Witness Name: Jeane Freeman

Statement No.: 3

Exhibits: JF3

Dated: 18 July 2024

UK COVID-19 INQUIRY

MODULE 3

WITNESS STATEMENT OF JEANE FREEMAN

In relation to the issues raised by the Rule 9 request dated 18 March 2024 in connection with Module 3, I, Jeane Freeman, will say as follows: -

1. I am Jeane Freeman of the University of Glasgow, University Avenue, Glasgow, G12 8QQ where I have held a part time post since November 2021 and am currently Dean of Strategic Community Engagement and Economic Development. In the preparation of this statement, I have referred to records and material provided to me by the Scottish Government. I have also received assistance from the Scottish Government Covid Inquiry Response Directorate, solicitors taking my statement via interview and other appropriate assistance to enable the statement to be completed. I have also been assisted in identifying documents and factual information relevant to the questions being asked to assist in the preparation of my statement. However, any views or opinions expressed in this statement are my own.

2. Prior to entering politics, I trained and qualified as a nurse on leaving school and subsequently completed my degree in 1979. From 1981 to 1985, I was General Secretary of the British Youth Council. I founded Apex Scotland, which is an employment organisation for people with a criminal record, in 1987 following a feasibility study in 1986. I was Chief Executive of Apex Scotland from 1987 to 2000. I was a senior civil servant working in education in Scotland from 2000 to 2001 and was then appointed as Senior Policy Special Adviser to Rt Hon Jack McConnell and held that post until 2005. Between 2005 and 2015, I held a number of public appointments on the Parole Board for Scotland, the Judicial Appointments Board, the Scottish Police Authority and was Chair of the NHS Scotland Golden Jubilee National Foundation for 7 years until 2015. A former member of the Labour Party, I was in no political party until 2015 when I joined the SNP. In May 2016

I was elected to the Scottish Parliament as MSP for Carrick, Cumnock and Doon Valley. In May 2016 I was appointed as the Minister for Social Security within the Scottish Government, and I held this role until June 2018. As part of this role, I led the establishment of Social Security Scotland, including the underpinning legislation under the newly devolved social security powers. In June 2018 I was appointed the Cabinet Secretary for Health and Sport. I held this role until May 2021. I had no involvement with the Scottish Government's response to the pandemic after that point.

3. Unless stated otherwise, the facts stated in this witness statement are within my own knowledge and are true. Where they are not within my own knowledge, they are derived from sources to which I refer and are true to the best of my knowledge and belief.

4. References to exhibits in this statement are in the form [JF3/Number - INQ000000].

Ministerial role

5. My responsibilities as Cabinet Secretary for Health and Sport included the NHS and its performance, staff and pay, health and social care integration, patient services and patient safety, national clinical strategy, quality strategy and national service planning, allied healthcare services, carers, adult care and support, child and maternal health and sport and physical activity. I was supported by the Ministers for Public Health, Sport and Wellbeing and for Mental Health. From January 2020 to May 2021, during the Covid-19 pandemic response, I was primarily responsible for Health and Social Care policy.

6. The National Health Service (Scotland) Act 1978 ("the 1978 Act") places a duty on the Cabinet Secretary to promote a comprehensive and integrated health service. As Cabinet Secretary I was responsible for setting strategic direction, while operational responsibility lay with my officials. That changed on 17 March 2020 when I put the NHS on emergency footing using powers under sections 1 and 78 the 1978 Act, a decision which was driven by my desire to secure greater cohesion of response across Scotland along with greater accountability. I considered that, as we were now facing a global pandemic and national emergency, it was necessary to ensure that every aspect of the NHS in Scotland was facing in the same direction. The scale of the problem, along with the ever-changing nature of the crisis, meant that both strategic and operational leadership was required in order to determine which areas should be focussed on. I was also of the view that it was important that the public knew who was responsible for making decisions which would frequently impact upon every person in Scotland.

7. Following my announcement of 17 March 2020, a joint letter by DG Health and Social Care (DGHSC) and the Chief Executive of NHS Scotland was issued to all Chairs and Chief Executives of Health Boards underlining that I would use emergency powers where necessary to instruct Health Boards to carry out certain actions to maintain the resilience of the NHS [JF3/01 – INQ000145709].

8. In my view, the NHS in Scotland was well equipped to operate as a single unit in the event of an emergency as a result of the unique way in which it is structured. In 2004 the NHS Reform (Scotland Act) Act was approved by the Scottish Parliament enacting the 2003 proposal to remove the Trust structure in Scotland along with the internal market which had been legislated for in 1990 by the UK government. The internal market and Trust structure remains in place elsewhere in the UK. When Scotland moved away from that model a significantly different governance and accountability structure from that pertaining elsewhere in the UK was established. The NHS in Scottish is not designed nor structured to create competition between Health Boards and is rather intended to be a cohesive system with collaboration and learning between Boards actively promoted and delivered. In addition, there is a more direct relationship in Scotland between the Health Secretary and NHS Scotland underpinned by the 1978 Act. This meant that the entire system was easier to direct and lead when it was put on an emergency footing.

9. As outlined above, the NHS was put on an emergency footing in large part to ensure consistency across the entire service during the pandemic. In the context of our rapidly evolving understanding of the virus and its impact, guidance was regularly issued by the Scottish Government including by the Offices of the Chief Medical Officer (CMO), the Chief Nursing Officer (CNO) and of the Chief Pharmacist (CP), NHS Scotland bodies such as Public Health Scotland (PHS) and where appropriate, the Royal Colleges and Antimicrobial Resistance and Healthcare Associated Infection Scotland ("ARHAI").]

10. The Scottish Government issued a range of clinical guidance over the course of the pandemic. This included clinical guidance for nursing home and residential care residents and also guidance on clinically vulnerable groups and shielding. The position I took was that all clinical guidance issued by the Scottish Government and other bodies as noted, was to be followed and we did not classify guidance as being "mandatory" or "non-mandatory". There could be no basis on which those without clinical experience could challenge clinical guidance, especially within the context of an emergency response to a global pandemic with significant implications for the health of the Scottish population. Therefore, my approach was that all guidance, informed by clinical and scientific advice,

should be followed. An example of an instance where guidance issued by the Scottish Government and another body were in conflict is detailed in paragraphs 183-185.

11. Bodies which were important points of contact and liaison for me when I was in office included PHS, health and social care trades unions, the Convention of Scottish Local Authorities ('COSLA'), Scottish Care, Health Boards and their Chief Executives, health trade unions and representative bodies including Royal Colleges, Astra Zeneca, Pfizer, the First Minister's Advisory Group on Covid, Scottish Care, the Lord Advocate and the Care Home Relatives Group. Regulatory bodies such as the General Medical Council (GMC) were also important liaison and where appropriate, permission bodies.

12. During the pandemic response, I attended or convened many "deep dive" meetings which covered subjects such as testing, vaccines, Scotland's Proximity app and the redesign of unscheduled care.

13. It is difficult to describe a consistent or typical daily work pattern during the period in question, given the rapidly developing understanding of the virus, its transmission and impact and the need to drive capacity across all areas of NHS and where possible, adult social care whilst also responding timeously to new challenges and pressures. Monday to Friday, my usual day began around 6.30/7 am when I would leave home to travel to St Andrews house in Edinburgh. The journey there and the return journey home was used to read documents, take decisions where required and deal with any parliamentary business. It was also the time to receive the first overnight or end of day statistical updates and updates from clinical advisers. Thereafter, each day had 'fixed points' which would include a morning meeting with the First Minister and CMO to discuss the current situation including infection levels and NHS capacity, preparation for the lunchtime media briefing, a follow up review. Alongside this there would be parliamentary business including Committee appearances and various meetings and deep dives with officials and advisers to monitor progress on key areas such as testing capacity or vaccine roll out. I would normally begin the journey home around 7pm, again using the travel time for paperwork, updates and on occasion, calls with colleagues in COSLA, trade unions or Scottish Care.

14. At the outset of the pandemic weekday daily media briefings covered the weekends as well but as the pandemic progress I generally undertook the Sunday media briefings as required. Saturday and Sunday were both working days with statistical, clinical and operational updates, media requests, and preparation for the week ahead.

The approach in Scotland

15. I think that it is important to set out some of the wider context which I consider to have been important in ensuring a collaborative, effective and informed response to the pandemic in Scotland in the relevant period.

16. Firstly, decisions of the Scottish Government were principally taken collectively by the Cabinet which worked in an extremely co-operative, collegiate way albeit with robust discussion. Throughout the pandemic, my Cabinet colleagues and I sought to understand the problems that we were each facing and work together in order to find solutions to those problems which aligned with the overall aim to protect the Scottish population from the harms of Covid-19 and minimise the loss of life. Importantly, we did not operate on a 'win-lose' basis, even though it would often be the case that compromise was required. Rather, we overwhelmingly sought to assist one another in reaching our common aim.

17. One notable feature of the approach taken by the Scottish Government to decision-making during the pandemic was that we, collectively and consistently, prioritised the direct risk of Covid-19 to health in Scotland over other important policy areas and considerations. This approach continued after the introduction of the Four Harms Framework which identified the four main categories of harm caused by Covid-19 being; i) the direct health impacts of Covid-19, ii) non-Covid-19 health harms, iii) societal impacts and iv) economic impacts.

18. My Cabinet colleagues and I well understood the importance of the wider harms caused by Covid-19, hence the introduction of the Four Harms Framework. We also understood that the harms were interlinked and that equality considerations cut across all four areas. However, we consciously and consistently prioritized the reduction of direct harm caused by Covid-19 throughout the course of the pandemic. While there were occasionally debates about this within Cabinet, we never deviated from the collective position that there was no equivalence between the four harms and that preventing direct harm caused from the virus was our paramount concern. In practice, this meant that even radical steps to prevent direct harm from the virus, such as lockdowns, would be taken whenever it was deemed necessary. Steps would then be taken to find mitigations in relation to the other harms. For example, purchasing private provision to increase NHS Scotland capacity and assist in ensuring that NHS resource would remain dedicated to emergency care and cancer treatment throughout the pandemic was an attempt to mitigate non-Covid-19 related health harms. Another example was the creation of community based Covid-19 health and dental pathway hubs to allow primary care to continue to operate for non-Covid-19 related healthcare, with extra resource to roll out video consultations and extend

Pharmacy First to provide additional clinically safe routes for primary health concerns and advice.

19. Collaboration during the pandemic built on the good working relationship already established with Cabinet colleagues and the Cabinet itself continued to operate on a hybrid basis. Even at the height of the pandemic, I would see the former First Minister on a daily basis at St Andrew's House and would regularly meet or be in touch with other colleagues. As restrictions eased, I would see Cabinet colleagues at regular meetings and most days of the sitting week in the Scottish Parliament. In Parliament, our Ministerial and Private Offices are all located beside each other which facilitates frequent contact and collaboration and a more informed understanding of what is happening on a daily basis beyond our own portfolio interests.

20. Similarly, Scottish Government Directorates and Divisions do not operate independently of one another but rather constantly communicate and work together in pursuit of common goals. This was particularly the case during the pandemic, in which officials worked across policy areas, and moved into new policy areas, to ensure the most effective response. For example, a new Covid Public Health Directorate was created in DGHSC comprised both of officials with public health expertise and of officials from across the Scottish Government who brought a diverse range of experience and skill to bear.

21. The ethos of the Scottish Parliament lent itself well to co-operation in the face of the national, and indeed global, emergency presented by the Covid-19 pandemic. I constantly had conversations with opposition MSPs in order to update them on the current position and with the support of my Private Office made sure that all MSP Covid-19 related queries or questions were acknowledged and responded to as swiftly as possibly. Throughout the pandemic, I provided regular briefings to the opposition parties which increased in frequency over the course of the pandemic. I also provided direct MSP briefings on issues such as testing and the vaccine rollout. MSPs were the first point of contact for members of the public who were, understandably, concerned by everything that was going on. Therefore, I felt that it was important that MSPs were fully informed and had up-to-date information to share with their constituents. I considered this to be an important communication channel from the Scottish Government to the public, but it also worked effectively the other way around. I found that keeping MSPs informed increased the amount of information which came back to the Scottish Government from local communities via their elected member. We received a great deal of feedback, along with ideas and suggestions, which were enormously helpful. Parliamentary Chamber based

business also continued including timetabled sessions of health questions, and emergency and topical questions, which allowed members to question me and colleagues on progress, decisions taken and areas of concern.

22. In addition, the Covid-19 Committee was established by the Scottish Parliament on 21 April 2020 to consider and report on the Scottish Government's response to the pandemic including the operation of powers under the Coronavirus (Scotland) Act, the Coronavirus Act and other primary legislation, and any secondary legislation, in relation to the response to Covid-19. Its successor, the Covid-19 Recovery Committee was established in June 2021.

23. All of the parties were represented on the Covid-19 Committee, providing an opportunity for them to scrutinise draft legislation. The members were regularly briefed by Scottish Government advisers and officials, affording another way to inform MSPs and provide up-to-date information.

24. A unique feature of the distinctive health infrastructure in Scotland, and one which made a significant contribution to the pandemic response, is the existence of National Services Scotland ("NHS NSS"). Amongst other functions, NHS NSS acts as a procurement arm for the whole of the NHS in Scotland. NHS NSS has tried and tested procedures in place with regards to the due diligence of suppliers, pricing, quality control, distribution and supply of a wide range of medical supplies and equipment and has longstanding, trusted relationships with a diverse range of suppliers. This gave Scotland a number of strategic advantages in responding to a global health emergency. For example, with regards to the procurement of PPE in the context of global shortages, NHS NSS was able to bring economies of scale due to the fact that it acted on behalf of the entire NHS in Scotland enabling more sustainable and cost effective supply routes. This meant that Scotland did not need to operate a fast-track system for any new supplier. Where new suppliers were needed, the standard tried and tested NHS NSS procedures for due diligence, quality control and pricing applied. The experience and expertise of NHS NSS was also deployed to increase distribution to primary care and adult social care, developing and improving new order and distribution routes over the course of the period. With the aid of the then Scottish Government Minister for Trade, we were also able to deploy NHS NSS to develop a domestic supply route providing increased security of supply and new jobs.

25. The role of NHS NSS was also critical in managing our PPE stock as it was able to track both the source and destination of all items of PPE in Scotland. I personally received a

daily sit rep on levels of PPE held in stock and on order and could directly question any areas of concern and take steps to address. The information provided by NHS NSS to me covered each item of PPE, current volume, current order volume and new deliveries expected. A traffic light system to highlight any critical areas was essential to the proactive approach to the supply and distribution of PPE across healthcare settings taken in Scotland and the fact that we were able to supply all aspects of primary and social care settings with PPE from bespoke ordering and distribution routes.

Ministerial Working Relationships in Scotland

26. As Cabinet Secretary for Health and Sport, I was a member of the Scottish Cabinet which met at least weekly as the key decision-making forum of the Scottish Government. I attended meetings of the Scottish Government Resilience Room ('SGoRR') as relevant to my portfolio, which was consistently the case throughout the Covid-19 pandemic. I also convened the Mobilisation Recovery Group from 28 August 2020, Covid-19 Strategic Issues meetings, which were chaired by the First Minister under SGoRR conditions, and attended deep dive meetings which were chaired by the First Minister and involved members of the Covid-19 Advisory Group ('C19AG') - with Sir Jeremy Farrar (16 December 2020) and on scenario planning (4 February 2021).

27. The primary individuals involved in reaching key political, administrative and where appropriate operational decisions on health within the Scottish Government were the First Minister and myself with advice from our clinical and civil service advisers. The First Minister was responsible for the overall response to the Covid-19 pandemic. The Deputy First Minister was responsible for the resilience structure. My responsibilities during the Covid-19 pandemic were specifically in relation to the response by the health and social care sector.

28. Our overarching objective as the Scottish Government was, as far as possible, to protect the Scottish population from the harms of Covid-19 and minimise the loss of life. The overarching principles guiding core political and administrative decision making within the Scottish Government in this period were as set out in the Framework for Decision-Making published in April 2020, which provided the following;

Safe	We will ensure that transmission of the virus remains suppressed and that our NHS and care services are not overwhelmed.
Lawful	We will respect the rule of law which will include ensuring that any restrictions are justified, necessary and proportionate.
Evidence based	We will use the best available evidence and analysis.
Fair & Ethical	We will uphold the principles of human dignity, autonomy, respect and equality.
Clear	We will provide clarity to the public to enable compliance, engagement and accountability.
Realistic	We will consider the viability and effectiveness of options.
Collective	We will work with our partners and stakeholders, including the UK Government and other Devolved Nations, ensuring that we meet the specific needs of Scotland.

29. As above, between January 2020 and May 2021, I worked very closely with the First Minister to reach key political and administrative decisions in relation to the management of the pandemic in Scotland. I met with the First Minister during this time at least twice per day. These meetings were in person. We would also on occasion make phone calls to each other to follow up on previously agreed actions and discuss any developments or new information which had occurred or been received. There would also be additional in-person meetings depending on what was required at any given time.

30. In my role as Cabinet Secretary for Health and Sport, my working relationship with the Deputy First Minister was principally through Scottish Cabinet and SGoRR meetings. I did not have regular one-to-one meetings with him. We would both attend the Scottish Cabinet and SGoRR meetings, and we were both part of the First Minister's Advisory Group on Covid-19.

31. I worked closely with the Ministers of Health, Sport and Wellbeing; Joe Fitzpatrick until 18 December 2020 and, subsequently, Mhairi Gougeon in operationalising key political and administrative decisions concerning the management of the pandemic in Scotland. In addition, I also worked closely with Clare Haughey in her role as Minister of Health with responsibility for mental health. Between January 2020 and autumn 2020, the frequency of meetings with the individuals mentioned above depended on the work required in any specific circumstance or area. Towards the autumn of 2020 and leading into 2021 I had regular meetings with all of above individuals in order to provide updates within the overall health portfolio.

32. I also worked closely with Kate Forbes, who was the Cabinet Secretary for Finance at the time. Other Cabinet Secretaries had respective roles within their portfolios which involved key decision-making. For example, the Finance Secretary would liaise with the UK Government on issues of funding. We spoke regularly about funding in relation to the Scottish Government's response to Covid-19 as far as that affected areas within my portfolio.

33. I worked closely with Ivan McKee who was the Minister for Trade at the time, specifically in relation both to the international procurement of personal protective equipment ('PPE') and the creation of a domestic PPE supply chain and had important assistance from Graeme Day, Minister for Parliamentary Business in monitoring the PPE helpline we established and issue resolution. I liaised closely with Michael Russell, Cabinet Secretary for Cabinet Secretary for the Constitution, Europe and External Affairs in the lead role he undertook for government in liaising with the Scottish Parliament on all Covid related legislation and the scrutiny supplied through the Covid-19 Committee.

34. The group of key decision-makers within the Scottish Government and their advisers had a close, trusting and effective working relationship. I believe this positively influenced the manner in which the Scottish Government managed the pandemic as it ensured that, as far as possible, the Scottish Government responded cohesively and timeously to new information, made strategic decisions based on the best available evidence and implemented those decisions as effectively as possible.

Official-Level Working Relationships

35. The key civil servants with whom I worked most closely during the pandemic response were the Chief Medical Officer ('CMO'), the Chief Nursing Officer ('CNO'), the Chief Pharmacist ('CP'), the Director General of Health/Chief Executive NHS Scotland

(‘DGHSC’), the National Clinical Director (‘NCD’), the Special Adviser for the Health portfolio, my Private Office and the Private Office of the First Minister. I also worked closely with John Connaghan who was the Director leading DCOO at the start of the pandemic and who was both Director for Performance and Delivery and Interim Chief Executive of NHS Scotland between May and December 2020 and then was designated as Chief Operating Officer (COO), NHS Scotland in January 2021 until June 2021.

36. There were a number of inter-governmental fora which provided clinical and scientific advice during the pandemic. As there were multiple groups operating in parallel, I would receive all key information and advice from key clinical and scientific advisors. While there may have been a risk of information overload given the volume of information, and the necessarily frequent updates to that information, I remain firmly of the view that it was essential for me to have all relevant information in order to allow me to make appropriate decisions. Being able to analyse large volumes of often complex information and then form the judgments necessary for decision-making is part of the job of a Cabinet Secretary in normal times and even more so during a global public health emergency.

37. I believe that the advice I received from the Chief Scientist (Health), CMO and Deputy Chief Medical Officers (‘DCMO’), the CNO, the CP, the NCD and John Connaghan in his various senior operational roles during the course of pandemic was clear and transparent. Our working relationship was open, focused and frank. I expected and received full information including where uncertainties lay, advice on considered best response in any given situation and importantly, challenge.

38. Between January 2020 and May 2021, I and the officials working within my area of responsibility consulted with NHS Boards, both Chairs and Chief Executives, Scottish Care, COSLA, the Royal Colleges, universities delivering medical, nursing and AHP education, health and social care trade unions and representative bodies such as the British Medical Association (‘BMA’), the Royal College of Nursing (‘RCN’) and the Royal College of Midwives (‘RCM’). Where appropriate, liaison and discussion was also held with the GMC, the Nursing and Midwifery Council and the Medicines and Healthcare products Regulatory Agency (MHRA). In other portfolio areas, Ministers would consult with relevant stakeholders and, where there was feedback or information provided which was relevant to health or social care, that would be timeously provided to me. Frequent and effective consultation was very important as it allowed the Scottish Government to ensure that information from stakeholders was properly considered in core decision-making. It was also important to understand what these stakeholders needed in order to help them deliver

on decisions made by the Scottish Government. I would feed back to the First Minister directly or at Cabinet meetings, following these consultations.

39. Specifically in relation to the patient experience within the healthcare system during the pandemic, I had access to information and advice from regular discussions with trades unions working in the health and social care sectors, the Care Home Relatives Group, Scottish Care, the BMA, the Royal Colleges and COSLA. In addition to this, the Director General for Health and Social Care, the Chief Executive of NHS Scotland, the COO of NHS Scotland and the former Minister for Public Health, Joe Fitzpatrick were in regular contact with the NHS Scotland Health Boards. Information from these conversations was fed back to me where relevant.

40. The lead minister in relation to our national resilience structures and systems, including our overall relations with local government and COSLA, was the Deputy First Minister. In my role, I had regular and frequent contact with Councillor Stuart Currie who was the COSLA representative for health and social care and had regular discussions with the trades unions which operated within local authorities as well as Scottish Care.

Four Nations Working Relationships

41. From the outset, the Scottish Government committed to a four-nation approach to handling the Covid-19 pandemic. It was the stated intent of all four nations to minimise the levels of harm and death caused by Covid-19, as far as possible, with the shared and understood proviso that where it was judged that a different approach was in the best interests of the population each government had responsibility for, and there was a scientific, clinical or demographic rationale for that judgment, then any one of the four nations may deviate. This was outlined in the Four Nations Plan which was agreed by and applied to all four nations of the UK. [JF3/15 - **INQ000057508**

42. Where differences in approach arose between the four nations, this was often due to our respective infrastructure and geographies which are very different from one another. In particular, the NHS in Scotland, and to some extent the social care sector, is different to the system which operates in England. It was not always appreciated by the UK Government how these differences might impact upon aspects of policy implementation, such as in relation to the delivery of the vaccine. In addition, the structure of the NHS is not uniform across the four nations. As discussed above, the removal of the internal market in Scotland allows the Scottish system to be a more cohesive system which

enables greater accountability particularly in the context of an emergency response. This allowed for a greater level of two-way direct contact between me as Cabinet Secretary and any one of the key stakeholders. The relevant legislation is clear that the Health Secretary in Scotland is responsible for the NHS in Scotland and there is no separate body, such as NHS England, with comparable powers or direct responsibility and accountability. In addition, the most senior civil servant in Scotland in charge of civil service work on the NHS is also Chief Executive of NHS Scotland and so the relationship between government in Scotland and the NHS is a direct one.

43. Where the Scottish Government communicated that it may make different decisions from that of the UK Government, there was no significant disagreement or push back from my colleagues in the other nations. I recollect conversations with Matt Hancock in which, on occasion, there was disagreement. We disagreed on the respective allocation of testing capacity within the Glasgow Lighthouse Laboratory for example and on the advisability of 'Eat Out to Help Out' scheme. There could, of course, be a degree of challenge in such conversations. However, there was clarity and acceptance from the outset that each Government would act in a way that they considered to be in the best interests of those they represented. That agreement was in my view correct and helpful but there were situations, where the disparity of powers between the four Governments meant that the decision of one could impact on another in terms that were not helpful. For example, in a situation where we in the Scottish Government considered, based on the evidence and advice before us, that a longer or new period of lockdown was needed, the necessary financial support for business and individuals could only come with agreement of the UK government. If they did not share our view that a longer or new period of lockdown conditions was necessary for England, no financial support would be made available to Scotland, thereby effectively curtailing our capacity to act in what we considered to be the best way to protect the population we serve.

44. Where the UK Government or other Devolved Governments made decisions that were different to the approach we were taking in Scotland, I would seek to understand why they wanted to take a different approach to that of the Scottish Government. I would then look to see what steps we could take to mitigate against any confusion or misunderstanding which might arise, particularly in relation to public messaging.

45. In broad terms, my experience was that engagement between the Scottish Government, the UK Government and the other Devolved Governments worked reasonably well. I would note at this stage that, as public health is fully devolved with only a very few

exceptions such as the regulation of medicines, my relationship with my UK government counterparts was clearly defined and facilitated a more equal relationship. I know that was not always the case for colleagues working in areas where critical aspects are reserved to the UK Government, for example, in relation to the extension of the furlough scheme or controls on inward travel to the UK.

46. From the beginning of the pandemic, planning was based on the reasonable worst-case scenario and was led by the respective Chief Medical Officers who in turn took advice from SAGE and the various Covid-19 advisory groups which were established. This expert advice, and associated modelling, guided our operational decisions, for example, as to how many ICU and other hospital beds would be needed in the event of the reasonable worst-case scenario. The modelling undertaken was critical with respect to symptoms, likely impact on the population overall, impact on sections of the population and level of hospitalisations, including for critical care. The expert advice came to all four Health Secretaries and so all decisions were taken based on the same understanding. On the whole, I believe that each of the respective Health Secretaries took similar decisions throughout the relevant period, albeit from the perspective of what they considered was in the best interests of their own nation.

47. Between January 2020 and May 2021, I had direct contact with the respective Health Secretaries across the four nations in relation to the management of the pandemic in Scotland and in their respective populations. We discussed where policy positions differed across the four nations in relation to health and explained the reasons for these differences. In particular, there were regular meetings on Thursday evenings which involved the Health Secretaries from the four nations and on occasion, their respective ministers. I would always have an official present. At these meetings, we discussed issues such as the performance of the Lighthouse Laboratory network, including where there were backlogs in the processing of tests in a particular laboratory and how that impacted on process times elsewhere across the four nations. There were also occasions when some disagreement arose, for example with regards to the delivery of the vaccine. There was a desire from all four Health Secretaries for the vaccine to be made available on the same day in all four nations. However, problems arose in identifying a date which was suitable for all. The date which was favoured by Matt Hancock for delivery of the vaccine in England was not viable for both Scotland and Northern Ireland due to the respective geographies of the latter two nations and the difficulties which would be encountered in providing the vaccine to remote communities. Agreement was ultimately reached through

discussion and a desire to reach consensus and this is a good example of the four nations seeking the same outcome but negotiation being required in order to achieve it.

48. A further example of collaboration and communication was the creation of the Mutual Aid agreement with regards to PPE. From the beginning of the pandemic, there was huge international demand for PPE which created the risk that one or more of the four nations could run out. The Mutual Aid agreement provided that, in such an event, one of the other nations could provide PPE to the nation which required it. Any PPE provided in this way would then be replenished when the recipient received their own supply. Scotland provided PPE in this way to both England and Northern Ireland.

49. As Cabinet Secretary for Health and Sport, I attended Cabinet Office Briefing Room ('COBR') meetings at the invitation of the UK Government on 24 and 29 January and on 5 and 26 February 2020. I also attended subsequent meetings on 2, 4, 9, 12, 16, 18 and 23 March, 9 and 16 April and 10 May 2020. I attended three meetings of the Healthcare Ministerial Implementation Group, chaired by the UK Secretary of State for Health, 24 March, 2 April and 9 April 2020. I also occasionally deputised for the First Minister on Four Nations calls with the Chancellor of the Duchy of Lancaster. [JF3/02 - INQ000056163] [JF3/03 - INQ000425550] [JF3/04 - INQ000056215] [JF3/05 - INQ000056201] [JF3/06 - INQ000056216] [JF3/07 - INQ000056157] [JF3/08 - INQ000056217] [JF3/09 - INQ000056218] [JF3/10 - INQ000056206] [JF3/11 - INQ000056219] [JF3/12 - INQ000056221] [JF3/13 - INQ000056210] [JF3/14 - INQ000056211]

50. Health Ministers from all four nations attended the Joint Biosecurity Centre ('JBC') Ministerial Board and the devolved administrations were represented on the JBC Steering Board and the JBC Technical Board. The JBC was established to provide early warning of Covid-19 outbreaks across the UK, as defined by section 1 of the Coronavirus Act 2020.

51. It is my view that communication between the Health Secretaries of the four nations was generally reasonably good, albeit slow at times.

Challenges to four nations' working

52. First Ministers and Health Secretaries were normally invited to COBR meetings on Covid-19. The Scottish CMO would also be in attendance. The invitation and the agenda for COBR meetings would come from the UK Government. As meetings moved from COBR

to Ministerial Implementation Groups (and later to Covid-O and Covid-S), it was entirely a decision taken by the UK Government as to who was to be invited to each of those meetings. To my knowledge, no explanation was offered as to why the Devolved Governments were not routinely included in these meetings, and it was a source of frustration and disappointment to Ministers in the Scottish Government. Similarly, my understanding is that the chairing of the meetings between Michael Gove and the First Ministers of Scotland and Wales and the First and Deputy First Ministers of Northern Ireland, was entirely a decision taken by the UK Government and I am not aware that the views of the Scottish Government were sought.

53. It is inevitable that, if one of the four nations takes a decision in a manner that fails to consult, consider or treat the Governments of the other three nations as equal, then the effectiveness of a four nations' approach is harmed. It has long been the Scottish Government's position, which was argued pre-pandemic, that the most effective inter-governmental structures are those which are jointly owned. Therefore, handling a public health emergency in a situation where those structures are not jointly owned is less effective than it could otherwise have been.

54. My view remains that inter-governmental structures should be jointly owned by all the governments who are participating. What I mean by that is that there should be equality of access in determining timing, agenda and follow-through action. This structure, along with a much needed significantly improved understanding of devolution on the part of Whitehall Departments and Ministers would in my view greatly assist in facilitating effective inter-governmental relations and a four nations' response in any future pandemic or UK wide emergency.

55. As noted earlier, the structure and governance of the NHS in Scotland differs creates a more direct relationship with the Scottish Government. Whilst NHS Boards have a responsibility to take account of local circumstances and characteristics in their delivery of healthcare, they are expected to meet the requirements set out by the Scottish Government alongside those required by all relevant regulatory and clinical bodies. Also as noted earlier, the 1978 Act provides for the Scottish Government to place NHSS on an emergency footing ensuring further enhancement to that relationship. Nonetheless, Boards could, and I believe did, exercise local discretion when for example, local circumstance of hospital site pressure or capacity did not allow for every aspect of guidance to be followed.

Response to the pandemic

56. As outlined above, I put NHS Scotland on an emergency footing using the relevant legislation in March 2020. This meant that the strategic direction taken by the health service in Scotland was determined by me.

57. I took a number of decisions to ensure that the health service in Scotland was ready to deal with the modelled high numbers of people expected to require hospital treatment, including intensive care, in line with the reasonable worst-case scenario. This included, for example, the cancelling of elective and non-urgent healthcare; the pause on cancer screening programmes, the redeployment of staff to areas anticipating high demand from patients with Covid-19 and arrangements to bring back retired health staff; and bringing into the health service final year medical students and nursing students to supplement the workforce, bearing in mind that the virus would impact healthcare staff.

58. Given the evolving knowledge and understanding of the means by which the virus was transmitted, there was significant iterative work undertaken, based on clinical advice, on the type of PPE needed and to ensure a flow of PPE through distribution routes including additional routes for social care and community-based care settings. As Cabinet Secretary for Health Sport, I was ultimately responsible for this activity, and for the establishment and performance of these distribution routes. National Services Scotland (NSS) National Procurement (NP) is in turn responsible for national PPE contracts in Scotland and was responsible for supplying PPE to the healthcare system during the pandemic through its National Distribution Centre (NDC). NSS was, and still is, accountable to Scottish Ministers, and reported to me in my capacity as Cabinet Secretary for Health and Sport.

59. At the start of the pandemic, NSS distributed PPE based on expected demand, rather than solely by receiving orders from individual health boards. This was known as the 'push' model. This model was adopted to reduce the administrative burden on boards, while ensuring optimum deployment of stock lines that were under greatest pressure. After the initial 'push' period, supply reverted to a 'pull' model whereby NHS boards placed orders with NSS based on their own needs.

60. Health boards, including the Scottish Ambulance Service, were also able to procure their own PPE for use in the pandemic where the central offering did not fully meet the needs of their workforce. This was managed via their local mobilisation plans.

61. PPE was supplied to GP surgeries on a ‘push’ basis. Prior to the Covid-19 pandemic, GPs sourced their own PPE, but with the changes to guidance that resulted in greater demand for PPE, along with a reduced global supply, GPs were supplied from the national stockpile. Supplies for GPs were provided either by direct delivery to the GP surgeries of via a central Health Board receipt point for forward distribution or collection.

62. The Scottish Government supported the provision of necessary PPE via NSS through the Helpline Mailbox. This is described in further detail in paragraphs 200-207.

63. In tandem, work was undertaken to establish a ‘Covid free’ pathway for patients in the community, in order to protect GP and emergency dental services as far as possible for patients who did not have Covid-19, alongside work to significantly increase Scotland's capacity to process Covid-19 tests while retaining a capacity to process other diagnostic tests needed for emergency care or cancer.

64. I believe that these initial decisions and work provided a sound foundation on which Scotland was able both to quickly and effectively respond to the pandemic in the early phase and to adapt our approach in line with the developing clinical and scientific advice.

65. There was considerable understanding within the Scottish Government of the potential wider health, social and economic impacts of non-pharmaceutical interventions (‘NPIs’) which widened and deepened as the pandemic progressed. From my perspective, in terms of health, I understood the risks that we were trying to manage between the impact of Covid-19 on citizens, particularly those identified as highly vulnerable to this particular virus, with the necessary reduction in standard NHS care that would be required in order to cope with the demands of the pandemic. For example, I had taken the decision to pause cancer screening programmes in the knowledge that this posed a significant risk of cancers being undetected. I was very well aware and conscious of the impact this would have given that the screening programmes exist precisely because the earlier cancer is detected, the greater the likelihood is of recovery. But a continuation of the screening programmes in themselves posed a risk to those staffing them and to those attending for screening in addition to diminishing available test processing capacity and the need to redeploy staff. This was one of the hardest decisions I had to take, and I think exemplifies the core dilemma of the response to the pandemic for all governments in that there was no risk free decision available.

66. In the early stages of the pandemic, we did not carry out formal Equalities Impact Assessments ('EQIAs') due to the emergency nature of the response at that time. There simply was not time to go through the processes required to undertake EQIAs given the rapidly changing nature of events. However, the Scottish Government over many years had worked hard to increase understanding of the impact of decisions on different groups of the population. That being the case, the advice I received, and the discussions held did focus on ensuring we were scanning impact as widely as possible in the time constraints imposed. I was also fortunate in being able to draw on my own personal experience and knowledge. As Minister for Social Security, prior to taking office as Cabinet Secretary, I had worked closely with our experience panels and stakeholder groups representing people with disabilities both to establish Social Security Scotland and to update and implement our disability plan designed to tackle the societal and economic obstacles imposed on citizens with disabilities. I knew and had learned from many of the stakeholder groups personally and knew that they would not hesitate to directly contact me if they felt we were remiss in our assessment of impact.

67. My understanding of clinically vulnerable and at-risk groups deepened during the course of the pandemic as new evidence, data and clinical consensus emerged. In particular, I became aware of the growing identification of the clinical impact of Covid-19 on people of different ethnic backgrounds. My awareness of the potential impact on those from different ethnic backgrounds initially came from anecdotal information from the CMO and CNO and media accounts of concerns over what was happening in England.

68. In particular, it increasingly became apparent that BAME healthcare staff required more/different PPE. I have set out, below, further information in relation to the work undertaken by the Scottish Government's PPE Unit in order to better understand the issues in relation to PPE fit for ethnic minorities and for women.

69. I met with Anas Sarwar MSP to on 16 August 2020 to discuss the impact of Covid-19 on Scotland's BAME communicates and on 13 September 2020 I met with the Expert Reference Group on Covid-19 and Ethnicity to talk about the disproportionate negative impacts that the pandemic was having on minority ethnic groups in Scotland.

70. I also received submissions from officials that detailed considerations of the impact of Covid-19 on minority ethnic communities in Scotland. On 25 May 2020, officials provided me with a submission that explored the disproportionate impact of Covid-19 on minority ethnic communities across the UK. This submission noted there was scope for improvements to collection of data on ethnicity in relation to Covid-19 in Scotland and

outlined a proposed programme of work to improve data and evidence collection on this, including work with PHS and National Records Scotland (NRS). [JF3/16 - INQ000480797].

71. Following my approval, this work was progressed, and I received a further submission on 23 June 2020, that included reassurances that work with PHS and NRS was underway to ensure that they were recording and collecting additional relevant data regarding ethnicity data in the course of their routine Covid-19 reporting. This submission is provided: [JF3/17 INQ000480799].

72. From previous work and engagement with organisations providing services and support to groups with particular needs or vulnerabilities, we were alert to potential barriers to our communication of critical health advice to communities which could be either mistrustful of state authority or very distant from statutory bodies and services. In these instances we knew from previous work that community-based and peer advocates were much more effective in working through and around those barriers and so wherever possible we worked with them. Our previous work and links with a broad range of statutory and informal community-based organisations proved invaluable here.

73. As Cabinet Secretary, I received specific advice from my clinical advisers on the impact of NPIs on clinically vulnerable groups. To ensure that I fully understood that advice I would interrogate advisors when necessary to work out how best to communicate that advice to the individuals affected, the public and health professionals and do what was necessary to ensure that other Cabinet Secretaries had the information they needed to provide the practical support necessary for clinically vulnerable individuals and their families to follow the seriously restrictive health advice being given. In addition, I received feedback from stakeholder groups, including those representing disabled people, which provided valuable insights into the lived experiences of people during some of the most restrictive measures. For example, in relation to the impact on critical support packages to independent living, I was made aware of discrepancies across the country and could work with colleagues in COSLA to try to address this.

74. In addition to the consistent flow of feedback, concerns and issues raised and actions taken, the introduction and application of the Four Harms Framework supported structured analysis and decision-making, informed by clinical and wider advice. Inequality was not considered as a separate 'harm', since elements of inequality were relevant to and contributed to each of the four harms in different ways for different groups. The ways in which inequalities were intrinsic to and/or exacerbated were considered as part the four

harms analyses undertaken and submitted to me, and the Cabinet, in the course of our decision-making.

75. Over the course of the pandemic, decision-making was also supported by various types of formal impact assessment including Equality & Fairer Scotland ('EqFSIA'); Children's Rights and Wellbeing ('CRWIA'), Business Regulatory ('BRIA'); and Island impact assessments. The Scottish Government published impact assessments at various stages of the pandemic which provide insights into the considerations relevant to our decision-making.

76. The impact on vulnerable and at-risk groups was assessed through regular EqFSIA and I understand that further information on this system is provided in the corporate statement of DG Communities for Module 2A and that details of these impact assessments have been provided to the Inquiry.

77. From the outset of the pandemic, I appreciated the importance of ensuring that I understood how things were going for those working on the front line. I always considered this to be of critical importance and did what I could to ensure I was kept up to date with the experiences of those workers. In this regard, I received daily updates from the Chief Operating Officer of the NHS, DG Health and Social Care and the Chief Executive of the NHS, and the CNO all of whom were in daily contact with NHS Boards. Through these updates and conversations, I received daily information on, for example, how many ICU beds we had available, what would be required to increase the number of beds, where there were potential gaps in capacity and when issues were likely to arise. I also had frequent contact with PHS who drove a lot of our data, as discussed below.

78. In addition, I had regular contact with those who were working on the frontline through interactions on social media and correspondence sent to my office. I tried to make myself as accessible as possible and to make it as easy as possible for individuals to get in touch with us. The levels of contact we received from frontline workers in this way was fairly consistent throughout the pandemic and was always at a high level. I also had regular formal contact, and also additional informal conversations, with health and social care unions who were able to provide me with detailed updates on the feelings and conditions being experienced by those working on the front line. In particular, I had lots of contact with the BMA, junior doctors' groups, GPs groups and all of the Royal Colleges. I also had regular bilateral conversations with trade unions and professional bodies to discuss a number of workforce issues, including, but not limited to, the Agenda for Change pay deal.

79. I expected and it became clear early on that staff on the frontline were working under enormous pressure. This inevitably had a huge impact on their wellbeing and resilience. Like everyone else they were anxious about their own health and the health of their loved ones. Prior to the pandemic, Dr Dave Caesar, an A&E consultant and Deputy CMO, had been working on staff wellbeing in our NHS and, from that work and his own personal professional experience, he was able to offer critical advice and practical options to help staff as they coped with the high level of Covid-related demand. For example, the introduction of staff break-out rooms close to wards or ICU where staff could take time out from often very highly charged and emotional situations or simply make a drink or have a snack was a small practical measure that I know from feedback made a positive difference. As important was enabling staff at the frontline to use their professional knowledge and expertise to make decisions which in pre-pandemic times would have gone through an NHS Board's sometimes extensive, committee structure. This was effective in empowering those with relevant knowledge and direct experience to address issues and find solutions quickly. This included for example, the swift redeployment of staff between work areas where demand on the ground required that.

80. As noted above, I believed that it was important to ensure members of the public and healthcare workers felt they could communicate with the Scottish Government through their MSPs. I worked hard to ensure this was the case and tried to address issues as speedily as possible when they were brought to my attention. For example, if an MSP raised a particular example in Parliament on behalf of a constituent, we always followed up with the MSP straight away as we considered this to be both the right thing to do and a valuable source of information which if addressed, may prevent the same issue or problem arising elsewhere.

Data

81. Responsibility for public reporting of statistical information and data on Scotland's healthcare system sits with PHS. As Covid-19 was a new disease, it was not part of data reporting prior to 2020. However, core data collections and core modelling were put in place quickly at the start of the pandemic to monitor and forecast the spread of the virus. This helped inform both operational responses and policy development and kept the public informed via Ministerial statements, the frequent media briefings and online publications.

82. 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. This led to

the development of Covid-19 daily data reporting with a core indicator set updated daily from April 2020 on the gov.scot website at 2 pm each day. This included data on:

- Hospitalisations - covering both admissions (data provided by PHS) and numbers of patients in hospital and ICU with Covid-19 (data provided by NHS Boards).
- Cases and testing (data provided by PHS).
- Infection rates (data from the ONS Covid-19 Infection Survey).
- Vaccinations (data provided by PHS).
- Daily deaths (data provided by PHS).
- Weekly registered deaths (data provided by NRS.)
- Number of delayed discharges (data provided by local authorities). This was updated daily until July 2020 and then weekly (on a Thursday).
- NHS staff reporting absent due to Covid-19 (data from NHS Education for Scotland (NES)).
- Schools – data on attendance and absence for Covid-19 related reasons (data provided by SG Education ASD).
- Care homes data covering; data on confirmed cases of Covid-19 amongst care home residents and staff, the number of adult care homes with a current suspected case of Covid-19, Covid-19 related staff absences in care homes and suspected cases in Care homes.

83. During July 2020, the public facing four harms dashboard was launched. This was updated every Monday and Wednesday until March 2022. It presented a variety of indicators covering the four harms to enable the public to understand and access key data used in the four harms assessments. The four harms assessments, drawing on a range of data and evidence, were led by senior analysts to support Cabinet consideration of changes to NPIs.

84. A summary brief covering the headline Covid-19 daily data was shared internally with Scottish Government Ministers and officials in advance of publication each day on the gov.scot website to inform statements made by the First Minister or me in Parliament and media interviews. This also formed part of the daily data I received which included updated data on PPE stock volumes and ordering and, on a regular basis, status reports on care homes and staff levels/absences across the NHS and adult care sector.

85. Analysis and evidence was provided as part of the four harm assessments and regular contributions from analytical teams were also provided for Cabinet papers.

86. As noted, I took clinical advice from the Chief Scientist (Health), CMO, DCMO, CNO, Chief Pharmacist and the National Clinical Director on a regular basis. I rarely challenged this advice but did routinely ask questions to improve my understanding of that advice and how it could best be used in policy implementation and operational matters. A good example is the advice provided by the CNO in relation to nosocomial (hospital-associated) infection and transmission which informed prevention and control measures and the placement of patients into the most appropriate clinical pathway. I would not seek to challenge the clinical basis of that advice but would seek to interrogate it to ensure that my decisions were informed, and that implementation of those decisions was robust to ensure that the risk of nosocomial infection was understood and managed as effectively in practice as possible.

87. My consistent focus throughout was to ensure an effective response by the health and social care sector to the Covid-19 pandemic, in pursuit of the overall objective of the Scottish Government to protect the Scottish population from the harms of Covid-19 and minimise the loss of life.

Increasing Capacity

88. I had no specific discussions about the rationing of healthcare. Clearly the steps taken and noted earlier paused or decreased the availability of some areas of pre pandemic healthcare and were taken specifically to ensure that our acute service was able to cope with the modeled worst-case scenario. The pausing of elective care, outpatient appointments, the pausing of screening programmes, the introduction of community based Covid hubs for primary and emergency dental care were all undertaken to free resource and redeploy staff to ensure we were able to cope in the acute setting including in ICU and HDU, whilst also recognising and taking some steps to mitigate the non-Covid health impacts on the population.

89. We also invited recently retired NHS and social care staff to return in support of these efforts and secured agreement from the academic institutions and regulatory bodies to

deploy final year medical and nursing students to active healthcare duties in a manner that would still allow them to complete their qualification and graduate on their expected date.

90. Additionally the design and build of the NHS Louisa Jordan was commissioned and secured to provide further acute ‘step down’ capacity as back up to the permanent acute estate if needed.

91. Our status capacity was constantly monitored directly with our board Chief Executives so that where there were concerns action could be taken to increase resource if needed.

92. As noted, I believe key decisions made by the Scottish Government were effective in protecting the NHS from being overwhelmed during the pandemic. The first decision was to put the NHS in Scotland on an emergency footing under the relevant legislation, which meant that all of our NHS boards would follow the same set of actions, albeit that the operationalising may differ according to local circumstances such as geography.

93. The second decision was to work through and identify which areas of healthcare could be paused; we ultimately retained only cancer and emergency care. Where possible, we purchased beds in the limited number of private healthcare facilities in Scotland to increase our capacity for non-Covid care.

94. The decision to pause certain areas of healthcare allowed us to redeploy staff in the health service inside our acute settings to the area of acute care that Covid-19 would demand. We also asked retired healthcare practitioners to return to work to supplement the workforce alongside the agreement of the relevant Royal Colleges and higher institutions to bring final year medical and nursing students into the NHS workforce in a way that did not compromise them being able to complete their degrees. Next, we established a Covid-19 community pathway for primary care, which would allow GP Practices to be ‘Covid-free’ and continue to provide primary care to their patients, alongside emergency dental care. In tandem, we scaled up the provision and use of Pharmacy First.

95. Increasing capacity in the hospital setting also had to take account of the reduction in bed numbers necessitated by the clinical infection prevention and control guidance on physical distancing. This, alongside the advice on vulnerability of patients to hospital acquired infection including Covid-19 led to the decision to increase the pre pandemic effort to reduce the numbers of delayed discharge patients. The primary reasons for delayed

discharge centered around either the availability of care packages to support home discharge or residential care availability.

96. We also made decisions around ordering volume of PPE and the increase in its distribution routes to not only cover acute settings, but also community, primary and social care.

97. Decisions were made, as noted, to resource growing capacity to process tests and to implement the Test and Protect programme and provide direct health support to residential care settings.

98. Finally, we also made decisions relating to the operationalisation of the vaccine programme.

99. On 11 March 2020, the Scottish Government asked NHS Boards to pause non-urgent elective activity to be able to continue to respond to Covid-19 patients and manage infection prevention and control requirements. On March 2020, I took the decision to pause the five adult screening programmes, including the cancer screening programmes. The decision was based on advice from the CMO and informed by a range of factors including the need to ensure physical distancing and minimise the impact on essential NHS services as they responded to Covid-19. I had specifically requested further clinical advice (which was provided on 18 March 2020) on the risks of pausing the three cancer-related screening programmes and an assessment of the level of staff resource released as a result, with information as to where those staff would be deployed including evidence of need in the proposed areas of redeployment. Key risks identified were delayed Bowel Cancer, Breast Cancer and Cervical Cancer diagnoses as well as the (statistically very small) possibility of Abdominal Aortic Aneurysm rupture. The decision to pause involved careful consideration of all of the risks involved, including the risk of screening programme participants becoming infected. The overall assessment within the advice was that the five national screen programmes should be paused to reallocate screening programme staff to support other essential services within Boards, including 52 laboratory staff assist in higher priority laboratories and minimise contact travel (Cervical and Breast) and reduce pressure on general practice (Cervical). The assessment also highlighted that staffing shortages were already arising as people became unwell or were self-isolating, meaning it was difficult to sustain screening services and that individuals were already choosing not to attend appointments. A structured pause would help ensure that people do not miss their screening altogether, rather it is delayed. The clinical advice has previously been provided to the Inquiry: [JF3/17A - INQ INQ000250654].

100. As a result of the level of aerosol-generating procedures within dental settings, activity within that sector was particularly impacted and therefore unable to respond to population need. Informed by specific advice from ARHAI Scotland, NHS dental teams were also required to stop, pause, and adjust patient services in the light of IPC guidance in March 2020. A regular series of letters from the Chief Dental Officer provided updates to the sector on the Scottish and UK Government's response to the pandemic and how this impacted the delivery of dental services. Practice teams were involved in formulation of specific advice to patients as part of wider communications on accessing health care during the pandemic.

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

102. In tandem with the decision to pause certain aspects of healthcare, NHS Boards were asked to prioritise critical and life-threatening care and A&E Departments remained open with measures in place to maintain physical distancing and a triage system to ensure that all 'walk in' patients were seen in the most appropriate healthcare facility or service. Hospitals adopted a 'red' (Covid) and 'green' (non-Covid) pathway system and implemented physical distancing measures in wards, patient and staff areas.

103. In addition, in March 2020, a decision was taken to utilise private hospital capacity for the treatment of urgent elective procedures and urgent cancer cases as hospital capacity was limited. This was based on the clinical need to have a standalone facility to deliver healthcare to the most urgent patients, predominantly cancer patients. The utilisation of this resource enabled urgent surgical cancer procedures to continue during the pandemic response in an environment not directly involved in the treatment of Covid-19, effectively preventing the risks posed to cancer patients of being treated in facilities used by Covid-19 patients.

104. Taken together, the pausing of non-urgent elective activity; the prioritisation of critical and life-threatening care; and the treatment of urgent elective and cancer cases in private facilities made a significant contribution to the overall aim of increasing of capacity in NHS hospitals in expectation of the reasonable worst-case scenario. For example, some emergency departments had tripled the number of beds in use at this time.

105. On 14 May 2020, John Connaghan, Interim Chief Executive NHS Scotland, wrote to NHS Boards requesting planning for the phased restart of services, with responses by 25 May 2020.

106. On 20 May 2020, guidance was issued by the Scottish Government to Health Board Chief Executives outlining what we expected Boards to do to ensure Covid-19 resilience for ICU and general acute beds. This was informed by up-to-date activity tracking and modelling and was designed to ensure the safe and incremental restart of some paused activity, whilst maintaining appropriate Covid-19 resilience planning and protecting support for social care. NHS Boards were expected to include an update responding to this expectation in their remobilisation plans.

107. John Connaghan wrote to NHS Scotland Chief Executives on 8 July 2020 setting out the process for local decision-making on paused non-urgent elective activity until the end of July 2020. To monitor Health Board reductions from October 2020 onwards, weekly templates were submitted to the Scottish Government's Planned Care Policy team.

108. On 21 December 2020, John Connaghan wrote to Health Boards regarding preparations for January 2021 and maintaining critical services in response to the restrictions announced on 19 December 2020. The letter advised that boards could pause all non-urgent elective and routine services during January and February 2021 to help free up capacity to manage service pressures.

109. As noted, the decision to pause healthcare services, as well as decisions to remobilise and recover services, influenced staff availability and redeployment in the relevant period.

110. A submission sent to Ministers, including myself, on 3 June 2020 provided an assessment of the workforce implications arising from the first–phase mobilisation plans of NHS Boards including an assessment of risk, competing pressures and emerging challenges.

111. NHS Boards have operational responsibility for deploying staff in accordance with their service provision responsibilities. Mutual aid arrangements exist for the provision of support between Health Boards. The Scottish Government did not directly oversee these. However, guidance on sourcing staff to allocate to areas of most need was issued to Boards on 28 April 2020, provided: [JF3/18 - INQ000469963] (*Delivering a whole system response to Covid-19: Guidance for the deployment of Health Board staff to community settings*).

112. In order to respond to the workforce challenges arising from the pandemic response, there were active recruitment campaigns for much of the acute phase and recruitment by the NHS in Scotland in 2020, 2021 and 2022 significantly outstripped mean average recruitment rates in the preceding decade. In particular, the demand for staff within ICU settings increased during Covid peaks, with the demand in elective care reducing when those services were suspended, enabling redeployment of staff to areas of priority need.

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

Increase in ICU bed capacity

114. As Cabinet Secretary, I made a statement to the Scottish Parliament on 17 March 2020 indicating that, while progress to double Intensive Care Unit ("ICU") capacity was well advanced in Scotland, the target was to now quadruple the number of ICU beds.

115. I took this decision to ensure that we were prepared for, and could respond to, the reasonable worst-case scenario. On 3 March 2020, I had made a statement in the Scottish Parliament which outlined the reasonable worst-case scenario and modelling, and, on 17 March 2020, I had placed NHS Scotland under emergency measures in light of the resources, such as hospital beds and medical equipment, required to ensure that the NHS in Scotland could meet demand in the event of the reasonable worst-case scenario coming to fruition.

116. On 24 March 2020, I made a further statement to the Scottish Parliament, setting out the plan to quadruple ICU bed capacity in NHS hospitals in Scotland.

117. On 1 April 2020, the former First Minister provided an update to the Scottish Parliament, reporting that a doubling of ICU bed capacity had been achieved and that work was underway to quadruple ICU capacity to over 700 beds.

118. By June 2020, we had reached a total ICU capacity of 585 (against a 173 baseline) , as detailed in a report from the Scottish Intensive Care Society Audit Group report on Covid-19, published on 8 July 2020 and provided [JF3/018A - INQ000390563] In August 2020, the Covid-19 ICU Expansion Legacy Planning Working Group reported that equipment was being procured "with deliveries in tranches by September 2020" to support the quadrupling of capacity to 714 ICU beds. A copy of the report is provided: [JF3/19 - INQ000480820]. In a report submitted to DGHSC in March 2021, the Covid-19 ICU Expansion Legacy Planning Working Group noted that consumables and equipment were in place so that Boards could extend ICU capacity to over 700, subject to staffing. A copy of the report is provided: [JF3/20 - INQ000480802]

119. In April 2021, John Connaghan (DGHSC), Gregor Smith (CMO) and Alex McMahon (CNO) jointly commissioned a short-life working group to consider ICU baseline capacity and associated factors in preparation for winter 2021/22. The group recommended that ICU bed capacity be increased, resulting in the baseline figure being revised from 173 to 203 level 3 ICU beds within NHS Boards in Scotland. Increasing ICU capacity at this scale and pace was contingent on the capacity of the workforce and the availability of specific equipment for use in ICU in NHS hospitals across Scotland.

120. As noted, measures to redeploy and recruit staff were taken to support the planned increase in ICU capacity.

121. In terms of equipment, the unique infrastructure of the NHS in Scotland and close collaboration between the Scottish Government, NHS Scotland and NSS enabled work to commence on the repurposing of operating theatre anaesthetic machines for use as ventilators in ICU.

122. The global shortage of ICU ventilators in March 2020, and the fact that there was no manufacturing base for ICU ventilators in the UK, led the NHS in Scotland to repurpose anaesthetic machines, which had become available due to the suspension of elective surgery, for use in ICU.

123. This innovation was actively promoted by the Scottish Government. In an email of 26 March 2020, the Chief Performance Officer requested all Health Board Chief Executives to commence immediate work to free up as many anaesthetic machines as was safely possible for use as ICU ventilators within the following seven days.

124. As of 28 March 2020, there were 693 anaesthetic machines with integral ventilators available which could be used to supplement ICU ventilation, if required. This was critical in bridging the gap between the number of ICU ventilators available and those predicted to be required in a reasonable worst-case scenario.

125. In addition to the procurement of ventilators and equipment to support ICU expansion in NHS hospitals in Scotland, I am aware that the DHSC procured a UK ICU stockpile of equipment and consumables which was available to the devolved nations on an allocated basis. I understand that up to 8.2% of the UK ICU stockpile was made available to the NHS in Scotland and, while the majority of these supplies were not preferred brands/specifications, NHS Scotland did benefit from the supply of medical equipment that helped to bolster resilience. Two ventilators were received through this route on 3 April 2020 and, by 15 April 2020, 6 ICU ventilators had been received and, by 13 May 2020, 34.

126. However, the DHSC could only confirm on the morning of each day what they had received and were available to deliver. For this reason, we could not include the UK stockpile in any forward planning assumptions.

127. I was provided with daily reports on bed capacity in Scotland, including at Health Board and hospital level, which included the following:

Acute

- Management information published daily by the Scottish Government and PHS on the number of Covid-19 patients in hospital and Covid-19 hospital admissions.
- Internal management information on the number of core sites with acute bed occupancy of 95% or over.

Intensive Care (ICU)

- The number of Covid-19 patients in ICU - sourced from daily NHS Board submissions and published daily.

- Total number of patients in ICU - sourced from Scottish Intensive Care Society Audit Group (SICSAG) management information (from the WardWatcher system).

128. I was not made aware that intensive care capacity had been reached in Scotland at any point from March 2020 onwards. This was primarily because of the impact of other measures, including the first UK lockdown in March 2020 in tandem with the decisions to place the NHS in Scotland on an emergency footing; to pause certain areas of healthcare; to significantly increase ICU capacity, including staffing and equipment; and to establish a 'Covid-free' pathway for primary care.

129. Over time, our knowledge of how the virus was transmitted and mutated developed as did our learning as to the effectiveness of non-pharmaceutical measures aimed at suppressing transmission and minimising prevalence. This was a dynamic process with decisions informed by evolving advice, primarily from SAGE and the SGCAG, and the assessment of wider harms and equalities impacts.

130. At one stage, there was a major outbreak of Covid-19 at a distribution centre of one of the principle suppliers of oxygen in Scotland. This led to some disruption at the time, however, we had resilience planning in place for the supply of oxygen with NHS Boards able to obtain additional capacity from the NSS central stockpile if required. I am not aware of any major issues with the oxygen supply systems in Scotland and can confirm that none of our hospitals ran out of oxygen at any stage.

131. Where there were concerns around the possibility of insufficient medical equipment or supplies, these were raised with me by unions, COSLA, MSPs and the Helpline mailbox. When this happened, the situation was checked and required steps were taken to remedy it.

132. The unique infrastructure of the NHS in Scotland and close collaboration between the Scottish Government, NHS Scotland and NSS enabled a proactive and innovative approach to ensuring sufficient levels of medical equipment and supplies even in the event of a reasonable worst-case scenario.

133. The removal of the NHS surcharge was a matter reserved to the UK Government and so I was not involved in discussions regarding this.

Expansion of telephone services

134. Since the programme launched in winter 2020, Flow Navigation Centres (FNCs) have been established in every mainland Health Board area to offer rapid access to virtual clinical assessment or arrange a scheduled appointment in person. This service is accessed by patients calling the NHS 24 service, who refer patients to the FNC for access to Minor Injury Units, Assessment Areas and clinics where appropriate. The overall aim of the programme is to reduce self-presenting attendances at A&E by 15% to 20% and ensure faster access for those who do require to attend. Through the Redesign of Urgent Care programme, capacity has been bolstered at NHS24, which has seen staffing levels increase by 65% since 2007 and now operates as a 24/7 service. More hospital alternatives are being provided to prevent unnecessary attendances to A&E.

135. The 111 service in Scotland is provided by NHS 24. NHS 24 was constituted on 6 April 2001 and under the National Health Service (Scotland) Act 1978 and the NHS 24 (Scotland) Order 2001, NHS 24 is responsible for the delivery of urgent care triage, and advice when GP, pharmacy or dental practices are closed. The Service also offers health and care information via its own digital services, NHS Inform and the NHS 24 online app.

136. Scottish Ministers are accountable to the Scottish Parliament for the activities of NHS 24 and its use of resources. They are not, however, responsible for the day-to-day operational matters (and founding legislation prevents them from directing NHS 24 in relation to specific statutory functions).

137. NHS 24 expanded workforce and estate and complete system collaboration during the period. This was in response to increased demand on NHS 24 services and the Redesign of Urgent Care (RUC). The service was required to accommodate a 40% increase in workforce at the same time as managing a 44% reduction in seating capacity.

138. During the relevant period, NHS 24 was required to develop a complete system response to the Covid-19 emergency. This included developing and establishing a range of Covid-19 specific channels and assets across the service as the forefront of digital access to self-help advice, including Test and Protect and the National Covid-19 Helpline. Rapid establishment of Covid-19 hubs and community assessment centres in primary care were established to minimise referrals to hospitals. NHS 24 took decisions under their delegated accountability framework to pause or cease some of their business-as-usual activity and redeployed staff and expertise to Covid-19 channels. Accelerated enhancement of NHS 24 digital services including the heavily promoted use of NHS Inform

for all public and professional facing content related to Covid-19. The Chief Executive of NHS 24 and Executive Team of NHS Scotland updated the Sponsorship Team and the Office of the COO through regular engagement including daily and weekly reporting against their Key Performance Indicators (KPIs). Pressures were escalated accordingly.

139. As a result of increased demand and changes to service delivery, SG increased NHS 24's funding by over £20 million for 2021/2022 to support the additional capacity and estate expansion. In August 2020, I approved the proposal for NHS 24 to expand both their estate and their workforce. In delivering this, over 500 people were recruited in 2020/21 and two new sites in Glasgow and Dundee were opened.

Increased use of technology by GPs

140. NHS Near Me is a video consulting service which was in place prior to the Covid-19 pandemic. Initially, it was mainly used in remote areas of Scotland, however, it became much more widespread during the Covid period.

141. The former First Minister and myself, and our officials (including the CMO and NCD) were actively involved in the decision to roll out on the use of Near Me. This included having a delivery plan for procurement of the video consulting platform, communications, training and resources and IT/connectivity requirements. The vision for the use of Near Me was signed off by me.

142. An evaluation of the Near Me video consulting service took place between July and September 2020, with a report published March 2021, provided: [JF3/21 - INQ000480806]. A separate public and clinician engagement exercise was also commissioned by the Technology Enabled Care programme from June to August 2020. In addition, a national Equality Impact Assessment of Near Me was carried out in September 2020, provided [JF3/22 - INQ000480807].

143. Survey data from this work indicated wide support among the public and healthcare professionals for the use of video consultations during the pandemic. The EQIA also found that the option of video appointments offered significant benefits in that it; i) enabled people to attend appointments safely and without risk of infection, ii) improved access to healthcare as a result of the removal of travel barriers, ii) reduced the amount of time people were required to take off work in order to attend appointments and iv) supported the attendance of carers, family members and translators at appointments when required.

144. However, both the survey data and EQIA also highlighted concerns in respect of Near Me in relation to digital access and health inequalities. In particular, barriers were identified in respect of poor internet connectivity, lack of access to the relevant technology, the cost of mobile phone data usage, lack of privacy, lack of IT literacy and communication and language barriers. As a result, appropriate mitigations were put in place including for people where English was not their first language. Through health boards and GP's, interpreters are made available on request for all appointment types. Near Me allowed for interpreters to attend remotely. The Near Me Impact Assessment highlighted having the option of interpreters as one of the mitigations to support digital inclusion. Patient information about Near Me was also translated into over 30 languages.

145. While the Scottish Government provided national guidance and an overarching EQIA, it was a matter for local services to ensure they met their equalities duties when implementing Near Me.

146. I had a strong interest in measures like internet connectivity to promote access and inclusion, and HSCDG supported improvements in that area where it could by providing targeted support to care homes so they could access services. However, overall responsibility for internet connectivity in its broadest sense, along with digital exclusion, was the formal responsibility of a different ministerial portfolio

NHS Louisa Jordan

147. With the establishment of the Excel Unit in London, there was agreement to explore an analogous option for NHS Scotland, in collaboration with on-site military colleagues. The military assessed the Scottish Exhibition Centre (SEC) as a suitable location for the build of a medical treatment facility, as the site offered accessibility, close proximity to hospitals in the West of Scotland, security, established infrastructure and transport links. The decision to create one temporary hospital, the NHS Louisa Jordan, situated at the SEC in Glasgow was taken as a contingency to ensure adequate hospital provision for Covid-19 patients if NHS Scotland's existing estate was fully utilised.

148. The decision to build a new healthcare facility was balanced against the potential that any such facility may not be used, and that existing estate capacity could instead be utilised. Initial modelling undertaken in March 2020 indicated that additional contingency was required. Whilst I believed that the existing NHS estate could cope with the challenges presented by the pandemic, I considered that not to proceed with a temporary facility presented too great a risk in the circumstances.

149. Given the need for temporary hospital provision to be up and running by mid-April 2020, when initial peaks of patient numbers were expected, accelerated governance processes were implemented to take forward approval for the hospital in the form of a submissions provided to the First Minister on 28 March 2020, on which basis agreement to proceed with commissioning was reached. After the decision had been made by Ministers to progress with the hospital and commit the funding, a request was received from the NSS Chief Executive for written confirmation that the funding should go ahead. This enabled contracts to be signed and work to commence.

150. I knew from the beginning of the project that we needed someone with a proven track record of getting things done. I therefore contacted Jill Young who had recently retired as the Chief Executive of NHS Golden Jubilee who agreed to get involved without hesitation. Jill was responsible for delivering the project, along with the interim Chief Executive of NHS Scotland, John Connaghan and the CNO, Fiona McQueen.

151. I would describe the whole operation as astonishing with regards to the speed with which everything came together and the dedication of all of those involved. Every effort possible was taken to ensure a safe working environment and I would describe the site as one of the most Covid-sensitive sites I witnessed during the course of the pandemic. Hotels in the area provided free accommodation to contractors who were working extremely long shifts while other businesses provided food and other supplies.

152. In relation to staffing the temporary hospital, Heath Workforce were aware from the national staffing picture and from the data available from the TURAS portal that there would have been difficulties with fully staffing a large field hospital like the Louisa Jordan alongside the existing estate. Staff were thereafter deployed from West of Scotland Health Boards initially and from other Health Boards across Scotland as required. The Louisa Jordan was not an employing authority, so staff flowed from and through the NHS Boards where the employment contract was held. The Louisa Jordan also had access to staffing via the Accelerated Recruitment Portal commissioned by me and operated by NHS Education for Scotland (NES). Staff recruited through the portal nationally included returning retirees and students. Health Workforce supported calls for clinically trained staff (not working in clinical roles) to be released to the Louisa Jordan.

153. In a press release on 1 April 2020, I confirmed that the temporary facility would be named the NHS Louisa Jordan. The hospital was operationally ready from 19 April 2020, and officially opened on 30 April 2020. The Louisa Jordan hospital had an initial capacity

of 300 beds, with physical capacity to increase up to 1,000 patients; including a high-dependency area with up to 90 beds.

154. It is important to note that it was always intended that any expansion of the facility beyond the initial 300-bed capacity would be taken on a phased basis, with the availability of workforce being a key consideration in any phased expansion of capacity. The national Accelerated Recruitment Portal was put in place to maximise the availability of qualified personnel to all Health Boards across Scotland, including the Louisa Jordan. The portal also facilitated the deployment of healthcare students on pre-registration programmes on paid placement. The redeployment of students on paid placement could and would have been considered had significant expansion of the hospital been required to supplement the total complement of available staffing.

155. Following the opening of the Louisa Jordan Hospital, it was used initially to support the delivery of paused outpatient orthopaedic and plastic surgery consultations, with some 315 patients having been seen by 27 July 2020. Subsequently the Louisa Jordan expanded its activity, seeing some 18,000 patients across 14 specialties by 7 January 2021. The hospital then became a mass vaccination facility. For the Covid-19 stand-up phase of the work, there were 36 staff working at NHS Louisa Jordan, although in the very early days when the facility was being developed there were many more people who were volunteers from other Boards and volunteers from the cohort of people who had retired from NHS Scotland with specific knowledge and expertise required for the development of the facility. For the elective and mass vaccination facility, there were 22 staff working at NHS Louisa Jordan. As noted above, all of these staff were employed by other NHS Scotland Boards.

156. In advance of its use as a Covid vaccination centre, the Louisa Jordan also received Health Workforce Directorate support as part of the national programme to recruit the vaccination workforce.

157. Regular updates were provided on capital and associated revenue costs for the NHS Louisa Jordan to the Cabinet Secretary for Finance and to me. The costs of commissioning/build were incurred through NSS contracts and using existing framework agreements. The total costs of the NHS Louisa Jordan including building, commissioning, operational costs and decommissioning were in the region of £70 million.

158. The NHS Louisa Jordan provided a number of services to support NHS Scotland, including outpatient services across 14 specialties and from three Health Boards: NHS Lanarkshire, NHS Greater Glasgow and Clyde and NHS Ayrshire and Arran. These

services included orthopaedics, diagnostic imaging such as CT scanning and general x-ray, dermatology, oral medicine, plastics, rheumatology, breast clinics and occupational health services. In addition, the National Skills Education Hub established at the NHS Louisa Jordan accommodated training for approximately 4,000 individuals from NHS Boards, the Royal Colleges, universities and colleges, all of whom used the healthcare facilities and simulation opportunities onsite.

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

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

161. The NHS Louisa Jordan was designed to as a medical treatment facility for non-critical care patients, with typical length of stay up to eight days, to help address the anticipated rise in demand for hospital beds within existing hospitals as a result of Covid-19. My additional understanding from the chief executive and CMO at the time was that NHS Louisa Jordan could also have provided the quality of care required to Covid patients who no longer required acute care but a further short hospital period before final discharge.

162. Under the initial license, NHS Louisa Jordan was due to close operationally on 31 January 2021 with decommissioning up to 30 April 2021, however agreement was reached to extend the license to allow ongoing review of the need for the hospital for Covid stand-up, should it be required, and for the operation of the hospital. On 18 March 2021, it was announced that the NHS Louisa Jordan would close on 31 March 2021, with ongoing

activity pertaining to mass vaccination clinics relocated to the nearby SSE Hydro. The decision to close the facility recognised the work undertaken by the 14 NHS Territorial Boards to remobilise following the initial disruption caused by the pandemic, as well as the need to release capacity within SEC to operate as a working events and conference centre. This was important given SEC's expected role during COP26 which ran from 31 October to 13 November 2021. I was provided with a briefing outlining the basis for decision, provided: [JF3/23 - INQ000469991].

163. It is my view that the design, build and operation of NHS Louisa Jordan is a strong testimony and example of dedication and hard work on the part ont only of healthcare staff but also of those involved in its construction and ensuring it was properly equipped. That it was not needed for Covid-19 patients is testimony to the exceptionally hard work and dedication of NHS Scotland staff across the country and our capacity to redeploy existing resource to meet Covid-19 demand. But NHS Louisa Jordan did provide an important service in dealing with a significant number of patients whose outpatient appointments or critical diagnostic tests had been paused as part of our overall Covid-19 response and consequently I firmly believe it provided significant value to patients, NHS Scotland and consequently provide itself to provide value for money.

Use of private hospitals

164. On 20 March 2020 there was a decision to utilise private hospital capacity for the treatment of urgent elective procedures and urgent cancer cases due to limited hospital capacity which was under pressure with Covid-19 admissions. The decision to utilise the private sector during the pandemic was based on the clinical need to have a standalone facility to deliver healthcare to the most urgent patients, predominantly cancer patients.

165. The virus necessitated the reduction and cessation nationally of non-urgent elective procedures to provide appropriate capacity to treat Covid-19 patients within the NHS. Critically, the utilisation of private hospital capacity enabled urgent surgical cancer procedures to continue during the pandemic as they took place in an environment not directly involved in the treatment of Covid-19, thereby avoiding the risks presented to urgent cancer patients of being treated in facilities with Covid-19 patients.

166. The NCD wrote to the independent sector on 1 June 2020 detailing that the implementation of these changes was to be undertaken on a phased timeline with cancer treatment being made available as soon as possible to support the reconfiguration ongoing

in NHS Health Boards. Each hospital had their own contract. The total value of the contracts was circa £13 million per quarter. These were signed off by me as Cabinet Secretary.

167. On 18 June 2020 a request for funding was made, seeking an extension of the agreement to enable NHS Scotland to continue to use private sector hospitals in Scotland from 30 July to the end of September 2020, particularly for cancer patients.

168. During the first wave of the Covid-19 pandemic, NHS staff treated NHS patients undergoing urgent elective procedures, including urgent cancer cases, within four private hospital facilities which were procured for an initial period of three months (until the end of June 2020), which was subsequently extended to 30 September 2020. Owing to increased winter and Covid-19 pressures, capacity within private hospitals continued to be used in a more limited way.

169. There have been long-standing arrangements for NHS Scotland to utilise private sector capacity to treat NHS patients through insourcing and outsourcing. This has been done in a structured and prioritised manner to provide capacity to manage local health services where there are gaps in services or to ensure treatment is provided to avoid delays.

170. From the quarter ending 31 March 2019 to the quarter ending 31 March 2020, there were 8,674 inpatient/day cases for all specialties provided by non-NHS providers for NHS patients. From 31 March 2019 to 31 March 2020, there were 5,917 outpatient appointments for all specialties in non-NHS provider facilities.

171. The arrangement with the private sector was based on the Scottish Government covering the overhead costs of using these facilities. No marginal cost was charged. This was verified by open book accounting, and represented the lowest cost at which these facilities could have been operated. Across four private hospital sites, a total of £20,864,310 was spent on securing continued delivery of services between March and September 2020.

172. This represented a positive outcome for the NHS as it facilitated the treatment of cancer patients, and for the private sector, which would otherwise have been required to mothball their facilities and place their staff on furlough. For the reasons outlined above, I therefore believe this represented an efficient use of resources and good value for money.

Infection Prevention and Control

173. CNOD was primarily responsible for the reporting of and advising on nosocomial (hospital-associated) infection and transmission, which informed infection prevention and control measures and assisted with the placement of patients into the appropriate Covid-19 clinical pathways in the relevant period.

174. Though weekly updates the Healthcare Associated Infection policy team within CNOD, I was made aware of the fact that nosocomial infection was increasing in Scotland prior to the pandemic and this remained a concern throughout the Covid-19 pandemic response. In order to tackle the issue, it was firstly important to build on the Scottish Patient Safety Programme which stipulated that each hospital ward should have a dashboard which outlined inspection levels, trips, falls and any other incident. The dashboards were effectively meant to act as performance charts, with monitoring of Covid-19 levels added once the pandemic began.

175. Hospitals attempted to prevent the spread of Covid-19 from the outset of the pandemic. Early on, separate routes were created for patients presenting at A&E, with patients separated into 'green' and 'red' routes. Patients who were known not to have Covid-19 were put into a green route while those with suspected Covid-19, along with other patients whose Covid-19 status was unknown, were placed into a red route. The route on which a patient was placed should have remained the same throughout their time in hospital, including if they were moved to different sections or wards. There was also guidance which advised that staff should not be moved between green and red sections during the course of their shift. This guidance extended to janitorial and maintenance staff. Different sets of PPE guidance were issued for green and red routes and different rules were imposed regarding social distancing, the spacing of beds and with regards to visitors. All of these measures were aimed at minimising the risk of spreading the virus.

176. Notwithstanding my comments above, it was not always possible to remove all risk of transmission of the virus. While efforts were made to ensure that staff did not move between green and red sections, this could create difficulties with staff rotas and it was sometimes simply not possible from a resourcing perspective. If staff were required to switch between wards, for example, that could lead to an increased risk of transmission of the virus even if all IPC protocols and PPE guidance were followed to the letter. The green and red routes were intended as a means to mitigate the spread of the virus but in reality, it was simply not always possible to remove all risk

177. I did not receive advice at any stage which indicated that healthcare workers from minority ethnic backgrounds were disproportionately affected by nosocomial infection, nor did I receive advice which indicated that healthcare workers in particular roles, such as healthcare assistants, were disproportionately affected.

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

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

180. Testing for healthcare workers was introduced in order to identify cases as early as possible, thus reducing the opportunity for onward transmission to either patients or colleagues. By offering a 'self-test at home' approach, those who tested negative had minimal disruption and those who tested positive were able to isolate immediately.

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

182. The need to better understand Covid-19 epidemiology and emerging evidence to identify any additional infection prevention control measure for consideration was identified by the CNO and CMO in consultation with SG officials and ARHAI Scotland (within NSS). This led to the establishment of the Covid-19 Nosocomial Review Group ('CNRG;) which was an advisory group.

183. The CNRG supported the Scottish Government, and senior clinical advisers by providing expert advice spanning the disciplines of infection prevention and control, nosocomial infection, epidemiology, virology, statistical modelling and clinical advice more generally. This includes making recommendations to CNO and CMO to reduce and mitigate against Covid-19 nosocomial infection, including but not limited to national surveillance, testing, screening, research, guidance and policy.

184. In June 2020, I approved the creation of the Policy Alignment Check (PAC) process. It was critical that guidance produced by other actors, in particular that from Health Improvement Scotland (HIS), which became part of PHS on 1 April 2020, was both aligned to and clearly reflected Scottish Government policy. This was particularly important given the role guidance played in ensuring societal compliance with the range of non-pharmaceutical measures to delay or mitigate the spread of the Covid-19 virus. The PAC process was a process for formal review of guidance and was intended to provide clarity on how confirmation will be given to HPS/PHS that their guidance is aligned with Scottish Government Covid-19 policy.

185. The PAC process was implemented to improve and expedite the process by which the Scottish Government and HIS/PHS were able to coordinate updates to policy and guidance within a fast moving and every changing environment. The process helped provide clarity in in public messaging around the guidance in effect within Scotland, and effectively mitigated instances where guidance and policy may have been in conflict.

186. Further detail on the PAC process is provided in paras 153-160 of the Scottish Government's corporate statement, HSCD01, submitted to Module 3 of the UK Covid-19 Inquiry on 18 June 2024.

187. On the whole, there was very little in the way of guidance or decisions being made by the Scottish Government that conflicted with those issued by other bodies. In practical terms, this generally related to the precise timing or extent of Non-Pharmaceutical Interventions (NPIs) where minor deviations from advice were made. An example of this related to IPC guidance, on 27 December 2021, Scottish Government officials spotted the publication on the Royal College of Midwives (RCM) website of new guidance on what PPE to use in maternity care, provided:[JF3/23A – INQ000492668

188. The guidance outlines the PPE to be worn in maternity care settings, based on whether no Covid-19 was suspected to be present, or whether it was suspected or confirmed. The Scottish Government were not consulted on the production of this

guidance, nor were ARHAI Scotland. The advice was not consistent with existing risk based approaches for healthcare staff in Scotland, where gloves and aprons were not required if there was no contact with blood or bodily fluids, and it did not take account of the differences between the unique needs for IPC in different care settings, such as maternity or emergency.

189. Officials recommended that the CNO discuss this with RCM in a phone call. Following a meeting on 7 January 2022 with CNO and CNOD officials, the RCM confirmed they would amend their publication in line with feedback, and ensure alignment of messages and clearer signposting to current IPC guidance in Winter Respiratory Guidance.

PPE

190. As Cabinet Secretary for Health and Sport I was ultimately responsible for ensuring that the health workforce in Scotland had access to appropriate PPE. As the CNO and CNOD had overall responsibility for IPC in hospitals, she led on guidance in relation to the types of PPE required. The CNO was informed by advice from PHS, SAGE and the Covid-19 Advisory Groups and her office would then distill this knowledge to create guidance. NHS NSS would then be informed as to the types and volumes of PPE required.

191. As noted, in terms of PPE, we had the advantage of a single procurement arm for the whole of NHS Scotland, namely NHS NSS which has a long-standing relationship with the providers and manufacturers of PPE. That being the case, at the very outset of the pandemic and despite very high global demand and associated pricing, we were able to increase the volume of PPE on order. In addition, the stocks of PPE had to increase because we were now supplying it to areas of health and social care not previously supplied from the public purse.

192. The level of global demand and the increased pricing posed severe challenges to health and social care provision outwith hospital settings. Therefore, we took the decision to supply these settings of primary, community and social care directly. We set up new order and distribution routes to enable us to do so and increased our volume demand from suppliers. We also secured the necessary equipment to allow two companies in Scotland to produce items of PPE and, therefore, created a domestic supply chain.

193. The new order and distribution routes of PPE inevitably experienced challenges. I wanted to ensure that we were quickly alerted to any problems and acted to resolve these. I personally received a daily sit rep on levels of PPE held in stock and on order and could directly question any areas of concern and take steps to address these. I was also able to assist in particular cases as a result of the fact that I was being kept updated.

194. On one occasion, I had a very senior clinician from a hospital in Edinburgh contact me to say that he and his colleagues were in the A&E Department and did not have access to the PPE they needed. The daily sit rep that I had received showed me the exact volume of each item of PPE that we had in stock so I could not understand why this PPE was not available. We investigated that evening and discovered that the PPE had been delivered to the hospital but was in a particular cupboard which no-one had told the clinician about and so he was able to access the supplies that he needed. Provision of PPE is the responsibility of the employer. In the case of clinicians, this would be the Health Board, and information on where PPE could be accessed would be provided via internal communication routes, such as through line management. In addition, in April 2020 each health board also had a nominated Single Point of Contact (SPoC) for PPE. The SPoC was responsible for managing PPE supply in their Health Board and were in place to resolve issues, and concerns and to be notified if the normal process is not working well.

195. The ability of healthcare and social care staff to contact me directly, alongside their unions or bodies such as Scottish Care, together with the PPE Helpline and the support of my Ministerial colleague Graeme Dey, then Minister for Parliamentary Business and Veterans, who took on the task of following up issues raised via the Helpline to ensure resolution, meant that I could become quickly aware of any glitches in supply reaching the staff who needed it and resolve these. These various routes and mechanisms were important in a fast moving and complex situation.

196. I believe that the above example is illustrative of the high quality of data (both as to supply and distribution) and the precise levels of co-ordination involved in the management of PPE in Scotland.

197. Social care providers received PPE support during the pandemic through: (i) recouping pandemic-related PPE costs from Scottish Government funding; and (ii) accessing PPE free of charge from local and national PPE Hubs when supply routes failed. The PPE Hubs were supplied by NHS NSS, with governance arrangements set out in a Memorandum of Understanding which was co-signed by Scottish Government, COSLA, NHS NSS, Health

and Social Care Partnerships, the Coalition of Care Providers Scotland, Scottish Care and National Carer Organisations.

198. Due to some services struggling to source PPE, and the size of some organisations, it was decided to bring in a large third-party supplier to purchase PPE which had more reliable supply chains and was able to purchase PPE at lower costs than smaller organisations. This supplier was Lyreco and the Lyreco Framework was set up on an exceptional basis to respond to unprecedented need and was awarded under a Non-Competitive Action (NCA) basis. The contract was awarded on 26 May 2020 and ran to 31 October 2021. There was a significant drop in orders from the beginning of 2021, which suggested normal business supply routes and market prices had stabilised. This correlated with wider understanding of the global market and the improved stability since the beginning of the pandemic, and therefore provided an acceptable justification to end the contract.

199. I commissioned the setup of additional distribution routes, the establishment of the Helpline mailbox, detailed in paragraphs 188-195, and the additional ministerial monitoring of it and support to resolve issues. Between April 2020 and August 2022, I received daily reports on the status of PPE stocks by location and item. These reports moved to twice weekly after August 2020 until I left office.

PPE Helpline

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

201. Correspondence received in the mailbox was triaged by officials within the PPE Directorate and was actioned depending on the content and the correspondent. Each email was categorised for a response and / or further action as required. A copy of the categorisation and triage process for this mailbox is provided: [JF/024 - INQ000470090].

202. In the first instance, staff or members of the public enquiring about availability of PPE were directed to their local Health Board PPE SPOC. Where there were supply or

distribution issues that could not be resolved at NHS Health Board level, the Health Board PPE SPOC engaged with NHS NSS for action and resolution.

203. The PPE helpline mailbox was invaluable in assisting us to understand the issues healthcare staff were facing with regards to PPE. In addition, I had frequent conversations with the healthcare unions who raised issues with regards to the appropriateness of the PPE they were receiving. The unions also had regular discussions with other Cabinet Secretaries and the CNO. These conversations were extremely useful as a means of understanding problems and finding resolutions for them.

204. Whilst the mailbox was open, I received weekly emails which provided me with information on the number of emails received, the number responded to, the number of outstanding responses and the median number of days a response had taken.

205. The table below shows the number of emails received and responded to from the Helpline mailbox and the median processing time for the first month of operation for the mailbox. These emails covered a wide range of issues, but were primarily businesses offering to assist with the production of PPE, concerns and criticism from members of the public about the procurement and use of PPE and, requests from businesses, including social care providers, for PPE supplies.

Date	Number of emails received	Number of responses completed	Median response time
w/c 30 March 2020	365	244	20
w/c 6 April 2020	693	600	10
w/c 13 April 2020	580	542	7
w/c 20 April 2020	233	233	5
w/c 27 April 2020	130	131	1

206. Following the first month of operation for the Helpline mailbox, traffic began to slow and a proposal to close the inbox was shared with Ministers on 8 July 2020, the relevant submission is provided [JF3/25 - INQ000480809] . The slowdown in traffic to the mailbox was understood to be the result of a number of factors, including:

- Stabilisation of PPE stock and supply lines

- The NHS National Services Scotland Social Care PPE Triage helpline
- Expanded local PPE Hubs
- A Single Point of Contact to manage local PPE supply and distribution in each Health Board
- A new SG PPE Division, providing strategic co-ordination in relation to all aspects of the provision of PPE in Scotland.

207. There was concern that closure of the mailbox could create confusion and it was therefore agreed that any emails to the mailbox would be rerouted to a different monitored email address. Therefore, I agreed that the mailbox could effectively 'closed' from 20 July 2020, but any emails that were sent would still be picked up. This would also allow a smooth transition back to it being 'live' should there be a need to restart the mailbox due to second Covid wave during the winter.

208. The Scottish Government's PPE Unit made contact with Health Protection Scotland and the Deputy Chief Nursing Officer in NHS England and NHS Improvement in order to better understand the issues in relation to PPE fit for ethnic minorities and for women. The PPE Unit also carried out a literature review in relation to this subject. Where there were a range of sizing options available for PPE items, NHS NSS bought and made available a wide range making it easier to ensure that the majority of HSC workers could get items that fitted. For example, NHS NSS was providing at least 8 different models of FFP3 by March 2021 and was issuing four sizes of nitrile gloves from pandemic stocks. Where available, products were bought with adjustable attributes. In addition, the Scottish Government, in its PPE Action Plan, published in October 2020, recognised the challenges that had been expressed by some women and BAME individuals who rely on PPE. The Action Plan detailed that work was ongoing to improve users' comfort. A copy of the Action Plan is provided: [JF3/26 - INQ000480810].

209. In 2020, NHS NSS agreed a contract for PPE with a Scottish based company, flowing from collaboration between the Scottish Government, NSS and Scottish Enterprise, to support the supply of vital Type IIR masks, visors and FFP3 masks for HSC workers until summer 2021. This partnership with a domestic manufacturer led to NHS Scotland receiving FFP3 masks to a specification that recognised the staff demographic within the sector in Scotland. A small scale study carried out in late 2020, in which 90% of the participants were female, showed that the overall 'fit pass rate' for this new range of masks was 81.5. The pass rate for comparable models was understood to sit between 55%–63%.

The NHS Scotland supplier also provided teams of expert fit testers to help hospitals introduce the new products quickly.

210. No specific Equality Impact Assessment was produced for the PPE Action Plan as it was an overarching plan, and so it was deemed to be more apt for officials to carry out impact assessments in relation to the different workstreams which were formed following on from publication of the Action Plan. These workstreams formed strands of the PPE Futures Programme. I understand that these work strands conducted EQIAs after I left office.

211. I do not recall receiving information regarding specific difficulties in implementing IPC in the hospital estate. Where such issues arose they would be dealt with by the CNO and her office and would only be raised with me if they could not be resolved within the IPC guidance.

212. A significant number of changes were made to visiting restrictions in hospitals during the course of the pandemic. This was required due to the constantly changing circumstances in which we found ourselves. Whenever a change needed to be made to be made to visiting restrictions, I relied on the expertise of the CNO who had responsibility for IPC in hospitals. The CNO was extremely knowledgeable, and I trusted the advice she provided. It is true that I had the authority to refuse to agree to a proposal made by the CNO, however, I do not believe this would have been appropriate as she was the one with the clinical expertise. My role was to firstly ask questions to ensure I understood the advice I was receiving. I next had to consider how best to put proposals into practice and how to communicate any changes to the public and to healthcare workers. For example, as it became clear that technology was required to ensure that patients had contact with their loved ones, we took steps to ensure hospitals had iPads which would allow people to use FaceTime and we also tried to ensure hospitals had chargers which people could use.

Other matters

213. It was the responsibility of clinicians to assess whether patients with Covid-19 had any rehabilitation needs, the nature of those and types of support suitable, on discharge from hospital. This would be set out in a discharge letter which a patient could subsequently take forward with their GP. This is a process which is clinically driven and is standard practice across Scotland.

214. What is now known as Long Covid emerged as a potential phenomenon which, over time, became better understood in the period before I left office and subsequently much more so.

215. I was informed in a submission of 15 December 2020 that a clinical guideline on the management of people with Long Covid was to be published on Friday 18 December. The guideline had been developed by the National Institute for Health and Care Excellence, the Scottish Intercollegiate Guidelines Network and the Royal College of General Practitioners and provided advice on how to care for people who had signs and symptoms that developed during or after an infection consistent with Covid-19, which continued for more than four weeks and are were explained by an alternative diagnosis. The CMO and Deputy National Clinical Director ('DNCD'), as well as the Scottish Government's Clinical Guidance Cell, Clinical Leads Advisory Group for Scotland ('CLAGS') and Professional Advisory Group ('PAG') had all been consulted during the development of the guideline.

216. It was drawn to my attention that the guideline was largely a non-evidence based guideline, as the evidence on Long Covid was continuing to emerge. A copy of the guideline is provided: [JF3/27 - INQ000480812].

217. In January and February 2021, I met with the DNCD (John Harden) and representatives from Chest Heart & Stroke Scotland to discuss support for people experiencing the symptoms of Long Covid including fatigue, breathlessness and severe headaches.

218. I understood stakeholders to be seeking recognition of Long Covid as a condition within the medical profession and a more holistic response to people experienced the symptoms of Long Covid by medical practitioners, potentially encompassing respiratory rehabilitation, nutritional support and mental health support. I could appreciate their concern at what they perceived as a degree of scepticism within the medical profession of Long Covid as a condition, perhaps fueled by the lack of recognition initially by WHO.

219. There was no specific 'ask' of the Scottish Government. However, we sought to ensure that Long Covid was better understood by the medical profession in order to enable a more holistic response to the condition. We encouraged the BMA to discuss this issue with its members and inform the Scottish Government of any support we could provide.

220. In May 2021, the Scottish Government published an Implementation Support Note on managing the long-term effects of Covid-19 to support delivery of the clinical guideline published in December 2020. The Support Note provided additional targeted information for clinicians and health care teams caring for those experiencing the long-term effects of Covid-19 and is provided: [JF3/28 - INQ000480813].

Do Not Attempt Cardio-Pulmonary Resuscitation

221. I understood there to be a concern that conversations initiated by GPs during the Covid-19 pandemic as to the wishes of patients whether to receive cardiopulmonary resuscitation, in the event that their heart or breathing stopped, were being interpreted by some people that access to ICU was being 'rationed'.

222. The impetus for GPs having early conversations with patients about their wishes came from the Royal College of General Practitioners and pre-dated the pandemic. From time to time, the Royal College would issue a view of what it considered to be good practice. In this case, it was encouraging GPs to have conversations early in a diagnosis of, for example, terminal cancer as to what that patient's wishes were as to treatment in the event that cardiac or respiratory function ceased.

223. I understood the concerns to have arisen because in some instances, GPs had only started to have such conversations with their patients during the Covid-19 pandemic. In the circumstance of general public anxiety about the nature of the virus and the danger it represented these discussions had led to the interpretation by some that these discussions were an indicator that access to ICU was being restricted.

224. In a period of already heightened public anxiety, I appreciated that having a conversation of this nature for the first time during a pandemic response could have increased that anxiety even further.

225. I am not aware of any evidence which shows that the conversations initiated by GPs during the pandemic had an impact on people accessing GP services. However, I think that it is reasonable to assume that some people would have avoided making an appointment with their GP for fear of being deprioritised in relation to ICU care.

226. In fact, it is categorically not the case that ICU access was being restricted in any way by the Scottish Government. No instruction or guidance was issued to GPs or anyone else indicating any such restriction. Specifically, I had announced an intention to quadruple ICU bed capacity in order that the NHS Scotland was prepared for even the reasonable worst-case scenario.

227. On 6April 2020 I agreed a CMO letter to be issued to GP Practices and Chief Executives of NHS Boards by CMO, that clarified that there was no specific requirement to have a DNACPR discussion as part of Anticipatory Care Plan conversations, unless a patient raises it or a clinician feels strongly that they need to discuss it. This letter was issued on 10 April 2020, provided: [JF3/29 – INQ000315587]. The Anticipatory Care Plan template was simplified to try and avoid duplication of more general information gathering and was designed to capture essential information to allow clinicians to record this in the centralised Electronic Key Information Summary (eKIS) system, an electronic register containing up to date information including patient wishes and latest treatment decisions that helps reduce the risk of patients having to relay their palliative care wishes repeatedly.

Communications

228. The core of the Scottish Government's public communications strategy was to provide as much validated information as possible to the Scottish public. Throughout the pandemic, evaluation of public messaging consistently demonstrated high levels of public trust in the Scottish Government.

229. I considered the 'Stay at Home, Protect the NHS, Save Lives' message to be helpful. However, I became aware that there was a significant reduction in the use of certain aspects of the NHS in Scotland including attendance at A&E departments and urgent cancer referrals into secondary care. The CMO, for example, indicated that there had been a 72% reduction in urgent cancer referrals during the former First Minister's statement on 20 April 2020. I wondered at this point if the message to 'stay at home' was working too well and had inadvertently had the effect of preventing people who should have continued to access NHS services from doing so.

230. In April 2020, the Scottish Government launched the 'NHS is Open' public campaign to address any perception by the public that they should not present to the NHS for fear of catching Covid-19 or because they did not want to be a burden. The campaign message "If It's Urgent, It's Urgent" ran from 24 April to 7 June 2020 and was aimed at the general

public. An evaluation of the campaign showed a positive impact on both urgent cancer referrals and A&E attendance.

231. Throughout the pandemic, including at daily briefings, the Scottish Government encouraged people to continue to seek help for urgent health issues and that surgeries and hospitals were still open to the public for non-Covid-19 conditions.

232. PHS continued to publish weekly statistics on A&E attendances throughout the pandemic and to publish quarterly statistics on cancer waiting times, including numbers treated within each quarter. I received weekly capacity and pressures reports which included a range of performance, demand and activity indicators to monitor pressure on the system.

Shielding

233. Throughout my time in office, the clinical advice I received was clear and I received frequent updates from the CMO and NCD with regards to vulnerable groups. My role was to work with Health Directorate colleagues, along with Cabinet colleagues responsible for other portfolios, to ensure we provided clear guidance to those affected and their families. In addition, along with my colleagues, I sought to ensure that those affected had access to practical support measures and that employers understood and were able to provide appropriate support where required.

234. At the start of the pandemic, on 18 March 2020, the definition of clinically extremely vulnerable ('CEV') was decided collectively by the CMOs of each of the four nations. The initial groups considered to be at highest risk from Covid-19 infection were as follows:

Group 1 – Solid organ transplant recipients
Group 2 – People with specific cancers
Group 3 – People with severe respiratory conditions
Group 4 – People with rare diseases
Group 5 – People on immunosuppression therapies which increased risk of infection
Group 6 – People who are pregnant and have significant heart disease

235. Aware of concerns of others not falling within these categorisations but still 'at risk' due to individual health conditions, clinicians in the community were given the ability to identify patients who they thought were at highest risk but did not fall into the existing six groups

of people identified by the Chief Medical Officers, and a 'Group 7 – Clinician-identified' cohort was established. Further to that decision, an Identifying Clinically Extremely Vulnerable Group was established early in the pandemic in Scotland to liaise with the CMO's office on the definition of groups at highest risk of severe illness or death from Covid-19 on an ongoing basis as new evidence emerged.

236. I also frequently liaised with colleague MSPs and others in order to gain a better understanding of the types of conditions people felt should be included in the Shielding List. As mentioned above at paragraph 20, I believe that MSPs provided an essential communication channel to the Scottish Government and these discussions allowed for questions to be raised as to which conditions were included and also for people to make a case for certain clinical conditions to be added to the list. Following on from such discussions, I would consult the CMO and his colleagues for advice. My role in determining whether or not any specific condition in question was included was to raise the issue with the CMO as quickly as possible so they could consider the available evidence, in conjunction with the other CMOs and offer recommendations accordingly.

237. People with Downs Syndrome were first considered for addition to the Shielded Patients List in July 2020, however, upon reviewing the available evidence at the time the four UK CMOs concluded that there was insufficient evidence to add them at that point.

238. The four UK CMOs reviewed additional evidence that was later produced from the QCOVID model which showed that 90% of people with Downs Syndrome were within the top 2% of risk of death from Covid-19, and, so on 30 September 2020, unanimously agreed that the list of conditions associated with CEV people should be expanded to include Down's Syndrome and that they be added to the Shielded Patients List too. Further detail on the background of this decision was provided in an advice note, produced by DGHSC on the back of the meeting between the four CMOs where they discussed the updated QCOVID model data and made this recommendation in respect of people with Downs Syndrome. This note is provided: [JF3/31 - INQ000109794].

239. In March 2020, the Scottish Government's Shielding Programme was established to identify, protect, support and advise people considered to be at the highest risk of severe illness or death should they contract Covid-19. A Shielding Division was formally established from July 2020 onwards and was re-named the Covid Highest Risk Division in June 2021, following a decision on 28 June 2021 to rename the Shielding List to the 'Highest Risk' List. The Shielding Division eventually merged into the Covid Ready Society

Division in August 2022, following the closure of the Highest Risk List in Scotland in May 2022.

240. On 26 March 2020, the CMO issued the first of a series of letters to approximately 100,000 people initially identified to be added to a Shielding List. In her letter, the CMO asked those people to self-isolate for the next 12 weeks, as they were deemed to be at extremely high risk from Covid-19, and advised them that they should either work from home or not attend work if working from home was not possible. The letter was based on, and consistent with, the letters issued across the other three UK nations. Further letters were sent to more people as they were identified as extremely high risk from Covid-19 during the course of the following weeks. People could use the letter from the CMO, which was called a 'shielding notification', to show employers that they could not attend their workplace; it acted as a FIT Note.

241. In the week of 23 March 2020, the Shielding Policy Team began working with Local Resilience Partnerships, multiple retailers and others to put in place a package of support to help people who were asked to shield including rapidly establishing:

- a national helpline
- a shielding page on NHS Inform
- an SMS service for shielding
- a shielding page on NHS Inform
- a national food box service
- a volunteer-led distribution service for people to access their prescriptions and medicines.

242. In May 2020, the Clinical Leads Advisory Group ('CLAGS') was set up and chaired by the Scottish Government on the request of the DNCD, Dr John Harden, who took on the role as the Clinical Lead for Shielding in May 2020. CLAGS was comprised of specialist clinicians with expertise in the conditions covered by the shielding categories and provided advice, information, data, proposals and outline approaches to the DNCD and the Shielding Division. On 29 May 2020, a further letter was issued by the CMO to individuals who had been asked to shield, extending the shielding period for a further four week period and as of 8 June 2020, the total number of people on the Shielding List was at 180,017. On 20 July 2020, the CMO issued a further letter, advising that, due to the low infection rate in Scotland, it was safe to further ease restrictions including allowing people who were

shielding to meet more people outdoors, and meet indoors with up to eight people from two other households.

243. On 31 July 2020, following clinical advice, I took the decision to pause the Shielding Programme and that people on the Shielding List should thereafter follow the advice provided to the general population advice, including that people on the Shielding List could now attend work, if they were not able to work from home.

244. On 7 September 2020, I took the decision to offer vitamin D to everyone on the Shielding List. While the CMO's advice was that it was not clinically necessary, I was keen to make this offer having asked people to stay indoors during the summer months [JF3/30 - INQ000147409].

245. On 30 September 2020, the four UK CMOs agreed to the addition of adults with Down's Syndrome and people with Chronic Kidney Disease stage 5 to the Shielding List in accordance with the UK Clinical Review Panel Recommendations informed by the interim data from the Covid-19 model which was based on the application of a risk prediction model from Oxford University [JF3/31 – INQ000109794].

246. On 23 October 2020 Scotland's Strategic Framework, with five protection levels, was published [JF3/32 – INQ000339830]. The Scottish Government provided enhanced advice at each of the protection levels for people on the Shielding List in relation to shopping, working, distancing and meeting with other households.

247. On 10 December 2020, the Scottish Government announced the establishment of a £15m Flexible Fund to support Local Authorities in 'Level 4' areas to provide enhanced support to people at highest risk. On 8 February 2021, an additional £15m was added to the Fund, targeted at people at highest and higher clinical risk, older people or disabled people.

248. On 16 December 2020, a decision was taken by the CMO to add people with liver cirrhosis (Child-Pugh class B and C) to the Shielding List [JF3/33 - INQ000470020] following a recommendation from the UK Clinical Review panel for Shielding Patients.

249. On 21 December 2020, following a change in advice due to rising case numbers, the CMO issued a letter advising that all of mainland Scotland was to be placed in 'Level 4' from 12.01am on Boxing Day [JF3/34 - INQ000470021]. That letter acted as a FIT note.

250. On 5 January 2021, mainland Scotland re-entered full ‘lockdown’ to reduce the opportunity of infection from a new, more transmissible strain. Those on the Shielding List strongly advised by the CMO to work from home or not attend work. [JF3/35 - INQ000470022].

251. On 20 January 2021, people on the Shielding List were offered a first coronavirus vaccine dose by mid-February 2021 and, if 80 years of age or over, by 5 February 2021.

252. On 31 January 2021, additional support with transportation to vaccination sites for people on the Shielding List was arranged and communicated in order to support safe access to vaccination clinics and, on 1 February 2021, a new medicine delivery service is launched to provide support to the clinically extremely vulnerable, which ran until 31 March 2021.

253. On 22 March 2021, the CMO issued a letter encouraging people to continue to follow the extra advice at each protection level and that, from 26 April 2021, it is expected that people on the Shielding List in Level 4 areas will be able to return to their workplaces. [JF3/36 - INQ000470027]. On 24 March 2021, people on the Shielding List were prioritised for PCR testing.

254. On 6 May 2021, the CMO issued a letter to those on the Shielding List to let them know that their adult household contacts were being asked to come forward for their vaccination [JF3/37 - INQ000470029].

255. It was after I left office that the decision was taken on 28 June 2021 to rename the Shielding List, of approximately 185,000 people, to the ‘Highest Risk’ List in light of the fact that the Scottish Government was no longer asking people to shield and the name was causing some confusion.

256. Due to the rapid nature of the introduction of shielding as a measure to protect those people, it was not possible to carry out an Equality Impact Assessment (‘EQIA’) in advance of implementation. However, an interim EQIA of the support required by people who were at the clinically highest risk of severe illness from Covid-19 was carried out at the beginning of April 2020 and is produced [JF3/38 - INQ000256754]. This EQIA highlighted a range of ways in which people with protected characteristics could be negatively impacted by the

shielding policy and sets out recommendations to mitigate these outcomes, or highlights where there were already mitigations in place.

257. In November 2020, a retrospective EQIA was carried out as a follow up to the interim report from April 2020, produced [JF3/39 - INQ000147447]. This EQIA found a number of negative impacts had arisen across equality groups as a result of the pandemic, whilst others were potential outcomes of the introduction of shielding policies. These included, but were not limited to, disadvantages for the roughly one in four people in Scotland who face challenges with literacy in accessing communications about the policy and victims of domestic violence living in refuges, homeless people and people with insecure leases who faced changes of address during the period in which shielding was advised. The Shielding Programme had brought in user researchers and content designers early on in the pandemic to engage with people with lived experience of shielding to develop insights that might improve the policy and delivery response to the pandemic. Following the EQIA work the team worked to ensure that communications were accessible and key public health messages were landing as intended. All Shielding communications were also made available in easy read versions, British Sign Language on videos and translated into a number of languages. People whose domestic circumstances were uncertain or changed during the period when they were advised to shield should have been made aware of the need for them to do so by their local authority or by their GP or clinical teams.

258. The Shielding Division also carried out Children's Rights and Wellbeing Impact Assessments, Data Protection Impact Assessments and Business and Regulatory Impact Assessments which were all published.

259. In addition, the Shielding Division contributed to EQIAs carried out in relation to the Scottish Government's Strategic Framework, thereby ensuring that consideration was given to any potential impacts of changes to restrictions/guidelines on people with protected characteristics on the Shielding List. For example, all relevant communications relating to testing were designed to be accessible to people with lower literacy levels in English, people whose first language is not English and people with a visual impairment. [JF3/40 - INQ000147453].

260. At the early stages of the Shielding Programme, people were advised to strictly self-isolate in line with a precautionary approach based on the very limited evidence available at the time. It was, however, recognised at this time that strict self-isolation could negatively affect people's mental health and physical wellbeing.

261. For example, early user research by the PHS Shielding Team found some common themes emerging from the lived experience of shielding:

a. Shielding was perceived to be impacting on mental and physical health, households and personal finances.

b. Individual household situations made advice hard to follow; the advice was not tailored to individual circumstances and some people were already adapting the advice to suit their circumstances.

c. There was anxiety about what was to follow the initial 12 week period and household circumstances becoming more complex when lockdown ended.

d. People were experiencing a sense of loss, a desire to retain independence and a feeling of disempowerment.

262. The development of the Shielding Programme was informed by a User Research Team embedded in the Shielding Division which conducted high level engagement with people asked to shield throughout the period April 2020 to April 2022 to inform policy design and support packages and to embed a deeper understanding of lived experiences of shielding. This produced insights from early May 2020 into the realities of shielding [JF3/41 - INQ000147410]. As a result of this work, the Scottish Government decided to amend its approach to shielding from May 2020 informed directly by the experiences of people asked to shield in the initial stages of the pandemic response. The basis for, and nature of, this change in approach is set out in submissions to me dated 20 May and 29 May 2020, provided in [JF3/42 - INQ000261982 and JF3/43 - INQ000261395] respectively.

263. The submission to me of 20 May 2020 proposed widening the criteria for assessing risk and harm since some degree of shielding was likely to be necessary for many months to come. Advice provided prior to that submission had not taken into account the harms arising from shielding *itself* over a long period of time. The submission outlined a need to test the assumption that the harms from the virus outweigh the harms from shielding, stating that "the ask to shield must be aligned to the evidence of risk, and, if possible, evidence from the Scottish context". It identified the need to move to a model where people could make informed decisions which balanced their individual risk with quality of life and set out the responsibilities of the Scottish Government to give people information and tools to allow them to make informed decisions about living with the threat of Covid-19. Beyond information, the submission outlined the practical support required, going beyond food and

pharmacy deliveries to include measures to reduce social isolation and support education, work, digital connectivity and the provision of accommodation.

264. The submission of 20 May 2020 further stated that Scottish Government officials would explore with clinical groups whether there were any modifications of the advice to people on the Shielding List which could be considered for the transition period [being the period where people deemed to be at high clinical risk for Covid-19 were advised to remain shielded whilst the effects of easing the lockdown were reviewed]. It was recognised that, during that transition period, the Scottish Government would need to be able to support individuals who were shielding to make informed decisions about their risk of exposure and to tailor their behaviour accordingly, taking into account considerations such as cognitive ability, including conditions such as dementia, health literacy and deprivation/health inequalities.

265. The submission to me of 29 May 2020 set out how this new approach to shielding would be achieved. On 29 May 2020, it was thereafter agreed by the former First Minister to extend the shielding period beyond the initial 12 weeks due to prevalence levels, but that the new approach to shielding would involve a more individualised assessment of risk.

266. From May 2020 onwards, the Scottish Government continue to conduct and commission research to ensure that the impact of the Shielding Programme was understood and that learning from the lived experience of people who were asked to shield informed the evolution of the Programme. A User Research Directory was created by the Shielding Division which detailed all user research carried out during the lifetime of the Shielding/Highest Risk List.

267. In July 2020, for example, a large online survey was conducted by the User Research Directory in DG HSC to find out more about:

- people's experiences of shielding as measures eased
- the mental health of people shielding
- the information needs of people shielding, particularly as measures eased.

268. In total, 3,033 survey responses were received from people who were shielding, representing a very high response rate, with over 72% of those contacted responding. Key findings from this survey indicated continued high levels of anxiety and fear about

catching Covid-19, concern that guidelines were not being followed by the rest of society and that the shielding group felt forgotten. The survey results also highlighted the practical challenges in following advice, especially if people lived in multi-generational households with people who were key workers, had school age children, or who required or provided care.

269. This work significantly shaped the Scottish Government's Shielding Programme and the results were shared with UKG and the other devolved administrations. For example, it informed the Scottish Government's communications strategy to ensure that timely, accessible and helpful information and advice was provided for as long as was necessary. In addition, guidance on balancing the risks of everyday living was published on 7 December 2020 to help people at highest risk start to make their own risk-based decisions, following feedback that people felt abandoned, scared and continued to 'self-shield'.

270. Between July and August 2020, Health and Social Care Analysis Division ('HSCA') carried out a survey of third sector organisations on support to people at higher risk. Respondents highlighted a range of issues requiring ongoing attention as Scotland emerged from the lockdown, such as access to practical supplies, mental health, the needs of certain groups including carers, longer-term health harms and unemployment [JF3/44 - INQ000414596].

271. HSCA also undertook in-house qualitative research on how local authorities were supporting people at higher risk which identified concerns about the sustainability of support going forward and made useful suggestions about how national and local government could work together in the future. The research was published in November 2020 [JF3/45 - INQ000414595].

272. HSCA commissioned PHS to conduct an evaluation of the Shielding Programme over the period March–July 2020, looking at the effectiveness of the advice to shield, the value of the support offer and lessons learned. Initially, the Scottish Government had asked PHS for rapid survey data, initial findings from which were shared on 12 June 2020. Further research by PHS included reviewing existing literature, data linkage and stakeholder research, the findings from which were published in January 2021 and informed the further development of the Shielding Programme.

273. Key findings included that the Shielding programme correctly targeted people at higher clinical risk of negative Covid-19 outcomes, but that some others who were not included

on the Shielding List, were also at higher risk. It was also not possible to assess whether shielding had a protective effect over and above population-wide restrictions, as it was not possible to know what might have happened had people not been asked to shield.

274. Following the publication of the January 2021 report, the Scottish Government asked PHS to evaluate the guidance and support offered to the highest risk group following the pause in shielding. PHS ran a survey, the findings from which were published in March 2022 [JF3/45A - INQ000326400]. These findings highlighted evidence:-

- of ongoing negative impacts on the lives of people on the Shielding/ Highest Risk List
- of ongoing worry and caution on the part of people on the Shielding/ Highest Risk List
- to suggest that the advice and support offered to people on the Shielding/ Highest Risk List made a positive difference
- of ongoing advice and support needs of people on the Shielding/ Highest Risk List.

275. A large proportion of respondents (77%) to the survey agreed that having been included on the Shielding/ Highest Risk List had made them feel supported. However, socio-economically vulnerable respondents were less likely to have felt supported.

276. In addition, four separate lessons' learned reports were produced by the Covid Highest Risk Division, reflecting the four principal workstreams taken forward by the Scottish Government from March 2022; start-up of the Shielding Programme (later renamed the Covid Highest Risk Programme); risk stratification; clinical policy; and Regional Resilience Partnerships. All reports were produced by members of the Covid Highest Risk Division and based on anonymous feedback from surveys sent to former and current colleagues and former and current stakeholders which had been involved in the various workstreams.

Regulatory Regime

277. I am aware that, in March 2020, Healthcare Improvement Scotland ('HIS') took the decision to suspend its existing acute hospital inspection programmes (comprising of the Healthcare Environment Inspectorate inspection programme and the Older People in Acute Hospital inspection programme) following a request from the Scottish Government to "non-patient facing boards" to suspend non-urgent business and to identify clinically qualified staff and any additional resources that could be deployed to support patient care as part of the pandemic response. The email submission on this is provided: [JF3/46 - INQ000429274].

278. On 30 May 2020, the CNO wrote to HIS requesting the recommencement of hospital inspections focussed on safety and cleanliness and older people. A copy of this correspondence is provided: [JF3/47 - INQ000315565].

279. In June 2020, HIS and the Scottish Government agreed a programme of inspections for community hospitals as they have a similar demographic profile of service users to those resident in care homes which had emerged as an area of significant concern at that time. There were also concerns as to the feasibility of recommencing acute hospital inspections at this stage of the pandemic because of the adverse impact this could have on the delivery of care. A Covid-19 focussed hybrid of the Healthcare Environment Inspectorate inspection programme and the Older People in Acute Hospital inspection programme was designed for community hospitals.

280. In December 2020, the CNO asked HIS to change priority from inspections in community hospitals back to acute hospitals. Covid-19 focussed Healthcare Environment Inspectorate-style inspections commended on 7 December 2020.

281. After considering HIS's proposal, on 21 January 2021 the DCNO wrote to HIS indicating that I had requested that, in addition to the streamlined process of two inspections per month and shorter inspection processes and reporting times, HIS should plan inspections based on intelligence as to nosocomial outbreaks and service pressures. A copy of this correspondence is provided: [JF3/48 - INQ000480818].

282. I understand it to be the case that further discussions took place between CNOD and HIS later in 2021 after I had left office and that the Scottish Government subsequently began sharing information with HIS with regards to nosocomial outbreaks and service pressures prior to inspections taking place.

Lessons learned

283. As noted, my view remains that inter-governmental structures should be jointly owned by all the governments who are participating. What I mean by that is that there should be equality of access in determining timing, agenda and follow-through action. This structure, along with a much needed significantly improved understanding of devolution on the part of Whitehall Departments and Ministers would in my view greatly assist in facilitating

effective inter-governmental relations and a four nations' response in any future pandemic or UK wide emergency.

284. It was clear at the outset of the pandemic that our NHS in-house testing capacity was inadequate. Notwithstanding the considerable and swift effort that was applied to significantly increase capacity in Scotland and as part of the UK wide effort, I believe that increased NHS Scotland core testing capacity and genomic capability should be secured in preparation for any future emergency that may arise. It may be that current work to introduce additional diagnostic testing as part of NHS recovery will provide this.

285. The consequences of Covid-19 and the necessary measure to reduce transmission had a significant effect on levels of anxiety and mental health in the general population and specific groups including young people and those with additional vulnerabilities. The resilience of our population in these terms is for me a significant lesson to be learned.

286. Additionally, we continue to face the major challenge of health inequalities which impact directly on individuals, communities and our NHS and economy. The pandemic simply but importantly underlined the criticality of finding ways to effectively address economic and income inequality and the linked health inequalities our population faces to ensure our population overall has greater resilience to any future health pandemic or global shock.

287. Throughout the pandemic in our NHS and elsewhere, what had been deemed impossibly pre pandemic became possible. For example the use of new technology in GP practices or the devolution of greater decision making to front line staff. It would be regrettable if these and other changes which in fact were improvements to working and delivery, were not sustained and built on.

Statement of Truth

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

Signed: Personal Data

Dated: 18 July 2024