Witness Name: Humza Yousaf
Statement No.: 3
Exhibits: HY3
Dated: 16 August 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF HUMZA YOUSAF

In relation to the issues raised by the Rule 9 request dated 25 March 2024 in connection with Module 3, I, Humza Yousaf, will say as follows:

1. I am Humza Yousaf of the Scottish Parliament, Edinburgh, EH99 1SP.

2. I have been asked to provide a written statement in respect of Module 3 of UK Covid-19 Inquiry ("the Inquiry") in response to a Rule 9 Request dated 25 March 2024. References to exhibits in this statement are in the form [HY3/number - INQ000000].

3. I have previously assisted the Inquiry. For Module 2A, I previously provided written statements dated 02 November 2023 [HY3/01 - INQ000273956] and 16 November 2023 [HY3/02 - INQ000273973]. I also appeared at the Inquiry in person on 25 January 2024 to provide oral evidence. Therefore, while this Module 3 written statement is self-standing, the reader may also wish to refer to my earlier statements and evidence for further information.

4. My current role is serving as the Member of the Scottish Parliament for the Glasgow Pollok constituency.

5. Between 28 March 2023 and 7 May 2024 I was the First Minister of Scotland. I was the Leader of the Scottish National Party between 27 March 2023 and 6 May 2024. Following my resignation from both of those positions, I am not currently serving in the Scottish Government.

6. Between 19 May 2021 and 28 March 2023, I served in the Scottish Government as Cabinet Secretary for Health and Social Care. I held primary responsibility for the Health and Social Care Directorates and NHS Scotland. This included, but was not limited to: primary care; allied healthcare services; healthcare and social integration; carers and adult care; and child and maternal mental health. I also had lead responsibility for a number of public bodies, including: NHS Scotland; the Care Inspectorate; the Mental Welfare Commission for Scotland; the Scottish Social Services Council; and Sport Scotland. This Module 3 statement primarily relates to my role as Cabinet Secretary for Health and Social Care.

7. Between 28 June 2018 and 19 May 2021, I served as Cabinet Secretary for Justice. I held primary responsibility for a broad portfolio which included: policing; fire and rescue services; the justice system; courts and sentencing; youth justice; and legal aid. I also had lead governmental responsibility for a number of public bodies, including: the Scottish Police Authority; the Scottish Fire and Rescue Service; Scottish Courts and Tribunals Service; the Scottish Social Services Council; and the Scottish Prison Service.

8. Between 18 May 2016 and 28 June 2018, I served as Minister for Transport and the Islands. My main portfolio responsibilities were public transport, energy, transport connectivity and cross-government co-ordination on islands.

9. Between 21 November 2014 and 18 May 2016, I served as Minister for Europe and International Development. My main portfolio responsibilities were international development, fair trade and cross government co-ordination on the European Union. I held similar responsibilities from 05 September 2012 to 21 November 2014 as Minister for External Affairs and International Development.

Role of Cabinet Secretary for Health and Social Care

10. In my role as Cabinet Secretary for Health and Social Care, health boards across Scotland were ultimately accountable to me. My responsibilities covered the areas of both health and social care, and involved doing everything possible to improve the health of the country. A lot of responsibility, and day-to-day operations, was in practice devolved to Scottish local authorities and to territorial heath boards. However, I worked closely with health boards and local authorities to improve public health in Scotland,

and of course to respond as effectively as possible to the Covid-19 pandemic, as well as recover our healthcare systems in Scotland from the effects of the global pandemic.

11. My responsibilities included:

- acute services;
- allied healthcare services;
- centre of excellence for rural and remote medicine and social care;
- community care;
- eHealth;
- health and social care integration;
- health improvement and protection;
- NHS estate;
- NHS performance;
- patient services and patient safety;
- person-centred care;
- primary care and GPs;
- quality and improvement;
- unscheduled care; and
- workforce, training, planning, and pay.

Decision-making and working relationships

12. During my time as Cabinet Secretary for Health and Social Care, my responsibility for decision-making in the NHS in Scotland was strategic rather than operational: operational decision-making was primarily the responsibility of health boards. Where I had concerns, or needed further information, I would seek to query or interrogate why a particular operational decision had been reached. I ultimately was accountable to the public and Scottish Parliament for decisions made by healthcare systems in Scotland during the pandemic, so it was not unusual for me as Cabinet Secretary, and for Government, to question operational decisions made by health boards or local authorities. That was particularly the case during the pandemic, when decisions were made at a quicker pace, given the urgency of the situation we were all facing. For example, during the vaccine rollout programme there were occasions when I questioned whether enough vaccine centres were open and why particular vaccine centres were closing in particular health boards.

13. The National Health Service (Scotland) Act 1978 confers upon Scottish Ministers a general power of direction in relation to the carrying out of functions by health boards, which I could have used if required.

14. I could also use the NHS Scotland support and intervention framework, also known as the "escalation framework", when issues arose [HY3/03 – INQ000480775]. The framework is a tool that is used in monitoring performance and managing risk across the territorial health boards in Scotland, and is overseen by the National Planning and Performance Oversight Group ("NPPOG") – a sub-group of Scottish Government's Health and Social Care Management Board. It has five stages from Stage 1, where a Health Board is performing well, to Stage 5, where there are serious concerns about a Health Boards performance, as detailed below:

- Stage One: the steady state situation for any Health Board and indicates that the Board is delivering in line with expected performance standards.
- Stage Two: applies when routine performance monitoring highlights localised areas of deteriorating performance which should be resolved through routine planning and performance management action on the part of the Board. This stage can also apply to situations where Boards themselves (and their partners) identify an area of risk and pro-actively seek access to tailored support to assist them to diagnose the issues and address the challenges identified.
- Stage Three: where significant risks are materialising and/or performance is varying significantly from agreed plans, a formal approach incorporating significantly enhanced support and scrutiny is required, which is likely to include a level of external intervention. This stage may also require a further investigation or diagnosis of the root causes of the performance issues. Where there are indications that the root causes are systemic in nature, or where the agreed support package does not lead to sustainable improvements over a reasonable timeframe, consideration may be given to further escalation.
- Stage Four: this is the highest stage on the Framework which can be reached without formal exercise of statutory powers of direction. The Board Chief Executive continues to be responsible for matters of resource allocation to deliver any transformation plan and continues in place as Accountable Officer. They retain overall control and responsibility, and all action is with their consent

as Accountable Officer. The Chair of the Board should also exercise control and responsibility on behalf of the Board. The Chief Executive and Chair are expected to make appropriate use of, and take advice from, the External Support team to construct and agree the required plan, and to take full responsibility for delivery.

- Stage Five: involves a formal exercise of Ministerial powers, with a range of options available to Ministers, primarily in terms of the National Health Service (Scotland) Act 1978. Escalation to Stage Five will indicate that the Board as a whole has been assessed as unable to deliver Ministerial priorities without direct intervention, due to fundamental organisational issues. Escalation to this stage is a very context-specific process, led by advice from the SG Legal Directorate (SGLD).

15. De-escalation is simply the re-grading of a health board to Stage One, or at least one step closer towards Stage One. It is an acknowledgement that there has been some level of improvement in a health board's performance. Of course, there could remain significant improvement required even after de-escalation. NHS Boards are made aware of the requirements for de-escalation as close as possible to the point of initial escalation. These requirements are likely to closely reflect the reasons for escalation and/or the underlying issues identified as part of any diagnostic exercise. The point of de-escalation will be reached when the Board and Accountable Officer can provide evidence-based assurance to Scottish Government that sufficient progress has been made and that they will be able to sustain improvements.

16. I used the escalation framework where the evidence from NPPOG supported escalation (for example, escalating NHS Forth Valley in relation to problems with organisational culture and unscheduled care in November 2022) or de-escalation (for example, de-escalating NHS Greater Glasgow and Clyde in relation to improvements regarding patient safety and nosocomial infections in June 2022), to ensure health boards were performing to the standards we, and the public, expected from them.

17. In relation to decision-making, my relationship with the Chief Executive of NHS Scotland and Director-General for Health and Social Care ("DGHSC"), Caroline Lamb, was critical. I spoke to both the DGHSC, and the Chief Operating Officer of NHS Scotland ("COO"), initially John Connaghan but for most of my time as Cabinet Secretary John Burns, multiple times per week. Doing so was key to understanding what was happening 'on the ground' in healthcare settings, often in real time, during

the course of the pandemic, and for me to ensure action that I deemed necessary to be taken at health board level was being communicated to senior management.

18. I often relied upon scientific and clinical data, evidence and advice to shape my decision-making. Various individuals in the Scottish Government presented this data and advice to me, including: the Chief Medical Officer ("CMO"; Professor Sir Gregor Smith); the Deputy Chief Medical Officers ("DCMOs"), the former National Clinical Director ("NCD"; Professor Jason Leitch), and the former Chief Nursing Officer ("CNO"; initially Professor Amanda Croft and then Professor Alex McMahon). I would also have the benefit of advice and data from a range of other credible sources, such as Public Health Scotland ("PHS"), and cross-UK bodies such as the Joint Biosecurity Centre ("JBC").

19. I also participated in UK Government fora where scientific data was shared. After considering the data, I would apply the Scottish Government's agreed 'Four Harms' approach – in particular harms one and two, which focussed upon direct harms caused by the virus and broader health harms, and the impact of the virus on health and social care systems.

20. I had regular meetings and very positive working relationships with the CMO, the DCMOs, the NCD, the DGHSC, and the COO, with whom I could challenge and probe advice and question data. I had regular conversations with the Chief Executives and Chairs of health boards and local authority partners, speaking with them as a collective on most Thursday mornings, and via regular bilateral engagement.

21. I communicated with Scottish Government colleagues using a mixture of face-to-face meetings organised by my private office as needed, telephone calls, e-mails, video calls and using informal messaging apps such as WhatsApp. Any informal messages I have, that have been previously requested, have been handed over to the Inquiry.

22. I attended regular online meetings and fora with UK Government Ministers and officials. My engagement with some UK Government Health Secretaries was more frequent than others. Most of my engagement with the UK Government was through formal meetings, usually arranged between private offices. However, on occasion, I would use informal messaging apps. Again, such messages have been provided to the Inquiry.

23. I also engaged with other stakeholders, such as the British Medical Association ("BMA"), the Royal College of General Practitioners ("RCGPs"), staff representative organisations such as the Scottish Committee for Orthopaedics and Trauma ("SCOT"), patients, and trade unions.

24. In terms of Covid-19 decision-making in Scotland, the Scottish Cabinet was the main decision-making group. There were also 'Gold Command' meetings in Scotland, which were attended by a smaller group of Cabinet Secretaries. Scottish Government engaged regularly with the UK Government, and there would be *ad hoc* meetings with the UK Government as needed. At times this engagement would be more frequent, depending on the circumstances. For example, with the initial emergence of the Omicron variant there was significant interaction with the UK Government regarding a 'Four Nations' response and the sharing of any data or intelligence from each of our respective nations.

25. My role in cross-UK groups engaged in response of healthcare systems to the pandemic was to provide intelligence on the latest developments with Covid-19 in Scotland, and to represent, where necessary, Scottish Government interests or highlight concerns.

26. I attended cross-UK meetings on a range of topics, including, for example, Omicron vaccine booster co-operation, and participated in an intergovernmental ministerial group hosted by Michael Gove whose purpose it was to consider and oversee specific elements of the pandemic response. Governments coordinated in relation to vaccines and testing, particularly because the Scottish Government was reliant upon budgetary allocation from the UK Government. Liaison between the UK and Scottish Governments mainly focussed on tackling Covid-19, but also facilitated discussion about, for example, whether there were unique approaches being taken in any of the four nations to respond to particular challenges, such as the pressures on Accident and Emergency departments, elective care, and access to GPs. Such discussions could be a forum for sharing best practice but also, crucially, intelligence on trends in relation to the virus we were witnessing in our home nations.

27. I always strived to maintain good and professional working relationships with UK and with devolved Government counterparts. My experience of UK Government Ministers

varied from individual to individual, but personally I would say I had a constructive working relationship with most of them. My relationships were quite good with Matt Hancock, Sajid Javid, and Nadim Zahawi. Matt Hancock made himself accessible through WhatsApp and calls if required, and we had regular Four Nations meetings scheduled; Sajid Javid made himself available if the Scottish Government made a request to speak with him. With Steve Barclay communication was scarce, and he often left his junior Ministers to engage with devolved Governments. I had no substantial engagement with Therese Coffey for the brief period she was Health Secretary.

28. There were WhatsApp groups between Health Ministers from across the UK, and I have provided those messages to the Inquiry.

29. I understand that official-to-official engagement between Scottish Government officials and UK Government health officials was good.

30. Although I generally had a good working relationship with Ministers in the UK Government, but there were, naturally, some challenges. The UK Government would far too often make decisions unilaterally that would have a direct impact on healthcare systems in Scotland and their ability to respond to Covid-19. For example, the UK Government decided to scale back the 'Test and Protect' scheme without first consulting the Scottish Government. Funding for Test and Protect came from the UK Government, so while the Scottish Government was able to fund the scheme in Scotland for a few extra weeks from its own budget, it ultimately ceased earlier than the Scottish Government would have liked. Similarly, the UK Government decided unilaterally to withdraw support for businesses.

31. Moreover, Scottish Ministers would at times only learn of UK Government decisions at the last minute or through the media, which resulted in frustration and, more importantly, a lack of ability for the Scottish Government, and those responsible for healthcare systems in Scotland, to respond as effectively as possible to the virus.

32. While the personal relationships were constructive, repeated failures in communication at a government-to-government level ultimately created issues in respect of trust. Despite that, I continued to make myself available for working with UK Government.

33. I had very positive relationships with the other devolved administrations, particularly my counterpart in the Welsh Government, Eluned Morgan. We would often speak ahead of Four Nations calls to ensure that, as devolved nations, we were speaking in support of each other, where it was in our interests to do so. This often helped in our engagement with the UK Government. The positive working relationship with devolved counterparts was also important in order for us to share best practice where appropriate. For example, I recall speaking with Eluned Morgan about the vaccine roll out in Wales, when Wales was ahead of Scotland with the roll out of the vaccine, and similarly she sought feedback from me about what was working well in Scotland when we were making good progress with vaccines when Omicron emerged. There were particular challenges facing Northern Ireland, given Stormont had not been re-established, but I was able to work with them too on occasion.

34. The Scottish Government has devolved responsibility for healthcare in Scotland, and our healthcare systems are organised differently in Scotland in comparison with other parts of the UK. That means that on a range of health-related matters we may well take different approaches. There was no conscious decision by Scottish Government to differ from the rest of the UK for the sake of difference. The idea that the UK Government's response in respect of England was the 'correct' response for the whole of the UK, and that the devolved administrations were therefore 'diverging' if they took a different approach, is incorrect.

35. The Scottish Government and the UK Government did have different approaches to 'lockdown' and other non-pharmaceutical interventions ("NPIs"), which would then in turn have an impact on healthcare systems. For example, Scotland on occasion maintained lockdown measures for slightly longer than in England; part of the rationale for doing so was to mitigate pressures on the healthcare system in Scotland. Differences in relation to testing would also have an impact on our healthcare systems.

36. There were also nuances in relation to how each nation delivered elective care. It is my understanding that the UK Government chose to put more of a focus on those waiting the longest for elective care – a perfectly reasonable approach to take. However, in Scotland, through our Clinical Prioritisation Framework [HY3/04 – INQ000480776], which we ceased using in July 2022, we chose to focus on those with the most urgent need, as opposed to simply those waiting the longest. The Clinical Prioritisation Framework was developed to support NHS Scotland through the Covid-

19 pandemic and, specifically, to support clinical decision making when prioritising patients for appointments and treatment. Urgency of need was prioritised over length of wait to ensure that patients with the greatest clinical need were treated quickest. To ensure strategic oversight in the development and implementing the Framework - on 14 October 2020 the Clinical Prioritisation Group was set up and tasked with delivering key principles for the framework to support Elective Care throughout NHS Scotland. The Group was chaired by Dr David Caesar (Deputy Chief Medical Officer) and was made up of Senior Clinical representation from each region. During the Group's first meeting, it was broadly agreed that six key principles should be adopted, outlined below:

- Access treatment in line with the Clinical Priority matrix
- Protection of Essential Services
- Active Waiting List Management
- Realistic Medicine remains at the core
- Review of Long Waiting Patients
- Patient Communication

37. On 30 October 2020 the framework was approved by John Connaghan, Interim Chief Executive, NHS Scotland, and issued to Chief Executives who were also content with the proposed principles. The Framework sat alongside section 8(3) of the Patient Rights (Scotland) Act 2011 which continued to require NHS Boards to take all reasonably available steps to ensure they were compliant with the treatment time guarantee (TTG). These steps included appropriately prioritising the start of the patient's treatment, taking account of their clinical needs and the clinical needs of other eligible patients, in accordance with the treatment time guarantee.

38. Nonetheless, for reasons that have been well rehearsed, there was a desire across the nations of the UK for a Four Nations approach on certain matters related to the pandemic. The approach to vaccine rollout, for example, was fairly uniform across the UK.

39. Decisions I made, during my time as Cabinet Secretary for Health and Social Care, were ultimately guided by advice from officials, and, where required, clinical input was sought to help inform decision-making.

40. In relation to decisions about the response of the Scottish healthcare system to Covid-19, I was able where necessary to speak directly with the former First Minister ("Former FM"; Nicola Sturgeon), the former Deputy First Minister ("Former DFM"; John Swinney), and the former Finance Secretary ("Former FS"; Kate Forbes). I also attended Gold Command meetings and participated in discussions with that group. I also knew that I was always able to pick up the phone and speak quite candidly with colleagues, or where necessary seek their advice or assistance. There is no doubt that we all had to be aware of the finances, as the Scottish Government has an obligation to balance the budget. However, both the Former FS and finance officials worked well with other Government departments.

41. It was up to the judgement of individual Cabinet Secretaries whether they sought a discussion, or even a decision, by the Former FM on any particular policy. I was keen to ensure the Former FM was not 'blind-sided' by any decisions I made as Cabinet Secretary for Health and Social Care, particularly if they were likely to garner significant political or public attention.

42. The main UK-wide challenge was budgets, given the extraordinarily high levels of expenditure required to combat the Covid-19 pandemic. There is no escaping the fact that finances placed constraints on the Scottish Government's ability to respond to the Covid-19 pandemic. Some pandemic responses, such as those related to Test and Protect, were funded directly by the UK Government, which meant that the Scottish Government was reliant on assurances given by the UK Government for those initiatives. Funding in other areas, for example the day-to-day spend on the NHS in Scotland, came from the Scottish Government's own budget.

43. In some areas, actions by the UK Government complemented what was being done in Scotland: for example, the Scottish Government received its fair share of the vaccine supply. However, as alluded to previously, the UK Government would sometimes make unilateral decisions that would mean that funding that was suddenly cut for initiatives that the Scottish Government believed were having a positive impact in Scotland, such as Test and Protect. Similarly, in respect of international travel restrictions, while the Scottish Government could decide which countries to put on its own 'red list', the reality, in practice, was that passengers could circumvent the rules by flying into an airport in England and then travelling up to Scotland. As a result, the

Scottish Government would, on most occasions, follow the UK Government's decisions about which countries to put on its own red list.

44. There were instances when I read stories in a national newspaper that looked, on the face of it, like UK Government briefing about an imminent change to its approach in a particular area. I recognised that if a change in approach was indeed coming then it would have a knock-on effect in Scotland, usually in respect of funding but indirectly on the Scottish healthcare system's ability to respond to the pandemic. However, it was not possible to know for sure where newspapers obtained such stories, as the UK Government had not consulted the Scottish Government about the proposed change. One such example involved a story in The Times newspaper, which suggested the UK Government was imminently proposing to withdraw access to free lateral flow tests [HY3/05 - INQ000480777].

45. This caused immediate concern, and I reached out to Sajid Javid MP, the UK Health Secretary at the time, to seek assurances. He was able to confirm that no such withdrawal was taking place at that time.

46. While there was no direct impact on this occasion, stories such as this one appeared all-too-regularly in the press, causing a level of wariness between Devolved Governments and the UK Government.

47. I attended Scottish Government Cabinet meetings nearly every week, at which the CMO was present; he and I would also have conversations routinely between those Cabinet meetings. The CMO also engaged with staff working in the health service with regularity, and shared with me helpful feedback about intelligence he was hearing 'on the ground'.

48. It is my belief that the CMO and my other advisers felt comfortable enough to approach me directly if there was something they needed to draw to my attention. My relationships with those advisers were very good and allowed them to be proactive in relation to sharing advice. I also knew that I could seek and receive advice in relatively short order, this was critical given the nature of the threat we were facing.

49. I most regularly engaged with the NCD, with whom I had almost daily conversations about the state of the pandemic.

50. I had good relationships with the DGHSC and the COO. We would be in discussions multiple times a week on a range of issues in relation to the pandemic, and response of both health and social care systems. I believe they felt empowered to flag any particular issues or concerns to me with a common goal to help the NHS through the Covid-19 pandemic.

51. I spoke less frequently with the CNO than with other advisers, however the CNO would often be on a number of calls with other officials and contributed regularly. When I did speak with the CNO, it was primarily about infection prevention and control. I would also seek their advice on issues that the Royal College of Nurses would raise with me from time to time.

52. I had regular calls and meetings with the Chief Executives and Chairs of Scotland's health boards. These would often be a mixture of bilateral meetings, me visiting healthcare settings in a local health board area, or as part of our weekly catch-up with all health boards. Given the scale and size of larger health boards, such as NHS Greater Glasgow and Clyde, NHS Lothian and NHS Lanarkshire, I would speak to the senior management in these health boards more regularly. The DGHSC and the COO would also have very regular engagement with health board Chief Executives and Chairs; if they felt an issue needed my attention they would flag it to me, either directly or via my private office.

53. I had a good relationship with trade unions and professional bodies and we engaged regularly, mainly on pandemic-related matters, and of course, on pay, terms and conditions. While the relationships on the whole were positive and constructive, there were of course tensions, and professional bodies and trade unions would make their concerns known, on occasion doing so publicly – as is their right. The fact that Scotland is the only part of the UK not to have had pay-related health strikes in recent years is a testament to the good relationship maintained between the Scottish Government and the unions.

54. In relation to trade unions and professional bodies, my most frequent interactions were with the British Medical Association, the Royal College of Nurses, the Royal College of GPs and Unison. Those conversations were very open, constructive and productive. Most contact was through my private office, but some trade unions officials had my

direct phone number, which was often crucial during pay negotiations as building relationships was key to any successful negotiations.

55. During the pandemic, and in fact even outwith the pandemic, as Cabinet Secretary for Health and Social Care no two days were the same. In relation to the pandemic, I was responding to new challenges on what felt like a daily basis. I would work from early in the morning until late in the evenings, often seven days a week, including on holidays such as Christmas Day. It was a very intense job, with frequent meetings and discussions to understand the latest situation on the ground with advisors and stakeholders such as health boards, UK Government counterparts, professional bodies, trade unions, patient groups and individual families. A significant amount of my day, and usually time on the weekends, would involve working through paperwork, usually a combination of lengthy submissions and data that required digesting. In addition, I attended Cabinet every Tuesday morning, participated in regular ministerial groups, and had weekly telephone calls with the Chief Executives and Chairs of Scotland's health boards.

56. I also had regular Parliamentary engagements. These included meetings with Opposition Spokespeople, answering questions in Parliament (there could be up to three question slots a week: Urgent Questions, Topical Questions, and either General Questions or Portfolio Questions), and attending Parliamentary Committees.

57. Given the nature of my brief, there were also regular media bids to undertake. Some of those were during regular slots (for example, we were likely to do bids on a Tuesday afternoon as a slew of health statistics tended to be released every Tuesday morning), and some were more *ad hoc* depending on latest developments.

58. The Scottish Government provided a strategic overview in terms of the response to the pandemic, but each health board had its own operational responsibility that incorporated a degree of flexibility. This was vital, given Scotland's varied geographical landscape and population demographic across the country. For example, a health board covering a largely urban area would have a different approach to vaccine administration compared to that of a more rural area. A more specific example of this would be the decision of Argyll & Bute Health and Social Care Partnership to involve GPs in Argyll and Bute in the administration of vaccinations, something not done in urban health and social care partnership ("HSCP") regions.

59. There were occasions when the Scottish Government ensured that all health boards were to follow certain approaches, by, for example, the CMO or CNO issuing national guidance dealing with matters such as access to PPE, the type of PPE used, testing of healthcare and social care staff, and approaches to infection prevention and control. Examples of such guidance have been provided to the Inquiry [HY/05A - **INQ000398868**, HY3/05B - INQ000470088 and HY3/05C **INQ000413478].**

60. The intended purposes of national guidance was to ensure a consistency of approach across NHS Scotland health boards, so it was our expectation that such guidance would be followed. The Government tried to be responsive to the individual needs of health boards where possible, and allow a degree of flexibility where required. An example of this would be the decision of Argyll & Bute HSCP, previously referenced, to utilise GPs on certain islands in Argyll and Bute in the administration of vaccinations. That approach was not taken in most of the rest of the country, and reflected the largely rural and island demographic of that HSCP region. That initiative was raised with the National Oversight Group in the first instance, and approval was then given for the HSCP to implement the measures which diverted from the national approach.

61. As mentioned previously, Scottish Ministers had the ability to direct health boards if necessary. However, that power has been used sparingly by Health Secretaries in Scotland, and only as a last resort. Regulations could also be made if necessary.

Response to the pandemic

62. The impact that NPIs were having on particular groups, including those who were most clinically vulnerable, was often discussed at Cabinet meetings. At those meetings, regular advice would be given by the CMO in relation to those who were at the highest risk from Covid-19. This was demonstrated by, for example, the development of the shielding policy.

63. Over time, however, it became clear that more work needed to be done to ensure a greater effort was being made to reach some groups, in particular those from Black and Minority Ethnic communities and those from more socio-economically deprived backgrounds. This became clear through our interactions with representative groups from those communities, but also from the data we were receiving in relation to

vaccine uptake. That led, for example, to the establishment of mobile vaccination units which attended mosques and gurdwaras, as well as more socio-economically deprived areas.

64. During the pandemic it was not always possible to obtain views from stakeholders prior to decisions being taken, due to the fast-moving nature of the pandemic. However, regular feedback from members representing vulnerable groups and those with a direct lived experience was sought by officials and thereafter relayed to me. The Scottish Government also set up a number of stakeholder groups to try and garner that information, for example the Expert Reference Group on Covid-19 and Ethnicity that was established in June 2020 [Terms of Reference provided: HY3/06 - INQ000321282].

65. Those fora and my direct engagement with stakeholders and those with lived experience was very important to me. I personally met with a range of stakeholders, including: Care Home Relatives Scotland; Black and Ethnic Minority Infrastructure in Scotland's Ethnic Minority National Resilience Network; the Glasgow Disability Alliance; Long Covid Kids, including an in-person meeting with Long Covid Kids, during which I was able to spend time talking to children and their families.

66. I believe that both Cabinet and, more widely, the Scottish Government would have benefited from hearing more of people's lived experience. For example, I think Cabinet could have benefited from having a wider Scottish Government view of the impact our policies were having on people with disabilities. One example of a practical step that could have been taken to engage with people with disabilities in relation to healthcare decisions is a post-Cabinet discussion with organisations representing those with a disability. That could have helped provide a cross-Government view of the cumulative impact our policies were having on people with a disability.

67. All Cabinet Secretaries engaged with external stakeholders, but I think that more structure and regularity of meetings between Cabinet and / or individual Ministers and those with lived experience would have been helpful. Of course, Cabinet would consider the impact of decisions it was making on people with a disability, complex needs or any vulnerabilities, and Ministers would get feedback from officials who were regularly engaging with representative organisations. However, due to the speed of the

development of the pandemic, it was not always possible to seek those views in advance of a decision being taken.

68. Similarly, due to the rapidly developing nature of the pandemic it was not always possible to carry out Equality Impact Assessments ("EQIAs") prior to certain decisions being taken. I find such assessments to be helpful in the preparation of general policy and legislation; however, they could have limitations when making decisions in a fast-paced environment, such as a global pandemic. For example, when emergency legislation required to be passed it would not always be possible to have such thorough and detailed conversations with equality groups as we would normally have outwith a pandemic.

69. EQIAs were, however, used where possible throughout the course of the pandemic, on a whole range of matters ranging from Covid-19 vaccine certification to the removal of the requirement to wear a face covering within places of worship or at marriage ceremonies, civil partnership registrations and funerals.

70. I was kept informed of the NHS in Scotland's ability to cope with the response to the pandemic in a number of key ways.

71. The first was regular engagement with the Chief Executives and Chairs of the various health boards, who I engaged with on a weekly basis, as previously noted. I always found health board colleagues to be upfront about the scale of the challenges they were facing throughout the pandemic. Together with frequent meetings with the DGHSC, COO, CMO, DCMOs, NCD and CNO, I was able to gain a good understanding of the picture on the ground in respect to the ability of the NHS in Scotland to cope with the pandemic.

72. Second was the vast amount of data and metrics being produced in relation to, for example, occupancy of hospitals, Accident and Emergency performance, and elective care being carried out. This data came to me and senior officials within Government. It could also be broken down not just by health board, but by acute site, as is the case with Accident and Emergency performance statistics. That allowed me to see the impact of the pressures of the pandemic on individual hospitals across the country. The other important data set sent to me regularly, that helped me to understand the pressures on our NHS, was staff absence rates. Unsurprisingly, during periods of peak

infection, we would see greater levels of absence from NHS staff. Clearly, the greater the levels of absence, the greater the strain on the NHS was going to be.

73. Third, my officials and I had frequent conversations with trade union partners from whom I was able to obtain a good understanding of what the feeling of staff on the ground was. This was important, as it helped me to ensure that what we were hearing from health board management was reflected by staff experience.

74. The views of those working in the frontline of healthcare were relayed to me via frequent engagement with trade unions, national health boards such as the Scottish Ambulance Service Board, and through direct contact from those workers. I also carried out visits to hospitals, acute sites and other important sites that make up our health and social care system in Scotland, such as: University Hospital Monkland's, on 26 May 2021; the Early Cancer Diagnostic Centre in Fife, on 28 June 2021; Golden Jubilee National Hospital, on 29 July 2021; Greenock Health Centre, on 20 October 2021; and NHS 24 in Dundee, on 14 January 2022. During those visits I often made time to speak directly to staff and patients to hear their experiences. Those conversations were often very frank, and both staff and patients were upfront about the challenges they were facing and the toll the pandemic was having on them.

75. The Scottish Government worked closely with PHS, as well as with NHS information leads, to develop reporting from NHS systems to understand the impact of Covid-19 on the healthcare system in Scotland. This led to the development of Covid-19 daily data reporting, with a core indicator set on the Scottish Government website updated daily from April 2020. This included data on:

- hospitalisations, covering both admissions and numbers of patients in hospital and ICU with Covid-19;
- cases and testing;
- infection rates;
- vaccinations;
- daily deaths;
- weekly registered deaths;
- number of delayed discharges; and
- NHS staff reporting absent due to Covid-19.

76. That Covid-19-related data was additional to data that we regularly received in relation to matters such as Accident and Emergency performance, delayed discharge, etc..

77. Advice on modelling and data was also provided from the Covid-19 Advisory Group ("C19AG"), the CMO and DCMOs, and other experts in various fields. Drawing on that, and the data supplied by PHS and from across the NHS, Health and Social Care Analysts ("HSCA") provided a suite of statistics on a regular basis, which naturally changed throughout the course of the pandemic. There were occasions where I asked for additional data to be provided, to help further aid decision making.

78. I would, as you would imagine, closely read all data that was sent to me. However, there were some data sets that were of particular importance due to the information they provided on the scale of the challenge facing our NHS, and certain data sets would be particularly important depending on the circumstances at a particular time. For example, we would receive regular updates on vaccine uptake rates: such data was always crucial, but took on an added significance and importance during our 'Boosted by the Bells' campaign, during which we were significantly accelerating our vaccination programme, given the emergent threat of the Omicron variant.

79. Accident and Emergency data was also of particular importance. If attendances at Accident and Emergency departments increased, or the performance of those departments was declining, that could be an indication of pressures across the wider healthcare system. Delayed discharge data was also important in a similar vein: if the numbers of those experiencing delayed discharge was increasing, then that indicated an increase in pressure across the social care system. I also paid particularly attention to case rates, infection rates, rates of hospitalisation with Covid-19, testing rates and deaths attributed to Covid-19.

80. Having received an initial data set, I would often ask for data for particular geographical locations in order to understand if there was a regional variation. For example, I would ask for vaccination data to monitor vaccine uptake and administration from one health board area to another.

81. One issue I had to contend with during my time as Cabinet Secretary was access to GPs. There was a significant amount of both public and political pressure for an increase in face-to-face GP appointments. As such, I asked my officials to work with

GPs, and professional bodies such as the BMA and RCGPs, to create a data set and dashboard that would allow us to monitor access to GP services, including face-to-face appointments.

82. I also asked for data to be collected, and again put into a dashboard format for ease of access and transparency, around the issue of delayed discharge. I wanted to know the accurate number of staffed social care beds, broken down by local authority area, and in tandem the accurate number of delayed discharges, again by local authority area. This data set helpfully allowed me to question why staffed beds were not being filled, in any given local authority area, when delayed discharge numbers were so high.

83. I also ask for other specific data at particular times, depending on the circumstances. For example, whenever there was a new variant emerging I would request data showing the location of any spikes, the apparent transmissibility, any initial data around immune escape, and common symptoms / severity of symptoms particularly in comparison to other known variants. Likewise, during vaccination roll out, I would ask for specific data at health board level, or even down to site level, at some of the mass vaccination centres, if I deemed it necessary.

84. Given that the advice provided by clinical advisors was based on their clinical expertise, it was often the case that Ministers, myself included, who did not have a clinical background would ask for further details or explanations in relation to that advice. Ultimately we all knew that it was the role of the CMO, CSA, DCMOs, CNO and NCD to provide advice, but by asking for additional details Ministers were better able to interrogate that advice and make final decisions on matters.

85. There were occasions where I would challenge advice provided as I wanted us to go further or faster in relation to a particular matter. For example, for the UEFA Euro Fan Zone in Glasgow to go ahead in the summer of 2021, I wanted further testing capability and capacity for those attending, including on-site testing capability via a mobile testing unit, and testing kits to be mailed to all those registered to attend the Fan Zone. I am pleased that additional testing was incorporated as part of the Fan Zone.

Healthcare capacity

86. I was provided with regular updates on intensive care unit ("ICU") data. From my recollection the surge capacity we had for ICU beds in Scotland was never breached during my time as Cabinet Secretary, although the national baseline was exceeded on eight occasions. Only one of those eight breaches occurred during my time as Cabinet Secretary, in mid-September 2021 during a Delta Wave of Covid. I am afraid I do not recall the exact circumstances around this breach. As previously referenced, even when baseline capacity was breached, there was appropriate protocols in place to create additional surge capacity.

87. As part of daily COVID-19 data briefings, I received daily updates on the latest number of COVID-19 patients in ICU, how this compared to the day before, alongside information on NHS Boards ability to increase their baseline ICU capacity. These updates were provided as part of standard data briefings from HSCA. They did not explicitly flag breaches as during these periods, Boards had capability to increase capacity with care delivered in areas of a hospital re-purposed to provide intensive care, with separate units for COVID and non-COVID patients.

88. There were periods in the early days of the pandemic, before my time as Cabinet Secretary for Health and Social Care, where there were real concerns about our critical care capacity. For example, in April 2021 the COO, CMO and CNO jointly commissioned a short-life working group to consider ICU baseline capacity, uplift capacity and associated factors in preparation for winter 2021-22. Those concerns resulted in additional capacity being created, both through surge capacity and the creation of the NHS Louisa Jordan, so that, if necessary, there could be flexibility within the healthcare system to convert non-critical care to critical care.

89. I do not recollect any period during my time as Cabinet Secretary for Health and Social Care when there was insufficient critical care capacity. Clearly, there was pressure on critical care capacity, particularly during waves of the pandemic, especially those that combined with the winter period. This, in turn, put pressure on non-critical care capacity at times.

90. When considering whether there was sufficient critical care capacity within the NHS in Scotland during my time as Cabinet Secretary, it is important to remember that we were dealing with a pandemic on a scale that none of us had dealt with before. NHS

Scotland staff should be commended for their use of initiative in increasing capacity for critical care. Of course, this increase in critical care capacity had to come at the expense of non-critical care capacity which would have had an impact on those in need of it. I had frequent meetings with the DGHSC and the COO to discuss capacity, both in terms of critical and non-critical care. As noted previously, I would regularly receive data on ICU capacity, as well as general occupancy levels across hospital sites.

91. Prioritisation of care was a feature of regular discussion between me and the DGHSC, the COO, clinical advisors and the CMO / DCMOs. I also regularly discussed it with health boards. The Clinical Prioritisation Framework was the key document supporting discussions I had with key advisors and health boards in relation to preserving critical care. Every week, I would have discussions with advisors and health boards, and capacity, more often how strained staffing capacity was, meant that the focus remained on the key areas within the Framework.

92. Clinicians were supported in making prioritisation decisions with the Clinical Prioritisation Framework, detailed further in paragraphs 36 and 37.

93. Elective care was the 'pressure valve' over which we had some control, and when urgent care pressure was particularly acute health boards could reduce the volume of elective care, or pause it altogether, in order to alleviate urgent care pressures.

94. Our key focus, understandably, was on emergency care, critical care, cancer care, maternity, and mental health: we tried to protect those areas of care as best we could, given the critical nature of such care, and the impacts of disruption to provision of such care. Before I became Cabinet Secretary for Health and Social Care, the Scottish Government took the very difficult decision to pause cancer screening for a period between March and July 2020, after which screening resumed on a staggered basis.

95. Every decision about what care to pause, halt or prioritise was very difficult to make, because patients outside the areas we were trying to protect who may not have needed immediate care could end up waiting longer for treatment – weeks, months or even years – during which time their condition could unfortunately deteriorate and they could experience deconditioning.

96. The Clinical Prioritisation Framework, established by my predecessor in November 2020, set out six principles that health boards followed when making decisions on elective care waiting lists. It was developed to provide NHS Boards with guidance around prioritising their planned care waiting lists throughout the Covid-19 pandemic. Patient cases were categorised into four levels of clinically agreed urgency based on their particular clinical condition. This approach supported patients and their clinical teams when discussing treatment plans and the categories informed how quickly patients were seen and treated, allowing boards to prioritise those most in need.

97. I took the decision, in July 2022 to step down the Framework, instead choosing to announce a series of targets for health boards to bring down waiting lists, with a focus, not just on those with the greatest need, but also on those who had been waiting the longest.

98. When we were making decisions about prioritisation of care, our considerations always included the Four Harms, as that was our key guiding framework. We clearly also needed to be mindful of staffing capacity as well as the impacts on hospital capacity: although we had record levels of staff working in the NHS, staffing was always going to be stretched during a pandemic with competing pressures. We had to be mindful about the sheer physical and mental exhaustion staff in the NHS were facing. NHS staff were going above and beyond, as they still do, particularly during periods of excessive pressure, which seemed relentless during the course of the pandemic.

99. During my time as Cabinet Secretary for Health and Social Care, I do not recall there being any issues with oxygen supply systems in Scottish hospitals. Nor do I recall there being any concerns about us having insufficient medical equipment and supplies, such as mechanical ventilators and non-invasive ventilation devices. Each health board had its own medical equipment management system that could be used to monitor any potential shortages in equipment; if there had been any critical shortages, health boards would undoubtedly have brought that to the attention of the DGHSC and / or the COO, who in turn would have alerted me.

100. There will always from time-to-time be shortages of specific medicines, due to global supply chain issues or even certain geopolitical events. However, I do not recall any there being any issues during my time as Cabinet Secretary for Health and Social Care in relation to the general supply of anaesthetics and other medicines. Access to

antiviral treatments was very important, particularly for those who were deemed as highest risk, and from my recollection feedback from those who required access to antivirals was positive.

101. During my time as Cabinet Secretary for Health and Social Care, there was clearly a need to try to reduce pressure on our acute services, and in particular our Accident and Emergency departments. For that reason, the more we could treat and provide support for patients with both physical and mental health conditions outside of acute services, the better. NHS 24 and the provision of telephone and video call services, such as 'Near Me', were of critical importance to help us reduce pressure on acute services while providing a high level of care to those who required assistance.

102. I was confident that via NHS 24 or NHS Inform, Scotland's national online health information service, the appropriate information and support would be provided to patients. We also knew that there was always the ability for people to call 999 or go to an Accident and Emergency department if it was required.

103. The vast majority of calls to NHS 24 – around 90% – did not involve onward transmission to Accident and Emergency departments, as the appropriate advice was provided with the assistance of Clinical Supervisors who were on-hand to assist NHS 24 call-handlers. If we did not have NHS 24 as a service to rely on, there is little doubt that many of those people would have ended up at an already under pressure hospital.

104. Consideration was built into NHS 24 regarding how to provide a service to people whose first or preferred language is not English, and who have accessibility issues, such as being deaf or having hearing issues. For example, a British Sign Language interpreting video relay service was available, as was the interpretation service 'Language Line'.

105. There were periods throughout the course of the pandemic when NHS 24 was receiving a particularly high volume of calls, and that the time it took for those to be answered was longer than we would have liked. During such periods, issues with call waiting times were brought to my attention through the regular data sets I received, but also were brought to my attention from MSPs on behalf of their constituents who had used the service.

106. There were challenges to recruiting new NHS 24 staff at pace, and budgetary constraints were factors that had be to be taken into consideration. Despite those challenges, between March 2020 and March 2022 the NHS 24 workforce was expanded from 1,154 to 1,431.8 WTE staff members – a 24% increase – and new sites were opened.

107. Although there were budgetary and financial constraints during the pandemic, there were no significant concerns brought to my attention about the patient care that was provided through NHS 24 or in response to someone calling 999. The feedback we received regarding the quality of care experienced by patients who used NHS 24 was consistently very positive: the percentage of service users who reported overall satisfaction with the service in the year to March 2021 was 91.4%, and in the year to March 2022 was 85.6%. Feedback on patient experience was obtained through an SMS service that texted a request for feedback following a patient's call to NHS 24. Patient Experience (%) is part of NHS 24's Key Performance Indicators that are published and shared with Scottish Government through annual performance reporting. The figures provided were obtained from NHS 24's Annual Review which took place in April 2022 [HY3/06A – INQ000492664] and NHS 24's Annual Account paper for year ending March 2022 [HY3/06B – INQ000492666].

108. The NHS 'Near Me' video conferencing system was available and used by GPs and patients pre-Covid-19. However, for obvious reasons, the use of Near Me grew exponentially during the pandemic.

109. Issues with accessibility were of concern, and as a result of our engagement with organisations representing older people, such as Age Scotland, we had concerns about the lack of availability of face-to-face GP appointments. That is why further adjustments to the Near Me technology were implemented, and collaborative efforts were made with GPs, and professional bodies such as the BMA and the RCGPs, to try and increase the availability of face-to-face appointments.

110. In November 2021, I announced £7 million of investment in GP surgeries, to fund work including:

- premises improvement for GP contractors who own or lease from private landlords;

- digitisation of paper GP records to release space;
- improved ventilation; and
- increased space in NHS-owned or leased premises to support multi-disciplinary teams, which in turn we hoped would increase availability of face-to-face appointments.

It was also hoped that this fund could help with accessibility issues for those with disabilities.

111. When considering the deployment, or further roll out, of digital services, the issue of digital connectivity is always considered. At the time of the pandemic, a number of programmes to boost internet connectivity were in progress. The Scottish Government's R100 programme ensured significant investment was directed to remote, rural and Island Scotland where internet connectivity has traditionally been poor. Nonetheless, in our literature and marketing assets used to promote 'Right Care, Right Place' treatment we highlighted the range of ways in which people could access medical advice and, if necessary, treatment, with a number of them not requiring internet connectivity. This included NHS 24, telephone GP appointments, Pharmacy First, and, if absolutely necessary, calling 999 for urgent care.

112. I had concerns about the response of primary care, pharmacies and the Scottish Ambulance Service when the new, more transmissible, Delta and Omicron variants emerged. There was a significant amount of concern around unknown variants: in the early days of both variants, immune escape and transmissibility were unknown, so we were unsure and concerned about their impact on the entire health system.

113. My concern in relation to primary care was the impact Delta, and later Omicron, would have on pressures already being faced by GPs, and crucially the impact the variants would have on the return to face-to-face appointments.

114. Pharmacy representative bodies were highlighting staffing concerns and medicine pricing concerns as the significant issues they were facing. These issue were exacerbated by the emergence of new variants, particularly due to self-isolation requirements, and the impact this had on staffing, and the availability of locums.

115. Decisions had to be made about protecting primary and secondary care as best possible. The impact that Delta and Omicron would have on primary and secondary care staffing levels, due to staff absences, was a particular concern, although by the time the Delta variant emerged there were already good infection control practices in place. As detailed in the Scottish Government Health and Social Winter Overview 2021-2022, the Scottish Government made a number of decisions to help protect primary and secondary care. These included continuing to provide whole population testing through the Test & Protect programme, expanding the healthcare workforce through improved recruitment campaigns and workforce support - including increasing overseas recruitment and providing £15 million to territorial NHS Boards to recruit 1,000 frontline staff, a further £4 million invested in wellbeing and support measures for the NHS workforce and communication campaigns to encourage members of the public to access the right care at the right time through services like NHS 24, NHS Inform and community pharmacies. A copy of this overview is provided: [HY3/06C – INQ000492663].

116. When Omicron emerged, we decided to accelerate our vaccination booster programme. As a result, staffing in other areas of the health service felt further pressure.

117. The increased demand that the Omicron variant placed on acute sites meant that it could inhibit the ability of ambulance staff to respond to emergencies, for example by slowing down ambulance turnaround times. Steps were taken by health boards, with varying degrees of success, to address that risk. For example, NHS Tayside had a consultant-led model for flow navigation within the Accident and Emergency department of Ninewells Hospital in Dundee, which worked well and helped to reduce ambulance turnaround times. The Scottish Government also provided additional investment for the Scottish Ambulance Service in order to assist with recruitment of staff.

118. Early data wasn't suggesting that Omicron possessed significant immune escape, and we knew the vaccine was still effective due to global data. However, we knew that, whatever we did, the pressure on the NHS due to the Omicron variant in the winter of 2021 was going to be very significant. We also had concerns that flu would return in a significant way not seen during the previous winter.

119. Winter is, of course, always a time of extreme pressure on the NHS, and we knew that people would want to attend events throughout the festive and New Year period. We knew there was going to have to be a joint approach of NPIs and vaccines, as they were the two key tools we had to help the Scottish healthcare system respond to Covid-19 and protect the healthcare system during what would be an incredibly pressured winter season.

120. Vaccines were by far the greatest tool that we had to tackle the harms of the virus. It was clear that we would have to accelerate the vaccination programme, so we implemented the 'Boosted by the Bells' campaign and set ourselves the target of having 80% of eligible adults vaccinated by 31 December 2021. The target was set, and that was communicated to health boards who in turn increased capacity. We were delivering record numbers of vaccines per day, all of which helped to reduce the impact on the healthcare system.

121. As mentioned previously, in order to accelerate vaccine rollout, further vaccinators were deployed from other parts of the healthcare system. This was left to individual health boards to determine, and to do in a way that would have minimal impact on other services.

122. As well as expediting the vaccine rollout, we limited the number of spectators at indoor events and allowed a greater number at outdoor events. The numbers were informed by the scientific and clinical evidence, as well as the knowledge that people would want to attend events throughout the festive and New Year period, hence we stipulated that the larger events that were permitted occur outdoors. As ever, we had to strike a balance between keeping society open and containing the spread of the virus. People had received the vaccinations and the most vulnerable would have had a booster, and this gave us further encouragement in relation to allowing for gatherings of controlled numbers to occur.

123. However, on 21 December 2021, Cabinet had to further consider if additional protection measures were required, given the rate at which Omicron was spreading in Scotland. At this point it was known that this variant was more transmissible than Delta and that it was better at evading vaccine-induced antibodies.

124. These further measures included the cancellation of all large events on 26 December 2021. One metre physical distancing measures were reintroduced for the hospitality and leisure sectors, while hospitality had to provide table service only. Nightclubs were required to close for a period of at least three weeks. The hospitality, retail and nighttime economy sector were generally based indoors, traditionally busy over the festive period, and were more likely to involve alcohol consumption that could make people less cautious in their physical distancing behaviours. These factors were all relevant, given our understanding of how the virus spread.

125. By 31 December we had not quite reached the 80% vaccination target, but the Scottish Government and partners had delivered booster vaccinations to 2,979,334 people – 76.7% of the eligible population.

126. The winter of 2021-22 was the most difficult time I had seen the NHS face during my time in Government up until that point, and probably one of the most difficult for the NHS in its history.

Impact on non-Covid-19 treatments

127. The decision to pause elective care was not taken by me, but by my predecessor, Jeane Freeman, during her time as Cabinet Secretary for Health and Sport. However, I know from being involved in Cabinet discussions at the time that we were conscious of hospital capacity in the face of a virus we knew little about, for which no vaccine had been developed. During Module 2A the Inquiry heard from Ministers, government officials and advisors about the detail of the worst case scenario modelling in the early days of the pandemic. There was a genuine concern that hospitals could be overwhelmed given the transmissibility of the virus, so the need to free up beds, and create additional critical care capacity, in particular, was vital.

128. Decisions around pausing or resuming elective care were communicated by the COO writing to the Chief Executives of Scotland's health boards, with guidance also issued. Health boards were given flexibility in relation to elective care, as some were able to manage their waiting lists better than others and had capacity available to assist other health boards with particular specialisms. For example, NHS Forth Valley's breast service was able to provide ongoing mutual aid to patients from NHS Lanarkshire, NHS Tayside and NHS Fife.

129. Working with the Centre for Sustainable Development, we also established the National Elective Coordination Unit ("NECU"), who assisted health boards with waiting list validation. This helped ensured that we had an accurate picture of how many people were still awaiting elective care, and how long they had been waiting. This work often resulted in waiting lists reducing.

130. The Government, and those in the health service, wanted to resume elective care as quickly but also as safely as possible. If there were any concerns about doing so, they would be raised by the particular health board and be communicated to me via the COO. For example, it became very apparent through early data sets that NHS Ayrshire and Arran and NHS Grampian were struggling to make progress with the resumption of elective care for those waiting the longest. The COO and I met with appropriate officials and the health boards involved to discuss what additional support could be provided to assist. As a result, support was put in place, such as a mobile elective unit moved to NHS Grampian.

131. Although NHS staffing was at a record high under this Government, there was simply no doubt that the impact of the virus would be severe and take its toll on staff working in the NHS. Pausing elective care allowed health boards to redeploy staff to those areas that needed further staff resource, particularly given the concerns we had in relation to pressures on urgent and critical care, both in the early days of the pandemic and during waves of the virus / when new variants emerged.

132. On 25 August 2021, the Former FM and I launched the NHS Recovery Plan [HY3/07 - INQ000228406]. The central purpose of the NHS Recovery Plan my officials and I developed was to create additional capacity within the NHS, to aid the resumption of elective care, as we recovered from the pandemic.

133. On 06 July 2022, I announced targets for the next two years to reduce the number of long waits for elective care. These targets encompassed both inpatient / day-cases and outpatients. As a result the National Clinical Prioritisation Framework ceased to be used, and the new targets were communicated to health boards. [More detail of the targets announced is provided: [HY3/08 - INQ000480778].

134. One of our concerns, in relation to which we were guided by the Scottish Government's Four Harms approach, was Covid-19's impact on non-Covid-19 related healthcare more generally. I don't believe anyone in Government was in any doubt that Covid-19 was going to cause significant disruption and challenge to our health service – not just in its own right, but by having a significant impact on other, non-Covid-19-related conditions.

135. It would be wrong to think that during the pandemic there was a 'Covid-19 healthcare system' and a 'non-Covid-19 healthcare system'. Some people had comorbidities that were exacerbated by Covid-19, and the healthcare system in Scotland was, and is, for all conditions. We encouraged people to continue to take up non-Covid-19-related healthcare, for example by a letter being sent in December 2021 from the CMO and NCD to every single household in Scotland [HY3/09 - INQ000480780]. The letter reminded people about NHS Scotland's 'Right Care, Right Place' guidance, and about services provided by their GP, pharmacies, and that, if necessary, they could attend Accident and Emergency, or phone 999. The letter was a reminder to people that whatever their condition, the NHS was there to support them.

136. The impact of Covid-19 on non-Covid-19-related healthcare was an issue I paid frequent attention to. We linked in with primary care services, such as GP practices and pharmacies, to try to understand the pressures upon them and what further support they required, and multiple data sets helped to provide a picture of the impacts being felt across healthcare systems.

137. I reviewed Accident and Emergency performance and attendance figures multiple times each week, if not daily. Accident and Emergency figures revealed that Covid-19 was clearly having a significant impact on our ability to see patients within the NHS Scotland target of four hours: in the year prior to Covid-19 (i.e. 2019), we were seeing 89.1% of patients within four hours in Accident and Emergency departments; in 2022, that figure dropped to 70.2% – a trend that was replicated across the nations of the UK.

138. I regularly reviewed cancer figures, in particular our 31 day and 62 day cancer targets. These figures were broken down by health board and also by cancer type, and I received these figures monthly, with the quarterly statistics published. These figures showed Covid-19 was having an impact on both the 31 and 62 day pathway. Through

these figures, I was able to determine where to allocate additional resources. For example, in August 2022 I announced £10 million to help with training for endoscopies, which can be crucial when detecting bowel cancer.

139. I also paid close attention to delayed discharge figures, having multiple meetings and conversations a week to see what further action we could collectively take to reduce the number of people whose discharge from hospital was delayed.

140. I was provided with a weekly NHS overview that contained various metrics such as occupancy figures, Accident and Emergency performance, staff absence levels, and a number of other important indicators, with a number of them coded red, amber or green depending on risk that particular week.

141. We were acutely aware that the reprioritisation and redeployment of resources and staff in the NHS could impact on people's non-Covid-19-related health, which was captured by harms number two and three in the Four Harms framework. As a result, my clinical team and I would communicate regularly with the public to help inform them that services were under pressure but still open to the public. To help aid us during a time of such pressure, it was crucial people sought the right care at the right place.

142. We ran our 'Right Care, Right Place' campaign throughout the course of the pandemic. This included radio and television adverts, a suite of digital and online materials, and leaflets and letters posted to households across Scotland. These letters were signed by the CMO and the NCD.

143. An evaluation of the campaign showed it performed well, with recognition exceeding average campaign levels, and the campaign was reported as being clearly understood. Key findings from the evaluation were:

- People who recognised the campaign were more likely to call NHS 24;
- Fewer people were seeing NHS 24 as an 'out of hours' service and awareness had risen that NHS 24 was available '24/7' – this was higher for people who recognised the campaign;
- People with children and people who had underlying health conditions were more likely to recall the campaign;

- Older people and males were less likely to have seen the campaign but recall levels were good;
- 41% of people claimed to have acted on the campaign messages – the most likely action to call 111 instead of attend Accident and Emergency services;
- Satisfaction levels for NHS 24 and Accident and Emergency services were high.

144. Returning NHS Scotland to day-to-day business was a key part of my work as Cabinet Secretary for Health and Social Care. That is why my officials and I developed the NHS Recovery Plan, which looked at increasing capacity and reducing waiting times over a five year period. It committed over £1 billion to help deliver necessary reforms and capacity within the health service, including significant investment to reduce waiting times for elective surgery. Through our investment in National Treatment Centres we had the ability to create capacity for tens of thousands of additional treatments. The recovery plan also committed the Government to investing £29 million to target diagnostic backlogs, providing 78,000 additional diagnostic procedures in 2021-22 rising to 90,000 per year from 2025-26.

145. I was also acutely aware of the staffing recruitment and retention issues our NHS was facing, and the impact this was having on NHS recovery and a return to day-to-day business. As well as negotiating a successful pay settlement for NHS staff, which helped with both recruitment and, crucially, retention of NHS staff, I was keen for the Government to do more in regards to international recruitment. I announced additional funding for new international recruitments campaigns and ensured we provided support for health boards to engage in ethical international recruitment, particularly of nursing staff. (It should be noted that I had no involvement in the decision to remove the NHS immigration health surcharge for non-UK healthcare staff; that was a UK Government decision. It had, however, been a long-standing position of the Scottish Government that the surcharge should be removed for all migrants, and that doing so would provide financial benefits to those within the scheme.)

146. In July 2022, I announced ambitious targets to help reduce waiting times for inpatient / day-cases and outpatients. Although we fell short of those targets, the focus on reducing waiting times had a significant impact and resulted in a 70% reduction in waits for treatment of over two years for outpatients and a 25% reduction for inpatients / day-cases.

147. I also ensured there was investment in mobile elective surgery theatres at Stracathro Hospital in NHS Tayside and the Vanguard theatre in NHS Shetland, and a mobile elective unit was moved to NHS Grampian. Additional capacity was also created in the form of mobile diagnostic services, including five mobile computed tomography scanners and six mobile magnetic resonance imaging scanners.

148. NECU, as previously mentioned, contributed to reducing waiting times for elective surgery, which also played a role in returning the NHS in Scotland to day-to-day business. So too did reforms in the NHS: I was keen to ensure a greater use of technology where possible, particularly where that technology could help us reduce waiting times for elective surgery. In June 2021 I announced £20 million for Robotic Assisted Surgery, mainly for the treatment of cancers and gynaecological treatments. This technology meant a less invasive procedure, quicker recovery time and fewer complications which, in turn, would help us reduce waiting times.

149. As mentioned previously, there was not a 'Covid-19' and 'non-Covid-19' healthcare system in Scotland. People who presented with Covid-19 would often have comorbidities and other conditions that were exacerbated by the virus. However, there is no escaping the significant impact the virus had, and continues to have, on our NHS. NHS Scotland is still dealing with the impact of the pandemic on non-Covid-19 related treatment of patients.

150. One significant challenge to our efforts to return to day-to-day business was that every time we felt progress was being made, a new wave or emerging variant of Covid-19 would hit the country, and impact our recovery of the health service. For example, the NHS Recovery Plan was introduced in August 2021 while we emerged from the Delta wave of the virus, but the Omicron variant arrived shortly thereafter.

151. Understanding the significant pressures across healthcare systems, particularly in our acute sites, I invested funding in a further expansion of our 'Hospital at Home' service. Hospital at Home is a short-term, targeted intervention that provides a level of acute hospital care in an individual's own home, which is equivalent to that provided within a hospital. A progress report published by Healthcare Improvement Scotland in January 2023 showed a 68% increase in patients managed by Hospital at Home services – 7,369 patients managed between April and November 2022, compared to 4,374 the same period the year before [HY3/09A – INQ000315597].

152. There were a number of challenges the virus presented to our recovery of the NHS, including the impact of necessary self-isolation measures that was felt on hospital wards and across healthcare sites up and down the country. I recall one visit to University Hospital Ayr in which I attended a ward to find that approximately three quarters of the ward's staff were at home due to the effects of Covid-19. All these factors were heightened even further when winter, always a time of great pressure for NHS Scotland, came around.

153. It was always very difficult to plan for a full NHS Scotland recovery as we did not know when there would be a new wave, new variant, or when new, even more effective vaccines or treatments would be available. In that respect, Covid-19 modelling and forecasting was helpful, although constrained as all forecasting by its nature is. If we were hit with a wave of Covid-19 we would use the Clinical Prioritisation Framework to effectively 'turn off' or reduce elective care to ease pressure on the NHS across Scotland.

154. The DGHSC or the COO had responsibility for writing to health board Chairs and Chief Executives to make them aware of the Clinical Prioritisation Framework and any changes to it, including the need to halt elective care, and to resume it when it was safe to do so. Close contact was maintained with health boards throughout my time as Cabinet Secretary, and we were able to identify any particular health board that was not making progress in terms of returning to elective care at sufficient pace and thereafter meet with the representatives of such a health board to discuss what could be done by the Scottish Government to assist them.

155. Although there were clear benefits associated with telephone appointments and the use of video consultations, there was a fair degree of pressure both politically and from the public to increase face-to-face appointments with GPs following the easing of restrictions. For that reason, we were keen to stress the need for greater access to face-to-face appointments. My approach was to work closely with those primary care providers, mainly through their professional bodies, with the goal of increasing capacity for face-to-face appointments in a way that worked for both the public and profession.

156. One challenge that became immediately apparent to me was the lack of data around access to GPs. I therefore worked, as previously noted, with bodies such as the BMA

to gather and review data in terms of the number of in-person appointments, telephone calls and video calls to monitor progress being made and how we could ensure a quicker return to fully in person appointments. The result was the creation of Primary Care In-Hours General Practice activity Visualisation Data which is made available on a monthly basis via Public Health Scotland.

157. During my time as Cabinet Secretary for Health and Social Care we invested significantly in general practice. Particular efforts were made to fill GP vacancies in rural locations with the introduction of 'golden hellos' (a bursary scheme, administered through health boards, to incentivise GPs taking up posts in remote and rural areas) and continued investment in the 'ScotGEM' programme – a four-year graduate-entry medical programme designed to develop doctors interested in a career as a medical generalist within NHS Scotland. The programme focuses on rural medicine and healthcare improvement. In addition, we had an almost 100% fill rate of junior doctors taking up spaces allocated for GP specialist training.

158. For those patients at high risk to the most harmful impacts of Covid-19, additional bespoke communication and arrangements related to our efforts to return to day-to-day business were put in place; these are addressed in more detail later in this statement. For patients that were at high risk of health harms that were not Covid-19-related, those requiring treatment were categorised by urgent need and priority, with a focus on those with the most urgent need being treated first. Unfortunately, this meant that those with less urgent need were often required to wait longer. There were a number of key areas we tried to prioritise and protect that impacted those we considered to be at highest risk of potential harm, such as emergency care, critical care, cancer care, maternity, and mental health. While we tried, collectively, to protect these particular areas of healthcare, there undoubtedly was, and continues to be, an impact on these services due to the pandemic.

159. I was not involved in the creation or eventual decommissioning of NHS Louisa Jordan ("NHSLJ"), as these events took place prior to my appointment as Cabinet Secretary for Health and Social Care. However, I understand that more than 32,000 outpatient and diagnostic appointments were carried out, over 6,900 healthcare staff and students were trained, and approximately 175,000 people across the Greater Glasgow and Clyde area were vaccinated at NHSLJ. The site also supported the Scottish Blood Transfusion Service, with over 500 donations carried out, as well as providing

Occupational Health services for the University of Glasgow for nearly 1,000 people. Initially, NHSLJ was established in the event that additional capacity was required to treat Covid-19 patients; while it was not, in the end, used to treat Covid-19 patients, the additional capacity created was nonetheless utilised efficiently.

160. It is my view that the creation of NHSLJ was necessary. It should be kept in mind that the facility was created in the early days of the pandemic when Covid-19 was spreading at a significant pace and rate, with very limited treatment options available and no vaccine yet developed. It would have been an abandonment of our responsibilities as a government if we had chosen not to increase capacity where possible, and it was absolutely vital that we did so. If NHS Scotland had reached capacity and NHSLJ had not been established, the results could have been catastrophic. That, together with the fact that non-Covid-19 related treatments such as outpatient and diagnostic appointments, vaccine administration and healthcare staff training were carried out at the NHSLJ, makes me firm in my belief that it provided value for money. Although the establishment of NHS LJ, and the decision to close the facility, was made before I was Health Secretary, I am sure the facility could have treated covid patients should it have been required to do so. It would have required appropriate IPC, critical care facilities and staffing to have been in place.

161. The independent healthcare sector has been used for additional capacity both prior to the pandemic and during my time as Cabinet Secretary for Health and Social Care. My understanding is that the independent healthcare sector is still used today to assist with addressing waiting lists and backlogs of care.

162. The management of contracts is generally carried out by individual health boards. I understand, broadly, that such contracts take the form of service level agreements. As Cabinet Secretary I was not involved in the micromanagement of individual decisions to use the independent sector or of service level agreements. I did, of course, keep an eye on the total cost of using the independent sector, given the financial pressures upon our budget.

163. The types of treatments contracted out to the independent healthcare sector can range depending on the need of each individual health board, but it is my understanding that no Covid-19 treatment was carried out under such service level agreements with the

independent sector. In fact, the benefit of using the independent sector was to utilise a Covid-19-free environment, allowing other, urgent treatments to take place.

164. The efficacy of using the independent sector would have been measured against the service level agreements put in place by individual health boards. We were given updates on the cost of the independent sector, and I judged the use of the independent sector as necessary given the severity of the pressures on the NHS, due to the pandemic.

165. As Cabinet Secretary for Health and Social Care I was always conscious of every penny of public funds being spent in my portfolio. As a Government, our view was that the independent healthcare sector was to be used only where necessary. An analysis had to be made of the cost of contracting with the independent healthcare sector against people coming to harm by their condition deteriorating while awaiting treatment. Of course, backlogs in waiting lists increased as a result of the pressures on NHS Scotland from the pandemic and for those waiting the longest there is frequently a risk of deterioration in their condition. In that vein, I judged the use of the private sector as necessary, and as a percentage of the health budget, it represented a small fraction.

166. As mentioned previously, I understand that in Scotland we had a different approach in tackling waiting lists from England and Wales, which applied to our use of private hospitals as well NHS services. We chose to target those who had the most urgent need, i.e. in categories P1 (those whose requirement for surgery ranged from emergency to within 72 hours), P2 (those requiring surgery within four weeks) and sometimes P3 (those requiring surgery within three months), rather than solely focusing on those who had been waiting the longest.

Infection prevention and control

167. Throughout the pandemic, Scottish Government was aware of the real challenges in prevention of infection of Covid-19 in healthcare settings for both patients and staff. Discussions around the possibility of nosocomial infection of patients and staff were taking place in the early days of the pandemic, pre-dating my time as Cabinet Secretary for Health and Social Care. The use of PPE, infection prevention and control methods, testing and vaccination were all key in tackling this, and prioritisation in any

relevant schemes such as the vaccine rollout was given to healthcare and social are staff, given the risk of spread of Covid-19 in the hospital environment. Regular reports were given to me and to the CNO, initially on a daily and latterly on a weekly basis, with details of hospital acquired infections and information about the likely spread of Covid-19 within healthcare settings. The CNO would take lead responsibility for appropriate IPC within the healthcare environment, and he would regularly update me on any particular issues that required flagging for my attention.

168. In May 2020, the Scottish Government established the Covid-19 Nosocomial Review Group ("CNRG"). This was a time-limited expert group chaired by Professor Jacqui Reilly, Nurse Director and Healthcare Associated Infection (HCAI) Executive Lead at NHS National Services Scotland ("NHS NSS"). The advisory group considered the scientific and technical concepts and processes that were key to understanding the evolving Covid-19 situation and potential impacts in hospitals in Scotland. The advisory group applied the advice coming from the World Health Organisation (WHO), the Scientific Advisory Group on Emergencies (SAGE), the UK-wide Infection Prevention and Control guidance cell and other appropriate sources of evidence and information. That advice was fed in to Government through the CNO, who would, alongside government officials, use it to inform policy development. This group was active until November 2022.

169. My understanding is that no one principal cause of nosocomial infections was formally identified. Hospitals are very sterile environments but, even with infection prevention and control measures, it is impossible to stop all human-to-human and human-to-surface contact. The main causes of nosocomial outbreaks that I was made aware of during the pandemic, include:

- the difficulties involved in managing patient movement within healthcare settings, and accommodating patients with Covid-19 together;
- the lack of doors on wards and partition walls not being at full height providing a route of transmission in clinical areas;
- low levels of staff awareness about atypical Covid-19 presentation in elderly people;
- failure to comply with physical distancing guidance and measures, including by staff in, for example, tea rooms and social spaces;
- patients and staff not appropriately using face masks and coverings; and

- reduced levels of staff, due to staff absence and / or testing positive for Covid-19, available to work and care for patients.

170. While adherence to IPC measures, such as wearing appropriate PPE, was good in healthcare settings, we worked continually with trade unions to reinforce the importance of IPC measures being followed within healthcare settings.

171. The risk that nosocomial infection posed to healthcare workers and, crucially, those they were caring for was undoubtedly one of the factors that led the Joint Council for Vaccinations and Immunisation's ("JCVI") recommendation to prioritise health and social care workers for vaccinations.

172. We sought to reduce the risk of nosocomial infections by ensuring that appropriate supplies of PPE were provided to healthcare workers, and that appropriate infection prevention and control measures were in place in healthcare settings. We also prioritised vaccination for healthcare workers alongside those at higher risk of Covid-19 harm, and ensured availability of testing for healthcare workers. Support to health boards in the event of an outbreak of infection was also always available from Antimicrobial Resistance and Healthcare Associated Infection ("ARHAI"). ARHAI is a clinical service providing national expertise for Scotland in relation to infection prevention and control, antimicrobial resistance (AMR) and HCAI.

173. I am not aware of any specific data in relation to the levels of nosocomial infection amongst healthcare workers from a minority ethnic background. However, through the data provided on vaccine uptake and Office of National Statistics Data on Covid-19 mortality, it was clear that people from minority ethnic backgrounds were disproportionately affected by the virus and had a lower uptake in vaccinations. The Scottish Government also established the Expert Reference Group on Covid-19 and Ethnicity to help investigate, in further detail, the impact of the virus on our ethnic minority communities. On 18 September 2020, the Expert Reference Group published a report that included, among other things, analysis of the higher prevalence of Covid-19 among ethnic minority communities. The report noted that intersections between socioeconomic status, ethnicity and racism intensify inequalities for ethnic groups and that this required additional vigilance in regards to the disproportionate impact that Covid-19 had on minority ethnic groups.

174. The report acknowledged that, at the time of its publication, a lack of high quality data on ethnicity hampered the understanding of ethnic variations on Covid-19 and its outcomes in Scotland. With this caveat in mind, however, the report provided examples of why Covid-19 risks may have disproportionately affected minority ethnic groups. Those included:

- differential exposure (such as increased representation in health, care and transportation workplaces, poor living conditions and poverty);
- differential vulnerabilities (including increased risk of diabetes and cardio-vascular disease); and
- differential access to treatment and other forms of support (noting that migrants without formal status have barriers in accessing NHS services and people from a minority ethnic community are more likely to face discrimination).

175. The report urged the Scottish Government to take action on a number of issues, including taking steps to ensure the inclusivity of public health messaging around Covid-19 for minority ethnic communities and migrants, taking into account language barriers, literacy levels, cultural and religious factors and differential access to health related information and to make sustained improvements to the collection and use of data on ethnicity and health.

176. Following the recommendations of this report, significant efforts were made to improve the Covid vaccine uptake through targeted communications and stronger collaboration with minority ethnic, religious and community groups. The collection of ethnicity data for Covid-19 vaccinations was introduced in November 2021, and is now routinely collected for Covid-19, influenza, shingles and pneumococcal vaccines, where a record is not already held. Ethnicity recording was also made mandatory on hospital admission datasets.

177. A copy of the report is provided: [HY3/09B – INQ000241567].

178. Issues with PPE that affected some members of our minority ethnic communities were brought to my attention, usually by the individuals themselves writing to me, or raised by individual MSPs. For example, I knew of a Sikh healthcare worker who required bespoke PPE to accommodate his beard. In this case, the health board involved was helpful in arranging bespoke PPE, however that took time given the availability of this particular item of PPE and the continued strain on global supply chains.

179. Similarly, I was not made aware of specific issues relating to nosocomial infections affecting particular cohorts of healthcare workers. However, Scottish Government was mindful of the challenges facing social care workers in adult care homes, given the intimate nature of the tasks they were often asked to carry out with frail, elderly residents, a number of whom had dementia.

180. The testing programme for hospital patients and staff was well established by the time I was appointed as Cabinet Secretary for Health and Social Care. No significant issues were brought to my attention regarding testing capacity or delays in relation to the testing of healthcare staff. At the time, we were continuing to work with the UK Government regarding the facilitation of the Lighthouse Laboratory, as well as using the NHS's own laboratory testing capacity.

181. Changes were made to the self-isolation rules in July 2021, following the receipt of clinical advice [HY3/10 - INQ000244527]: *in extremis*, if a healthcare worker was identified as a close contact of someone who tested positive with Covid-19 but had been vaccinated, had a negative PCR test and daily negative lateral flow tests then there was no requirement to isolate. These changes were not as a result of any issues with testing capacity, but rather to ensure we were not increasing the risk of a nosocomial infection against having increased staffing capacity which was incredibly strained during the pandemic, and was having an impact on our ability to recover the NHS.

182. There were well-documented concerns raised in the early days of the pandemic in relation to some of the older parts of the Scottish hospital estate, including around ventilation and adjustments that had to be made. For example, a group of clinicians and staff wrote to senior management in NHS Greater Glasgow and Clyde with concerns about the Glasgow Royal Infirmary and the adequacy of its ventilation, which was well-publicised at the time [HY3/11 - INQ000480783]. These issues were largely flagged up in the early days of the pandemic and dealt with then, before I was Cabinet Secretary for Health and Social Care. I do not recall any issues around ventilation in the hospital estate being brought to my attention whilst I was Cabinet Secretary.

183. There was always a very difficult balance to strike between having effective infection prevention and control measures robustly in place, and the need to utilise every bit of

hospital capacity we could. Adjustments to infection protection and control were made where possible, while maintaining safety, to utilise NHS space. Patient safety was very much in mind, and decisions were always informed by the best available clinical advice including from the CMO, CNO, NCD and other specific groups, such as the CNRG.

184. In certain circumstances, NHS Boards derogated from national guidance to make local decisions when it was essential to do so in order to prioritise patient safety and care. Examples of derogation during the pandemic included; bed spacing being decreased due to space having to be made available for people in wards to which they wouldn't otherwise usually be admitted because of increase number of patients.

185. When a NHS Board adopted practices that differed from those stated in National Infection Prevention and Control guidance, that individual organisation was responsible for ensuring safe systems of work including the completion of a risk assessment approved through local governance procedures. Boards were only required to inform Scottish Government via the Chief Nursing Officer of derogation from patient testing, detailing what the current Board position was, how the move was agreed and what review structures were in place.

186. NHS NSS was responsible for the operational supply of PPE in the NHS in Scotland. If there were any shortages, NHS NSS would highlight those shortages, and individual health boards would also draw the issue to my attention. During the Covid-19 pandemic, the global PPE market was experiencing unprecedented demand and traditional distribution networks were significantly disrupted. To decrease reliance on global supply chains, the Scottish Government in conjunction with Scottish industry took steps to boost production of PPE. This was done in the early days of the pandemic, prior to my time as Cabinet Secretary for Health and Social Care. A lot of effort was put into domestic supply of PPE, which paid off during the rest of the pandemic – one of the key critical learnings of the pandemic.

187. During my time as Cabinet Secretary for Health and Social Care, there was some lobbying by opposition parties, trade unions including the BMA, staff side, the media, Fresh Air (an NHS lobby group), healthcare workers, and infection prevention control specialists to change from using Fluid Resistant Surgical Mask Type IIR ("FRSM") to FFP3 respirators ("FFP3s"), in the light of emerging Covid-19 variants. I requested an evidence paper on the topic on 13 January 2022, given the concerns voiced by trade unions and professional organisations about the psychological safety of their members

in relation to not being permitted to wear an FFP3 rather than a FRSM in settings where they were not performing aerosol generating procedures (AGPs) on patients.

188. In light of that evidence paper, and further to discussions with stakeholders, discretionary access to FFP3 masks was introduced on 19 April 2022 – not as an IPC measure per se, but to improve the confidence and wellbeing of health and social care staff. Discretionary access guidance is provided: [HY3/11A – INQ000429256].

189. In order to keep me informed of available stocks of PPE, there was some regular reporting on PPE levels to me. From taking up post in May 2021 through to 15 September 2021 I received a weekly PPE demand and supply briefing. There was then a pause in issuing these briefings to allow for completion of the review of the dashboard reporting system that provided the data for those briefings. The briefings recommenced on a monthly basis from December 2021 and continued until April 2022. The briefing began with an overview of the current situation, including stock levels, projections of future demand, and whether potential requirements were likely to be met, along with any relevant operational information. The briefing was completed with a description of the PPE modelling assumptions used to inform the forecasts.

190. I also monitored a series of PPE-related dashboards, showing the following:

- PPE Demand and supply dashboard: showed the weekly demand, orders and stock position over the next 12 weeks for all PPE categories;
- Aprons dashboard: showed the weekly demand, orders and stock position over the next 12 weeks along with information on risks, mitigation, opportunities and any other additional information related to aprons;
- Covid-19 AGP gowns dashboard: showed the weekly demand, orders and stock position over the next 12 weeks along with information on risks, mitigation, opportunities and any other additional information related to Covid-19 AGP gowns;
- Disposable full face visors dashboard: showed the weekly demand, orders and stock position over the next 12 weeks along with information on risks, mitigation, opportunities and any other additional information related to disposable full face visors;

- Gloves dashboard: showed the weekly demand, orders and stock position over the next 12 weeks along with information on risks, mitigation, opportunities and any other additional information related to gloves;
- Hand sanitiser dashboard: showed the weekly demand, orders and stock position over the next 12 weeks along with information on risks, mitigation, opportunities and any other additional information related to hand sanitiser;
- FFP3s dashboard: showed the weekly demand, orders and stock position over the next 12 weeks along with information on risks, mitigation, opportunities and any other additional information related to FFP3s;
- FRSM dashboard: showing the weekly demand, orders and stock position over the next 12 weeks along with information on risks, mitigation, opportunities and any other additional information related to FRSMs; and
- Transparent masks dashboard: showing the weekly demand, orders and stock position over the next 12 weeks along with information on risks, mitigation, opportunities and any other additional information related to transparent masks.

191. The Primary Care PPE Steering Group was established in May 2020 [terms of reference provided: HY3/12 - INQ000320396], before my time as Cabinet Secretary for Health and Social Care, and consisted of policy representatives and clinicians to consider PPE issues for primary care independent contractors. Membership consisted of representatives from across primary care services, as well as Scottish Government officials. The steering group ceased regularly meeting in early 2023 on the basis that the group could be reconvened if anything arose which necessitated doing so.

192. Sometimes NHS staff would come to me directly with concerns about PPE. For example, during a visit to the Royal Alexandra Hospital, I met with staff and Trade Union representatives. During that discussion a number of issues were raised, including concerns about FFP3 masks not being routinely available for staff, some of whom felt more comfortable wearing it. In another instance, I was directly contacted by a constituent of the Sikh faith who had a beard and did not have the appropriate PPE to carry out his specialist role within the NHS given global shortages of the particular item required. My direct communication with trade unions was very important in respect of PPE, and representatives of such bodies would approach me directly. I would approach staff in hospitals and ask them for the unvarnished truth on whether they were receiving the PPE that they required. I also spoke with Chief Executives of individual health boards.

193. Where a concern about PPE was raised with me, I would categorise the issue as either being one that could be dealt with at health board level or one that could be addressed through national guidance. Where it was a health board issue I would raise the concern with the Chief Executive or Chair of that board; if the issue stemmed from Scottish Government guidance, I would consult the NCD, the CNO, and / or the CMO. An example of the latter is the previously mentioned amendment to national guidance to ensure that those health workers who wanted access to FFP3 masks would be provided with them on a discretionary basis.

194. In my opinion, there were effective processes and procedures in place for healthcare and social care workers in Scotland to raise any concerns they had about PPE. Individual staff members would provide Scottish Government with feedback: by the time I became Cabinet Secretary for Health and Social Care the dedicated PPE mailbox had closed due to the reduction in usage as PPE supplies stabilised, however NHS staff could feedback on PPE by directly emailing me. Feedback could also be, and was, received by and dealt with by officials via the various groups set up during the pandemic, such as:

- the Single Point of Contact (SPoC) oversight group. The group had an information and advisory role, feeding into policy officials, Board Chief Executives and the Chief Nursing Officer. There was direct contact between officials and SPoCs for information sharing purposes and to address individual reports of localised PPE supply issues.
- The Primary Care PPE Steering Group. This group was formed to consider alternative supply options in order ensure the sector (dentists, GPs, pharmacists, optometrists) had access to an adequate supply of PPE throughout the pandemic.
- The Adult Social Care PPE Steering Group was established in November 2020 to manage the Social Care PPE Hub Network from a strategic perspective. This included monitoring the use of the Hub Network, the levels of supply and demand, in addition to addressing ad hoc issues of concern raised by Steering Group members.

195. We also had regular engagement with trade unions. My expectation was that senior management at health board level would listen carefully to any concerns raised by staff or representative groups and trade unions. We ensured that appropriate

whistleblowing procedures were in place, including a 'Whistleblowing Champion' in each health board and the Independent National Whistleblowing Office that was established by my predecessor. I personally held a meeting inviting all Whistleblowing Champions from across health boards in Scotland to raise any concerns with me. My recollection is that PPE was not one of the substantive issues that was raised.

196. I also met with opposition health spokespeople, and MSPs had ample opportunity to raise with issues related to PPE with me, in the Parliamentary Chamber, at Committee or with me directly.

197. I believe all of those feedback loops worked well. Where I raised concerns with health board senior management, I was confident that there were adequate processes in place to address those concerns. My engagement with health boards was very regular. I also visited hospitals in person. We were in the middle of a global pandemic, so, as would be expected, there was never a hospital visit where staff told me everything was working perfectly, but we did listen and constantly looked to support health boards to make improvements where staff raised concerns.

198. I do not recall there being a substantial number of issues raised in respect of protected characteristics and PPE during my time as Cabinet Secretary For Health and Social Care. I do recall there being concerns in relation to people who have a hearing impairment or are deaf not being able to lip-read due to healthcare staff having to wear face masks, so we made provision for transparent face masks to be introduced.

199. Throughout the Covid-19 pandemic, the Scottish Government had to strike a very delicate and difficult balance between maintaining infection control and prevention measures in hospitals and allowing relatives to visit in-patients in hospitals. The pandemic was constantly evolving, so we kept hospital visitation under regular review, which involved monitoring case numbers, the R-number, and the progress of the vaccine rollout. The Scottish Government's route map guided decisions about different levels being introduced across the country. Local areas could fall under different levels from one another, so depending on which level a hospital was in the restrictions may be greater than they would be in others.

200. Between May 2021 and June 2022 official guidance on hospital visiting from the Scottish Government recommended that visiting restrictions should vary in accordance

with local levels according to the route map. Some broad parameters were set out for each level in the guidance. The guidance encouraged a flexible approach to allow additional local factors to influence how family support was managed in practice. Principally, these factors were the needs of the person and their family and the nature of the local NHS estate. Throughout this period the official guidance also stressed the importance of allowing "essential visiting" to continue and emphasised that a person-centred compassionate approach focused on facilitating visiting should be the default approach.

201. It has long been understood that, despite many infection prevention and control measures being in place, hospitals are environments where nosocomial infection can and will spread. Prior to vaccines being discovered and manufactured, one way to combat Covid-19 was a reduction in person-to-person contact. Covid-19 related restrictions on hospital visiting were already in place by the time I became Cabinet Secretary for Health and Social Care. While we believed these restrictions were absolutely necessary, we were aware of the additional emotional toll they would place upon patients and their families. We also knew that visiting was particularly important for certain patients, such as those who were at the end of life, giving birth or facing an acute mental health crisis, so a flexible person-centred approach was encouraged.

202. In respect of hospital visiting restrictions, regular conversations with stakeholders were very important, as was feedback from patients and trade unions representing NHS staff. Constituents would speak with their member of the Scottish Parliament about their concerns. I worked very constructively with members of my own party and of the opposition when I received feedback through MSPs about constituents' experiences. None of the Scottish Ministers took the impact of visiting restrictions at all lightly, and indeed many of us were personally affected by those regulations when we had family and friends in hospital who we could not easily visit.

203. At all times during my time as Cabinet Secretary for Health and Social Care I was acutely aware of the impact of visiting restrictions upon patients and families. This awareness led to regular ongoing discussions in Government about striking a balance between facilitating hospital visiting that was as normal as possible, and keeping hospitals as safe and sterile as possible.

Other matters

204. Throughout the Covid-19 pandemic as a society and as a Government we were learning about the long-term effects of Covid-19 – the condition known as 'Long Covid'. Clinicians and scientists, and therefore the Scottish Government, are still developing their understanding of Long Covid with the aim of discovering suitable treatments.

205. In July 2021, NHS NSS conducted a mapping exercise of NHS Boards to identify how they were supporting people with Long Covid, what the resulting pressures were, and what health boards' additional needs were in that regard. A Long Covid 'lead' was identified within each health board, who acted as a central point of contact for coordinating local responses and sharing information. In September 2021, a short life working group was established to work through the results of the mapping exercise and identify the next steps required.

206. As the Cabinet Secretary for Health and Social Care, I was aware of the requirement to treat and rehabilitate patients who were suffering from Long Covid, and encourage research to find better treatments for Long Covid in the future. With these two challenges in mind, in September 2021 I announced the creation of a £10 million 'Long Covid Support Fund', which gave health boards additional financial resource to support local services to provide support for those suffering with Long Covid. That care could include strengthening and improving the co-ordination of existing services, or establishing dedicated services, potentially including dedicated 'Long Covid Clinics' or other models of care. In March 2022 health boards were requested to conduct a gap analysis exercise and submit applications for funding, outlining initiatives they planned to take with Long Covid Support Fund allocation. On 03 May 2022 applications received from health boards were discussed at the National Strategic Network for Long Covid's strategic oversight board meeting. I approved those funding allocations on 05 May 2022, and on 19 May 2022 NHS boards received letters confirming their Long Covid Support Fund allocations for 2022 to 2023 [board papers provided: HY3/13 - INQ000480786]. A total of £3 million was made available from the fund over the financial year 2022–23, with a further £3 million being made available over 2023–24.

207. There was some political and public pressure for specific Long Covid clinics to be established in Scotland, as they had been in England. There was nothing preventing

health boards from establishing a Long Covid clinic, but we wanted to give each health board autonomy to provide adequate support for those suffering from Long Covid, in a way that best suited their local population. Moreover, initial feedback from some parts of England suggested the Long Covid clinic approach set up another layer of bureaucracy, where the clinic would then make multiple referrals to different medical specialisms, effectively passing a person 'from pillar to post'. We expected health boards to use their allocation under the fund to assist Long Covid patients in the best way for their area, and thus to help ensure there was no postcode lottery. Health boards were given flexibility to think about the best approach for them, and thereafter to bid for the necessary funding. Where methods employed in on health board area worked well, we tried to share that learning with others.

208. One effective model I saw personally was in NHS Lanarkshire, during a visit to University Hospital Monklands on 01 September 2022 to meet service managers and clinical staff involved in NHS Lanarkshire's Long Covid rehabilitation pathway. The pathway was supported by a specialist team of professionals including dieticians, occupational therapists, physiotherapists, speech and language therapists, and psychological practitioners and offered support through group programmes or focused one-to-one sessions to support symptom management and improve people's quality of life.

209. While the composition of individual staffing teams across health board areas does vary, the model employed by NHS Lanarkshire shares common elements with some of those developed in other health board areas, particularly in terms of utilising the skills of physiotherapists and occupational therapists in providing support to those with Long Covid, providing a single point of access for assessment and co-ordinated support, and supporting symptom management.

210. The Scottish Government commissioned NHS National Services Scotland to establish a National Strategic Network for Long Covid led by Dr John Harden, which was set up in March 2022 2022 [HY3/14 - INQ000480789]. This brought together representatives from NHS boards across Scotland to provide a forum for the exchange of learning and best practice from within and beyond Scotland in developing support and services for people with Long Covid. I also ensured that I regularly engaged with those who had lived experience of Long Covid, including the group 'Long Covid Kids', as the impact of Long Covid on children was less well understood.

211. I cannot recall any substantive concerns about Do Not Attempt Cardio-Pulmonary Resuscitation ("DNACPR") orders being raised with me during my time as the Cabinet Secretary for Health and Social Care. I recall concerns about DNACPR notices being raised in the early days of the pandemic, but they were less of an issue by the time I became Cabinet Secretary for Health and Social Care.

212. The impact that our public messaging encouraging people to stay at home might have in terms of deterring those who needed treatment for Covid-19 or other conditions was an issue at the forefront of my and Cabinet's minds. I was always concerned that people would be deterred from seeking treatment due to the pandemic, which is why it was always emphasised, throughout our comms and marketing assets, that people should attend healthcare settings if necessary.

213. If people didn't require to be in an acute setting such as hospital, then we were very keen to try to keep them at home, or as close to home as possible where they could access the appropriate advice or treatment required. One way we tried to achieve that was by increasing the capacity of our Hospital at Home service during my time as Cabinet Secretary for Health and Social Care.

214. Our 'Right Place, Right Care' campaign aimed to ensure that people knew and understood the range of options available to them should they need to seek clinical advice or treatment. Campaign letters and leaflets were sent to household across Scotland, and radio and television adverts were broadcast about where people could access treatment, for example at a pharmacy, using NHS 24, phoning their GP, going to their dentist or optician, or in an urgent emergency calling 999 or going straight to hospital. A significant amount of that messaging was repeated by me, other Ministers, and clinical advisors. It was also emphasised by the Former FM during daily briefings, and by the clinical advisors that would also attend those briefings.

Shielding and the Highest Risk List

215. We had not been asking people to shield for a considerable amount of time at the point when I took over as Cabinet Secretary for Health and Social Care in May 2021. At that time there was still a shielding list, but this was renamed 'the Highest Risk List' in June 2021, as people had not been asked to shield since August 2020. I don't recall being

asked to make any decisions about shielding, other than those that are described below. However, as also described below, I was asked to note and approve decisions made by the CMO in relation to those on the Highest Risk List.

216. The CMO took the clinical lead for those who were on the Highest Risk List. I was on occasion asked to note decisions he had made, and at times was asked for approval. My own involvement in regards to the Highest Risk List was as follows:

- On 28 June 2021, I was asked to note a proposal to move the narrative around shielding to 'people at highest risk from Covid-19' and to change the 'Shielding List' to the 'Highest Risk List'. Shielding had paused close to a year previously, and we anticipated no return to that very restrictive form of shielding again, largely because of the detrimental impact to mental and physical health of shielding. User research and PHS survey work showed large numbers continued to 'self-shield', and using this terminology was confusing and a contributor to people who no longer needed to shield doing so. I noted the proposal [HY3/15 - INQ000243054].
- On 15 July 2021, I was asked to approve a decision that had been taken by the UK's four CMOs to remove children from the shielding list [HY3/16 - INQ000470033]. I approved the decision [HY3/16A – INQ000470032].
- On 23 August 2021, I was asked to note the decision by CMO to pause the decision to remove children from Scotland's shielding list. The Former FM and I were invited to note the proposed communications and process set out in a paper on the topic. I noted the decision and the proposed communications / process [HY3/17 - INQ000492662].
- On 07 October 2021, I was asked to approve the decision to enact the CMO's earlier recommendation to remove children and young people from the list. I approved the decision [HY3/18 - INQ000470036].
- On 26 October 2021, I was asked to note the decision to delay removing children and young people from the list due to the context at the time. I noted the decision [HY3/19 - INQ000470037].
- On 17 December 2021, I was asked to approve the decision to add c. 9,000 people identified as severely immunosuppressed on the ChemoCare database to the Highest Risk List. ChemoCare was a new data source that identified people who had received cancer therapy recently and met the criteria for inclusion on

the Scottish Government's Highest Risk List. I approved the decision [HY3/20 - INQ000470039].

- On 31 May 2022, I was asked to approve the decision to retire the Highest Risk List in Scotland. Guidance for people who are severely immuno-suppressed was to be published. It was agreed that the SMS service would end once the list did, as PHS no longer had a legal reason to retain people's data. I approved the decision [HY3/21 - INQ000243699].

217. Any decision to make amendments to the Highest Risk List would be driven by clinical considerations and the CMO's advice. Where appropriate, decisions around the Highest Risk List were taken on a Four Nations basis. The main factors when considering making changes to the Highest Risk List were clinical. They focussed on the impact that any NPI would have on the safety of any individual in terms of them contracting Covid-19, including any high risk of them experiencing harm resulting from, or succumbing to, Covid-19 – harm one of our 'Four Harms' approach.

218. Other factors that were considered included the mental health impact. We had seen the detrimental impact of shielding on the physical and mental health of those we were asking to shield, which, alongside the other harms in the 'Four Harms' approach, was one of the reasons shielding was ended.

219. On 31 May 2022 the Highest Risk List was ended. The CMO sent letters to 170,000 people who were on the list to let them know it was ending.

220. Through shielding, we were trying to protect people who were already vulnerable from significant harm. This was primarily to protect the individuals themselves from harm, this in turn would also reduce the need for those individuals to seek treatment from the NHS at a time of great pressure for the health service.

221. Feedback from those on the shielding list about what was and wasn't working, including in relation to the physical and mental health impacts of shielding, was sought by Scottish Government. I understand that everyone on the shielding list was given an e-mail contact point through which such feedback could be shared. (There were also two dedicated mailboxes for those who were previously told to shield: shielding.correspondence@gov.scot and shielding@gov.scot. The mailboxes were promoted on the relevant pages of the Scottish Government website. The Scottish

Government's central enquiries team also forwarded all shielding / highest risk related enquiries to the correspondence mailbox.) The Shielding / Covid-19 Highest Risk Division of the Scottish Government Health and Social Care Directorate also received regular feedback to help assess the impact of shielding. An online survey was conducted in July 2020 to learn about people's experience of shielding, in response to which I understand over 3,000 responses were received, but that was before my time. EQIAs were also carried out.

222. We were often tortured by decisions about easing restrictions: although those decisions were informed by clinical advice and were good for the general population, there was a risk to those on the shielding / Highest Risk List. Cabinet could see both sides of the equation.

Regulatory regime and patient safety

223. The decision by Healthcare Improvement Scotland's to pause routine inspections of healthcare settings and thereafter to make the specific focus of those inspections the measures being taken in healthcare settings to prevent the spread of Covid-19 is one I was not involved in, and was taken before my time as Cabinet Secretary for Health and Social Care.

224. Following a submission made to me on 05 November 2021 [HY3/22 - INQ000480793], I approved the change from pausing routine inspection to 'safe delivery of care' inspections in November 2021. Those inspections continued until April 2023, when inspection methodology and reporting structure were updated to fully align to the Healthcare Improvement Scotland Quality Assurance Framework [HY3/23 - INQ000480795].

225. As previously mentioned, we had processes in place whereby staff could raise concerns about any patient safety issues, both at local health board level and nationally if required. We also closely monitored data in relation to hospital acquired infections and could provide additional support to health boards via ARHAI if required.

Lessons learned and recommendations

226. I want to thank healthcare staff for the incredible work they did during the emergency phase of the pandemic, and the incredible efforts they continue to make during the recovery phase.

227. There are a number of aspects of the healthcare system that worked well during the pandemic. The healthcare system adapting at pace to the emerging threat of the pandemic was incredible, with staff rolling up their sleeves and many showing incredible ingenuity and innovation, such as the technicians who worked tirelessly to convert as much equipment into ventilators as possible, should they be required.

228. The vaccination programme in particular worked incredibly well. During its peak, the 'Boosted by the Bells' Campaign, we were administering record numbers of vaccinations a day: on its busiest day over 77,000 vaccines were administered. This required a colossal logistical effort, and deployment of staff resource. I have no doubt in my mind that many lives were saved due to this effort, and in fact we know this to be the case given studies have looked specifically at Scotland's vaccination efforts.

229. I feel we could have ensured our healthcare system communicated more clearly with those suffering from Long Covid, in relation to the efforts we were making to learn more about the condition and to provide support. While I believe our approach was the correct one, i.e. to allow flexibility at local health board level, for too many sufferers the lack of communication felt like very little support was being given to them or the condition they were suffering from. By not having one central approach, people were not being informed of the work being done to support approaches to treating Long Covid at a local level. We could, and should, have initiated single points of contact in each health board area sooner, so that at the very least those suffering from Long Covid would have regular communication from a point of contact within their health board area.

230. In addition, elective care has clearly faced some of the most significant impacts during the pandemic. While it was difficult to resume elective care due to emerging variants and waves of the pandemic, I believe the Government could have done more centrally to help coordinate and support the resumption of elective care. For example, we could have considered 'ring-fencing' specific sums of money purely for the purposes of

resuming elective care, as has been announced recently. This may well have incentivised health boards to resume elective care earlier and provided the adequate financial support to do so.

231. There are also lessons to be learnt about how the health service better coordinates elective care across health board boundaries. Although service level agreements do exist between health boards, a more centrally coordinated process could ensure maximisation of any spare capacity.

232. Our healthcare system is still not utilising digital technology as well as it could and should be. For example, we know that accessing face-to-face GP appointments continues to be a concern for a number of people across Scotland. There are, quite astonishingly, still GP practices where a person will have to phone up at 8am and wait in a queue in order to receive a call back from the doctor. Where virtually every other service allows the use of digital technology, such as apps, to book appointments, our primary care access is still very much in the analogue age. That must change, and Government must continue to work collaboratively with the profession to incentivise the greater use of digital technology.

233. There is also far more that could and should be done to recruit healthcare staff from overseas. While immigration is a reserved function of the UK Government, there are possible supports we can put in place to help health boards recruit, in an ethical manner, from overseas, such as creating a central 'one-stop-shop' for immigration advice for healthcare workers. This would be helpful both for workers who wish to come here from overseas, and in terms of providing support to health boards in relation to navigating the complexities of the immigration system, possibly even by supporting them with the necessary paperwork and sponsorship requirements. This is going to be crucial for the future if we are to have the workforce required for our population needs. While it is right that we 'grow our own', given our population demographics we will need overseas recruitment to help meet our future healthcare demands.

234. I do not think it is my place, as a witness, to suggest recommendations to the Chair of the Inquiry: those recommendations will of course be for the Chair to determine. I do however hope that this statement, alongside any oral evidence I am asked to provide, will be helpful to the Chair in her deliberations. I look forward to reading the

recommendations of the Inquiry, and have no doubt they will help to inform any response to a future pandemic.

Statement of Truth

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

Signed: Personal Data

Dated: 16 August 2024