

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

24

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

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

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

22 **Q.** Visiting restrictions next.

23 Can we go to INQ000478112.

24 This is guidance established by the board to  
25 support compassionate visiting arrangements at the end  
26

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

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

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

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

20 **A.** This particular component of this guidance which is  
21 clearly set out as a framework, but this specific  
22 component of it led to significant concern from the  
23 senior clinicians, particularly those managing patients  
24 in our open Nightingale wards. And it was certainly  
25 something that I had anxiety about how we would actually  
26

27

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

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

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

8 If we consider point 3 in the box, under

9 "Minimising Harm" we read this:

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

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

24 **A.** Yes, that's exactly what that says. In the complex  
25 environment that we're describing, where sometimes even  
26

26

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

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

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

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

21 **A.** Yes. The Inquiry has heard a lot about PPE and PPE  
22 resilience. I guess the first thing I would reiterate  
23 is that we understood there was a national stockpile of  
24 PPE and it certainly became quickly apparent that there  
25 either wasn't or that the PPE wasn't entirely what we  
26

28

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

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

14 So I think those would be the two things.

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

24 **MR MILLS:** Professor, thank you.

25 My Lady, that's all I ask.

29

1 500 members of staff. At the beginning of that time  
2 there were maybe -- I think there were 25% of those  
3 staff were at work and after four months of support,  
4 that figure was 60%.

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

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

12 **A.** No, we had -- certainly towards the mid to end of 2020,  
13 we were having regular weekly reports on Covid-related  
14 absence and although Long Covid wasn't initially  
15 identified within that, it subsequently became  
16 a specific reported criteria and I think was defined as  
17 an individual who had been off work for more than  
18 10 days, I think was the criterion that was used.

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

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

25 **Q.** Thank you, that would help.

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1 **LADY HALLETT:** Yes, and now it's some more questions from  
2 the core participants, Professor.  
3 Ms Sivakumaran.

#### 4 Questions from MS SIVAKUMARAN

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

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

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

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

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

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

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

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

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

12 **Q.** And you've mentioned that you saw an improvement from  
13 25% of staff in work to up to 60%. Can we take it,  
14 then, that the Long Covid service did improve staff  
15 retention rates and help staff with Long Covid who  
16 wanted to return to work to do so?

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

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

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

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1 **MS SIVAKUMARAN:** Thank you.

2 Those are my questions, my Lady.

3 **LADY HALLETT:** Thank you.

4 Ms Mitchell.

5 That way, Professor.

6 **Questions from MS MITCHELL KC**

7 **MS MITCHELL:** Professor, I appear as instructed by

8 Aamer Anwar on behalf of the Scottish Covid Bereaved.

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

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

33

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

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

16 **Q.** I'm obliged.

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

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

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

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

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

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

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

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1 so that such confusion is limited?

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

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

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

19 **MS MITCHELL:** I'm obliged.

20 My Lady, those are the questions.

21 **LADY HALLETT:** Thank you very much, Ms Mitchell.

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

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

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1 surgeons, particularly during the first wave, I'm  
2 afraid.  
3 **LADY HALLETT:** Thank you so much for all that you did to try  
4 to ensure that the Glasgow Royal Infirmary continued to  
5 serve the people of Glasgow, very grateful to you. And  
6 thank you for your help to this Inquiry.

7 **THE WITNESS:** Thank you, my Lady.

8 **(The witness withdrew)**

9 **LADY HALLETT:** Right, Ms Price.

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

11 **MS CAROLINE LAMB (affirmed)**

12 **Questions from COUNSEL TO THE INQUIRY**

13 **LADY HALLETT:** Welcome back, Ms Lamb.

14 **THE WITNESS:** Hello.

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

17 **A.** Yes, Caroline Sarah Lamb.

18 **Q.** I will be asking today about matters covered in two  
19 witness statements which you have provided for the  
20 purposes of Module 3 of the Inquiry, both dated  
21 18 June 2024, the first running to 287 pages with the  
22 reference INQ000485979 and the second running to  
23 89 pages with the reference INQ000485984.

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

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1 those directorates?

2 **A.** That's correct.

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

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

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

10 **A.** That's correct.

11 **Q.** Who do you report to?

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

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

18 **A.** That's correct.

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

21 **A.** That's correct.

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

24 **A.** Correct.

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

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1 contents of them; is that right?

2 **A.** That's correct.

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

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

9 **A.** That's correct.

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

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

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

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

23 **A.** That's correct, yes.

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

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1 a legal entity or is it the health boards which

2 collectively make up the NHS Scotland which are legal  
3 entities?

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

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

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

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

24 **A.** That's correct, yes.

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

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1 17 March 2020 and this remained the case until 30 April  
 2 2022; are those dates right?  
 3 **A.** Yes, that's correct.  
 4 **Q.** How, if at all, are the roles of DGHSC and  
 5 Chief Executive of NHS Scotland different when the NHS  
 6 in Scotland is on an emergency footing compared to when  
 7 it is not?  
 8 **A.** When the NHS Scotland is on an emergency footing then,  
 9 essentially, ministers are taking more direct control of  
 10 activities and, therefore, I think we're probably more  
 11 directive in terms of how we work, although we would  
 12 always work in collaboration with our NHS boards. One  
 13 of the advantages of a country the size of Scotland is  
 14 that we are able to get everybody in a virtual room and  
 15 quite often in a physical room to have those very, very  
 16 regular discussions.  
 17 So I would say that there's a sort of more  
 18 immediate relationship but, actually, that's maybe just  
 19 a sort of enhancement on the way in which we would  
 20 normally operate.  
 21 **Q.** Turning, please, to infection prevention and control and  
 22 PPE issues. You deal with the Scottish Government's  
 23 role in relation to IPC guidance at paragraph 419  
 24 onwards of your longer statement ending 979.  
 25 There you say that:  
 41

1 that right?  
 2 **A.** That's correct.  
 3 **Q.** "At the start of the pandemic, SG aligned with the rest  
 4 of the UK in relation to IPC measures to reduce Covid-19  
 5 transmission. This ensured a consistent approach until  
 6 further scientific evidence was available. Covid-19  
 7 guidance was developed using a variety of sources such  
 8 as the WHO, alongside other international and UK  
 9 clinical expertise, research reviews and contextual  
 10 considerations."  
 11 Is it right that the Covid-19 Nosocomial Review  
 12 Group was accountable to the Scottish Government through  
 13 the Chief Nursing Officer to whom it provided advice?  
 14 **A.** Yes. That group was established fairly early on in that  
 15 the Scottish Government, through the chief nurse, had  
 16 asked Health Protection Scotland, I think it was, for  
 17 advice as to nosocomial infection. And their  
 18 recommendation was that we should set up an expert group  
 19 to provide advice on that, so that was set up and  
 20 reported into the chief nurse, yes.  
 21 **Q.** And is it right that the Covid-19 nosocomial review  
 22 group approved IPC guidance drawn up by ARHAI?  
 23 **A.** So the ARHAI is our expert group in relation to  
 24 infection prevention control and management. So ARHAI  
 25 were involved in both feeding in to the formation of  
 43

1 "[Whilst] the UK Government and subsequently ARHAI  
 2 Scotland held and maintained IPC guidance for Scotland,  
 3 [the Scottish Government] played a role in communicating  
 4 updates and changes in IPC guidance to [the health]  
 5 boards and other stakeholders, including [the] unions."  
 6 Before we come on to that communication role for  
 7 Scottish Government, I'd like to deal, please, with the  
 8 extent to which the Scottish Government was involved in  
 9 the formulation of IPC guidance for healthcare settings.  
 10 Could we have on screen, please, paragraph 542 of  
 11 INQ000485979 -- there we are.  
 12 At paragraph 542 of your statement you say  
 13 Scottish Government:  
 14 "... worked collaboratively with the four nations  
 15 to adopt IPC measures informed by the UK IPC cell."  
 16 And you highlight in the next paragraph that any  
 17 change to measures or guidance would be in response to  
 18 the latest and emerging evidence.  
 19 Over the page, please, paragraph 544, there is  
 20 this:  
 21 "The emerging evidence was assessed via ARHAI  
 22 Scotland's rapid reviews of literature. These rapid  
 23 reviews were presented and discussed in relation to IPC  
 24 measures at the UK IPC cell, HOCl and the CNRG."  
 25 That's the Covid-19 Nosocomial Review Group; is  
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1 infection control -- infection prevention and control  
 2 guidance at a UK level. The Covid Nosocomial Review  
 3 Group were very interested in particularly the spread of  
 4 infection within hospital and other healthcare settings,  
 5 so they would provide advice depending on exactly what  
 6 type of infection prevention and control measures were  
 7 being considered.  
 8 **Q.** So whose decision was it as to what the IPC measures and  
 9 guidance should be?  
 10 **A.** So, in general, Scotland would adopt the same measures  
 11 that were being adopted by the rest of the UK and it was  
 12 ARHAI who were predominantly feeding into that advice  
 13 around infection prevention and control measures.  
 14 However, we also took steps to contextualise some of  
 15 those -- some of that advice and guidance to the  
 16 Scottish context by producing an addendum to our  
 17 National Infection Prevention and Control Manual and  
 18 there were some occasions where Scotland took a slightly  
 19 different approach around risk -- occupational risk  
 20 assessment and personal preferences for people in terms  
 21 of in relation to specific types of protective  
 22 equipment.  
 23 **Q.** And when that was an IPC measure, or an IPC change,  
 24 rather than the discretionary policy type of changes  
 25 we'll come on to, whose decision was that? Was that  
 44

1 ARHAI or was that the nosocomial review group?  
 2 **A.** So, my recollection is that that was predominantly ARHAI  
 3 who were making recommendations. The Covid-19  
 4 Nosocomial Review Group would particularly look at  
 5 measures that related to spread within hospitals, but  
 6 I think predominantly it was ARHAI providing that  
 7 advice.

8 **Q.** Did the Scottish Government have any direct role in the  
 9 final sign-off on IPC measures and guidance that were  
 10 strict IPC measures and guidance as opposed to  
 11 a Scottish Government policy for other reasons?

12 **A.** We would provide advice to ministers that indicated when  
 13 IPC guidance and advice was changing and set out the  
 14 reasons for those changes, and ministers were very keen  
 15 to ensure that they were aware of that so that in their  
 16 communications we could try, as far as possible, that  
 17 that made -- that that remained aligned. But the  
 18 advice, the actual guidance and advice, other than with  
 19 the exception of some, I suppose, relaxations was  
 20 absolutely based on the evidence that was available.

21 **Q.** Were you made aware, when you took up your role as  
 22 DGHSC, that in December of 2020, so shortly before that,  
 23 a representative of Public Health England at an IPC cell  
 24 meeting, a UK IPC cell meeting, had proposed wider use  
 25 of FFP3 masks in healthcare settings on a precautionary

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

4 So the role was to try to ensure that we kept, in  
 5 a situation where guidance was changing quite rapidly  
 6 and where there were many differences of opinions around  
 7 exactly what was happening with the virus, our role was  
 8 to really try and keep all that advice aligned and to  
 9 make sure that the most up-to-date guidance was  
 10 available.

11 **Q.** Who was it who sent out updates to IPC guidance to NHS  
 12 health boards and other stakeholders?

13 **A.** So my recollection is that that would generally have  
 14 come from the chief nurse's office but there would also  
 15 be occasions when health workforce colleagues were  
 16 involved in issuing that guidance as well.

17 **Q.** You say at paragraph 420 of your longer statement that  
 18 while there was regular communication with all  
 19 stakeholders, there was no central mechanism in place to  
 20 monitor the efficiency of communications. Why was that?

21 **A.** I think that certainly in the early days and when  
 22 guidance was changing quite quickly, that was just --  
 23 that was part of the -- I suppose one of the issues that  
 24 we were struggling with -- with keeping up with all of  
 25 that.

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1 basis in light of the evolving evidence on aerosol  
 2 transmission of Covid-19, and that that was something  
 3 that ARHAI did not support?

4 **A.** I cannot recall being specifically made aware of any  
 5 recommendation for Public Health England. I was aware  
 6 of the ongoing discussion between clinicians and others  
 7 about the precise mechanisms by which Covid was spread.

8 **Q.** Do you think that that discussion is something that  
 9 should have been reported up to Scottish Government so  
 10 that senior civil servants and potentially ministers  
 11 could be made aware of it?

12 **A.** My understanding is that the groups that we were using  
 13 to feed into that formation of advice were all engaged  
 14 in the UK conversations as well.

15 **Q.** Turning to communication of IPC guidance and changes to  
 16 it. What was the Scottish Government's role in relation  
 17 to communication?

18 **A.** So the Scottish Government's role was really to try to  
 19 ensure that our communication was consistent and  
 20 coherent. So we would, through our workforce senior  
 21 leadership group, as an example, we would discuss with  
 22 both representatives from our HR directors in boards,  
 23 but also staff side, trade unions. Obviously, Scottish  
 24 Government was also involved in the daily briefings and  
 25 members of our team, particularly the Chief Medical

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1 We did have, through the workforce senior  
 2 leadership group -- so we did have feedback mechanisms  
 3 through that, through the regular meetings with all the  
 4 directors of nursing in our health boards, through the  
 5 regular meetings with all the chief executives, that we  
 6 did have feedback mechanisms, but I would accept that  
 7 there wasn't a sort of, you know, structured method of  
 8 actually assessing how good those detailed  
 9 communications were. We were carrying out surveys  
 10 across the public in terms of how effective some of our  
 11 broader communications were, but not to the same extent  
 12 in terms of those very, I suppose, very specific  
 13 communications.

14 **Q.** The Inquiry has heard evidence that difficulty was  
 15 caused by updates to IPC guidance being sent out on  
 16 Friday afternoons, which gave little time for  
 17 dissemination and implementation of changes before the  
 18 weekend. Was that something that you were aware of or  
 19 received feedback on?

20 **A.** Yes, I think that we were aware of the challenges that  
 21 were faced when we issued -- not just around IPC but  
 22 other changes to guidance on the occasions where those  
 23 were issued late in the week.

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

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

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

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

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

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

20 (11.16 am)

(A short break)

22 (11.32 am)

23 **LADY HALLETT:** Ms Price.

24 **MS PRICE:** Thank you, my Lady.

25 Ms Lamb, turning, please, to the approach to  
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1 underlying health conditions, on 30 March 2020, and we  
2 issued interim guidance around black, Asian and minority  
3 ethnic staff on 21 May.

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

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

16 **A.** Yes, yes absolutely.

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

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

22 "Guidance was provided by Scottish Government to  
23 the service on 4 September 2020 in regard to  
24 vulnerable healthcare workers and to staff from some  
25 ethnic backgrounds. This guidance was adopted in its  
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1 protecting healthcare workers at greatest risk from  
2 Covid-19.

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

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

14 **A.** I do.

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

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

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

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

9 **A.** That's correct.

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

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

22 In preparation for this I've been trying to  
23 identify what guidance we did issue in September 2020  
24 and all I've been able to identify is an update to the  
25 prior guidance which was -- and we were updating that to  
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1 add some additional information that was emerging about  
2 specific health conditions. So my assessment is that we  
3 did issue that guidance in July and the previous two  
4 bits of guidance, they went to the ambulance service as  
5 well, and I just wonder whether this statement was  
6 referring to a later piece of guidance.

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

17 **A.** I do, yes.

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

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

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

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

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

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

25 Ms Lamb, just for those who are following but are

55

1 **A.** That's correct.

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

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

14 And, again, looking back at the timeline around  
15 that, Jill Vickerman was due to meet with the cabinet  
16 secretary the day after that email was sent, so there  
17 was a meeting scheduled with the cabinet secretary on  
18 14 January. That wasn't an unusual meeting, that was  
19 part of a regular routine of meetings that the cabinet  
20 secretary held with the BMA and it had been expected  
21 that those issues would be raised at that meeting.  
22 Unfortunately, the cabinet secretary had to reschedule  
23 that meeting at very short notice.

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

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1 not familiar with the Scottish structure --

2 **A.** Sorry.

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

5 **A.** That's correct.

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

8 **A.** Yes, my apologies for that.

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

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

17 "[The Scottish Government] worked with NHS boards  
18 to manage and reduce the number of hospital onset cases  
19 of Covid-19 through the implementation of robust IPC  
20 measures. These measures were aligned with the guidance  
21 set out in the Covid-19 addendum, then the Scottish  
22 Winter 201-22 Respiratory Infections in Health and Care  
23 settings IPC Addendum, which was replaced by the  
24 National IPC Manual. This included measures as much as  
25 the appropriate use of PPE, the extended use of face

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1 masks and face coverings ..."  
 2 Et cetera, including ventilation.  
 3 You then refer to the timeline for that IPC  
 4 guidance. In relation to -- if we go on to  
 5 paragraph 550, please, you say here:  
 6 "Any change to IPC measures in Scotland was  
 7 based on the best available scientific evidence,  
 8 expert opinion and consensus at that time. The only  
 9 exception to this is the offering of RPE because of  
 10 a health or social care worker's personal preference.  
 11 This was not based on the IPC evidence base and, as  
 12 such, was not an IPC measure."  
 13 So is it right to summarise your evidence that in  
 14 Scotland there were occasions on which guidance was  
 15 provided to the health boards about discretionary  
 16 provision of respiratory protective equipment for  
 17 healthcare workers such as FFP3 masks outside of the  
 18 strict IPC guidance circumstances where this was the  
 19 healthcare worker's preference?  
 20 **A.** That's correct, yes.  
 21 **Q.** Could we go to page 162 of the statement, please. This  
 22 is the table that you describe as a timeline, and it  
 23 includes reference to some of the Scottish guidance  
 24 which was issued on the discretionary use of FFP3 masks  
 25 as well as some occasions when the Scottish IPC guidance

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1 And then underneath this:  
 2 "However, we are in unprecedented times and it  
 3 is paramount that frontline healthcare professionals  
 4 are supported to find a pragmatic solution to ensure  
 5 their safety and that of their patients. NERVTAG  
 6 recognises that the evidence-base is extremely weak  
 7 and heavily confounded by an inability to separate out  
 8 the specific procedures performed as part of CPR ..."  
 9 And then the paragraph below:  
 10 "Therefore, CPR within a hospital setting should  
 11 be considered as a continuum which is likely to  
 12 include an AGP as part of airway management. In this  
 13 case, the precautionary principle should apply and the  
 14 healthcare professional should be supported by their  
 15 organisation to make a professional judgment about  
 16 whether to apply airborne precautions; which would  
 17 include FFP3 face mask, long-sleeved gown, gloves and  
 18 eye/face protection. NHS Boards must ensure this PPE  
 19 is available for these frontline staff."  
 20 Is it right that this applied to hospital settings  
 21 but also to ambulance workers?  
 22 **A.** That's correct, yes.  
 23 **Q.** Is this another example, in addition to those listed in  
 24 your table in May 2020, of the guidance on the  
 25 discretionary use of FFP3 masks being issued in

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1 diverted from what the rest of the UK was doing.  
 2 The first date in the table is October 2020.  
 3 Before we go to that entry, and for completeness,  
 4 I'd just like to ask you about an earlier example of  
 5 guidance on the discretionary use of FFP3 masks, please.  
 6 Could we have on screen, please, INQ000477445.  
 7 This is dated 20 May 2020, and it is a joint  
 8 statement which was issued by the Chief Nursing Officer,  
 9 the Chief Medical Officer and the National Clinical  
 10 Director, dealing with PPE and aerosol-generating  
 11 procedures. This was, I appreciate, before you took up  
 12 your role, but in terms of that timeline.  
 13 Going to page 2 of the statement, the third  
 14 paragraph on this page, there's a description --  
 15 apologies the one below that, under that heading.  
 16 This is the description of NERVTAG's decision  
 17 saying:  
 18 "NERVTAG ... states ... it is biologically  
 19 plausible that compressions could generate an aerosol,  
 20 this is only in the same way exhalation breath would  
 21 do."  
 22 And in bold:  
 23 "Based on this evidence review and NERVTAG's  
 24 findings, UK IPC guidance will not add chest  
 25 compressions or defibrillation to the list of AGPs."

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1 Scotland?  
 2 **A.** Yes, that's correct.  
 3 **Q.** Going back, please, to the table at page 162 of  
 4 Ms Lamb's statement.  
 5 You describe here a change in the guidance  
 6 produced by ARHAI in October 2020, specifically the  
 7 guidance contained within the Scottish Covid-19 IPC  
 8 addendum upon its publication. The reason for the  
 9 change was said to be to minimise staff anxieties during  
 10 the pandemic, and the change was limited to healthcare  
 11 workers conducting aerosol-generating procedures and the  
 12 use of FFP3 masks.  
 13 Can you explain briefly, please, what the change  
 14 was.  
 15 **A.** Yes. The change was to recognise that whilst the  
 16 guidance was that in the low-risk pathways, so where  
 17 people had not tested positive -- patients had not  
 18 tested positive for Covid, that there wasn't need to use  
 19 FFP3s when performing aerosol-generating procedures, but  
 20 we recognised that staff may be anxious about doing  
 21 that, albeit in a low-risk pathway, and therefore they  
 22 could choose to wear an FFP3 respirator.  
 23 **Q.** The next change is said to be, going over the page,  
 24 please, in April 2021, and it was made by way of  
 25 an update to the Scottish Covid-19 IPC addendum.

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

8 **A.** That's correct, yes.

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

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

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

17 **A.** Yes, that's correct, yes.

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

20 **A.** Yes. It looks like it, yes.

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

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

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1 page, please.

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

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

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

20 And then in bold in the box below:

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

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

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

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

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

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

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

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

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

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

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

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

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

21 **A.** That's correct, yes.

22 **Q.** Did it apply across all health boards?

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

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

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1 that right?

2 **A.** That's correct, to my knowledge, yes.

3 **Q.** Can you just explain, please, why this policy was

4 introduced and the circumstances in which FFP3s could be

5 offered to healthcare workers over and above the

6 circumstances provided for by the IPC guidance?

7 **A.** So I think this was introduced in particular to support

8 staff who may want to be back at work but who may have

9 some underlying health conditions that would mean that

10 they might be at a higher risk of Covid and, therefore,

11 whilst they might be working in areas which wouldn't

12 normally require that level of protection, we felt that

13 it was important to be able to offer people that level

14 of protection.

15 **Q.** And this is described as personal preference, access to

16 FFP3.

17 The last change listed in this table introduced

18 in March 2022. And here this is, again, described as

19 a workforce policyholders and, again, personal

20 preference access to FFP3. Did this apply across all

21 health boards?

22 **A.** Yes, it did apply across all health boards, yes.

23 **Q.** Is it right that this policy was introduced in

24 consequence of a December 2021 WHO update to

25 recommendations on the use of FFP3 masks by healthcare

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1 guidance (21 December) based on the individual staff

2 member's personal preference.

3 "With this in mind, [IPC] managers do not have

4 a role in the process to allow staff access to an FFP3

5 mask, if it is being done on the basis of their own

6 personal choice. Rather, an individual risk

7 assessment should be carried out by the line manager,

8 in line with current guidance and with consideration

9 of the staff member's overall health, safety, physical

10 and psychological well-being, as well as personal

11 views/concerns about risks."

12 So this was not a change in the IPC guidance; it

13 was a policy decision taken by the Scottish Government.

14 Is that right?

15 **A.** That's correct, yes.

16 **Q.** A policy decision which you say was not replicated in

17 the rest of the UK?

18 **A.** That's my understanding, yeah.

19 **Q.** Why was the decision made to introduce this policy?

20 **A.** As I've said, my recollection is that after the WHO

21 updated their guidance in relation to Omicron, ministers

22 asked for additional evidence and to be given advice

23 really about what further measures they could take.

24 I think ministers were concerned to ensure that staff

25 felt protected and as it says here, taken into account

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1 workers, taking into account the increased

2 transmissibility of the Omicron variant?

3 **A.** Yes, that's correct, the WHO issued an update to their

4 guidance and the UK infection prevention control

5 structures decided that that didn't merit a change in

6 the guidance around what infection prevention control

7 measures were offered. If I recall correctly, our

8 ministers asked for specific evidence in relation to

9 that, and took a view, again, that we should offer that

10 enhanced level of protection to staff who expressed

11 a preference for that.

12 **Q.** Notification of this policy was given in a letter dated

13 19 April 2022, sent to the health boards.

14 Could we have that letter on screen, please. It's

15 INQ000429256, and starting four paragraphs down.

16 "The UK IPC cell reviewed the WHO

17 recommendations on mask use by health and care

18 workers, in light of the Omicron variant of concern

19 statement and agreed that no changes were required to

20 the extant UK guidance for Infection Prevention and

21 Control ... for seasonal respiratory infections in

22 health and care settings (including SARS-CoV-2).

23 Therefore, this letter does not reflect a change in

24 the IPC guidance, but rather is in response to

25 a conditional recommendation within the WHO updated

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1 their overall health and safety, but also psychological

2 well-being of staff, as well, and it was on that basis

3 that ministers made the decision that the staff should,

4 if it was their preference, be offered access to an FFP3

5 mask.

6 **Q.** So WHO update to recommendations came in December 2021.

7 Why did it take until April 2022 for this policy to be

8 introduced?

9 **A.** I think, as I've said, the first step in that, so first

10 of all, there was no update to the extant UK guidance so

11 I think, first of all, we waited to see if there would

12 be an update to that, which there wasn't. Ministers

13 then asked for further evidence to consider, but

14 effectively they were taking a decision that went beyond

15 the IPC guidance so it was a process of working through

16 that for them.

17 **Q.** If this was a decision that was a pure policy decision

18 to do things differently over and above the IPC

19 guidance, to make staff feel reassured, and you've

20 referred to that psychological benefit, why could this

21 policy that personal preference should be -- someone's

22 personal preference to wear an FFP3 mask should mean

23 they should have access to one, not be introduced sooner

24 in the pandemic? And I don't mean just

25 after December 2021. But if this is a policy decision

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

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

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

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

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

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1 I should have raised it with you earlier.

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

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

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

18 **THE WITNESS:** Yeah.

19 **MS PRICE:** Thank you, my Lady.

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

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1 should be available.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 against moving ARHAI.

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

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

19 **A.** Yeah.

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

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

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

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

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

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

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

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

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

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

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

25 "Daily reports were provided relating to the

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

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

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

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

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

20 And then at 166, Mr Bassett says:

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

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

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

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

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

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1 could not maintain this level of supply ..."

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

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

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

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

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

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

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

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

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

23 "... Scotland's traditional PPE supply routes,  
24 just-in-time supply model and PPE stockpiling  
25 arrangements were not sufficient in pandemic

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1 circumstances. A reformed stockpiling and buying  
2 approach for pandemic PPE is required.  
3 "... Long-term and sustainable PPE supply  
4 arrangements are required for the primary care sector  
5 to ensure the challenges of any future pandemic can be  
6 met.

7 "... During the Covid-19 pandemic Scotland  
8 always had a sufficient supply of PPE. However, as  
9 the traditional routes of supply failed under  
10 worldwide demand pressures, new supply chains had to  
11 be set up quickly in order to meet demand, therefore,  
12 surge capacity needs to be available to ensure that  
13 anticipated PPE demand is met during the volatile  
14 early stages of any future pandemic."

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

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

25 So I think the first thing that we have done is

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

7 **Q.** In what way inequitable?

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

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

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

20 And at paragraph 378 you deal with the Scottish  
21 Government PPE Action Plan, which was published in  
22 October 2020. And you explain towards the bottom of the  
23 page, at paragraph 380, that there was no specific  
24 equality impact assessment produced for the action plan.

25 Instead, the PPE division and unit policy officials

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1 that we have significantly increased the amount of PPE  
2 that we hold in Scotland. Originally I think we went to  
3 16 weeks' worth of PPE based on the quantities that we  
4 were using during Covid. That's been slightly scaled  
5 back so we're currently holding 12 weeks' based on --  
6 again based on the amounts that we were using during  
7 Covid.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 **A.** Yes, and to others, I expect.

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

12 **A.** Yes, I'd agree.

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

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

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

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1 with the daily report for Scottish Government.

2 Could we have on screen, please, INQ000372596.

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

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

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

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

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

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

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1 **A.** Yeah, that's correct.

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

4 **A.** That's correct, although I think all of us who were  
5 looking at this report knew exactly what the baseline  
6 capacity was and where we were with the surge capacity  
7 as well. So looking at this, our baseline, this is  
8 2020, so that's before we'd added 30, so our baseline  
9 level 3 was 173.

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

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

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

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1 data the Scottish Government would like to receive from  
 2 Public Health Scotland?  
 3 **A.** Yeah, I was certainly involved, not so much around the  
 4 critical care provision but as we started to really  
 5 develop our data collection and as we moved through  
 6 different phases in the pandemic, we were very keen to  
 7 ensure that we were able to get a much more holistic  
 8 view of what was happening with the system, and when  
 9 I talk about the system, I'm talking not just about  
 10 acute care but also what was happening in primary care,  
 11 what was happening in social care, because none of these  
 12 things exist as islands -- what's happening in one bit  
 13 of the system absolutely impacts on the other bit of the  
 14 system.

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

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

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

4 We also have a chart underneath here which shows  
 5 as a graph the percentages against baseline which are  
 6 set out in that table 2 we've just looked at, and it's  
 7 broken down by health board. And it's fairly easy to  
 8 see at a glance, for example, that as at  
 9 2 February 2021, NHS Ayrshire and Arran were  
 10 significantly over baseline capacity with overall bed  
 11 occupancy against baseline being at 250%.

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

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

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

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

14 Could we have on screen, please, INQ000474554.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 **A.** Yes, I think so, yes.

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

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

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

20 **A.** So I don't think you can make that direct correlation.  
21 So what this shows is the actual occupancy levels  
22 compared to our baseline. So our baseline was 173 beds  
23 going into the pandemic. And that was the number of  
24 beds that boards were financed to staff, as well.

25 However, I think you've heard already earlier this

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1 down, please:

2 "National baseline capacity was exceeded on  
3 8 occasions between 1 March 2020 and 15 March 2022. The  
4 highest peak was 44% above baseline on 10 April 2020.  
5 Patients with a positive PCR test for SARS-CoV-2  
6 comprised 76.7% of all those in ICU during the period of  
7 peak capacity (as of 10 April 2020), which reduced to  
8 56% during other episodes of activity exceeding baseline  
9 capacity later ... During these periods, care was often  
10 delivered in areas of the hospital re-purposed to  
11 provide intensive care, with separate units for Covid-19  
12 and non-Covid-19 patients, resulting in additional  
13 stress on staffing."

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

19 **A.** That's correct, yes.

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

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

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

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

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

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

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1 **LADY HALLETT:** Certainly. I shall return at 1.45.

2 (12.43 pm)

3 (The short adjournment)

4 (1.45 pm)

5 **LADY HALLETT:** Yes.

6 **MS PRICE:** Thank you, my Lady.

7 Can we please have on screen INQ0000470091.

8 Ms Lamb, this is a report published by SICSAG on  
9 13 October 2021. On page 62 of that, please, it deals  
10 with nurse staffing levels in ICU. There is this  
11 explanation of the data gathered on this and it says:

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

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

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

4 "39% of units were able to maintain recommended  
5 nurse-to-patient staffing ratios with ICU-trained  
6 registered nurses from their own unit ... In the  
7 remaining 61% of units, staffing ratios could only be  
8 maintained with registered nursing staff who did not  
9 usually work in the ICU.

10 "67% of units required nurses to work in the unit  
11 who were not part of their usual nursing staff  
12 complement ...

13 "72% of units were able to retain a supernumerary  
14 senior nurse on duty ..."

15 "This snapshot ..."

16 At the bottom paragraph here:

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

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

4 **A.** That's correct, yes.

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

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

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

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

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1 interpreting data relating to the ICU bed capacity."

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

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

9 **Q.** ICU-trained nurses?

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

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

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

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

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

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

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

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

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

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

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

16 **Q.** Outside of the question of ratios being maintained to  
17 standard, that is an ICU-trained nurse as opposed to  
18 a non-ICU-trained nurse, to what extent were you aware  
19 of dilution of staffing ratios, that is 1:1 becoming one  
20 1:3, for example?

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

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

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

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

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

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

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

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

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

16 **A.** That's correct, yes.

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

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

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- 1 your skills inevitably will degrade and so I think there  
2 is a -- and it's back to the questions about how we  
3 would manage a future pandemic and the extent to  
4 which -- some of that is dependent on us having a bit  
5 more capacity and resilience in health services than we  
6 have at the moment.
- 7 **Q.** Is any consideration being given to how you could  
8 collect the data in a way that was less onerous for the  
9 particular units?
- 10 **A.** So we are, through a number of mechanisms, looking at  
11 how we can improve the data that we have around staffing  
12 levels in all areas of our provision. In Scotland we  
13 have the safe staffing legislation which was implemented  
14 on 1 April this year and we're also looking to roll out  
15 nationally an e-rostering system that will give boards  
16 much more granular information around the acuity of the  
17 patients they're looking after, not just in critical  
18 care units, and how that matches against staffing ratios  
19 available.
- 20 **Q.** Going back to the question of baseline capacity. Would  
21 you agree that looking at the baseline position across  
22 the whole of Scotland does not give any insight into  
23 variations across the country in terms of how well  
24 hospitals were coping with demand?
- 25 **A.** Yeah, absolutely, I think that's -- you know, that's one  
105

- 1 obviously that -- the capacity issues linked very  
2 strongly to what we were seeing in terms of the  
3 proportion of Covid infections across the country and  
4 also links to some of the underlying demographics which  
5 differ across Scotland as well.
- 6 **Q.** I think you've had sight of a number of territorial  
7 health board statements providing data on the number of  
8 times between March 2020 and June 2022 that their  
9 critical care units reached 100% occupancy. The Inquiry  
10 has provided you with several of those. Have you had  
11 a chance to look at those?
- 12 **A.** I have, yes.
- 13 **Q.** It's right to recognise that the experience of the  
14 health boards is varied, as you might imagine, and there  
15 are statements from some territorial health boards that  
16 did not report significant capacity issues. But taking  
17 just one example of a territorial health board that did  
18 so struggle, could we have on screen, please,  
19 INQ000492651.
- 20 This is a statement provided on behalf of NHS  
21 Ayrshire and Arran, so that that was the health board we  
22 saw that high point on the graph for earlier.
- 23 **A.** Yes.
- 24 **Q.** And going to page 4 of this, please, under the heading  
25 of "Data Relating to Hospital Capacity", paragraph 11  
107

- 1 of the challenges of looking at national level data is  
2 that it can hide things that are going across different  
3 parts of the country. And as part of that whole-system  
4 information modelling, we had the sort of national level  
5 picture. But also a map of Scotland that showed the  
6 different boards and BRAG, so black, red, amber, green,  
7 rated them according to a number of measures not just  
8 critical care.
- 9 **Q.** You will have seen from figure 22 in the PHS report we  
10 were looking at earlier, where there's a breakdown of  
11 patients receiving level care against baseline capacity  
12 broken down by network. Do you know the figure I'm  
13 talking about?
- 14 **A.** Yeah.
- 15 **Q.** We can put it up on screen, it INQ000479816.
- 16 **A.** Yes.
- 17 **Q.** And we can see here it's broken down with those red  
18 lines indicating over baseline capacity. And it's  
19 broken down into Covid-19 cases and other cases. And we  
20 can see at glance, can't we, that the west network  
21 struggled far more with capacity issues than the --  
22 certainly more than the north network and more than the  
23 east network. Was that something you were aware of at  
24 the time?
- 25 **A.** Yeah, absolutely, and so we were aware of that because  
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- 1 explains that critical care services were provided by  
2 both of the board's acute receiving hospitals.
- 3 Going over the page, please. We see here  
4 recorded, in this top table, level 3 critical care beds  
5 and the number of times on which 100% occupancy was  
6 reached. Is it your understanding that this is 100%  
7 occupancy using surge capacity as well as baseline?
- 8 **A.** No, my understanding is that this is based on baseline  
9 and particularly if I look at the occupancy, so it's  
10 showing that on 8 March both of the hospitals were at  
11 100% occupancy. That was before we had really triggered  
12 the full extent of the surge so this is -- my  
13 understanding is this --
- 14 **Q.** This is baseline?
- 15 **A.** -- measuring against baseline yeah.
- 16 **Q.** So in that table, on my count there are nine occasions  
17 when level 3 critical care beds in at least one hospital  
18 reached 100% occupancy. Two of these occasions were  
19 in March 2020 and on one date that was the case in both  
20 hospitals simultaneously. Five of these occasions were  
21 October 2020 and the two remaining were November 2020.
- 22 And then in respect of level 2 care, the table  
23 below, that table goes over three-and-a-half pages and  
24 on my count there were 179 occasions in the relevant  
25 period where level 2 critical care beds, so HDU, high  
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1 dependency unit beds, in at least one hospital reached  
2 100% occupancy. And that happened on multiple occasions  
3 in each month during this period save for April  
4 to July 2020.

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

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

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

21 So, there are a number of occasions when there was  
22 one hospital, and I don't know whether it was University  
23 Hospital Ayr or Crosshouse, but -- one of them would be  
24 full but there are still facilities remaining. And the  
25 other hospital is about -- they're about 20 minutes  
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1 put someone in or not, it's about whether staffing  
2 ratios were being maintained, it's about the pressures  
3 on the staff, it's about the working environment for  
4 those staff. So did it prompt any action like that?

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

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

24 So, whilst we didn't have a specific team doing  
25 that, I'm -- I think I'm confident that we had really  
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1 apart. So that's one thing to be clear about.

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

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

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

25 Because it's not just about there being a bed to  
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1 good routes. And each of our boards had their bronze,  
2 silver, gold mechanisms of escalating issues within  
3 their own systems, including escalating to Scottish  
4 Government between all our regular engagement sessions.

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

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

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

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

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

21 **A.** So I think the thinking behind the permanent uplift was  
22 recognising that whilst, you know, actually there were  
23 not that many occasions when we breached baseline  
24 capacity, as you've seen already, there was a sufficient  
25 amount of those that we should look to implement  
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1 a permanent increase to our baseline, and the short-life  
2 working group were an expert group looked at our  
3 experience through the pandemic, looked at how that had  
4 played out, and it was their recommendation that 30 was  
5 the number that we should seek to increase beds by and  
6 that -- the cabinet secretary accepted that and we then  
7 funded that increase so that we now have a permanent  
8 funded increase in terms of that baseline capacity.

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

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

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

25 When you gave evidence in Module 2A of this  
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1 Covid, not necessarily in ICU but people requiring  
2 hospital treatment for Covid, coupled with an increase  
3 in more general presentations at A&E. We'd seen a huge  
4 reduction in presentations at A&E during the early part  
5 of the pandemic and we'd got a bit more back to, sort  
6 of, business as usual around that. And also we had seen  
7 an increase, quite a gradual increase but a sustained  
8 increase, of the people who were in hospital who were  
9 delayed in their discharge. So people who no longer had  
10 a clinical need to be in our hospitals but whose  
11 discharge had been delayed largely because they were  
12 waiting on social care packages to enable them to return  
13 generally into their home.

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

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

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

5 **A.** That's correct, yes.

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

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

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

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

23 **Q.** Please do.

24 **A.** So the issues that we faced in winter 2021-2022 were  
25 around a significant increase in people in hospital with  
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1 **A.** No.

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

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

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

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

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

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

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

24 **A.** I suppose that -- yeah, that could be an interpretation  
25 on this. I think as well that having these arrangements  
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1 in place are pretty much what we -- you know, what our  
2 clinicians do every day because being mechanically  
3 ventilated is not the best option for all people and  
4 obviously the earlier you can have those conversations  
5 the better. So I think I did hear from the evidence  
6 earlier this morning that maybe calling this  
7 a Covid-19-specific plan wasn't the best title for it,  
8 but -- yeah.

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

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

20 And that's the last sentence in that paragraph.

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

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

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

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

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

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

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

14 **MS PRICE:** My Lady, understood.

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

20 **A.** That's correct, yes.

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

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

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

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

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

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

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1 escalation of care and clinical prioritisation?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 **A.** Yes, that's correct.

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

23 **A.** Yes, it was very significant for them.

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

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1 blue, the target, three columns in from the left, at  
2 50%. And in '20 to '21, we have only 38.4% of calls  
3 being answered in this time. And the following year,  
4 25.9%.

5 The target for percentage of calls abandoned after  
6 five minutes was up to 10%, so that's the row beneath  
7 there, and in 2021 -- 2020 to 2021, 13.7% of calls were  
8 abandoned in the time frame. And '21 to '22, it was  
9 15.1% of calls.

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

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

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

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

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

22 **Q.** Turning please to ambulance capacity issues.

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

25 It's paragraph 69, and this is the statement of  
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1 demand?

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

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

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

19 And in terms of hospital turnaround times, as  
20 I've explained earlier, the times that -- hospitals  
21 being unable to move people out -- sorry, ambulances  
22 being unable to move people into hospitals was all  
23 aggravated by the sheer occupancy levels in hospitals,  
24 some of which was driven by Covid and some of which was  
25 driven by delayed discharges. And in relation to both  
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1 Paul Bassett again. He deals in this paragraph with  
2 staffing difficulties from early summer 2021, and he  
3 says:

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

23 How was the Scottish Government monitoring the  
24 impact of pressures on the Scottish Ambulance Service  
25 and what steps were taken to support the SAS to meet  
126

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

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

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

18 **Q.** You refer in your statement to the role of the Covid-19  
19 helpline, the national Covid-19 helpline, Covid-19 hubs,  
20 and community assessment centres in primary care in  
21 reducing referrals to hospitals. You also refer to the  
22 launch by the SAS in 2022 of the Integrated Clinical  
23 Hub. How effective were these initiatives in reducing  
24 pressure on emergency departments, and what lessons have  
25 been learned from their use?  
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- 1 **A.** So I think I've already really covered that piece around  
2 trying to reduce the number of people self-presenting at  
3 A&E through offering other routes through which  
4 people --
- 5 **Q.** And these are the other routes?
- 6 **A.** -- can access services -- yeah, but the one that's --  
7 the one I maybe haven't covered so much is the ambulance  
8 hubs. And -- I sort of touched on those earlier. So  
9 that was an initiative from the ambulance service to  
10 ensure that ambulance crews have access to expert  
11 clinical advice and support, and it's that that has  
12 enabled them to reduce -- I think we're on about 50% of  
13 call-outs now don't get conveyed into A&E departments  
14 because the paramedics and the crews are able to deal  
15 with the patients in their own homes and to, you know,  
16 provide support for them, but also link them into local  
17 community services.
- 18 And I think that's been a hugely valuable piece of  
19 work and one that we continue to pursue in terms of  
20 identifying whether there are other opportunities.
- 21 As far as possible we need to try to keep people  
22 who don't need to be in hospital away from our acute  
23 hospitals.
- 24 **Q.** Could we have on screen, please, INQ000335968, page 19,  
25 please.

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- 1 Government to legislative or policy changes which might  
2 have allowed for the use of private ambulances to help  
3 meet demand on the Scottish Ambulance Service during the  
4 pandemic?
- 5 **A.** Yes. So Healthcare Improvement Scotland are responsible  
6 in Scotland for the regulation of private clinics, as  
7 an example. They do not currently regulate -- they're  
8 not regulated for private ambulances. My understanding  
9 is there is now provision for that in legislation but  
10 that hasn't yet been implemented and it is one of the  
11 things that we will look at in 2025/2026 in terms of the  
12 relative priority of starting to regulate and therefore  
13 be in a position for NHS services to access private  
14 ambulances should that be required.
- 15 I think though, as I've said, I think our actions  
16 in relation to pressures on ambulances has been more  
17 about trying to address the root causes of those  
18 pressures, particularly those turnaround times at our  
19 hospital front doors, rather than looking to, you know,  
20 maybe including unregulated providers in that provision.
- 21 **Q.** Coming now, please, to Long Covid. You explain in your  
22 shorter statement that, following a funding call from  
23 the Chief Scientist Office in October 2020, nine  
24 Long Covid research projects were funded with a total  
25 funding commitment of £2.5 million. Was that Scottish

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- 1 This is Paul Bassett's statement again. Looking  
2 at paragraph 73 he says:  
3 "One area which offered a potential pool of  
4 additional resource was private ambulance providers.  
5 Recognising the potential impact on service depend,  
6 the SAS undertook a voluntary review of private  
7 providers that indicated they would be willing to  
8 support the NHS if required. This review was  
9 conducted by a senior manager and primarily based upon  
10 the ... (CQC) Standards as laid down in England."  
11 And he goes on that:  
12 "However, Scotland does not have a legislative  
13 framework in place for the regulation of private  
14 ambulance providers. Consequently, there is no formal  
15 agreed governance mechanism by which NHS Scotland  
16 Health Boards, the SAS included, can be assured of the  
17 standard that private ambulance providers meet. This  
18 includes not only clinical standards, but also matters  
19 relating to financial probity, vetting ..."  
20 Et cetera.  
21 "75. The SAS therefore does not ordinarily  
22 contract the services of private providers. There were  
23 limited circumstances in which third sector  
24 organisations ... were asked to provide support ..."  
25 Was any consideration given by the Scottish

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- 1 Government funding?
- 2 **A.** Yes, it was, yeah.
- 3 **Q.** You say that in July 2021, the Scottish Government  
4 commissioned NHS National Services Scotland to conduct  
5 a mapping exercise of NHS boards to identify how  
6 services were being delivered across Scotland to support  
7 people with Long Covid.
- 8 The need for a clinical guideline for Long Covid  
9 had been identified back in September 2020, and there  
10 was a guideline in place, a clinical guideline,  
11 by December 2020. Can you help with why a mapping  
12 exercise didn't take place sooner than July 2021?
- 13 **A.** So I think what's important to recognise is that the  
14 clinical guidance was issued in December 2020 but then  
15 that was followed up by an implementation support note  
16 which I think was issued in May 2021. So that was  
17 really about providing boards with support and  
18 information based on the best evidence that there was  
19 around Long Covid at that point.
- 20 So, after having issued that implementation  
21 support guidance that was felt appropriate to actually  
22 then ask NSS to do the mapping and to identify how  
23 boards were in fact providing support to people with  
24 Long Covid.
- 25 **Q.** In September 2021, the Scottish Government introduced

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1 a centrally funded Long Covid service in Scotland; is  
 2 that right?  
 3 **A.** That's correct, yes.  
 4 **Q.** Could we have on screen, please, INQ000421758, page 13.  
 5 This is the expert report of Professor Brightling  
 6 and Dr Evans on the treatment of Long Covid. And there  
 7 is this observation at paragraph 28:  
 8 "The provision of Long Covid services in  
 9 Scotland was left to the discretion of health boards  
 10 for the first 18 months of the pandemic and therefore  
 11 there was variation in access and quality."  
 12 Was it not foreseeable that leaving the provision  
 13 of Long Covid services to the discretion of the health  
 14 boards was likely to lead to a variation in access and  
 15 quality?  
 16 **A.** So I suppose yes, but -- yes, but. And the "but" is  
 17 that our health boards operate in very different  
 18 geographical areas with very different local  
 19 demographics, that range from really big urban settings  
 20 to very small island settings. And therefore -- and  
 21 I think the NICE and SIGN guidance issued  
 22 in December 2020 recognised that there isn't  
 23 a one-size-fits-all in relation to Long Covid provision  
 24 and that it was really important -- we felt it was  
 25 really important, therefore, that health boards be in  
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1 **A.** So it relates to the period prior to September 2021.  
 2 I think the provision in question was in NHS Tayside,  
 3 and so NHS Tayside had set up their Long Covid service  
 4 and they then -- I don't have any data around the demand  
 5 for that. But what did become clear to them was that  
 6 they needed to work more closely with their health and  
 7 social care partnerships to ensure that they were making  
 8 best use of services available in the community and  
 9 therefore they, you know, they reworked the way in which  
 10 they were providing services.  
 11 So although, in one approach, the service stopped,  
 12 they actually set up other approaches to the service and  
 13 that then became part of that funded provision.  
 14 **Q.** The national strategic network for Long Covid was  
 15 established in March 2022; is that right?  
 16 **A.** That's right. I think that the recommendation that  
 17 a national strategic network be set up was made in,  
 18 I think, either September or October 2021, and it was  
 19 following on from that work that NSS did on mapping.  
 20 There was a short-life working group.  
 21 That was then considered by -- as we would with  
 22 any strategic network, it was considered by the  
 23 NHS board of chief executives who agreed that that would  
 24 be a helpful enhancement to the services that they were  
 25 delivering locally. And NSS were tasked with setting  
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1 a position to work with their local partners, because,  
 2 you know, a lot of these services need to be provided in  
 3 the community, and that's where some of our health and  
 4 social care partnerships and the way in which  
 5 integration works in Scotland comes into play as well.  
 6 So it was important for local systems to look to see  
 7 what would be the best way of providing those services  
 8 for them. I think after the work that was commissioned  
 9 from NSS, it was recognised that some central funding  
 10 would assist the boards in providing those services and  
 11 that funding has continued and we've confirmed to boards  
 12 that that funding will continue as well.  
 13 **Q.** Paragraph 29 below says that:  
 14 "A report funded by the Scottish Government Chief  
 15 Scientist Office up to July 2022 indicated that once the  
 16 public became aware of the one of the Long Covid  
 17 services they were unable to meet demand and the service  
 18 closed after 18 months due to a lack of funding, with  
 19 the waiting list distributed to local community  
 20 rehabilitation teams."  
 21 Can you help, please, with whether this report of  
 22 the clinic being unable to cope with the level of  
 23 referrals once it was set up related to the period prior  
 24 to September 2021, that is prior to the introduction of  
 25 centrally funded services, or after?  
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1 that up, and I think that became operational  
 2 in March 2022.  
 3 **Q.** Can you help with why that was not established sooner?  
 4 Was it simply a case of building on the work of what had  
 5 gone before or do you think there was a delay?  
 6 **A.** I think it was a case of building on the work that had  
 7 gone before and also ensuring that we had -- well, we  
 8 had -- the NSS and the strategic network would have the  
 9 best possible chance of success by ensuring that we had  
 10 buy-in from all the NHS boards, which is the key part of  
 11 actually having that process agreed by all the NHS board  
 12 chief executives in one of their regular meetings.  
 13 **Q.** Could we have on screen, please, INQ000510079.  
 14 This is a response from the Minister for Public  
 15 Health and Women's Health in Scotland to the Convener of  
 16 the Covid-19 Recovery Committee, following  
 17 recommendations that it had made. It's dated  
 18 16 June 2023.  
 19 Going, please, to page 10. Point 173, in the  
 20 column on the left, from the committee was that:  
 21 "The Committee notes the evidence on the need for  
 22 Long COVID clinical pathways across all health boards  
 23 and is disappointed to hear that, to date, only six  
 24 health boards have these in place and two more were  
 25 aiming to have them in place by the end of March 2023.  
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1 The Committee recommends that the Scottish Government  
2 works with the National Strategic Network on  
3 implementing Long COVID pathways across all territorial  
4 health boards in Scotland."

5 And then the response to the right was that:  
6 "At present ..."

7 The second paragraph there, in June 2023:  
8 "... 9 Boards have Long COVID pathways in  
9 operation, and 5 remain in development."

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

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

16 **A.** Yes, I was, yes.

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

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

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

8 **Q.** Moving to data collection on Long Covid.

9 Could we have on screen, please, INQ000468127.

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

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

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

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1 more quickly.

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

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

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

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

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

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1 point being reported on in the last quarter of 2023?

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

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

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

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

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1 in the same fields consistently.

2 **Q.** And you say you're working with partners on this.

3 **A.** Yes.

4 **Q.** What is being done specifically?

5 **A.** So we have a programme for improvement in data, of the  
6 data in primary care, and this will be one of the  
7 elements that that programme of work is looking at. At  
8 the end of the day, though, this does rely on  
9 individuals being skilled and trained at a very local  
10 level.

11 **Q.** In terms of reflections and lessons learned in relation  
12 to Long Covid, it was the evidence of the CMO for  
13 Scotland to this Inquiry that for future pandemic  
14 preparedness, adequate surveillance mechanisms should be  
15 in place monitoring not just the pathogens but also the  
16 longer-term effects of those pathogens to enable  
17 planning for healthcare resources in the longer term.  
18 Do you agree with that?

19 **A.** Yes, I would agree with that, yes.

20 **Q.** Is work being done on that at the moment?

21 **A.** So as I've explained, we are working with primary care  
22 and others to try and improve the quality and  
23 consistency of our data.

24 **Q.** Forgive me. Setting aside the data, for a second, and  
25 just concentrating on should there be another situation

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

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

15 **MS PRICE:** My Lady, that brings me to the end of one topic.  
16 Might that be an appropriate moment for the afternoon  
17 break, please?

18 **LADY HALLETT:** Yes. I shall return at 3.10.

19 I promise you, we shall finish your evidence  
20 today.

21 **THE WITNESS:** Thank you.

22 **(2.55 pm)**

**(A short break)**

24 **(3.10 pm)**

25 **LADY HALLETT:** Ms Price.

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1 with a novel virus, is work being done on what could be  
2 put in place to monitor the longer-term effects from the  
3 outset?

4 **A.** So I think that's very difficult until you know what  
5 those -- what the implications are -- of that virus are.  
6 This is one of the challenges in trying to second-guess  
7 what a new virus might present us with. I think it's  
8 a bit of trap we fell into in terms of planning for  
9 an influenza pandemic and then what we got was something  
10 different. What we need is to have flexibility and  
11 capacity within our systems to be able to respond  
12 agilely to what is sent us. And to be honest, that's  
13 quite hard at the moment because the system is still  
14 under really immense pressure.

15 **Q.** And just having taken you away from data, presumably the  
16 accuracy of data recording in general terms is important  
17 to monitoring of any sort of --

18 **A.** Absolutely, yes.

19 **Q.** Was the potential for longer-term health consequences of  
20 Covid-19 given adequate consideration by the Scottish  
21 Government and the NHS in Scotland in your view?

22 **A.** I think that certainly clinicians and others were  
23 signalling the potential for longer-term implications.  
24 My understanding -- I think that during -- quite early,  
25 I think August 2020, the Cabinet Secretary was asked to

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1 **MS PRICE:** Thank you, my Lady.

2 I'd like to move, please, to shielding and the  
3 Highest Risk List. At paragraph 873 of your statement,  
4 in case it helps you to refer, you describe findings of  
5 a PHS evaluation of the shielding programme between  
6 March to July 2020. A key finding was that in terms of  
7 wider lessons learned for future pandemic planning  
8 a repeat of the shielding programme in its initial  
9 format is not recommended. The principle of protecting  
10 those at higher risk remains valued.

11 Is work ongoing now to consider how those at  
12 higher risk might be protected in a future pandemic?

13 **A.** So I think the things that we learnt from the work that  
14 was done around shielding, I think the PHS research also  
15 concluded that there were lots of good things around  
16 standing up support for people really quickly in terms  
17 of groceries and medications and other things like that,  
18 but I think, and I think the Chief Medical Officer  
19 indicated this, that maybe a blanket approach is not the  
20 most helpful one and I think in the future, and again  
21 this entirely depends what sort of future pandemic we  
22 have, and who are the most vulnerable in relation to  
23 that, but I think that the way in which we move towards  
24 more of a person-centred approach and trying to ensure  
25 that people had enough information to be able to make

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

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

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

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

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

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

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

11 What steps have been taken to act on that  
12 evidence?

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

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

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

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

5 **Q.** Before we come on to that, the PHS evaluation gave rise  
6 to a recommendation that future programmes consider more  
7 fully the risk of Covid-19 infection during a hospital  
8 admission and the support needs of the wider shielding  
9 household. What steps had been taken in relation to  
10 those two specific recommendations, so taking the first,  
11 the need to protect at risk groups from nosocomial  
12 infection? And more generally, that they can access  
13 healthcare without fear of nosocomial infection?

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

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

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

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

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

7 **A.** It is.

8 **Q.** And you say:

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

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

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

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

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

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

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

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

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

8 You explain at paragraph 90 of your shorter  
 9 statement that there are no NHS Scotland national level  
 10 plans -- sorry, there were no NHS Scotland national  
 11 level plans put in place specifically for antenatal  
 12 care, maternity services, and postpartum care between  
 13 notice of Covid-19 first being received and  
 14 1 March 2020, although there had been some discussion at  
 15 UK level; is that right?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 **A.** That's correct.

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

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

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

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

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

25 **LADY HALLETT:** Sorry to interrupt, Ms Price.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 **A.** Yes.

20 **Q.** And that was commissioned by the Scottish Government in  
21 2021?

22 **A.** That's correct.

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

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1 catching the virus.

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

9 **A.** Yes, that is correct.

10 **Q.** And what prompted that change?

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

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

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

7 **A.** Yes, I do.

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

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

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

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

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

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

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

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

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

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

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

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

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1 November 2020.

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

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

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

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

18 The framework became no longer applicable on  
19 22 July 2020 (sic) when it was stood down by the  
20 Scottish Government.

21 How was the framework used to prioritise elective  
22 care?

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

24 **Q.** If we scroll down a little, please.

25 **A.** So the table there is essentially the prioritised

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1 their quality of life.

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

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

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

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

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

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

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

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

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

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

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

4 **A.** Yes, that's correct. Yes.

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

6 **A.** Yeah.

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

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

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

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

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

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

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

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

19 So yes, I would recognise all of those.

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

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

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1 right?

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

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

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

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

20 **A.** That's right, yes.

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

23 **A.** Yeah.

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

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

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

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

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

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1 with the necessary training and resources on how to  
2 support staff remotely."

3 What steps have been taken by the Scottish  
4 Government in furtherance of those recommendations?  
5 **A.** So obviously what we put in that, we put in the original  
6 funding. We also worked with boards to appoint  
7 well-being champions across our board structures. And  
8 we have recently -- well, in the last year or so, we've  
9 stood up our leadership, culture and well-being board  
10 which looks at measures of leadership, culture,  
11 well-being across boards and brings forward  
12 recommendations for work that we should continue to do.  
13 Because I think, as this recognises, this isn't just  
14 about that immediate response to the pandemic, I think  
15 it's also very much about valuing our workforce, about  
16 having cultures in place that value and support our  
17 workforce. And that really is and will be important to  
18 us as a system going forwards.

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

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1 scores.

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

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

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

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

18 **Q.** And the opportunities, which were recognised with ease:  
19 "[Recognising] that wellbeing response to the  
20 pandemic will be needed in the long-term. Leaders must  
21 consider how to transition this into business as usual  
22 and continue to support the physical and psychological  
23 wellbeing of staff;

24 "Line managers continue to be a source of support  
25 to staff. Leaders should consider how to equip managers

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

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

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

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

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

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1 statement?

2 **A.** Yes, I think there are a number of themes there. So  
3 that report was produced, I think, based on the first  
4 six months' experience in the pandemic. I think that we  
5 would recognise most of those points and it's clear that  
6 you can start to bring those recommendations together  
7 into themes.

8 **Q.** Finally, I'd like to ask for your views, please, on the  
9 reflections given to the Inquiry, again by the Chief  
10 Medical Officer for Scotland, about the impact of the  
11 structure of the NHS in Scotland on the healthcare  
12 response to the pandemic.

13 In his evidence, Professor Sir Gregor Smith  
14 highlighted the lack of an equivalent to NHS England in  
15 Scotland suggesting that a "once for Scotland approach"  
16 was made more difficult by the absence of a national  
17 entity to oversee the healthcare response to the  
18 pandemic. Do you agree with him?

19 **A.** On this occasion, no, I don't agree with the Chief  
20 Medical Officer. Very rare for me to disagree with him  
21 but on this occasion, no. I think, as I explained right  
22 at the outset today, we do not have a legal entity  
23 called NHS Scotland but what we do have is very, very  
24 close working relationships. So in my job I wear one  
25 hat as the Director General and I wear another hat as

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

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

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

10 It's also the case that ministers have the power  
11 to direct NHS boards, so should we be in a situation  
12 where there is something that needs to be done on a  
13 "once for Scotland" basis and, for whatever reason, NHS  
14 boards aren't responding to that, ministers have the  
15 power to direct that.

16 **MS PRICE:** My Lady, those are all my questions.

17 **LADY HALLETT:** Thank you very much.

18 I think we now go to Ms Munroe.

19 **Questions from MS MUNROE KC**

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

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

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1 Chief Executive of NHS Scotland.

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

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

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

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

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

12 You also say at paragraph 700 of the same  
13 statement that there was an awareness quite early on  
14 that in terms of, and you looked at the staffing picture  
15 nationally in Scotland and also the data from the portal  
16 called Turas -- I think?

17 **A.** That's right, Turas.

18 **Q.** Turas. I knew I'd pronounce it incorrectly, which is  
19 NHS Scotland's digital platform, I understand?

20 **A.** That's right.

21 **Q.** That:

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

25 Now, that all said, what additional pressures did

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1 the establishment of the Louisa Jordan Hospital place  
 2 upon existing hospitals in the estate and health boards?  
 3 **A.** So the decision to establish the Louisa Jordan, as  
 4 you've correctly identified, was not to set it up as  
 5 an intensive care facility because I think, as we've  
 6 already heard, the evidence around boards having to  
 7 manage on a larger geographical footprint were already  
 8 creating pressures and to have established yet another  
 9 geographical facility somewhat remote from our existing  
 10 hospitals would have exacerbated those pressures.

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

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

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

25 So because we never got into needing to use that  
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1 can be utilised effectively?

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

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

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

18 So the measures that we've already been taking  
 19 around redesign of urgent care, so that only those  
 20 people who really need to go to hospital for urgent care  
 21 arrive at urgent care, and the measures that Scottish  
 22 Government have been taking to improve and enhance  
 23 social care, so that people who don't need to be in  
 24 hospital are not left in hospital when they have -- no  
 25 longer have a clinical need for that. And also that our  
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1 for very ill patients, albeit not critically ill, it  
 2 didn't place pressure on our other hospital staffing  
 3 complements and where we were using it for outpatient  
 4 clinics, that was really around providing an environment  
 5 that was Covid-free, so it was for -- staff were able to  
 6 move their clinics, if you like, to a different location  
 7 and obviously the vaccination programme was a huge use  
 8 of it as well.

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

20 So in terms of lessons learned, what is being done  
 21 by the Scottish Government and the directorate to look  
 22 at improving resilience and preparedness in the event of  
 23 a future pandemic, to ensure that if these field  
 24 hospitals aren't required again, that (a) they have  
 25 a full complement of staff, and (b) that they actually  
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1 social care services need to be strong enough because  
 2 they have a real role in preventing people from being  
 3 admitted to hospital in the first place.

4 So I think our focus at the moment is very much on  
 5 how we best use the capacity that we have in the most  
 6 appropriate way, in a way that enables people to be  
 7 cared for in the right place for them rather than  
 8 thinking about standing up facilities that we may or may  
 9 not need.

10 **MS MUNROE:** Thank you very much, Ms Lamb.

11 Thank you, my Lady.

12 **LADY HALLETT:** Thank you, Ms Munroe.

13 Miss Sivakumaran.

14 Back there. If you can make sure your answers  
 15 stay on the microphone, I'd be grateful.

#### 16 **Questions from MS SIVAKUMARAN**

17 **MS SIVAKUMARAN:** Good afternoon, I represent the Long Covid  
 18 groups. My first question touches on the impact of  
 19 Long Covid on NHS Scotland healthcare workers.

20 At paragraph 51 of your witness statement and in  
 21 your evidence this morning you have said that you have  
 22 data on healthcare worker deaths and data on staff  
 23 absences. You've also explained that there is -- whilst  
 24 there's data on absences due to Covid-19, you don't know  
 25 if that's because healthcare workers had Covid-19 or if  
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1 they were -- if it was because a family member was  
 2 infected and they're quarantining.  
 3 Does it follow that there are no records of staff  
 4 reporting the long-term effects of Covid-19, that is  
 5 Long Covid.  
 6 **A.** That is my understand, yes, that the coding within our  
 7 staff time system groups together the Covid absences and  
 8 that those Covid absences could be as a result of  
 9 Long Covid, could be as a result of people having Covid,  
 10 but also, equally, could be as a result of family  
 11 members having Covid and therefore people  
 12 self-isolating. That is in the national statistics.

13 There may be intelligence available, more  
 14 intelligence available at a NHS board level where our  
 15 expectations would be that, and I think you heard some  
 16 of this from Professor McKay this morning, that staff  
 17 with Long Covid are being supported, ideally to return  
 18 to work in the way that we would expect any member of  
 19 staff on a long-term absence to be supported, but  
 20 I don't have access to that data on a national level.

21 **Q.** And so it follows that you haven't requested from the  
 22 health boards whether they hold data on the number of  
 23 staff that have Long Covid?

24 **A.** I'm not aware that we have requested that, no.

25 **Q.** Do you agree that it would be useful to know nationally  
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1 INQ000468129.

2 Now, this study found that most participants were  
 3 in work in NHS but managing complex and dynamic symptoms  
 4 with periods of improvement and exacerbation. It also  
 5 found that 17% of participating health workers were so  
 6 severely disabled by Long Covid that they were not able  
 7 to return to work. What support, if any, is there  
 8 available for healthcare workers suffering from  
 9 Long Covid?

10 **A.** So I think the support that is available will very much  
 11 be at a local board level in regard to the board's  
 12 responsibilities as employer of those staff and, again,  
 13 we would expect all boards to be regularly engaging with  
 14 staff who have been off work for any time or who are  
 15 experiencing difficulties and perhaps having multiple  
 16 experiences of absence as a result, but we don't have  
 17 that data centrally.

18 **Q.** And there's been no review at a national level of  
 19 consistency across the boards of support for healthcare  
 20 workers?

21 **A.** Not that I'm aware of.

22 **Q.** Now, the CSO research report also refers to NHS  
 23 Long Covid payments which ended in October 2022 and the  
 24 report states that the NHS Long Covid payment had been  
 25 fundamental in enabling participants to work in  
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1 how many healthcare workers are affected with  
 2 Long Covid?

3 **A.** Yes, I do.

4 **Q.** And you've also mentioned this afternoon that Covid is  
 5 with us to stay and because we're still experiencing  
 6 Covid right now and are going to continue to experience  
 7 waves of Covid-19, would it be fair to say that along  
 8 with new waves of Covid-19, patients and healthcare  
 9 workers continuing to be infected with Covid-19 may  
 10 develop Long Covid?

11 **A.** Yes, that is my understanding. I'm not aware what the  
 12 more recent research is in relation to the success of  
 13 the vaccination programme particularly in terms of  
 14 protecting people from Long Covid.

15 **Q.** But it follows that you're not taking steps to monitor  
 16 any of those new cases of Long Covid?

17 **A.** So I think I would need to go back to NHS boards and  
 18 establish whether -- the extent to which we're seeing  
 19 new cases of Long Covid coming through.

20 **Q.** Thank you. My last topic is on support for healthcare  
 21 workers with Long Covid. A CSO research project  
 22 briefing that you have exhibited to your statement  
 23 reported on the experience of healthcare workers with  
 24 Long Covid in Scotland, that's the LoCH study.

25 The URN, for reference purposes only, is  
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1 a reduced capacity without reduced pay, but there were  
 2 high levels of anxiety about when the payment would stop  
 3 and the implications for them and their family  
 4 financially. And it continues that the reduction in pay  
 5 and job security would have resulted in additional  
 6 stress and anxiety for those unable to meet their  
 7 contractual obligations.

8 Was there any dedicated financial support for  
 9 health workers with Long Covid after the NHS Long Covid  
 10 payments ended?

11 **A.** I'm not aware that there were. I think the NHS  
 12 Long Covid payments were an extension to our normal  
 13 occupational sickness policy, so it enabled people who  
 14 were unable to work to continue to enjoy their salary  
 15 for longer than would normally be the case.

16 **MS SIVAKUMARAN:** Thank you.

17 Those are my questions, my Lady.

18 **LADY HALLETT:** Thank you.

19 Mr Wagner.

20 Mr Wagner is over there.

21 **Questions from MR WAGNER**

22 **MR WAGNER:** My name is Adam Wagner and I ask questions on  
 23 behalf of the Clinically Vulnerable Families.

24 I want to ask you first, please, about the  
 25 non-shielding at-risk category of people that you refer  
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1 to in your statement. I'm just looking at paragraph 824  
2 of your longer statement where you say:

3 "In addition to the Shielding List, there had  
4 been consideration early in the pandemic to other  
5 people at risk: these were the 'non-shielding at  
6 risk' ... People in this group were not individually  
7 identified but were encouraged to seek help via  
8 a helpline which channeled calls to local authority  
9 health services, should they not have family or  
10 existing community support or not have access to  
11 online support."

12 Do you recall that category?

13 **A.** Yes, so I recall the work that was done -- I think this  
14 was in -- this must have been early summer 2020, with --  
15 in partnership with local government, recognising that  
16 there would be people who were not officially on the  
17 shielding list and therefore were not in receipt of the  
18 support, groceries, delivery, et cetera, but who might  
19 be vulnerable and might not have family members to  
20 support them, and therefore we worked with local  
21 government to try to ensure that those people had  
22 access, as it says, to a helpline and were able -- the  
23 local government colleagues were able to then support  
24 them.

25 **Q.** So we now know that a significant proportion of those  
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1 done, do you accept the approach of essentially  
2 requiring that the non-shielding at-risk people self  
3 refer to local authority health services was  
4 insufficient given the heightened risk that they faced?

5 **A.** So I think that it was appropriate for people who felt  
6 that they were particularly at risk to make that  
7 decision for themselves. I think the Inquiry has heard  
8 from the Chief Medical Officer concerns that the blanket  
9 approach that was taken to shielding was not helpful for  
10 some people, and that -- I think, you know, I think  
11 there is this -- I'm not an expert in these matters but  
12 I do think that there are questions to be asked about  
13 whether in future we should take such a blanket approach  
14 to people or whether we should focus on ensuring that  
15 people have the information that they need to understand  
16 what level of risk they are exposed to and what level of  
17 risks they think is appropriate for them.

18 **Q.** Wouldn't that approach require a more targeted strategy  
19 for contacting those people? Because, if you see, the  
20 difference is, if you're going to be saying to people,  
21 "This is -- you're at risk and it's your choice what to  
22 do", and you know that they are at significant risk,  
23 isn't it very important that the government, as they did  
24 with shielded people, find out who those people are and  
25 contact them?

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1 who ended up dying or suffered adverse effects from  
2 Covid-19 were part of that non-shielding at-risk group.  
3 It makes sense because they would be particularly at  
4 risk of Covid but not deemed to be clinically extremely  
5 vulnerable.

6 Do you think, looking back, was enough done to  
7 inform that group of their heightened level of risks and  
8 the steps that they could take, or others around them  
9 such as their family or employers, to mitigate the risk?

10 **A.** It's a difficult question to ask, isn't it: was there  
11 enough done? I mean, I guess in circumstances there's  
12 always more that can be done. I think what we tried to  
13 do was to ensure that people who understood themselves  
14 or felt themselves to be particularly at risk had access  
15 to support. And certainly what increasingly we tried to  
16 do was to make data available to people so that they  
17 could understand, for example, what the levels of Covid  
18 prevalency was in their local communities so they were  
19 able to make their own judgments about what was  
20 appropriate for them and, you know, how they wished to  
21 manage those circumstances.

22 **Q.** Well, I suppose you could always say there's always more  
23 that you could have done, but it's not really an answer  
24 to that question, is it?

25 Just in relation to what more could have been  
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1 **A.** So I would agree that the more targeted we can get, the  
2 more helpful that is. And certainly, you know, with the  
3 shielded group we tried to take steps to get more  
4 targeted around different clinical conditions, for an  
5 example.

6 I think when you start to look at -- you know, at  
7 quite large groups around, for example, people over 70,  
8 there is a big difference in terms of the level of  
9 fitness and other issues that affect that group, and  
10 therefore I think some form of self identification is  
11 perhaps always going to be necessary and that we  
12 wouldn't necessarily hold all the details to enable  
13 that.

14 **Q.** You refer in your statement a number of times to  
15 an individualised or person-centred approach. What do  
16 you mean by that and how could that be better or more  
17 extensively implemented in a future pandemic?

18 **A.** So I think that is absolutely back to this point around  
19 ensuring that people are, if you like, equal partners in  
20 terms of some of the decisions that are being made, that  
21 we are giving people advice and guidance that helps them  
22 to make an assessment about what it is that they feel  
23 comfortable doing and what they don't feel comfortable  
24 doing, and that that is accompanied by appropriate  
25 support to enable people who do feel that they want to

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1 absolutely minimise contact with others, that they  
 2 are -- that they're able to be supported to manage their  
 3 life in that way, whereas others who may be taking an  
 4 account of all the risk factors, and indeed the impact  
 5 on their own mental health by cutting off contact with  
 6 others, are more prepared to take a different approach.

7 **Q.** So it's identification, contact, support, are the three  
 8 sort of pillars of it?

9 **A.** Yes.

10 **Q.** Finally, a June 2020 framework for decision-making  
 11 called "Shielding: A way Forward for Scotland" described  
 12 the necessity of developing an evidence base about the  
 13 virus so that the people who were shielding or had  
 14 shielded could be provided access to support that could  
 15 help them make informed choices about their lives and  
 16 put their choices into practice.

17 Do you think those aims were achieved?

18 **A.** I think that those -- I think that we certainly  
 19 partially achieved those aims. We certainly continued  
 20 to provide people on the shielding list with -- as  
 21 I've said already, with information as it related to  
 22 their own individual health condition.

23 I think it's important also to recognise that we  
 24 didn't, in June 2020, know everything that we know now  
 25 about the Covid virus. I'm not sure we know everything

1 I won't be asking you to come back.

2 **THE WITNESS:** Thank you very much.

3 **LADY HALLETT:** Thank you, and safe journey back to Scotland.

4 **THE WITNESS:** Thank you.

5 **(The witness withdrew)**

6 **LADY HALLETT:** Very well, Monday 18 November at 10.30.

7 **(4.16 pm)**

8 **(The hearing adjourned until 10.30 am**  
 9 **on Monday, 18 November 2024)**

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1 there is to be known about Covid virus right now, but as  
 2 the Covid virus continued to develop, so as we went  
 3 through the wave, the Omicron wave, and as vaccinations  
 4 developed, then those things changed as well. I think  
 5 that we did -- we tried to do what we could to make sure  
 6 that we were providing personalised information and also  
 7 that we were making information available to people so  
 8 that they could understand what was happening in their  
 9 local community and in their local environment, so what  
 10 level of risk they would be exposed to, because that  
 11 varied, again, from period to period.

12 **MR WAGNER:** Thank you.

13 **LADY HALLETT:** Thank you very much, Mr Wagner.

14 Ms Lamb, I think you've already helped us in  
 15 relation to yet another module, haven't you, so I'm  
 16 afraid you know -- three more modules. I was going to  
 17 mention, as I've mentioned to other colleagues, I do  
 18 understand the burden that this Inquiry -- and indeed  
 19 other inquiries, because in Scotland you not only have  
 20 a Scottish Covid Inquiry, I think you have other  
 21 inquiries also making demands on you.

22 **A.** I have.

23 **LADY HALLETT:** So, I am extremely conscious of that, as  
 24 I've said before, so I'd just like to thank you for the  
 25 help you've given so far, and I'm sorry I can't say that

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<b>W</b> <b>written... [2]</b> 50/22 122/17 <b>wrote [4]</b> 53/24 55/2 139/18 150/15	185/13 189/9 <b>yesterday [2]</b> 86/8 87/17 <b>yet [3]</b> 131/10 177/8 190/15 <b>you [401]</b> <b>you know [24]</b> 16/5 24/16 36/2 48/7 49/6 70/12 71/8 103/24 105/25 111/13 111/16 111/22 117/1 120/12 135/9 142/4 147/15 149/22 152/13 157/11 179/15 187/22 188/6 190/16 <b>you'll [2]</b> 88/22 157/20 <b>you're [12]</b> 35/9 36/11 64/24 69/1 94/14 104/3 104/25 141/2 150/2 182/15 187/20 187/21 <b>you've [22]</b> 32/12 50/12 52/4 54/11 68/19 69/5 78/7 93/19 95/25 107/6 109/15 112/24 118/9 122/24 139/17 164/19 175/25 177/4 180/23 182/4 190/14 190/25 <b>young [6]</b> 138/4 138/6 138/13 138/16 138/24 139/3 <b>your [78]</b> 1/7 2/15 3/9 3/13 4/24 5/14 8/18 10/22 13/13 14/1 15/17 16/17 30/9 32/22 32/24 33/9 35/18 36/24 37/6 37/15 38/3 38/10 41/24 42/12 45/21 47/17 50/15 56/9 56/14 57/13 58/12 59/24 61/15 70/6 73/16 74/24 75/5 80/16 86/14 93/19 95/3 101/15 101/16 104/10 105/1 108/6 112/13 123/21 128/18 131/21 139/24 142/21 143/19 144/3 149/8 149/17 150/11 155/3 158/3 165/17 166/23 168/22 170/6 172/17 172/25 173/8 175/24 176/4 176/7 178/14 180/14 180/20 180/21 182/22 185/1 185/2 187/21 188/14			
<b>Y</b> <b>yeah [19]</b> 67/18 71/18 74/19 84/4 88/1 89/3 105/25 106/14 106/25 108/15 114/14 114/17 116/24 117/8 129/6 132/2 155/11 167/6 168/23 <b>year [11]</b> 73/23 74/16 74/18 102/11 105/14 124/3 124/20 124/21 169/5 171/8 176/4 <b>years [3]</b> 2/12 29/10 34/25 <b>yellow [1]</b> 62/5 <b>yes [135]</b> 2/8 4/14 5/18 8/13 10/11 11/20 12/3 13/19 14/4 16/16 18/12 18/18 20/7 21/16 24/5 26/24 28/21 30/1 32/7 32/10 32/21 34/16 36/25 37/17 38/12 38/23 39/6 40/4 40/6 40/24 41/3 43/14 43/20 48/20 50/20 51/16 51/16 53/17 54/5 56/8 57/20 59/22 60/2 60/15 61/8 61/17 61/17 61/20 61/20 64/13 64/21 64/23 64/23 65/2 65/22 65/22 66/3 67/15 70/9 72/12 72/23 73/20 78/13 79/24 81/19 84/4 84/10 86/15 86/16 87/5 87/8 87/12 92/12 94/19 95/4 95/4 97/5 98/4 100/10 100/14 102/18 104/16 106/16 107/12 107/23 114/5 114/11 114/11 114/13 116/6 119/20 120/21 122/16 122/23 131/5 132/2 133/3 133/16 133/16 137/16 137/16 137/25 138/20 140/22 141/3 141/19 141/19 142/18 143/18 149/16 149/16 150/25 154/3 154/6 156/7 158/9 159/12 159/19 160/7 164/6 164/22 166/19 167/4 167/4 167/9 168/9 168/20 170/15 173/2 179/9 181/6 182/3 182/11	<b>Z</b> <b>zone [1]</b> 34/19			