

Tuesday, 19 November 2024

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 2 (10.00 am)
 3 **LADY HALLETT:** Ms Price.
 4 **MS PRICE:** Good morning, my Lady. May I please call
 5 Jeane Freeman, who will take the oath.
 6 **MS JEANE FREEMAN (sworn)**
 7 **Questions from COUNSEL TO THE INQUIRY**
 8 **LADY HALLETT:** Welcome back, Ms Freeman.
 9 **THE WITNESS:** Good morning, my Lady.
 10 **MS PRICE:** Would you give us your full name, Ms Freeman.
 11 **A.** Yes. It's Jeane Tennent Freeman.
 12 **Q.** You have prepared a witness statement for this module of
 13 the Inquiry dated 18 July 2024, and the reference to
 14 that is INQ000493484. I understand you're familiar with
 15 that and have a copy in front of you; is that right?
 16 **A.** I do.
 17 **Q.** I'd like to start, please, with the role of Cabinet
 18 Secretary for Health and Sport and some particular
 19 features of that role during the pandemic.
 20 You became Cabinet Secretary for Health and Sport,
 21 it was a role that you held until May 2021; is that
 22 correct?
 23 **A.** That's correct.
 24 **Q.** Is it right that you had no involvement in the Scottish
 25 Government's response to the pandemic after that date?

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1 with your officials?
 2 **A.** That's correct. Although I should say, if I may, while
 3 the responsibility lay with officials, accountability
 4 for all of it rested with me.
 5 **Q.** Can you explain, please, to what extent that changed,
 6 that divide between strategy for you and operations for
 7 your officials, during the pandemic?
 8 **A.** So the change occurred when I used the emergency powers
 9 of the 1978 Act which allows a cabinet secretary for
 10 health to direct directly, if you like, the National
 11 Health Service in Scotland.
 12 **Q.** And why did you take the step of putting the NHS in
 13 Scotland on an emergency footing?
 14 **A.** Because -- for two reasons. One, I wanted to ensure
 15 that every part of the health service, if you like, was
 16 facing in the same direction. And two, given that it
 17 was a global pandemic, I wanted it to be crystal clear
 18 that I was accountable to the Scottish public for the
 19 decisions made and the performance of the health
 20 service.
 21 **Q.** What did it mean in practice once the NHS in Scotland
 22 was on an emergency footing?
 23 **A.** So in practice it in effect meant that decision-making
 24 at a board level, individual -- we have 14 territorial
 25 boards, as I'm sure you know, and the national boards --

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1 **A.** That's correct.
 2 **Q.** As Cabinet Secretary for Health and Sport, your
 3 responsibilities included the NHS in Scotland and its
 4 performance, staff and pay?
 5 **A.** Correct.
 6 **Q.** Health and social care integration?
 7 **A.** Yes.
 8 **Q.** Patient services and patient safety?
 9 **A.** Yes.
 10 **Q.** National clinical strategy?
 11 **A.** Yes.
 12 **Q.** Quality strategy and national service planning?
 13 **A.** Yes.
 14 **Q.** Allied healthcare services and child and maternal
 15 health?
 16 **A.** Correct.
 17 **Q.** And in this role you were supported by relevant junior
 18 ministers; is that right?
 19 **A.** That's correct.
 20 **Q.** From January 2020 until May 2021, you were primarily
 21 responsible for health and social care policy?
 22 **A.** Yes.
 23 **Q.** In your statement you draw a distinction between
 24 responsibility for setting strategic direction on the
 25 one hand and responsibility for operations, which lay

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1 that decision-making at board level was superseded by my
 2 decisions.
 3 **Q.** The NHS in Scotland was on this emergency footing from
 4 17 March 2020, and it was still on this footing when you
 5 left your role in May 2021; is that right?
 6 **A.** Yes.
 7 **Q.** At paragraph 8 of your statement you describe the NHS in
 8 Scotland as being well equipped to operate as a single
 9 unit in the event of an emergency as a result of its
 10 structure. Can you explain, please, why you consider
 11 that to be the case?
 12 **A.** For a little bit of context, in I think just before
 13 2014, in the early 2000s, we in Scotland, the
 14 government, abolished the internal market for the NHS.
 15 So whilst we have individual boards, they do not compete
 16 with each other for funds or in terms of their
 17 performance. That meant, in addition to the fact that
 18 Scotland is a small country -- there are just over
 19 5 million of us -- you can effectively get everyone who
 20 makes decisions on delivery or on policy into the same
 21 room. For those reasons, NHS Scotland is structured to
 22 operate as a single unit, where the board's discretion,
 23 the individuals board's discretion, is to apply the
 24 national strategy to local circumstances.
 25 So, for example, you would expect in some

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1 instances the application of a national approach to
 2 differ in the highlands or the borders of Scotland from
 3 the more highly populated urban areas of the central
 4 belt. Geography, population distribution, and so on, is
 5 for board to make decisions how they apply national
 6 approach on whatever it might be.

7 **Q.** When he gave evidence in this module of the Inquiry,
 8 Professor Sir Gregor Smith highlighted the lack of
 9 an equivalent of NHS England in Scotland, and he
 10 suggested that the "Once for Scotland" approach was made
 11 more difficult by the absence of a national entity to
 12 oversee the healthcare response to the pandemic.

13 What do you see as the advantages or disadvantages
 14 to having such an entity?

15 **A.** So, I, with respect, disagree with Sir Gregor on that.
 16 I think the "Once for Scotland" approach, which has been
 17 around for some time -- it's been around since
 18 I chaired, myself, a health board -- where it doesn't
 19 operate is actually down to, if you like, human factors.
 20 Where it operates well is in our clinical communities,
 21 where, for example, the pain relief approach that is now
 22 a national pain relief approach in elective surgery,
 23 particularly orthopaedic surgery, was applied across
 24 Scotland as a result of clinical cooperation.

25 I don't believe NHS in Scotland requires

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1 **A.** I believe it did, yes.

2 **Q.** How?

3 **A.** Because -- well, two things. I think, generally
 4 speaking, I'm sure this applies in England and Wales and
 5 Northern Ireland too, but I think -- I can only speak
 6 for Scotland. I think our National Health Service
 7 responds very well to situations of crisis and emergency
 8 where everyone knows what needs to be done, and works to
 9 achieve that end. However, knowing that there was
 10 a central direction to that, both in policy terms and
 11 decision-making and in operation, I think allowed us to
 12 be confident that, with the caveat of that degree of
 13 local discretion that I mentioned earlier, which we
 14 saw -- I know it's a separate module, my Lady, but for
 15 example in vaccine delivery and testing, is another
 16 example -- but with the caveat of that, where you take
 17 account of the different geographies, I think that it
 18 was possible to see that across the health service we
 19 paused the screening programme across Scotland at the
 20 same time, we paused elective work at the same time.

21 Every health board nonetheless focused on cancer
 22 and urgent treatment at the same time. So you could see
 23 that consistency across the service, which also gave the
 24 public a degree of assurance that what was happening in
 25 their area was also happening elsewhere; that they

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1 a separate entity for two reasons. Partly I've touched
 2 on that, but also because I think it's very important
 3 that our National Health Service, which is our highest
 4 spending public service in Scotland, our largest
 5 employer in Scotland, that the direct accountability to
 6 the elected politician, ie the cabinet secretary is
 7 critical, and I don't think you sensibly have
 8 an arm's length body to deliver such a critical service,
 9 because that loses that accountability.

10 Now, there is a legitimate debate to be had in
 11 Scotland about whether or not you should separate out.
 12 At the moment, in one individual, with absolutely no
 13 disrespect to that individual, whoever they might be,
 14 they are both the Director General for Health in the
 15 Civil Service in Scotland, they're also the
 16 chief executive of the NHS in Scotland.

17 There is a legitimate argument that has been
 18 visited from time to time in Scotland, and would
 19 worthily be visited again, about whether or not you
 20 separate those roles. But I think that that's
 21 a legitimate debate, not whether or not we create
 22 a distinct entity.

23 **Q.** Did putting the NHS in Scotland on an emergency footing
 24 bring the greater cohesion of healthcare response and
 25 the accountability which you hoped it would?

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1 weren't better or worse off, if you like, than anyone
 2 else.

3 **Q.** You explain in your statement that clinical guidance
 4 issued by the Scottish Government ensured consistency of
 5 approach --

6 **A.** Mm-hmm.

7 **Q.** -- but that health boards were able to exercise local
 8 discretion, and you give the example of the local
 9 circumstance of hospital site pressure or capacity,
 10 perhaps not allowing for every aspect of the guidance to
 11 be followed. Can you recall any specific instances of
 12 this, of which you were made aware?

13 **A.** No, I can't especially. Certainly it is the case,
 14 slightly later into the pandemic, when physical
 15 distancing became part of the guidance. It is the case
 16 in our older acute hospital settings that was more
 17 difficult to achieve than, for example, in a hospital
 18 like the Queen Elizabeth where the accommodation for
 19 patients is single rooms. Now, arguably you don't need
 20 to take beds out to, then, create that physical
 21 distance. We did have to do that in other hospitals,
 22 which are older and may have four- or six-bedded wards.

23 **Q.** Turning, please, to four nations working, and the
 24 Scottish approach during the pandemic. You set out in
 25 your statement at paragraphs 52 to 54 some challenges

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1 that there were to four nations working and, in
2 particular, you deal with the extent to which Scottish
3 ministers were invited to UK Government meetings. Did
4 any of the concerns you express here have any impact
5 upon the healthcare response to the pandemic in
6 Scotland?

7 **A.** So I'd say two things. I've said in this statement
8 towards the end, and I think also in a previous
9 statement, that genuine four nations working requires
10 equal participation in decisions that are -- that will
11 impact across all four nations. And so the example in
12 my mind at this point -- I'm aware, my Lady, it does
13 stray into a future module -- but it is around testing,
14 where you'll recall the network of Lighthouse labs of
15 which Glasgow had one, where the decision was taken
16 outside of Scotland to divert the processing capacity in
17 Glasgow Lighthouse lab to processing tests from
18 elsewhere in the UK and not tests that were taken in
19 Scotland.

20 That resulted -- that was unknown to us, to me,
21 and I only became aware of it when our drive-through
22 testing facilities could not accept people for tests,
23 couldn't accept people for tests because we couldn't
24 process those tests.

25 Now, the nature of the relationship established
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1 enough beds. That, in normal times, tells you that
2 either your capacity in general isn't sufficient or you
3 have a clinically unnecessary delay in discharge.

4 So during the pandemic, so I always found my
5 meetings with Dr Chung very useful and helpful indeed,
6 him and his colleagues. During the pandemic that was
7 particularly so because they were also, if you like, the
8 providers of on-the-ground intelligence, not only about
9 the rest of the hospital and the green and red
10 Covid/non-Covid pathways but also what was flowing into
11 their particular part of the acute setting, and the
12 triaging, the outcome of the triaging that they were
13 introducing for people who were appearing in A&E who
14 were actually accident or emergency, as opposed to
15 requiring to be somewhere else.

16 So over the piece, not just from him and his
17 colleagues, but generally from other data, that tells me
18 whether my Covid community pathways that we had
19 established are working, how primary care is doing, or
20 whether there's a trend or a blip, which is important to
21 know because that then allows you to direct improvements
22 or change or not.

23 **Q.** You describe in your statement the commitment by all
24 four nations to a four-nation approach to handling the
25 pandemic. You also refer to the four nations plan and

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1 between the four health secretaries was such that it was
2 possible for me to speak to Mr Hancock and resolve that
3 issue, the end result of which was there was
4 an agreement on a proportion of tests at any point would
5 be tests that had been taken in any of our community or
6 other facilities in Scotland would be processed in the
7 Glasgow Lighthouse lab as well as our own NHS Scotland
8 labs.

9 So it resolved the issue, but it was an issue that
10 arose with no involvement from either myself or my
11 officials, and came to my attention via the media.

12 **Q.** In terms of liaison with other stakeholders, it was the
13 written evidence of the president of the Royal College
14 of Emergency Medicine, Dr Katherine Henderson, that the
15 vice president of the college in Scotland met with you
16 on four occasions between March 2020 and February 2021.
17 Were these meetings helpful in keeping you abreast of
18 what was happening in emergency departments in Scotland?

19 **A.** Yes, they were for two reasons, and I think certainly
20 emergency clinicians will describe what happens in A&E
21 as the canary in the hospital setting because it is
22 an indicator of how well the rest of the hospital,
23 including discharge, is working. Because oftentimes you
24 will see A&E has a delay in transferring a patient from
25 an A&E setting into a ward setting because there aren't

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1 the circumstances set out in that plan where there might
2 be deviation for any one of the four nations from the UK
3 approach. Can you give an example of an occasion in the
4 context of the healthcare response to the pandemic when
5 Scotland took a different approach to the rest of
6 the UK?

7 **A.** I don't think there is a particular example, other than
8 perhaps in timing. The rest of the UK paused cancer
9 screening programmes, changed or dropped elective work.
10 The differences were in -- will appear in later modules
11 in terms of vaccine delivery or testing. But, generally
12 speaking, I think in the overall response of the NHS
13 they were comparable across four nations. And of course
14 the four health secretaries regularly met, weekly in
15 fact, via Zoom to discuss how each of us were doing, how
16 our response was going and whether or not there was aid
17 we could offer each other or whether or not there would
18 be differences in how we responded.

19 **Q.** You also refer in your statement at paragraph 43 to the
20 impact of Scotland's reliance on financial support from
21 the UK Government on decisions about whether to deviate
22 from the UK approach. Was there ever a time when this
23 had an impact on decision-making in Scotland about the
24 Scottish healthcare response in particular?

25 **A.** Yes. So in Scotland we wanted, the Scottish Government

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1 wanted an extension of the furlough scheme, which was
2 allowing individuals to -- with a bit more financial
3 support, to do as we asked them to do, which was to
4 isolate at home and so on.

5 **LADY HALLETT:** I'm sorry, I'm going to interrupt,
6 Ms Freeman. I've been into this. The position isn't
7 clear, there are different views, and I don't think in
8 this module we're calling people who have put forward
9 the contrary view as to how clear this view was. So I'm
10 sorry, Ms Freeman, to interrupt you, but I'm afraid
11 we're going to have to move on from that.

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

13 Scotland set out its approach to responding to the
14 pandemic in its framework document published in
15 April 2020, and the Inquiry has heard evidence about the
16 four harms approach in particular.

17 Could we have on screen, please, paragraph 17 of
18 Ms Freeman's statement. That's page 5.

19 And you say:

20 "One notable feature of the approach taken by the
21 Scottish Government to decision-making during the
22 pandemic was that we, collectively and consistently,
23 prioritised the direct risk of Covid-19 to health in
24 Scotland over other important policy areas and
25 considerations. This approach continued after the

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1 about levels of harm and whether or not one could
2 mitigate the harm that you anticipated would be caused
3 by taking a particular decision. And so, whilst our
4 priority was to minimise as far as we could the harm of
5 the virus, including its, if you like, mutating harms as
6 various strains emerged that had slightly different
7 characteristics, the other harms, whether they were
8 non-Covid health or societal or economic, were given
9 full consideration on the basis of how can we mitigate
10 those harms.

11 But what was not the case was that the -- in the
12 four harm approach, that there was equity between the
13 harms. The primary one to focus on was preventing, as
14 far as we could, the direct harm of the virus.

15 **Q.** Turning, please, to Scottish Government workforce policy
16 and guidance on the use of FFP3 masks, which went beyond
17 the Scottish IPC guidance.

18 The Inquiry has heard evidence from Caroline Lamb
19 that there were occasions when, as a matter of policy,
20 the Scottish Government went beyond the IPC guidance and
21 made provision for healthcare workers to use FFP3 masks
22 on a discretionary basis where that was their personal
23 preference.

24 An example of this was a statement issued in
25 May 2020 by the Chief Nursing Officer, the Chief Medical

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1 introduction of the Four Harms Framework which
2 identified the four main categories of harm, caused by
3 Covid-19 being; i) the direct health impacts ... ii)
4 non-Covid-19 health harms, iii) societal impacts and iv)
5 economic impacts."

6 You go on to say the Scottish Government
7 priorities was to prevent direct harm. Do you think
8 that adequate consideration was given to mitigating
9 indirect health harms resulting from Covid-19
10 restrictions, particularly in the early stages of the
11 pandemic?

12 **A.** So I think in advance of the formal introduction of the
13 four harms approach and the assessment of each decision
14 through that approach, I think both myself and the
15 former First Minister, Ms Sturgeon, and her advisers,
16 were very clear on the impact of other health issues of
17 some of the decisions we were taking in response to the
18 pandemic, particularly, for example, in pausing the
19 screening programme, the cancer screening programme.

20 As I've said before in previous occasions, none of
21 the decisions that we were making were risk-free. So
22 none of the decisions that we -- that I recall at any
23 point being presented with were decisions that had, on
24 the one hand, the self-evidently right harm-free choice
25 versus the harmful choice. They were always decisions

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1 Officer and the national clinical director to the effect
2 that, although NERVTAG had decided that CPR would not be
3 classified as an aerosol-generating procedure,
4 healthcare workers and ambulance staff conducting CPR
5 who wished to wear them could wear FFP3 masks and, where
6 that was the case, health boards must ensure that FFP3
7 masks were made available to them to facilitate this.

8 Do you recall there being debate about the
9 circumstances in which healthcare workers should be
10 provided with respiratory equipment such as FFP3 masks?

11 **A.** Yes, I do.

12 **Q.** And when did you first become aware of that debate?

13 **A.** I don't have the exact date to mind but it would be very
14 early in the emergence of that debate. I think you have
15 heard from our CMO that we never wrote out the
16 possibility of aerosol distribution of the virus.

17 Whilst the focus was on droplet transmission, aerosol
18 was never ruled out as a definite no in our minds, so we
19 were open to that.

20 But it was also my view that where there was such
21 a debate, the sensible approach was to go with the
22 professional judgment of healthcare and clinical staff
23 on the ground. It was, if you like, to trust their
24 professional judgment. And whilst the guidance might
25 say one thing, if their professional judgment was that

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1 they should be wearing additional PPE, then we should
2 provide that additional PPE.

3 And we took that approach also into our decisions
4 on the provision of PPE for staff providing adult care
5 at home.

6 **Q.** Did you understand that FFP3 masks were more protective
7 than fluid-resistant surgical masks?

8 **A.** Yes.

9 **Q.** And who was it who briefed you on that?

10 **A.** It would be most likely our national clinical director.

11 **Q.** Ultimately in April 2022, nearly a year after you left
12 your role, a workforce policy was introduced in Scotland
13 which allowed for healthcare worker access to FFP3 masks
14 based on personal preference.

15 When this update about the -- first of all, are
16 you aware of the fact that that happened after your
17 departure?

18 **A.** No, but it sounds like a good thing to me.

19 **Q.** Was that something that was ever either proposed to you
20 or proposed by you to cut through the debate on aerosol
21 transmission when it came to FFP3 masks?

22 **A.** So if we step back to your previous question, I think
23 what I've said is that certainly our national clinical
24 director, possibly the CMO or the Chief Nursing Officer
25 made me aware of the debate around, for example, CPR and

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1 **A.** So, yes, I think I've given you the example of adult
2 healthcare care in the community, healthcare workers
3 providing care in the community.

4 **Q.** Okay, but focusing just for a minute on healthcare
5 staff --

6 **A.** Well, they are healthcare staff.

7 **Q.** Forgive me, if I can just finish -- in hospitals, was
8 consideration given to wider use in that setting?

9 So we've already got the deviation in practice
10 when it comes to specifically CPR. Did anyone ever say
11 to you "We should have a wider discretionary policy"?

12 **A.** Not that I recall.

13 **Q.** Turning, please, to understanding of the
14 disproportionate impact of Covid-19 on ethnic minorities
15 and the increased risk for minority ethnic healthcare
16 workers, is it right that a submission to you in
17 May 2020 identified the need for improved data
18 collection on ethnicity in Scotland?

19 **A.** Yes.

20 **Q.** And part of the problem was that the "ethnicity" field
21 on the form completed within the NHS in Scotland was not
22 mandatory; is that right?

23 **A.** That's right.

24 **Q.** Can you help with why limitations on ethnicity data
25 collection within the NHS in Scotland in particular had

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1 the feeling on part of some staff, perhaps all staff,
2 that regardless of the guidance they should be wearing
3 FFP3 masks. And as I've said, my view was that we
4 should go with their individual professional judgment
5 and trust that.

6 Certainly my position as a non-clinician is it is
7 not for me to make that decision for someone who is on
8 the front line making those decisions for themselves.

9 And I think as the Inquiry has heard before, where
10 CPR begins in a hospital setting, the journey of the CPR
11 is known. You are going to start with chest
12 compressions, but you are going to move through --

13 **Q.** I can stop you there, Ms Freeman. On that particular
14 guidance and that particular exception that was limited
15 to the context of CPR.

16 **A.** Yes.

17 **Q.** So, in terms of a wider application of the approach,
18 that the IPC guidance may say one thing but in terms of
19 looking after the confidence and looking after the
20 well-being of your staff and looking to anxieties that
21 existed among staff, was any consideration given to
22 a broader application of a workforce policy that people
23 could wear FFP3 masks if they wanted to, regardless of
24 the position on aerosol transmission, regardless of what
25 NERVTAG was saying?

18

1 not been identified pre-pandemic?

2 **A.** No, I can't.

3 **Q.** Had these limitations been addressed before you left the
4 role of cabinet secretary in May 2021?

5 **A.** I believe they had.

6 **Q.** At paragraph 177 of your statement you note that at no
7 stage did you receive advice indicating that ethnic
8 minority healthcare workers were disproportionately
9 affected by nosocomial infections. Was any proactive
10 assessment of this issue carried out?

11 **A.** So, from my recollection, two particular things
12 happened. So as a consequence of that submission
13 in May 2020 that you've referenced, interim guidance was
14 issued which asked individual health boards to undertake
15 individual risk assessments for staff but also our Chief
16 Scientist -- officer in health, Professor Crossman,
17 commissioned or put out a call for research proposals,
18 and I think in December 2020 he issued the result of
19 that call and allocated 3.5 million, from memory, to
20 specific research proposals to -- short-term research to
21 try and help us secure better data and better
22 understanding in this regard but also it may have wider
23 application once the pandemic is over.

24 **Q.** So did the limitations on ethnicity data cause any
25 difficulties in understanding that issue?

20

1 A. It would have done, yes.

2 Q. At paragraph 174 of your statement you say you were
3 aware of the fact that nosocomial infection in Scotland
4 was increasing prior to the pandemic. What was your
5 understanding for the reasons of this increase in
6 nosocomial infection pre-pandemic?

7 A. My understanding was that it was inconsistent
8 application of basic infection prevention and control
9 measures in a hospital setting.

10 Q. What was done to address that?

11 A. So the Chief Nursing Officer would, with her nurse
12 directors from each board, would reference, again, the
13 national manual, which I think had been in place since
14 2012, which sets out very clearly the procedures to be
15 followed, and asked them to ensure that in their board
16 area that that was being followed, including, kind of,
17 on-the-spot checks to be sure there was a big piece of
18 work undertaken about hand washing and the use of
19 basic-level PPE in particular settings to try and remind
20 everyone of what should be habitual infection prevention
21 and control.

22 Q. How did this pre-pandemic rise in nosocomial infection
23 inform your approach to the healthcare response to the
24 pandemic? Was it a relevant factor?

25 A. Well, the awareness that nosocomial infection occurred
21

1 IPC guidance in older parts of the hospital estate in
2 Scotland. Do you recall that issue?

3 A. I do.

4 Q. What steps were taken to deal with ventilation problems
5 relating to older parts of the Scottish hospital estate?

6 A. In relation to ventilation I believe that a number of
7 HEPA filter machines were used.

8 Q. Did you understand the concerns about ventilation
9 problems to have been resolved?

10 A. I think it's probably fair to say that I did, inasmuch
11 as they did not come back to me. And certainly in terms
12 of other concerns at various points throughout that
13 period where a resolution was not reached, then it would
14 come back on to my desk, either directly from my own
15 advisers or policy officials, or indirectly through
16 social media, or directly through the unions, and I had
17 regular meetings with healthcare unions.

18 Q. I'd like to come, please, to PPE supply and access
19 issues. You explain in your statement at paragraph 190
20 that as cabinet secretary you were ultimately
21 responsible for ensuring that the health workforce in
22 Scotland had access to appropriate PPE. With that in
23 mind, I'd like to ask you, first, please, about PPE
24 stock at the outset of the pandemic.

25 Could we have on screen, please, INQ000380849.
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1 informed an expectation on my part that we may well see
2 it in the context of the Covid pandemic.

3 Q. With that particular consideration in mind and going
4 back to the discussions before about whether anyone
5 proposed to you a discretionary policy for access to
6 FFP3s, did it ever occur to you to propose a wider
7 discretionary use of respiratory equipment, particularly
8 bearing in mind that knowledge that there might be
9 an increased risk of nosocomial infection?

10 A. So, nosocomial infection, by and large, occurred in the
11 ward setting not in ICU or high dependency where those
12 masks were worn.

13 The debate around CPR came from clinicians to me.
14 No other concern came from clinicians to me about other
15 settings, and including from the CNO or her office
16 which, of course, was the lead office on infection
17 prevention and control. And as I've said, as
18 a non-clinician, whilst I might ask what are we doing
19 about nosocomial infection, it did not feel to me that
20 as a non-clinician I would start making clinical
21 judgments about PPE.

22 Q. The Inquiry has received evidence that concerns were
23 raised by clinicians and staff about the adequacy of
24 ventilation at the Glasgow Royal Infirmary in
25 November 2020, linked to problems with complying with
22

1 This is an email dated 24 March 2020 to your
2 private office, attaching a submission on the use of
3 time-expired stock of PPE, and in particular FFP3 masks.

4 And going to the second page, please, under
5 "Purpose" we see the submission was:
6 "Seek[ing] your approval to release/make available
7 to Boards the use of FFP3 respirator mask, which has
8 recently passed its expiry date, but has passed
9 stringent Quality Assurance tests."

10 The timing is:
11 "Immediate -- given the current position with FFP3
12 masks."
13 And then under "Background" it is explained that:
14 "You are aware of the current challenges in the
15 supply chain for clinical consumables, particularly in
16 relation to PPE and specifically the FFP3 respirator.
17 This is most often used in intensive care units but will
18 be used in all areas where aerosol-generating procedures
19 are carried out ..."

20 And then at paragraph 4 there is a reference to
21 an earlier submission, noting:
22 "... the fragile position in relation to the
23 current FFP3 stock and in relation to new supplies."
24 And some figures are given there for the national
25 stockpiles now only holding 16,000 after distribution to
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1 the boards of 73,000 the week before.
2 And the position was that the time-expired stock,
3 which had been held, the position had been reached where
4 consideration needed to be given to using it.

5 Do you recall this submission and approving the
6 use of time-expired FFP3 masks?

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

8 **Q.** What lessons have been learned about the levels of PPE
9 stock which should be held outside of a pandemic in
10 preparedness?

11 **A.** So I think this is a dilemma for our national
12 procurement service in that, sensibly, you would think
13 you should hold a volume of stock that is there ready to
14 respond in the immediate period to an emergency that
15 might arise, but equally, stock has a time limit to it
16 and this is a good example of stock that was held but at
17 the point where the emergency arose and you needed to
18 use it, it had passed -- on the basis of its time limit,
19 it had passed that date. And so work had to be done to
20 be assured of its efficacy and, as you have seen from
21 the papers, additional assurances that I sought from the
22 academy of royal colleges, and others, to be sure that
23 people were content about its efficacy before we could
24 then issue it.

25 So in terms of thinking ahead to a future

25

1 healthcare workers because, generally speaking, the
2 model of mask preparation and development was for the
3 male face. There was also emerging concerns around the
4 fit for people from ethnic minority backgrounds. So
5 there was a rolling concern around fit, and that
6 included in this instance, but what we did know was that
7 a number of accredited bodies had already agreed that
8 these masks were -- worked as they should do.

9 The issue around straps was not one I was aware
10 of. I presume that at the time that was then resolved
11 by other means because it never came to me as a problem
12 that meant those masks could not be used.

13 **Q.** So you weren't aware of wider concerns about
14 time-expired stock falling apart, in essence --

15 **A.** No, I was -- sorry.

16 **Q.** -- denaturing, albeit that the filtration device itself
17 might work fine?

18 **A.** So the filtration device was the key part of this. If
19 the filtration device does not work there's no point in
20 this mask. Any other issues, for example like straps,
21 I wouldn't diminish the concern that that caused but
22 that can be resolved. So I was aware of a concern by
23 staff as to whether or not these masks were efficient
24 for their purpose, ie the filtration device worked or
25 not, and that's why I sought additional views from the

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1 situation, our procurement service on PPE will be faced
2 with that dilemma. Now, there may be ways by which you
3 can hold stock, issue it before its time lapse and keep
4 that rolling process going rather than think: we've got
5 enough of those masks for now and that will kind of do
6 us, if you like, but having a rolling programme so that
7 you are, in normal times, you don't have a huge demand
8 for that level of PPE, you know what your demand is
9 likely to be from your normal times, ICU and
10 high-dependency unit usage, but you need to keep rolling
11 the stock on, not re-ordering on the basis that you
12 think you have enough.

13 I think that is the lesson. It's about rolling
14 stock distribution.

15 I'm sorry I took quite a way trying to get there,
16 but that's the lesson.

17 **Q.** Not at all.

18 The Inquiry has received evidence from
19 Professor McKay from the Glasgow Royal Infirmary that
20 there were problems with fit testing of stock received
21 and that there were concerns about the straps on
22 time-expired stock. Were you aware of that at the time?

23 **A.** I wasn't aware of the strap issue at the time. There
24 was a continuing issue around fit for a number of
25 reasons but primarily fit, particularly for women

26

1 royal colleges but also discussion with the unions.

2 And remember that the masks were being used and
3 issued as we continued to look for volume of new masks
4 to come in.

5 **Q.** Did you ever ask your officials or advisers to follow up
6 on what the impact of using time-expired stock had been
7 on healthcare workers?

8 **A.** No, they would do that. So, I had regular meetings with
9 the trade unions and if they -- all the concerns, they
10 would not hesitate to raise those, particularly where
11 they affected the safety of their members or the
12 perceived safety of their members. My directors, so the
13 senior level civil servants, but including the clinical
14 advisers, met every morning and into those meetings were
15 fed the update situations, status reports from each
16 health board, and that would include PPE as well as bed
17 capacity, whatever might be the issues, and from that
18 meeting a read-out of that would come to me.

19 So, in some respects there were certain matters
20 that I did not need to ask them to look at, because
21 I knew from the read-out they were already on top of
22 those.

23 **Q.** I think you're aware of the BMA PPE survey results
24 from April 2020; is that right?

25 **A.** Mm-hm.

28

1 Q. The results were UK-wide, but they were sent to the CMO
2 in Scotland and the Director of Health Workforce in
3 Scotland on 7 April 2020 by the director of the BMA in
4 Scotland. Do you know the email I'm referring to? We
5 can put it on the screen if you need to see it.

6 A. Yes, please. I don't.

7 Q. It's INQ000117023. Do you recall that email now, to
8 Catherine and Gregor, from Jill from the BMA --

9 A. Yes, I do.

10 Q. -- passing on those survey results.

11 And the results included reports of shortages or
12 no supply of face masks for doctors working in high-risk
13 environments, issues with access to eye protection, and
14 the statistic that 55% of respondees to the survey said
15 they felt pressured to work in a high-risk area despite
16 not having adequate PPE.

17 Was the setting up of the PPE helpline mailbox,
18 which you cover in your statement, in early April 2020
19 linked to the BMA survey results?

20 A. Not directly, no. You'll notice from that email that
21 Ms Vickerman says:

22 "We [have] decided not to release [the] Scottish
23 figures ..."

24 So it is difficult to know then what proportion of
25 respondents working in Scotland responded to that

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1 from an A&E consultant in Edinburgh who contacted me
2 directly one evening, he was on shift and he didn't have
3 PPE. And when we enquired about it in realtime, we
4 discovered that the PPE was there but it was in
5 a cupboard and no one had told him which cupboard it was
6 in. So that told me -- there are things that are
7 one-off instances, but with one-off instances you want
8 to say: is this happening elsewhere, how does this work?
9 And that told me we needed to change the normal
10 procedure in a hospital setting of when the PPE
11 arrives: you don't wait for it to be asked, to be
12 requisitioned out, you proactively send it out and you
13 make sure that the people on the front line who would
14 use it know where you've put it.

15 Q. You set out in your statement a summary of the number of
16 emails received each week in April 2020 by that helpline
17 mailbox. And taking a week by way of example, in the
18 week commencing 13 April 2020, there were 580 emails
19 received into the mailbox. You explain that the emails
20 covered a range of issues and came from a range of
21 senders. Can you give us some examples of the type of
22 issues that were being raised by that mailbox?

23 A. So the bulk of the issues -- so the raising of the
24 issues would come from staff working in the NHS, staff
25 working in social care, because by then we had

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1 survey, and what they specifically were saying.

2 Nonetheless, I was very keen to ensure that PPE was
3 reaching -- so I received daily a stock update from our
4 national procurement service: for every single item of
5 PPE, told me how much we had, how much had been
6 distributed, what was on order, when the order was
7 expected, and it had a RAG status. And that then
8 allowed me to question the person in charge of our
9 procurement service where it didn't look like we were
10 going to get the order in on time, to cover any
11 shortfall, but also to make sure what was held or
12 distributed was actually being distributed.

13 So, in normal times, the only distribution of PPE
14 is to the hospital setting, and it arrives in the
15 hospital to a particular point and it goes out from that
16 point on request. That's how it normally works. That's
17 provides an audit trail etc.

18 What I understood needed to change was in the
19 hospital setting that process needed to change. That
20 when it arrived in the central point in the hospital it
21 needed to be distributed straight away, regardless of
22 whether anybody had asked for it or not. And that
23 understanding on my part arose partly from the work that
24 my officials undertook in response to this email but
25 also I think I've raised before the direct contact I had

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1 introduced the additional distribution routes, perhaps
2 primary care too, where there was now a direct
3 distribution route, about the -- majority would be about
4 the availability of PPE. Sometimes from family members:
5 "My daughter is a nurse and she went on shift last night
6 and ...", et cetera.

7 The point of the helpline was not just to give
8 people somewhere to raise those issues directly, but
9 then to follow through.

10 So the helpline was monitored constantly but I had
11 the additional assistance of a minister in government,
12 not a health minister, a minister in government who
13 I asked to oversee the operation of the helpline with --
14 with two particular remits. One to make sure that all
15 the issues that were being raised were being resolved,
16 so we didn't have the "I phoned the helpline three weeks
17 ago and nothing has happened", but also to identify if
18 there were trends, so the similar issue being raised
19 more than once, and was that indicative of a problem in
20 a particular area of healthcare or in a particular
21 geography or whatever that we could then look to
22 resolve.

23 Q. The Inquiry has heard evidence from Rozanne Foyer, the
24 general secretary of the Scottish Trades Union Congress.
25 That there were a range of issues being raised by them

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1 on behalf of their members early in the pandemic,
2 including issues relating to adequate supply of PPE, and
3 she drew a distinction between how the position may have
4 looked to those involved in procurement in government
5 and the experience of healthcare workers on the ground.

6 Is that a distinction you recall being raised with you
7 in the early months of the pandemic?

8 **A.** So that distinction is one I understand, and that's
9 partly why we had the helpline. But it's also in part
10 why I had not only regular formal meetings with
11 individual healthcare unions, but phone calls with them
12 to -- directly to me or to my office, so that they
13 understood that, if you like, the door was open, and
14 I did want to hear where there were particular issues or
15 concerns so that I could then -- not personally but
16 instruct someone go and look at what is actually
17 happening there and come back and tell me.

18 **Q.** And so through these various sources, the mailbox and
19 meetings with the Trades Union Congress, did you
20 understand or were there reports of a shortage of supply
21 of PPE on the ground?

22 **A.** Yes, there were from time to time reports of shortage of
23 supply, and oftentimes that was about -- not about the
24 overall national position on supply, but whether or not
25 the distribution, either directly to a particular

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1 make sure that we had as many open channels to know
2 where there were problems as possible, but equally
3 important to ensure that we had follow-through on those
4 channels.

5 **Q.** You've already referred this morning to becoming aware
6 of issues with ill-fitting PPE experienced by some
7 minority ethnic healthcare workers and female healthcare
8 workers. What steps were taken specifically to address
9 that issue to do with PPE?

10 **A.** So the difficulty with that is that, as I've said, by
11 and large, the maker of the masks model them on the male
12 face. So I can't fix the issue around fit if I don't
13 have masks that have been modelled for the average
14 female face, I think, or the average face of someone of
15 particular issues around the fit for someone from
16 an ethnic minority community. So all that we could do
17 was partly look ahead and see, and I think at a later
18 point you'll know that we introduced a domestic supply
19 chain and that was partly to resolve that, but it was
20 relatively low volume.

21 We looked at whether or not there were mitigating
22 measures that could be taken around fit, and of course,
23 it's very individual, and I recall, for example, the
24 ambulance service setting up their face fitting
25 exercise. In hospitals, as crews arrived, they would

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1 hospital or healthcare centre or whatever it might be,
2 had worked or whether or not internally, inside that
3 hospital, the internal distribution was working as well
4 as we needed it to.

5 **Q.** Ms Foyer said that there were early meetings which
6 representatives from the Scottish Trades Union Congress
7 had with Scottish Government, either with you or the
8 economy minister. She wasn't sure which. In particular
9 she said that at one point the Scottish Ambulance
10 Service was about to walk out because they did not have
11 access to the PPE they required. Do you recall that?

12 **A.** That was not a meeting with me. It may have been with
13 the economy secretary. But I know that the ambulance
14 service, as other parts of the healthcare system, had
15 concerns about -- I can't think of another way of
16 putting it -- getting their hands on the PPE that I knew
17 we had. And so my job is -- was to try to resolve that
18 issue. If we actually had that stock, we needed it to
19 get to the front line.

20 Now I accepted, of course, in the nature of
21 a pandemic and the pace at which everyone is working at,
22 and the demand and the concerns around it from
23 healthcare staff about their own safety and the safety
24 of their own families, that there will be -- nothing
25 will run smoothly all the time. So my concern was to

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1 then make sure that they had been fitted for their face
2 masks before they went out to the next job. It was
3 a very efficient way of doing it.

4 **Q.** Had those fit issues been recognised before the
5 pandemic?

6 **A.** I don't believe so.

7 **Q.** Why do you understand that to be the case?

8 **A.** I don't know. I would speculate that those particular
9 masks that require individual face fitting were only
10 used in very specific settings, and the issue may --
11 either may not have been raised. It depends on the
12 gender mix of staff in ICU or ITU -- HDU, or they were
13 raised but were not pursued. But they were never raised
14 with me prior to the pandemic.

15 **Q.** Taking into account what you knew at the time and also
16 what you know now, do you accept that at times
17 healthcare workers in Scotland treating Covid-19
18 patients were doing so with inadequate PPE? And
19 I stress "at times".

20 **A.** I accept that at times healthcare workers in Scotland
21 treating Covid patients did not have the ease of access
22 to PPE that I would expect them to have, and those were
23 the issues that I set out to resolve.

24 **Q.** Turning, please, to hospital capacity issues and the
25 response to those. And starting, please, with the

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1 question of what information was available to you at the
2 time to help you to respond to capacity issues.

3 During the pandemic you met daily with the
4 First Minister and the Chief Medical Officer to discuss
5 matters like infection levels and NHS capacity; is that
6 right?

7 **A.** That's correct.

8 **Q.** And these were daily meetings. Were they the ones
9 hosted by Public Health Scotland?

10 **A.** No.

11 **Q.** They were different?

12 **A.** Yes.

13 **Q.** Do you recall there also being meetings hosted by Public
14 Health Scotland?

15 **A.** There may have been.

16 **Q.** Can we have on screen, please, INQ000372596.

17 This spreadsheet provides figures for each
18 hospital grouped by health board and then network. And
19 this particular one is dated 29 December 2020. And for
20 the day it's dated and the previous day it provides
21 numbers of empty, full and closed beds, the number of
22 patients at each level of care and the number of
23 suspected or positive Covid cases.

24 Is this the daily report which would have been
25 discussed at the daily meeting you had with the

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1 to get to and we knew that we certainly needed to double
2 our intensive care capacity but we chose to
3 quadruple it.

4 So those were the figures that I was working to
5 and what I wanted to know was: were we meeting those
6 milestones.

7 This particular spreadsheet, given that it
8 is December, would be the kind of information we were
9 looking at as we were setting the different levels of
10 restrictions on our local authority by local authority
11 basis where we would also be -- there would be other
12 data in front of us which would be about levels of
13 infection, but it was telling us whether the levels of
14 infection were such and the estimate you would make from
15 that about hospital demand, whether we looked capable of
16 meeting it. But it was on a very localised basis, much
17 more so as we moved through the pandemic than at the
18 outset.

19 **Q.** So the information in this spreadsheet, was that
20 presented to you in this spreadsheet or was it
21 summarised for you at a meeting?

22 **A.** No, when we were doing the various levels of
23 restrictions, I'm sure colleagues will recall, this was
24 the information we were looking at. And we were looking
25 at it with the local authority as well, with the chief

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1 First Minister and the CMO?

2 **A.** No.

3 **Q.** No?

4 **A.** No. You'd need to go a step back or earlier in the day.

5 So, every day we had, as I described, the directors
6 meeting, and the key person in that -- two key people in
7 that meeting would be John Connaghan, as our chief
8 operating officer, at one point also interim chief exec,
9 and our chief exec, and DG. And prior to that meeting,
10 Mr Connaghan will have spoken to every health board
11 chief executive or medical director about the status
12 report in their hospitals that morning, and he would
13 feed that into that directors meeting.

14 He was doing that and then any issues would come
15 in the update to me from that meeting which was prior to
16 my meeting with the First Minister, and the Chief
17 Medical Officer, sometimes the national clinical
18 director.

19 You will recall that in early March Mr Connaghan
20 wrote out to every health board with very specific clear
21 instructions about healthcare to be paused, number of
22 beds that we needed to increase, the increase in
23 intensive care and so on, all of that fed from the
24 original worst-case scenario modelling for the UK. So
25 we knew the worst-case capacity of beds that we needed

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1 exec, and often the leader of the council because, you
2 will recall that we had different levels of restrictions
3 at different times in different local authorities.

4 **Q.** Focusing on what this report tells us about how well
5 hospitals were coping with demand. The report doesn't
6 contain any information about ICU staffing ratios or
7 whether they were being maintained to the recommended
8 standards. It didn't specify whether the empty beds
9 were level 0, 1, 2, or 3 beds, and there are no figures
10 for bed occupancy as a percentage of baseline or surge
11 capacity. How easy did you find it, at a glance, to
12 understand from this spreadsheet how well hospitals were
13 coping with demand?

14 **A.** Well, I didn't have only this spreadsheet, I think is
15 the important thing -- I appreciate this is what
16 the Inquiry has, but I would have a spreadsheet like
17 that. I would also have information from our Chief
18 Nursing Officer about staff ratios, sickness levels
19 coming from our workforce, regular sickness levels
20 coming from our workforce director, and information
21 directly from Mr Connaghan about, in addition to the
22 data, how is that hospital doing, and that would include
23 whether or not the chief executive was saying: yes,
24 I know we've got X-amount of capacity but I've got
25 a high level of sickness, so I don't really have that

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1 amount of capacity, I've got this amount instead.

2 **Q.** Just focusing on the information from the Chief Nursing
3 Officer about staffing ratios. The Inquiry has heard
4 that staffing ratio data was not being reported by
5 individual hospitals or health boards to SICSAG, the
6 Scottish intensive -- I'm going to get my acronym wrong,
7 but do you know the organisation I'm referring to?

8 **A.** Yes.

9 **Q.** So that data wasn't being reported and held centrally in
10 a way that could be looked at, you know, over time, for
11 example. So how was the Chief Nursing Officer providing
12 you information on staffing ratios across all those
13 hospitals and health boards?

14 **A.** Through her daily conversations with nurse directors.

15 **Q.** Turning, please, to the steps that were taken to address
16 expected hospital demand and how effective those steps
17 were. You say at paragraph 57 of your statement that
18 you took a number of decisions to ensure that the health
19 service in Scotland was ready to deal with those
20 modelled high numbers you've referred to. Can you
21 explain, please, what the key steps you took were?

22 **A.** So this is very early and then followed up by that
23 letter in early March from Mr Connaghan that
24 I mentioned. So it was a pausing of elective care,
25 which then frees up not only beds but staff to redeploy.

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1 at the outset to ensure that ICU-trained staff could
2 treat patients in the expanded surge capacity beds?

3 **A.** I'm not quite sure I understand your question.

4 **Q.** Well, there was going to be a surge of beds, and in
5 terms of the recommended staffing ratios that would be
6 one ICU-trained nurse to a patient. When that was
7 surged there would be a greater requirement for
8 ICU-trained nurses. Were any steps taken at the outset
9 of the pandemic to increase the numbers of people so
10 trained to increase the chances that you would have
11 ICU-trained nurses treating those patients?

12 **A.** Yes, thank you. Thank you, I understand.
13 So, pausing of elective work meant that we freed
14 up theatre teams, not only the surgeons but the entire
15 theatre teams. The advice that I received was that
16 those teams could be trained to operate in an ICU
17 capacity more quickly than any other staff because of
18 the skill set that they already had and practised, so
19 that work was undertaken to increase the number of
20 appropriately trained staff to work in an expanded
21 intensive care.

22 **MS PRICE:** My Lady, would that be a convenient moment for
23 the mid-morning break?

24 **LADY HALLETT:** Yes, I shall return at 11.30.
25 **(11.12 am)**

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1 And it was the pausing of the screening programmes,
2 cancer screenings but also the -- I can't recall what it
3 is -- the two screening programmes we retained was for
4 maternity and newborns but all other screening
5 programmes were paused. The steps taken to begin
6 discussions with the relevant regulatory bodies about
7 permitting the entry into the hospital setting on
8 a full-time basis of final year medical constitute
9 departments and final year nursing students that would
10 allow them to still complete their qualification in the
11 time frame they had anticipated pre-Covid. The work to
12 ask recently retired healthcare professionals to return.
13 And the establishment of the community Covid pathway,
14 which was an attempt to retain some primary care
15 provision for patients who did not have Covid. That was
16 replicated a little bit in the red and green pathways in
17 hospital where you delineated from the Covid areas and
18 the non-Covid areas. That was a difficult position to
19 maintain but it was done. And all the PPE work, around
20 increasing the distribution routes of PPE and the supply
21 of PPE to all parts of the healthcare service, whether
22 or not they were private, that we had not done before,
23 and of course to social care.

24 **Q.** Setting aside the permanent ICU bed uplift, which was
25 decided upon in Scotland in 2021, what efforts were made

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1 **(A short break)**

2 **(11.30 am)**

3 **LADY HALLETT:** Ms Price.

4 **MS PRICE:** Thank you, my Lady.
5 Ms Freeman, it's your written evidence to the
6 Inquiry at paragraph 92 that the key decisions taken by
7 the Scottish Government, which we were talking about
8 just before the break, were effective in protecting the
9 NHS from being overwhelmed during the pandemic.
10 What did you understand NHS overwhelm to look like
11 or mean?

12 **A.** So that would be if we -- if you go back to the
13 modelling of worst-case scenario this would be -- and,
14 of course, those numbers would not all appear at once,
15 but if we were ever in a position where we did not have
16 the capacity to care for patients presenting at hospital
17 or requiring intensive care because -- as a consequence
18 of the virus, that would be us overwhelmed and,
19 of course, as an additional precaution to that, was also
20 why we took the decision to create NHS Louisa Jordan.

21 **Q.** At paragraph 128 of your statement you say you were not
22 made aware that intensive care capacity had been reached
23 in Scotland at any point from March 2020 onwards. What
24 definition of intensive care capacity are you using when
25 you say that?

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1 A. Our commitment to quadruple, from baseline, our
2 intensive care.

3 Q. Just thinking in terms of whether capacity had been
4 reached, so your understanding that capacity had not
5 been reached --

6 A. That's right.

7 Q. -- when you're referring to intensive care capacity --

8 A. Yes.

9 Q. -- are you referring to baseline capacity or surge
10 capacity? What is your definition of the intensive care
11 capacity?

12 A. So my definition of intensive care capacity for the
13 purposes of the work that we undertook to respond to the
14 virus is the quadrupling of intensive care capacity, so
15 we had not reached that.

16 **LADY HALLETT:** Ms Freeman, a question I suspect we're going
17 to put to various health ministers. If a system has had
18 to close down cancer screening, a potentially fatal
19 disease, if it's had to cancel elective surgery where
20 people can suffer in huge pain for years, why does that
21 not mean the NHS is overwhelmed?

22 A. In terms of responding to the pandemic I think
23 overwhelmed means your capacity to respond to those
24 cases that come to you as a result of the virus, people
25 contracting the virus. There are other non-health harms

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1 A. Yes, I understood that.

2 Q. How did you make sure you knew what was happening on the
3 ground?

4 A. As I've said already, my directors, including clinical
5 advisers, had that morning meeting. Feeding into that
6 was the overnight update report from each health board,
7 and the update from that meeting was fed to me directly,
8 almost always by the chief executive, walking along the
9 corridor and briefing me, and then followed up in
10 writing.

11 Q. At the time did you fully appreciate that when baseline
12 capacity was breached, even if surge capacity was
13 technically not, this had consequences for the quality
14 of care being received by patients?

15 A. I would have a concern that it would have consequences
16 for the quality of care, because as you, I think, have
17 alluded to before, it's not simply about the number of
18 beds you have, it's also about the staffing levels you
19 have.

20 One of the consequences of, for example, pausing
21 elective work, as I've mentioned, is that you free up
22 staff, but also the work that we undertook -- pausing
23 screening programmes also freed up staff, allowed them
24 to return. We had qualified healthcare staff from some
25 of our national boards like Education for Scotland or

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1 that you've just rightly highlighted, my Lady. Probably
2 the most critical of those is the pausing of screening
3 programmes, and I think I've said before most likely the
4 most difficult decision I made.

5 **LADY HALLETT:** So that is really -- you're saying the NHS
6 isn't overwhelmed if you can cater for all the Covid
7 cases. But if by catering for the Covid cases you have
8 to stop people being cancer screened, surely on one
9 definition that might say the NHS was overwhelmed?

10 A. "Overwhelmed" is not a word I would agree with, I don't
11 think it was overwhelmed as a consequence of that, but
12 undoubtedly non-Covid harm was created as a consequence
13 of that particular set of decisions and, longer term,
14 the pausing of elective care, yes.

15 **LADY HALLETT:** Sorry to interrupt.

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

17 It was the evidence of the Chief Medical Officer
18 for Scotland to the Inquiry in this module that the
19 number of people who were in hospital was really quite
20 immense and exceeded capacity on several occasions, with
21 hospitals having to adopt novel approaches to how they
22 used other clinical areas to effectively provide care.
23 At the time did you appreciate that this was the
24 position on the ground in emergency departments in
25 critical care units?

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1 some of the others returning to frontline work, they
2 return, and also bringing in final year medics and
3 nursing students. And so you're trying to move people
4 with the highest level of skill to operate at that level
5 of skill, and back-filling them from the staff that you
6 are securing by other means. In that way you're trying
7 to make sure that the quality of care in areas of the
8 hospital in addition to high dependency or intensive
9 care is as good as it can be.

10 Q. The Inquiry has heard evidence from Professor McKay that
11 during the first wave instead of one ICU-trained nurse
12 to one patient there was, in effect, one ICU-trained
13 nurse supervising four non-ICU-trained nurses each
14 caring for a patient. Were you aware of this kind of
15 change in the standards for staffing ratios during the
16 first wave at the time?

17 A. Yes.

18 Q. And did you have any concerns about that?

19 A. Well, yes, I did, but equally I was conscious of the
20 limitation of choice. So people were not actively
21 choosing to staff those beds in this way in the face of
22 a better choice. They were choosing to do this to the
23 best standard they could, with the highest level of
24 supervision that they could, to secure equal quality of
25 care in circumstances where they were dealing with

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1 higher numbers than in peak Covid times.

2 **Q.** Do you consider that entering the pandemic with low ICU

3 bed numbers and high bed occupancy put hospitals in

4 Scotland under even greater strain?

5 **A.** I think entering the pandemic with fewer beds capable of

6 modification to be ICU beds, as -- for example, there

7 was a case, I understand, in Germany where more beds in

8 a hospital setting are equipped, for example, with

9 an oxygen supply for use if needed. So entering the

10 pandemic without that circumstance put greater pressure

11 on our system, and it would be one of the lessons

12 I would hope we would learn, that we have greater

13 capacity to increase that level of care, not just in the

14 beds we have but also in the trained staff that we have.

15 **Q.** Did this also have a knock-on consequence for the

16 ability to restart non-urgent elective care?

17 **A.** I don't believe so.

18 **Q.** You say at paragraph 88 of your statement that you had

19 no specific discussions about the rationing of

20 healthcare. What type of healthcare are you referring

21 to there?

22 **A.** Any type of healthcare.

23 **Q.** Do you mean --

24 **A.** There were no discussions at all about rationing of

25 healthcare. Where decisions are made in a hospital

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1 **Q.** Did you receive any reports of the scale of the change

2 impacting the quality of the service when capacity was

3 first increased?

4 **A.** I don't recall any specific reports but inevitably that

5 level of increase and change would not go as smoothly as

6 you might wish.

7 **Q.** Is there any learning that can be taken from that quite

8 dramatic change to the pathways and is it something that

9 you would do again?

10 **A.** If I had the same advice again, then I would do the same

11 again, yes. But you don't know what any future

12 circumstance might be like so it's impossible to be

13 certain of the answer to a question like that.

14 I can't recall the second part of your question.

15 **Q.** Just whether there had been any learning identified?

16 **A.** So I believe NHS 24 have undertaken reviews of how that

17 increase in capacity and resultant demand and what the

18 lessons learned for them are, and they will have fed

19 that into the NHS as a whole.

20 **Q.** The intention behind the change was to reduce emergency

21 department self-presentation; is that right?

22 **A.** Yes.

23 **Q.** How successful was the change in achieving that?

24 **A.** My understanding is that that was reasonably successful.

25 Of course this happened after a trial of the approach,

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1 setting about the care that a patient should receive,

2 the appropriate care, those are clinical decisions.

3 **Q.** Turning, please, to NHS 24 and ambulance capacity

4 issues. In December 2020 there was a redesign of the

5 urgent care pathways which saw NHS go from being

6 an out-of-hours service to a 24-hour service. Written

7 evidence from NHS 24 received by the Inquiry suggests

8 that NHS 24 additional workforce requirements equated to

9 a 43% increase in staff and that around 2 million

10 patients have accessed the pathway since it was

11 launched. So this was a significant operational change

12 for NHS 24, wasn't it?

13 **A.** Yes.

14 **Q.** Was there a clear plan for how extra staff would be

15 sufficiently trained and supervised, given the emergency

16 nature of the expansion and the complexity of providing

17 the service to caller patients?

18 **A.** My recollection is that NHS 24 had devised such a plan,

19 and certainly that would have been over seen by

20 Mr Connaghan, and challenged by him if he did not think

21 that that met what was required.

22 I do recall a discussion within NHS 24's

23 chief executive and chair about physical location. They

24 needed to expand the physical footprint that they had in

25 order to accommodate additional staff.

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1 which took place in Ayrshire, in advance of that, and

2 very much was a modification of the model used in

3 Denmark.

4 **Q.** In relation to the level of 111 calls in the first wave

5 and wait times for those calls, could we have on screen,

6 please, page 32 of INQ000474258.

7 This is a statement provided for the Inquiry by

8 Stephanie Phillips on behalf of NHS 24. It provides

9 some data for calls offered, calls answered, and average

10 time to answer, on this page for the week beginning

11 24 February 2020. And we can see that in that week

12 31,182 calls were offered, 25,807 were answered, so

13 that's just under 83%, and the average time to answer

14 was 6 minutes and 31 seconds.

15 And then the table over the page gives the same

16 data for the month of March 2020 with the calls offered

17 for the entire month, showing at the bottom there, of

18 235,660, with 119,201 being answered, so that's just

19 over 50%. And the average time to answer being

20 32 minutes and 14 seconds.

21 What consideration was given by the Scottish

22 Government to the need to increase 111 capacity prior

23 to March 2022 -- apologies, March 2020. I'm struggling

24 with my years today.

25 **A.** So I think it would be fair to say that the

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1 consideration was limited until we were in a situation
2 where we had our first -- I think 1 March was when we
3 had our first Covid-positive patient in Scotland, and
4 then, of course, as you'll see from the volume of calls
5 from the public, increased awareness produced increased
6 demand on NHS 24. And as we see that demand and
7 particularly the time taken to answer calls, that would
8 trigger -- before then, actually, the previous slide you
9 showed, would begin to trigger a requirement and
10 a demand from NHS 24 that they be allowed to increase
11 their capacity.

- 12 **Q.** Given that the public were being urged to use 111
13 services as a first port of call, what steps were taken
14 to monitor the efficacy of 111?
15 **A.** So there would be data produced similar to what we're
16 looking at on screen now where the key number is --
17 you're certainly interested in calls offered/calls
18 answered because if you see a dip there, then you know
19 that either people feel they're waiting too long and
20 they give up on the call, but also the time it takes,
21 the average time it takes to answer in the first
22 instance. Some calls will take longer to deal with than
23 others, but the initial pickup is a key number that
24 you want to look at.

25 So, that would be being monitored by the

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1 pandemic by previous governments, since 2000 probably,
2 to reduce waiting times on elective work. So the
3 arrangements and the relationships were not new, but
4 were obviously increased exponentially and I think we
5 bought up all private capacity for the pandemic.

- 6 Whether or not a protocol for future use makes
7 sense, I can see advantages for that but, of course,
8 it's a decision for a future health secretary.
9 **Q.** Turning, please, to Long Covid. You refer in your
10 statement to a submission dated 15 December 2020
11 informing you that a clinical guideline on the
12 management of people with Long Covid was to be published
13 on 18 December.
14 **A.** Yes.
15 **Q.** Were you advised at any point before this of long-term
16 consequences of Covid-19 in the Scottish healthcare
17 system or the potential for this?
18 **A.** So the first indication I recall, and it was not at that
19 point put to me or discussed as "Long Covid", but was
20 what appeared to be, for some patients, impact of the
21 virus on their heart functioning. Generally speaking,
22 if I'm correct in my memory, young men. So otherwise
23 fit people who contracted the virus being left with
24 a difficulty in their heart function. I can't be
25 clearer than that.

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1 directorate.

- 2 **Q.** In relation to the pressures on the Scottish Ambulance
3 Service, the Inquiry has received evidence that the SAS
4 conducted a voluntary review of private ambulance
5 providers which indicated that they would be willing to
6 support the NHS if required. But that was not taken
7 forwards because Scotland does not have a legislative
8 framework in place for regulation of private ambulance
9 providers. Were you ever asked to consider the merits
10 of making legislative or policy change which might have
11 allowed for the use of private ambulances to support the
12 Scottish Ambulance Service during the pandemic?
13 **A.** I don't recall being asked that.
14 **Q.** In relation to private hospital providers, you refer at
15 paragraph 164 of your statement to the decision
16 in March 2020 to make use of private hospital capacity
17 for the treatment of urgent elective procedures and
18 urgent cancer cases. In your view, would it be
19 beneficial in anticipation of a future pandemic to put
20 in place a protocol in consultation with private sector
21 providers to plan for the provision of emergency
22 capacity and surge support by private providers?
23 **A.** So the use of private providers in Scotland at that
24 time, the capacity of private providers was relatively
25 small but the use of them had been made prior to the

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- 1 So I recall that and I recall the Chief Medical
2 Officer at the time saying this is something we need to
3 watch out for, and reminding me that viruses can leave
4 a longer-lasting impact of a different kind so we should
5 reasonably keep an eye out for whether Covid did,
6 whether it was going to be -- sorry -- in the cardiac
7 area or whether it was going to be something else.
8 **Q.** Can you recall even roughly when that was?
9 **A.** I think that would probably be late spring, summer of
10 2020. But you're relying on my memory at this point and
11 I should caution you against that.
12 **Q.** Apart from deciding to keep an eye, were you advised to
13 take any other steps?
14 **A.** At that point, no. At that point, no, because I think
15 it's reasonable to say at that point across the UK, and
16 elsewhere, there was an aware -- well, there was
17 an awareness anyway in the clinical community that
18 viruses can do that. So there was no reason to think
19 that Covid would be different. So it might, I think is
20 the -- keep on open mind approach: let's keep an eye on
21 it, let's see what comes through, what might be
22 emerging, through our -- "our" being our clinical
23 advisers' -- relationships, particularly in Europe, and
24 in Italy, and see what they are identifying as emerging
25 in their area.

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1 So at that point it was a: this is a possibility,
 2 we will keep an eye on it and see what comes through.
 3 But it is more reasonable to expect a longer-term
 4 impact, the scale and nature of which we do not know,
 5 than it is to not expect it.

6 **Q.** You refer at paragraph 217 of your statement to
 7 a meeting you had with representatives from Chest Heart
 8 & Stroke Scotland in January and February 2021. You go
 9 on at paragraph 218 to discuss your understanding of
 10 what stakeholders were seeking in terms of Long Covid.
 11 Was it from these representatives that you understood
 12 that stakeholders were seeking recognition of Long Covid
 13 as a condition within the medical profession and a more
 14 holistic response to people experienced -- experiencing
 15 the symptoms of Long Covid?

16 **A.** From that meeting but also from my discussion
 17 particularly with BMA -- the BMA GP group, so it was
 18 largely to our general practitioners that patients were
 19 presenting with a range of symptoms but some commonality
 20 between them and GPs looking for more information and
 21 guidance as to what they might -- how they might respond
 22 to that.

23 **Q.** When you say at paragraph 219 of your statement that
 24 there was no specific ask of the Scottish Government in
 25 relation to Long Covid, again, is that the source -- is

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1 themselves suffered from some of the symptoms that were
 2 considered to be Long Covid, and what Chest Heart &
 3 Stroke were saying to me was: we are pretty well used to
 4 dealing with this but we need some additional resource
 5 in order to work more closely with GP practices for our
 6 service to be offered to them. That was the ask, if you
 7 like. And the concern that they were all expressing was
 8 that they didn't see that -- we didn't allow
 9 a repetition of what people had experienced around ME,
 10 where for some time there a refusal to recognise it as
 11 a physical condition and not say it was purely
 12 psychological.

13 **Q.** You referred to an ask of additional resource. What
 14 type of resource did you understand that to be?

15 **A.** It was financial.

16 **Q.** And was that forthcoming?

17 **A.** Yes.

18 **Q.** Were you aware of any other stakeholders in relation to
 19 Long Covid apart from the BMA and Chest Heart & Stroke
 20 Scotland?

21 **A.** At that point, no, but in that meeting was our then
 22 deputy national clinical director, and what was clear to
 23 me was that this was going to be a changing position as
 24 we understood what was happening better.

25 **Q.** You say in your statement that you sought to ensure that

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1 the source that -- that representative group that you
 2 met and the BMA GPs group?

3 **A.** So what they were not asking for were specific clinics
 4 or facilities to be established. What they were asking
 5 for was a sharing of information across GP practices of
 6 all the data that we knew at that time and all the
 7 maybes as well -- because there were not a wide range of
 8 symptoms but there was a range of symptoms -- and
 9 guidance to GPs about how to respond to that if
 10 a patient presents and says, "These are my symptoms and
 11 I've had Covid". And broadly speaking, from memory, the
 12 guidance was you respond to that in the way you would
 13 respond to those symptoms in any event, and that is you
 14 start ruling out different conditions or diseases or
 15 illnesses, and if you have ruled out the normal or the
 16 expected ones then you are probably dealing with
 17 Long Covid, in which case we need the multidisciplinary
 18 team to be enacted so that the individual is provided
 19 with physio, diet, psychological support as well as
 20 anything you as a medical practitioner might want to do,
 21 in which you could include referral to a consultant
 22 service.

23 And that was what both BMA, as I recall it, and
 24 Chest Heart & Stroke were saying. Chest Heart & Stroke
 25 had in that meeting general practitioners who had

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1 Long Covid was better understood by the medical
 2 profession. How did you go about that?

3 **A.** So that was by asking for information to be distributed
 4 across primarily our primary care system, and the
 5 interim guidance that I referenced, which would be
 6 clinically produced.

7 **Q.** What advice did you receive from your officials and
 8 professional advisers about the options for the model of
 9 the provision of Long Covid services and, in particular,
 10 whether they should be centrally directed or funded?

11 **A.** I don't recall any specific advice about whether they
 12 should be centrally directed or funded. At that point,
 13 the overall advice was: there is a need here; the
 14 absolute parameters of that need we are not clear about.
 15 The part of the healthcare system experiencing the most
 16 demand is our general practice and so that is where we
 17 should focus our resource in order to provide them with
 18 more of what they're asking for so they can do their
 19 job.

20 **Q.** Were you made aware, while you were Cabinet Secretary
 21 for Health and Sport, of the Long Covid service in
 22 Scotland which was unable to cope with demand and closed
 23 after 18 months due to lack of funding?

24 **A.** So that was a specific service in Tayside. It was the
 25 only one and the board there took that decision that

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1 that's what they would do. So I was aware of that, and
 2 aware, too, that -- I think, in fairness, the board
 3 would say if they were here that they established that
 4 without thinking through whether or not they could cope
 5 with that demand, as opposed to provide resource and
 6 support to their general practices to be able to deal
 7 with their patient cohort. For most of us, our first
 8 point of call is our GP, our general practice. The
 9 general practice, certainly now through the KI record
 10 system is able to access the totality, for example, of
 11 my medical records, or whoever, and therefore they have
 12 a more holistic picture of your medical history and are,
 13 arguably, better placed to then respond to the symptoms
 14 that you are presenting with and present a diagnosis
 15 even if that initial diagnosis involves a number of
 16 tests that will rule in or rule out a condition.

17 So a separate clinic isn't hooked into that system
 18 in that way and I think that is why Tayside stepped back
 19 from that approach.

20 **Q.** Wasn't the demand for that service and it becoming
 21 overwhelmed indicative of a need for Long Covid clinics
 22 to be set up?

23 **A.** I don't believe so. If that was the case, then I would
 24 have seen that demand elsewhere and I didn't.

25 **Q.** Moving, please, to the Shielding and Highest Risk List.

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1 fulfilled after shielding was paused?
 2 **A.** So, some of the support systems that had been in place
 3 during the period of shielding were retained in terms of
 4 home deliveries and so on. I know that some of the
 5 community-based support continued in some areas but, in
 6 addition, because we were moving now to a situation of
 7 different levels of restriction across different parts
 8 of the country, depending on the prevalence of the
 9 virus, I know some of what we discussed before the break
 10 with that dataset that you had on the screen, the
 11 intention was that that would be publicly available so
 12 that individuals could, at a very granular level, look
 13 at that data and make a decision for themselves as to
 14 whether or not they felt it reasonable to return to more
 15 normal living, less restricted living, along with the
 16 rest of the population in their community or not.

17 So the intention behind that May submission was to
 18 recognise two things. One, you can't ask people to
 19 shield in the way that we did in the first phase to that
 20 degree forever. And secondly, that individuals have
 21 a right to make decisions about themselves, and their
 22 own lives and how they will live. And many people with
 23 immune suppressed conditions, in particular, understand
 24 their conditions very well and already pre-Covid took
 25 precautions about their vulnerability to infection and

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1 You received specific advice from your clinical advisers
 2 on the impact of non-pharmaceutical interventions on
 3 clinically vulnerable groups; is that right?

4 **A.** That's right.

5 **Q.** On 31 July 2020, you took the decision to pause the
 6 shielding programme and that people on the Shielding
 7 List should thereafter follow the advice provided to the
 8 general population, including that those on the
 9 Shielding List could attend work if they were not able
 10 to work from home?

11 **A.** Yes.

12 **Q.** Planning for a new approach to shielding was addressed
 13 in a submission to you, dated 20 May 2020. Do you know
 14 the submission I'm referring to?

15 **A.** I do.

16 **Q.** That submission referred to the concept of a social
 17 contract underpinning a new model where people could
 18 make informed decisions that balance their individual
 19 risk with quality of life?

20 **A.** Yes.

21 **Q.** And that envisaged giving people the information and
 22 tools to equip them to make those decisions. It also
 23 envisaged providing practical support and suppressing
 24 rates of infection in local communities. To what extent
 25 were the various elements of this social contract

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1 so on.

2 So the data did become public. Did we do it to
 3 the degree that met the needs of every group within that
 4 overall shielding group? I would say no, we didn't, and
 5 there was room to improve the level of data. And I know
 6 that a number of individuals remained particularly
 7 concerned later in the course of the pandemic about the
 8 advice that said to the general population, for example,
 9 that wearing face masks was no longer needed, that that
 10 made some individuals feel, and continue to feel, that
 11 their capacity to return to normal had been limited by
 12 some of those decisions.

13 **Q.** Turning, please, to DNACPRs. Can you explain, please,
 14 how and when concerns about the use of DNACPRs came to
 15 your attention and what those concerns were?

16 **A.** So they came to my attention either -- probably both
 17 together actually -- via media reports and questions
 18 from colleagues in the Parliament, and my understanding
 19 was there was a perception that there was a kind of
 20 blanket approach now being adopted for particular groups
 21 of the population, to require a DNACPR to be imposed.

22 That, of course, is utterly contrary to the
 23 principles and thinking behind those advanced care
 24 discussions that have been asked for in our NHS for some
 25 time pre-Covid and the nature of the discussion and the

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1 decision that should be reached and by whom around
2 DNACPR.
3 So, I wanted to ensure that those concerns were
4 addressed as quickly as possible. I did not -- I knew
5 that there was no blanket instruction or requirement
6 emerging from Scottish Government and I wanted to ensure
7 (a), that we looked in detail at the concerns that were
8 being raised, and was that localised, was it in more
9 than one place in Scotland, what was this, and sought to
10 make it crystal clear what should happen, and if that
11 isn't what was happening, what we were going to do
12 about it.

13 **Q.** You say in your statement that you approved a letter
14 from the CMO Scotland to GPs and chief executives of NHS
15 boards, and that was issued on 10 April 2020, and that
16 clarified that there was no specific requirement to have
17 a DNACPR discussion as part of anticipatory care
18 planning.

19 Was that the letter that was intended to address
20 the concerns that had been raised, in particular about
21 the blanket use of DNACPRs?

22 **A.** In part. It was intended to remind GPs of anticipatory
23 care planning, which, within the GP cohort of Scotland,
24 had long been a piece of work that all GPs were
25 encouraged to pick up and engage with. That wasn't

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1 "It's not a blanket". But I do think that we covered it
2 in our media briefings, particularly in journalist
3 questions to us, and particularly where the CMO was with
4 us during those daily media briefings.

5 **Q.** At paragraph 225 of your statement you say that you
6 weren't aware of any evidence which showed conversations
7 initiated by GPs during the pandemic had an impact on
8 people accessing GP services, but that it is reasonable
9 to assume that some people would have avoided making
10 an appointment with their GP for fear of being
11 deprioritised in relation to ICU care. And is this in
12 relation to this DNACPR issue?

13 **A.** Yes. Yes, it is. I mean, I think we also had a growing
14 concern that people -- that one of the unintended
15 consequences of the early messaging, which was Stay at
16 Home, Protect the NHS, was that people took that to be
17 don't ask the NHS for anything unless you've got Covid.
18 And you'll know from material that has been supplied
19 that the CMO quite early on started to use media
20 briefings to remind people that the NHS was open and
21 that concerns you might have that may indicate heart
22 trouble or stroke or whatever, they needed to access the
23 NHS as quickly as they would otherwise.

24 But this -- and fairly widespread but relatively
25 limited in length of time coverage about concerns around

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1 consistent across the country but there was a lot of
2 work, GP-led work, to do that.

3 So it was intended to remind them about what the
4 anticipatory care plan discussion should be, how it
5 should be conducted, when it might be introduced, and
6 where, if at all, a discussion around DNACPR sat in that
7 discussion.

8 **Q.** The letter didn't expressly say that there shouldn't be
9 blanket use of DNACPRs. Given that that was the
10 issue that had been raised, do you think that it should
11 have so expressly said that?

12 **A.** I think it said it in as much as it made crystal clear
13 that anticipatory care planning is individualised and
14 DNACPR discussions are individualised to each patient.
15 That's the point of them. That's partly why, to
16 an extent, they take a long time, because they're
17 an individual discussion. So your anticipatory care
18 plan is as likely to be different from mine as it is
19 from anybody else's, because it's solely about you as
20 an individual and what you want, and that applies to the
21 DNACPR discussion too.

22 So I'm not sure, although it is rightly for the
23 CMO to decide what balance he wants to strike between
24 making it clear what those discussions are, and by
25 implication it's not a blanket, or saying expressly

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1 blanket imposition, alleged blanket imposition of DNACPR
2 notices will have impacted, I'm sure -- I think it's
3 reasonable, as I say, to think that that might have
4 impacted on some individuals being reluctant to approach
5 the health service.

6 Now, in addition to everything I've said already,
7 Dr Chung, we've mentioned earlier, made a podcast, it
8 was broadcast across Scottish media, explaining how
9 clinicians make decisions about intervention or not in
10 the situation of the emergency department or ICU, and
11 that I think had quite a powerful impact on those who
12 heard that podcast.

13 **Q.** And was that done, that podcast, at the time these
14 concerns were raised?

15 **A.** It was around about the same time I believe. Our BBC
16 Scotland radio station asked a number of individuals to
17 make podcasts about their experience during the Covid
18 pandemic, and he made one about the kind of decisions
19 that clinicians in emergency and intensive care and
20 otherwise make every single day around intervention or
21 not.

22 **Q.** You referred earlier to wanting to understand what was
23 going on with DNACPRs, but during your time as cabinet
24 secretary, was any review or investigation done on the
25 use of DNACPRs to that point during the pandemic in

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1 Scotland?

2 **A.** So there was a look at where it was alleged these
3 blanket DNACPRs were being imposed to see whether or not
4 that was the case, but there was no more than that done.
5 We were, after all, in the middle of a pandemic.

6 **Q.** Moving, please, to non-Covid care. In March 2020 you
7 decided to pause five adult screening programmes,
8 including the cancer screening programme, and you've
9 referred to that already. You describe in your
10 statement that decision as one of the hardest decisions
11 you've had to make?

12 **A.** Mm-hm.

13 **Q.** What was done to ensure that the screening programmes
14 could get back on track as soon as possible?

15 **A.** So, two things. When we paused the screening programmes
16 we -- so the screening programmes operate on the basis
17 that you are called for screening with a frequency.
18 I think it's every three years for breast screening, for
19 example. So we had to make sure that when we restarted
20 them that the people who had not been called were called
21 at the start but equally anyone due to be called at that
22 point was called as well. So you needed to look at
23 whether or not you could resource up in order to be
24 coping, if you like, with two streams of demand, and
25 that applied in the other programmes as well. So that

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1 has at his fingertips what the waiting times and lists
2 are, and so he can tell you, and did, if you pause
3 these -- if you pause it for this amount of time this is
4 the backlog you create, for this amount of time this is
5 the backlog you create, and so on.

6 So I was aware that I was, by my decision,
7 creating a backlog.

8 The additional element we put in which does matter
9 is that people did not drop to the bottom because their
10 procedure had not gone ahead. They stayed there. And
11 so there needed to be decisions about, when you restart,
12 how you're prioritising this. Are you going to
13 prioritise it on the basis of those who have waited the
14 longest or are you going to prioritise it on the basis
15 of a clinical judgment about need, in other words how
16 badly deteriorated a hip might be?

17 We went for clinical judgment, balanced against
18 length of time, and actually looked to begin that in the
19 winter planning work that was underway in the summer
20 of 2020.

21 **Q.** What were the key challenges in dealing with the
22 backlogs which had been built up for elective care in
23 Scotland?

24 **A.** So, one of the key challenges would be that, just as
25 you're about to do that, the virus mutates and you enter

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1 work was undertaken to see how best we could do that.

2 **Q.** Non-urgent elective activity was also paused; is that
3 right?

4 **A.** Yes.

5 **Q.** Is it right that the decision to restore elective
6 surgery capacity was left to individual health boards,
7 who could decide to prioritise other services in
8 preference to restoring elective surgery?

9 **A.** So the decision to restart elective care was national
10 across Scotland. If individual boards wanted to veer
11 from that in any respect, that had to be approved. And
12 obviously they had to have reasons for that.

13 **Q.** Taking the examples of hips, the Inquiry has received
14 evidence the number of hip replacements done in Scotland
15 dropped by 50% in 2020 in comparison to 2019, and
16 by 2022 that had not returned to 2019 levels. It has
17 also received evidence that in Scotland patients were
18 waiting 18 months to two years for hip replacements
19 during and since the pandemic in Scotland.

20 When were you made aware of the increasing
21 backlogs and what steps were proposed to tackle the
22 issue?

23 **A.** So it was not difficult to know the backlog that you
24 were creating at the point when you pause it, because
25 those numbers are held. So someone like Mr Connaghan

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1 another period of significant transmission and
2 additional lockdown, so that sets you back.

3 In addition, you have NHS workforce as you go
4 towards the end of 2020, into 2021, who itself, whatever
5 area they have been in, is physically and mentally
6 exhausted. And so you can't flick a switch and say
7 we're going back to where we were in 2019. That would
8 be to completely deny the impact of what has happened on
9 your workforce.

10 So -- and we were very clear in our public --
11 I was very clear in our public statements that it needs
12 to be a phased return to normal working, partly for that
13 reason but also, in some instances, you still have high
14 levels of sickness absence, either for physical reasons
15 or because people are mentally exhausted and they are
16 suffering in that way, and also staff who, towards the
17 end of the pandemic period, are deciding that now is the
18 time to leave the health service. And so there are
19 workforce challenges there. So you cannot say, "We're
20 through the virus, the transmission levels are such that
21 they're low enough we can carry on now and restart", and
22 flick the switch and think you can restart it in 2019
23 level from day one. That's simply not reasonable to
24 expect.

25 **Q.** What use was made of the independent sector to help deal

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1 with elective care backlogs? And related to that, what
2 use was made of the Louisa Jordan in that relation?

3 **A.** So, as I've already said, we effectively bought up all
4 available capacity in the independent sector, and that
5 was to deal with what limited elective -- urgent
6 elective care that we could, and to a degree urgent
7 cancer care, although that was still continuing in our
8 acute settings.

9 NHS Louisa Jordan was created to free up capacity
10 if needed in the acute setting. As it happens, that was
11 not needed to the degree that we expected, and so
12 NHS Louisa Jordan picked up on paused day cases, some
13 elective care, and outpatient appointments.

14 **Q.** What support was provided by the Scottish Government to
15 assist particular health boards in re-establishing
16 services and dealing with backlogs?

17 **A.** So there would be a guidance support and there would be
18 financial support.

19 **Q.** Do you think, on reflection, that any more could have
20 been done centrally to co-ordinate and support
21 resumption of elective care, through, for example,
22 ring-fenced spending if necessary?

23 **A.** So board spending is agreed on -- there is a formula but
24 in addition boards submit what they believe they need,
25 and for different categories of their spend, and the

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1 **A.** So I would hope in a future pandemic that by that stage
2 we will have the five specialist elective centres in
3 Scotland that have been in the planning for some time.
4 And that would allow you to designate those as non-Covid
5 or non whatever it might be hospitals and continue your
6 elective work.

7 The point of those elective hubs is to speed up
8 the management of elective cases because you take them
9 out of the acute setting. Where, in an acute setting,
10 the theatre time allocated to hip operations, for
11 example, today, could easily have been lost because
12 emergencies come in and those theatres are needed for
13 the emergencies to save lives. If you lift elective
14 care out of that acute settings into a specialist
15 setting then it's not interrupted in that way.
16 Golden Jubilee is an excellent example of that.

17 So the intention was and remains, I hope, to build
18 five elective centres in Scotland to do precisely that.

19 **Q.** Coming, please, to some final questions about lessons
20 learned. In relation to data collection and monitoring,
21 was any department or organisation monitoring the deaths
22 of healthcare workers from Covid-19 in Scotland?

23 **A.** So I'm pausing here because I have a recollection that
24 Public Health Scotland, which was monitoring deaths, was
25 asked to try to develop a more granular approach to

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1 allocation presumes that those categories of spend will
2 be met. So you don't need to ring-fence funds in that
3 way and you do need to allow boards to be able to flex
4 their use of their resource according to the demand that
5 they are experiencing. But additional -- significant
6 additional resource was given to boards for the Covid
7 response overall and that includes restarting paused
8 work.

9 **Q.** Do you think that enough use was made of elective hubs
10 in Scotland to enable diagnosis and/or treatment for
11 non-pandemic conditions to continue during the pandemic?

12 **A.** So NHS Golden Jubilee, which is our national elective
13 centre and heart and lung specialist centre, was
14 designated as a non-Covid hospital precisely to allow
15 some elective work to continue, as well as being able to
16 deal with emergency heart work.

17 **Q.** Was that the only elective hub in Scotland?

18 **A.** Yes, because at that point the construction of other
19 elective hubs was in construction. The only one that
20 was near completion and may well have been completed
21 during the pandemic, but I can't recall, was the
22 specialist ophthalmic unit at Golden Jubilee.

23 **Q.** Do you think in a future pandemic contingency plans
24 should include a strategy for a continuation or at least
25 very prompt recovery of non-urgent elective care?

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1 that, so that we could have a better understanding of
2 healthcare workers and their numbers there. I don't
3 recall if that was secured by the time I stood down.
4 They were able to delineate settings, if you like, but
5 they were asked if they could delineate further into
6 occupation.

7 **Q.** Do you consider that the visiting restrictions struck
8 the right balance between the benefits of visits to
9 patients and their families and reducing the risk of
10 visits bringing in infection?

11 **A.** So in a healthcare setting I think the national
12 restrictions did strike the right balance, but I am
13 aware in some of the operational delivery of those
14 restrictions they may have been too restrictive. And in
15 particular where families were able to be with a loved
16 one who was dying.

17 And I think I can understand in the very early
18 stages of the pandemic very restrictive practice, but
19 I think as we understood the virus better and moved
20 through the pandemic, some of the practice of
21 restrictions was too restrictive.

22 Where we were made aware of that, then we were in
23 touch with that particular hospital or setting to remind
24 them of what the national guidance said and what they
25 could do to mitigate any concerns they had about

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1 infection prevention.

2 **Q.** Looking back at both the things that went well in
3 Scotland in terms of the Scottish healthcare system
4 response and things that went less well, are there any
5 key lessons learnt which we've not already covered which
6 you would like to raise?

7 **A.** So I think it's one and the same. I think the things
8 I would single out that went well are -- is that, first
9 of all, the response of our healthcare workforce across
10 the piece. I think it was extraordinary.

11 We introduced some level of well-being support for
12 those staff and particularly wanted it to be as close to
13 where they were clinically practising as possible. Very
14 simple, simple things like the availability of
15 microwaves and kettles, a few steps away from -- safely,
16 a few steps away from your clinical area rather than
17 schlepping it all to the canteen. It is a matter of
18 regret to me if those have been removed now because
19 I think the well-being of our staff and the mental
20 health support is a lesson we should learn and
21 incorporate in standard practice.

22 So I think that was a good thing we did and it's
23 a lesson we should learn and continue to do.

24 The other main, and it came from staff feedback to
25 me, also in social care, we can come to that on another

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1 Was it brought to your attention at that time that
2 the two main considerations when deciding not to
3 recommend were: the logistics of fit testing everyone --
4 a necessary step for FFP3 masks -- and the level of
5 stock of FFP3 masks available at that time?

6 **A.** I don't recall that being brought to my attention, no.

7 **Q.** If that wasn't brought to your attention and by your
8 recall it wasn't, should it have been?

9 **A.** So, I think there is a balance to be struck between
10 clinical advisers and experts in a particular area
11 making those assessments and judgments, and being
12 allowed to do that and those judgments and assessments
13 being followed by a politician who isn't a clinician,
14 and the politician, ie me, who is directly accountable
15 for what happens, having all the information that they
16 need.

17 I am not sure, if it had been brought to my
18 attention, whether I would necessarily have disagreed
19 with the final decision. What I may have done, if it
20 had been brought to my attention, was ask for a timeline
21 of how quickly if, for example, stock was a problem, how
22 quickly we could secure the necessary volume of stock
23 or, if fit testing was a problem, and I can see that as
24 a greater difficulty because it is individualised, it
25 takes time, it takes people away from delivering care,

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1 day, but in healthcare, was the removal of a number of
2 layers of decision-making in a health board and the
3 devolution of decision -- greater decision-making to
4 frontline staff.

5 And, again, if you take this in the sense in which
6 I mean it, nothing bad happened as a consequence of
7 devolving decision-making to frontline staff, and so
8 I would believe that that is a practice that should be
9 continued.

10 **MS PRICE:** My Lady, those are my questions.

11 **LADY HALLETT:** Thank you.

12 We'll carry on and try and get you done before
13 lunch if that would help you, especially given the
14 weather conditions.

15 Ms Mitchell, who's over that way.

Questions from MS MITCHELL KC

17 **MS MITCHELL:** I appear as instructed by Aamer Anwar &
18 Company on behalf the Scottish Covid Bereaved.

19 At the beginning of the pandemic after the
20 declassification of Covid-19 as a high consequence
21 infectious disease, consideration was given by those
22 responsible for infection prevention and control
23 guidance as to whether to recommend that all healthcare
24 workers in the NHS dealing with Covid-19 patients should
25 wear FFP3 masks on a precautionary basis.

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1 how could we do that?

2 And I gave the example, I think earlier, of the
3 ambulance service --

4 **Q.** Well, we don't need to go further into that. I think we
5 have your answer in relation to that.

6 **A.** Okay.

7 **Q.** You've explained that as a non-clinician earlier on you
8 wouldn't start making clinical judgments about PPE and
9 you've also explained that as part of your role you were
10 the person who would set out to resolve any issues with
11 PPE. So a clinical decision being made in part based on
12 the stock levels of FFP3, am I correct in saying that
13 you would have liked to have known about that and had
14 you known about it you would have put things in place to
15 find out how to resolve that?

16 **A.** Yes.

17 **Q.** Moving on. In December 2020, further consideration had
18 been given at a UK IPC cell meeting to the wider use of
19 FFP3 masks in healthcare settings on a precautionary
20 basis in light of the evolving evidence on aerosol
21 transmission of Covid-19. Following discussion, this
22 was not recommended.

23 Again, was this brought to your attention?

24 **A.** I believe that was, yes.

25 **Q.** And that being so, what was then done about it?

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- 1 **A.** So I'm not sure if the timing is right here, and whether
2 or not that relates to what I was asked earlier about
3 CPR. No?
- 4 **Q.** No, it's in general, December 2020, at a UK IPC cell
5 meeting, it was advocated that a wider use of FFP3 masks
6 in healthcare settings on a precautionary basis, as
7 aforementioned, in light of the evolving evidence about
8 aerosol transmission of Covid-19.
- 9 **A.** Presumably, though -- I do recall this, but I presume
10 that whilst those concerns would be raised inside that
11 cell meeting, there would be counter views and those
12 counter views would prevail. So as the health
13 secretary, I am in a situation where the expert advice
14 is X. I do not necessarily have the evidence or the
15 basis to contradict that.
- 16 **Q.** I see that. Had you been made aware, as we've already
17 identified first of all, that the initial advice but for
18 the levels of stock and but for fit testing, where the
19 FFP for healthcare workers would have been used, and you
20 said that you would have taken action upon that, would,
21 then, had you known that in December 2020 it was being
22 advocated for a further reason, namely that emerging
23 information about aerosol transmission, had you known
24 all those things, would that have spurred you to action
25 at that time?

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- 1 "... simply ... not [enough] time to go through
2 the processes required to undertake [equality impact
3 assessments] given the rapidly changing nature of
4 events."
- 5 How, in those circumstances, did you ensure that
6 a rights-based approach was taken to the decisions made
7 during this time?
- 8 **A.** So the simple answer is: as best I could, bearing in
9 mind that -- formal equality impact assessments are
10 important and are critical for governments to undertake
11 in normal course, but it shouldn't be taken to imply
12 that only through a formal equality impact assessment
13 does a government minister understand equalities,
14 protected characteristics and the likely impact of any
15 decision on particular groups. Particularly when
16 decisions are being made collectively or discussed
17 collectively where you have different government
18 ministers with different areas of portfolio expertise.
- 19 So, in those very early days, as I said, the pace
20 of response of emerging understanding of the virus and
21 of decisions and actions that needed to be taken limited
22 our capacity to undertake formal EQIA assessments. You
23 will see that others took place retrospectively and, as
24 we moved through the pandemic, they were more part of
25 policy and decision-making as time allowed.

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- 1 **A.** It would certainly have made me have a long discussion
2 with the Chief Nursing Officer to try and understand
3 what were the various views being expressed and the
4 evidence behind those views, which is critical, that
5 then led to the IPC cell's decision and whether or not
6 we had any options around that.
- 7 **Q.** But the fact is that none of this information was known
8 to you?
- 9 **A.** No.
- 10 **Q.** Moving on. You have mentioned in your statements
11 equality impact assessments. And for those perhaps
12 listening, the equality impact assessment is a process
13 that evaluates the potential impact of a policy on
14 people with protected characteristics. And of course
15 some of them were very important during Covid, such as
16 age, disability, race, and pregnancy and maternity.
- 17 And the purpose of such equality impact
18 assessments are, amongst other things, to ensure that
19 policies don't unlawfully discriminate against people
20 with protected characteristics or remove -- sorry, and
21 remove or mitigate negative or adverse impacts.
- 22 Now, at paragraph 66 of your statement you say
23 that in the early stages of the pandemic you did not
24 carry out formal equality impact assessments as there
25 was, and I quote:

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- 1 **Q.** But what --
- 2 **A.** But in those early days I think my personal
3 understanding, and the understanding of my senior
4 advisers, allowed us to make some assessment of the
5 impact of our decisions on the groups you're talking
6 about.
- 7 **Q.** If these are important and critical as you've
8 identified, and likely impact upon groups, the issues of
9 age, disability, pregnancy and maternity, race, were all
10 ones that were critical in those early days and indeed
11 throughout the entire pandemic. Wasn't it all the more
12 critical to ensure right from the outset the
13 rights-based approach was focused on to ensure that you
14 might remove or mitigate negative or adverse impacts on
15 those specific groups?
- 16 **A.** There was undoubtedly important but I'm trying to help
17 you understand the volume of work, the pace of work, the
18 pressures to ensure that our NHS was realigned to be
19 capable of dealing with the numbers that were projected
20 in the worst-case scenario. That meant not only the NHS
21 was focused on that, but my entire directorate of civil
22 servants was focused on that. So in those early days --
23 and by early days we are talking about late February,
24 into March -- it was not possible to formally conduct
25 a new EQIA assessment before decisions were made,

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1 because decisions were required multiple times in any
 2 one day.

3 **Q.** Moving on to my next issue. Following on from that
 4 question, was there any thought given to any additional
 5 dangers in asking retired people to return to NHS care
 6 when you were trying to increase capacity for staff?

7 **A.** I'm not sure what you might mean by "dangerous".

8 **Q.** Well, we as a generality might be aware that older
 9 people are more likely to fall ill. As a very broad
 10 generality. And I had asked you a question about
 11 whether or not equality impact assessments had been
 12 carried out on people with protected characteristics,
 13 including age and/or disability, in order to remove or
 14 mitigate negative or adverse impacts. And what I'm
 15 asking you is, when a decision was taken to ask people
 16 to return to the NHS, retired people, was there any
 17 thought given to those additional dangers while you were
 18 trying to increase capacity, that you might be putting
 19 older people at risk?

20 **A.** So two points. First of all, we shouldn't assume that
 21 retired healthcare workers are older. Many of them are
 22 in their 50s and have chosen to retire from full-time
 23 healthcare work, particularly medics but also senior
 24 nurses, at a younger than -- age than in the rest of the
 25 population.

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1 government, do take and should take a rights-based
 2 approach. Stakeholders have a really important role to
 3 play. Critical to that is the relationship that I had
 4 with many of the stakeholder organisations, which meant
 5 that where there were issues that they were aware of
 6 that I was not necessarily aware of, they felt perfectly
 7 able to raise them with me immediately, formally or
 8 informally. And as I've already said, very shortly
 9 after the early stages of the pandemic formal EQIA
 10 assessments were undertaken.

11 **Q.** In retrospect.

12 **A.** And also in advance.

13 **Q.** Do you recognise that many of the stakeholder groups
 14 that you were talking about were themselves dealing with
 15 the impacts of the pandemic and may not have been able
 16 to raise concerns directly with you because of what they
 17 were dealing with?

18 **A.** I certainly recognise that they were dealing with the
 19 impact of the pandemic, as were many others. None of
 20 them ever indicated to me that that in any way impacted
 21 on their ability to raise concerns with me.

22 **Q.** Moving on. You have indicated in your evidence that the
 23 NHS Louisa Jordan, thankfully, was not needed to the
 24 degree expected, and the Louisa Jordan was commissioned
 25 and secured to provide further acute step down capacity

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1 Secondly, their return was entirely voluntary,
 2 so people were rightly making those assessments and
 3 decisions for themselves. And actually, my apologies,
 4 a third point is they would not be deployed into
 5 frontline work.

6 **Q.** Indeed, I'm not asking you about those issues that
 7 you've pointed out, I'm asking whether or not the
 8 Scottish Government gave consideration --

9 **A.** The answer is yes.

10 **Q.** They gave consideration to that?

11 **A.** Yes, I did, yes.

12 **Q.** And what was done about that?

13 **A.** I've just taken you through what was done about it. It
 14 was voluntary. It was not frontline work. And many of
 15 them were in their middle to late 50s.

16 **Q.** Moving on to the next issue. You said that you knew
 17 stakeholder groups would not hesitate to directly
 18 contact you if they felt you were remiss in the
 19 assessment upon impact on them. Should the onus be on
 20 stakeholders to raise equality issues with you after the
 21 decisions are made or should it be the Scottish
 22 Government take a rights-based approach to their
 23 decision-making in the first place?

24 **A.** So in normal course the Scottish Government, as I think
 25 you'll have seen from my previous track record in

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1 as a back up to the permanent acute estate.

2 We know, thankfully, we didn't get to the stage
 3 where the Louisa Jordan was becoming overwhelmed or that
 4 all the people that you thought might need to go there
 5 actually went there. But whilst the Louisa Jordan
 6 provided for extra bed capacity, how was it intended to
 7 increase the staffing capacity of the Louisa Jordan?

8 **A.** So a lot of the staffing capacity came from other parts
 9 of the health service where we had paused activity and
 10 in the senior levels of staffing at Louisa Jordan they
 11 were, from memory, certainly the chief executive and the
 12 medical director were recently retired, in their 50s,
 13 individuals.

14 **Q.** So it was for retired people and other people who were
 15 already paused in doing their work to come and do the
 16 work of the Louisa Jordan?

17 **A.** Yes.

18 **Q.** And had investigations been carried out as to whether or
 19 not that would have sufficed in terms of staffing? Are
 20 there any reports we can see in that regard, or
 21 anything?

22 **A.** Yes, the CMO and the medical director for Louisa Jordan
 23 undertook work to ensure that if it needed to be used
 24 for the purpose that it was created that there were
 25 adequate staffing levels and the right skill set to meet

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1 that need.

2 **Q.** I see. And will we be able to find therefore somewhere

3 record and reference to that?

4 **A.** I think you will need to ask Scottish Government that

5 question.

6 **MS MITCHELL:** My Lady, I'm obliged, those are the questions.

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

8 Mr Burton.

9 Mr Burton is that way, Ms Freeman.

10 **Questions from MR BURTON KC**

11 **MR BURTON:** Good afternoon, Ms Freeman. I asked questions

12 on behalf of the Disability Charities Consortium which,

13 as the name suggests, is a consortium of all the main

14 disability charities.

15 My learned friend has asked you some questions

16 about quality impact assessments and I won't repeat any

17 of those questions. I wanted to ask a couple of bit

18 more specific questions. I perfectly appreciate,

19 however, that this is some time ago and your memory may

20 have been sufficiently taxed already, so if you don't

21 remember, please, of course, just say so.

22 **A.** Thank you.

23 **Q.** In particular, I'm interested in the equality impact

24 assessment that was carried out retrospectively in

25 relation to shielding, and some observations that were

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1 some gaps in the data that was available but nothing is

2 said about gaps in relation to disability. So can we

3 take it from that that from the Scottish Government's

4 perspective, at least, there weren't any relevant gaps

5 in terms of the data pertaining to disability?

6 **A.** No, I don't think you can. Prior to being health

7 secretary, one of my ministerial responsibilities in

8 another portfolio was disability and so I was personally

9 aware of gaps in the data but at that point no work was

10 undertaken to try and fill those gaps or find a way by

11 which we could do that. So that then fed into that

12 situation that the EQIA describes. Whether or not there

13 has been subsequent work undertaken, I cannot tell you.

14 **Q.** Do you think that's something that the Scottish

15 Government might be able to tell the Inquiry should

16 a request be asked?

17 **A.** It might be able to tell the Inquiry, and equally,

18 the Inquiry might want to suggest that it is work that

19 is done.

20 **Q.** I'm most grateful, thank you. I wanted to ask you next

21 a question about the user research directory survey that

22 was done in relation to the shielding programme or, if

23 I can put it more broadly, the overall support that was

24 provided to people who were clinically vulnerable during

25 the pandemic, and you may recall that that survey

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1 made in relation to the protected characteristic of

2 disability. And in particular, for those who are

3 following the documents, it's at section 2 on page 7 of

4 that equality impact assessment under the title "Data

5 and Evidence Gathering, Involvement and Consultation".

6 It's said in relation to disability that 42% of

7 households in Scotland contain at least one person who

8 is long-term sick or disabled. This figure covers all

9 household members including children.

10 However, in relation to the question of shielding,

11 the document goes on to say this:

12 "The evidence gathered suggests that there is

13 likely to be a number of disabled individuals within

14 the shielding cohort. However, currently, there is no

15 breakdown of that number."

16 Why was it not possible to obtain a breakdown of

17 that number? Do you recall?

18 **A.** I don't recall why that would not be possible.

19 **Q.** Okay. That's fine. Just in relation to the sources of

20 that data, the Inquiry has heard quite a lot about the

21 paucity of available data in relation to the prevalence

22 of disability. And that EIA quotes two sources; one was

23 a Scottish household survey of 2016, and the other was

24 the 2011 census.

25 Now, the EIA, I can tell you, goes on to identify

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1 demonstrated that about 50% of people who were surveyed

2 thought that not everybody who needed protection had in

3 fact received protection during the pandemic. And one

4 of the groups identified was people who were disabled

5 and it was said in particular, at page 5 of that

6 document, those with disabilities, was the group, people

7 who normally cope well had routines disrupted, lost

8 support services and faced health difficulties and

9 reduced social contact.

10 I just wondered if you were able to help

11 the Inquiry with this question: did the findings of that

12 survey inform policy considerations thereafter in terms

13 of what was done or wasn't done to help people who were

14 clinically vulnerable but were otherwise identified as

15 not receiving the support that perhaps they might have

16 needed?

17 **A.** So one of the areas I can recall is in the area of adult

18 social care and the support to individuals who were

19 disabled in order to help them live as independently as

20 possible, and in my opinion, despite significant

21 additional resource, some parts of our country, of

22 Scotland, withdrew elements of those care packages and

23 that had a significant impact on people with

24 disabilities being able to live independently even in

25 abnormal times. And that was a situation raised very

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1 directly with me from the Glasgow Disability Alliance
 2 and Inclusion Scotland and we sought to resolve those
 3 issues with the relevant local authorities.
 4 **Q.** If I could just have one follow-up question. Can you
 5 remember roughly when that process began?
 6 **A.** I would think it would be the summer of 2020, perhaps
 7 a little earlier than that.
 8 **Q.** So certainly ahead of the second wave?
 9 **A.** Yes.
 10 **MR BURTON:** I'm very grateful, thank you, Ms Freeman.
 11 My Lady, those are our questions.
 12 **LADY HALLETT:** Thank you, Mr Burton.
 13 Mr Jory.
 14 He's over that way, behind you, but could you make
 15 sure, please, that your answers go into the microphone.
 16 **Questions from MR JORY KC**
 17 **MR JORY:** Ms Freeman, two quick areas, please, I hope
 18 they're quick. But just way of introduction, I ask
 19 questions on behalf of the Independent Ambulance
 20 Association, and I wonder if you can just help me with
 21 this, please. In your statement at paragraph 43 you
 22 mention your role in seeking guidance to reflect
 23 Scottish Government policy.
 24 Given the specific challenges of working in the
 25 ambulance sector, including the constrained working

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1 **A.** Yes, I do agree with that.
 2 **MR JORY:** Thank you very much indeed.
 3 **LADY HALLETT:** Thank you very much, Mr Jory.
 4 Right, that completes the questions we have for
 5 you, Ms Freeman. Thank you very much for your help.
 6 I don't know whether I can say it's the last time. As
 7 you know, I've been trying to make sure that the burden
 8 we place on people like you is limited, but sometimes
 9 I'm afraid it's just necessary.
 10 **THE WITNESS:** I understand that, my Lady, thank you.
 11 **LADY HALLETT:** Anyway, thank you very much for your help so
 12 far, and if you're going back to Scotland, I hope you
 13 have a safe journey.
 14 **THE WITNESS:** Thank you.
 15 **(The witness withdrew)**
 16 **LADY HALLETT:** I shall return at 2 o'clock.
 17 **(12.57 pm)**
 18 **(The short adjournment)**
 19 **(2.00 pm)**
 20 **LADY HALLETT:** Ms Price.
 21 **MR HUMZA YOUSAF (sworn)**
 22 **Questions from COUNSEL TO THE INQUIRY**
 23 **LADY HALLETT:** Mr Yousaf, thank you for joining us again.
 24 I'm sorry to have to ask you to keep coming back.
 25 **THE WITNESS:** No problem.

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1 conditions, paramedics were often the first to come into
 2 contact with patients, and they often had no knowledge
 3 of any pre-existing conditions of those patients, do you
 4 agree that any future guidance should include specific
 5 and clear guidance for the ambulance sector addressing
 6 the unique working environment in which they operated?
 7 **A.** I think that is reasonable. I would hope that guidance
 8 like that would be developed in conjunction with the
 9 ambulance service.
 10 **Q.** Thank you, that's very helpful.
 11 One other area, please. You mention in your
 12 statement at paragraph 42 about lateral flow testing and
 13 then PPE, at paragraph 44, being made available for NHS
 14 and primary healthcare staff. You were -- you said
 15 within questioned this morning by Ms Price, Counsel to
 16 the Inquiry, that in your opinion the professional views
 17 of healthcare workers needed to be respected. That if
 18 they wished to have additional PPE or FFP3 masks, for
 19 example, then they should be made available when they're
 20 requested and it's appropriate.
 21 Just this, do you agree that in any future
 22 pandemic anyone working as a frontline healthcare
 23 worker, so, for example, as a paramedic in an ambulance,
 24 whether employed by the NHS or someone else, should be
 25 provided with the same access to testing and PPE?

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1 **LADY HALLETT:** Ms Price.
 2 **MS PRICE:** Can you give us your full name?
 3 **THE WITNESS:** I'm afraid I am not hearing you at the moment.
 4 **LADY HALLETT:** Ah, okay. Did you hear me?
 5 **THE WITNESS:** That's better. I can hear you now, yes.
 6 **LADY HALLETT:** Try again, Ms Price.
 7 **MS PRICE:** Could you give us your full name, please,
 8 Mr Yousaf?
 9 **A.** Humza Haroon Yousaf.
 10 **Q.** You've prepared a witness statement for this module of
 11 the Inquiry, dated 16 August 2024, and the reference for
 12 that is INQ000480774. I understand you're familiar with
 13 that and you have a copy with you; is that right?
 14 **A.** That's correct.
 15 **Q.** Starting, please, with your role as Cabinet Secretary
 16 for Health and Social Care during the pandemic.
 17 You held this position between 19 May 2021 and
 18 28 March 2023; is that right?
 19 **A.** That's correct.
 20 **Q.** And in that role you held primary responsibility for the
 21 health and social care directorates and NHS Scotland?
 22 **A.** Correct.
 23 **Q.** Whilst you were in that role, is it right that the
 24 health boards across Scotland were accountable to you?
 25 **A.** Correct.

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1 **Q.** Although you had strategic rather than operational
2 responsibility, the latter being the primary
3 responsibility of the health boards?
4 **A.** That's right.
5 **Q.** During your time as Cabinet Secretary you worked closely
6 with the health boards and local authorities to respond
7 to the Covid-19 pandemic and to recover the healthcare
8 system in Scotland?
9 **A.** That's right.
10 **Q.** You refer at paragraph 13 of your statement to the
11 powers conferred by the National Health Service
12 (Scotland) Act 1978 upon Scottish Ministers.
13 The Inquiry understand that your predecessor Ms Freeman
14 put the NHS in Scotland on an emergency footing on
15 17 March 2020 which continued until 30 April 2022; is
16 that correct?
17 **A.** That is correct.
18 **Q.** By the time you were appointed what practical difference
19 did this status make to your role?
20 **A.** Can I, first of all, thank her Ladyship and the Inquiry
21 for allowing me to give evidence remotely. I'm very
22 grateful to that and I'm pleased to be back at the
23 Inquiry and hope that responses I can give will give
24 some insight into decisions that were made and the
25 rationale for decisions that were made at the time.

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1 stenographer I think is picking stuff up, but if you
2 could speak slowly and deliberately it might make the
3 audio better. And I see you've moved in closer, thank
4 you.
5 **A.** I will endeavour to do that, your Ladyship.
6 **LADY HALLETT:** Thank you.
7 **MS PRICE:** It was your decision to take the NHS in Scotland
8 off the emergency footing in April 2022. Can you
9 explain why?
10 **A.** Yes, I'm happy to. The emergency footing of the NHS was
11 reviewed every six months and it was due to end actually
12 at the end of March, from my recollection, March 2022.
13 However, the number of cases, Covid cases at that point
14 was going in the wrong trajectory and we were seeing
15 an increase in cases and I felt it was the wrong time to
16 do it and it was extended until the end of April, so
17 another month, and at that point a submission came to me
18 from my officials and I had discussions with my
19 officials to remove the emergency footing status from --
20 on the NHS.

21 And that was done primarily for two reasons: one,
22 of course, there were still an overwhelming pressure on
23 the NHS but we were out of, at that point, I would
24 suggest, the immediate emergency phase of the pandemic.
25 But also it was an important signal to our NHS boards

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1 In terms of the answer to your question, you're
2 absolutely correct. Of course, the NHS was already on
3 an emergency footing by the time I was Cabinet Secretary
4 for Health and Social Care. That meant that the NHS
5 understood the severity of the emergency that was in
6 front of us, and they also understood that any direction
7 that was given by the Cabinet Secretary was then to be
8 followed pretty much to the letter of that direction,
9 and as it was in statute.

10 In terms of the practical difference it made when
11 I was Cabinet Secretary for Health and Social Care, it
12 meant that the NHS, despite the change in Cabinet
13 Secretary, still understood that we were in the
14 emergency phase of the pandemic and of course that then
15 means that priority is then given to emergency care,
16 different to of course non-emergency elective care and
17 that also helped to inform the decision to then take the
18 NHS off emergency footing as well.

19 And, of course, as Cabinet Secretary, the powers
20 of direction were available to me as to my predecessor
21 although I didn't have any cause to use them at the time
22 I was Cabinet Secretary.

23 **LADY HALLETT:** Mr Yousaf, your audio isn't great, it's okay,
24 but if you could please speak as slowly and deliberately
25 as possible. At the moment I can follow because the

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1 that we needed to put a significant greater focus on
2 non-emergency care, particularly elective care, and
3 elective care, I would suggest, had been one of the
4 biggest victims in terms of prioritisation during the
5 emergency phase of the pandemic. Some health boards
6 completely stopped elective care altogether. Some,
7 of course, continued but at a much reduced scope.

8 So this was also a signal, a clear signal to the
9 health boards that I expected a resumption or scaling up
10 of non-emergency care.

11 **Q.** You refer in your statement to a further mechanism which
12 was available to you. The NHS Scotland Support and
13 Intervention Framework, or the escalation framework.
14 Can you explain, please, what that is.

15 **A.** So the escalation framework exists for cabinet
16 secretaries to escalate or de-escalate an NHS board.
17 There's five levels of escalation. The most severe
18 effectively results in, usually, the termination of
19 the -- termination of position for the board and senior
20 management of a health board and the government directly
21 intervening. And the levels below that have various
22 different degrees of intervention and support from
23 government and from officials.

24 And therefore, if, through our regular engagement
25 with an NHS board on a particular issue or set of

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1 issues, we believe that the progress is not going far
2 enough, fast enough or progressing at the pace we would
3 like, the escalation framework is available to us. And
4 I made the decision, for example, in my time as Cabinet
5 Secretary for Health and Social Care to escalate
6 Forth Valley on broadly two issues, an issue around
7 culture but also because of their A&E performance being
8 so poor.

9 I also took the decision to de-escalate a health
10 board, Greater Glasgow and Clyde, when the feedback that
11 we were getting from -- there's a national oversight
12 group that will help to monitor whether or not a board
13 is making sufficient progress. When it was clear that
14 Glasgow had met and had implemented the recommendations
15 of the oversight group, they could then be de-escalated.

16 So the escalation framework is a tool, as I say,
17 for appropriate levels of intervention and support from
18 ministers and officials towards a particular health
19 board.

20 **Q.** Picking up on that second example where you
21 de-escalated. The concerns, you say in your statement,
22 had originally referred to patient safety and nosocomial
23 infections. What concerns particularly were there in
24 relation to those issues that had led to escalation?

25 **A.** A range of well publicised issues. There had been
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1 a very good relationship with the Chief Medical Officer,
2 Sir Gregor Smith, but in my experience as Cabinet
3 Secretary for Health and Social Care, given the size
4 that we are in Scotland, the direct relationship with
5 health board chief executives and chairs is
6 a relationship that is a good one, is one where you can
7 meet with frequency. You build up good personal
8 relationships where necessary and at the same time, if
9 you need to make your views clear on what should happen,
10 there's a variety of ways of doing that, through
11 national guidance and then, of course, through, as we've
12 already discussed, if necessary, a power of direction.

13 My concern about having a kind of NHS Scotland
14 overarching entity in the same way that NHS England
15 exists, is you're effectively adding another layer of
16 bureaucracy with little in return. Not only do you get
17 little in return, I think the worry is that the direct
18 relationship between Cabinet Secretary for Health and
19 chairs and chief executives is diluted.

20 But also in a sense you -- it could allow
21 a Cabinet Secretary to feel like, in some respects,
22 they're somewhat off the hook when they should never be
23 off the hook. Being Cabinet Secretary for Health and
24 Social Care, and I can say this from my own experience,
25 you should be held accountable, not operationally, in
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1 issues around infection into wards, in, particularly,
2 a very new hospital, the Queen Elizabeth Hospital on the
3 south side of Glasgow, and had been significant concerns
4 of infection, including in wards where children had been
5 as well. These were well publicised at the time and my
6 predecessor took the decision rightly to escalate
7 Glasgow. There is also a public inquiry ongoing into
8 some of these issues as well. But for me, the decision
9 to de-escalate was taken when I was assured that the
10 recommendations of the oversight group had been
11 implemented and therefore de-escalation was appropriate.

12 **Q.** Your predecessor, Ms Freeman, has described the NHS in
13 Scotland as well equipped to operate as a single unit in
14 the event of an emergency due to its structure and also
15 due to it being -- there being a more direct
16 relationship between the health secretary and NHS
17 Scotland. It was, however, the evidence of the Chief
18 Medical Officer for Scotland to this module of
19 the Inquiry that a "Once for Scotland" approach during
20 the pandemic was made more difficult by the absence of
21 a national entity with a role akin to that of
22 NHS England in England to oversee the healthcare
23 response. What is your view?

24 **A.** I would certainly lean more towards Jeane Freeman's view
25 of this. I have a tremendous amount of respect and had
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1 terms of the operational decisions that are made
2 day-to-day by health boards, but you should absolutely
3 be held to account if there are failures of progresses
4 not being made on certain issues in health boards. And
5 if you have an overarching Scotland structure, that
6 could dilute the responsibility as well as the
7 accountability. So I would lean more towards
8 Jeane Freeman's view on this as opposed to
9 Sir Gregor Smith's.

10 **Q.** You note at paragraph 17 of your statement that in
11 relation to your decision-making, your relationship with
12 the Director-General Health and Social Care,
13 Caroline Lamb, was critical. Can you explain, please,
14 how your meetings with Ms Lamb and the chief operating
15 officer of NHS Scotland helped you to understand what
16 was happening on the ground in healthcare settings.

17 **A.** So I would meet John Burns, who was the chief operating
18 officer for the majority of the time that I was Cabinet
19 Secretary for Health. John Connaghan, his predecessor,
20 was there for a period and you referenced Caroline Lamb
21 and her role as DG Health and Social Care.

22 I met with John Burns, I would say, more
23 frequently than I would have met with Caroline because
24 John and I, during our regular discussions, usually
25 multiple times a week, John would have the view of what
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1 was going on on the ground. He would speak to each of
2 the chairs and chief executives of both the territorial
3 and the national health boards with great regularity,
4 sometimes daily he'd be speaking to most of them, and
5 therefore, he was able to give a view on the ground of
6 what was happening.

7 Caroline, of course, was also plugged in on the
8 ground, but Caroline and I would meet often to talk
9 about some of the overarching issues and concerns around
10 the health service and what action we could
11 realistically take, whereas the discussions with John
12 were very, very helpful, informing me about what was
13 going on on the ground usually in realtime.

14 **Q.** In terms of relationships with stakeholders in Scotland,
15 to what extent did you liaise with trade unions and
16 professional bodies during the pandemic?

17 **A.** Very regularly, indeed. I met with a number of trade
18 union groups not just because of pay negotiations --
19 that's when we probably met with most frequency -- but
20 we'd often meet with trade union groups, professional
21 bodies, stakeholder groups, and it's something I put
22 a lot of time, effort and energy, as did my predecessor,
23 and I don't doubt as have my successors.

24 **Q.** Your predecessor met with the vice president of the
25 Royal College of Emergency Medicine in Scotland on

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1 were under and that's still an issue that I know my
2 successors as Cabinet Secretary for Health and Social
3 Care spend a significant amount of time on.

4 **Q.** Turning, please, to the challenges which there were in
5 assessing the disproportionate impact of Covid-19 on
6 particular groups.

7 At paragraph 66 of your statement you acknowledge
8 that the Scottish Government would have benefited from
9 hearing more of people's lived experience. You give
10 an example that Cabinet would have benefited from having
11 a wider Scottish Government view of the impact of the
12 policies on people with disabilities.

13 What was the impact on healthcare decision-making
14 and policy of not fully understanding the lived
15 experience of people with disabilities and the impact of
16 policies on them?

17 **A.** I think from my point of view there was often
18 discussions in Cabinet about what any measures that we
19 were to bring -- bringing forward to help to curb the
20 effects of the virus, what impact that would have on
21 people with vulnerabilities. Those vulnerabilities
22 could be those who live in areas of higher deprivation,
23 those vulnerabilities could be people with a disability,
24 but I have often benefited from Cabinet sessions that
25 have been done where we bring people from the outside,

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1 a number of occasions. Did you ever meet with the
2 Scottish representatives of the college?

3 **A.** The college of emergency medicine, did you say?

4 **Q.** Yes.

5 **A.** Yes, I met with them on -- six times when I was Cabinet
6 Secretary for Health.

7 **Q.** And how informative were those meetings for you in terms
8 of what was going on, on the ground?

9 **A.** Very informative. Both the vice president of Scotland
10 and his deputy were practising healthcare workers and
11 professionals. One of them, I think, JP Loughrey was
12 based in the Queen Elizabeth Hospital, from my memory
13 and my recollection. So our busiest, if not our
14 busiest, one of our busiest hospitals in the entire
15 country, so to be able to get a view from him in
16 particular was extremely insightful. I suppose the
17 difficulty in those meetings was we knew how challenging
18 emergency care was and emergency medicine was, and there
19 was no, as you'd imagine, no silver bullet, there was no
20 quick way to turn around what was an extremely
21 challenging situation and I would say, I reflect back on
22 my time as Cabinet Secretary for Health and Social Care,
23 if there's one issue that took up the greatest chunk and
24 amount of time of mine, it would have been trying to
25 work hard to alleviate the pressure that our hospitals

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1 from stakeholder representative organisations, those
2 with lived experience, into Cabinet, usually it's at
3 a post-Cabinet session, so we'll do the formal business
4 privately then post-Cabinet we'll set aside maybe
5 45 minutes, an hour, perhaps longer, to hear directly
6 from people with lived experience, and from my
7 recollection, I don't think we ever did that with people
8 with disabilities during the pandemic. And, of course,
9 we could have done that remotely as well, and we may
10 well have benefited.

11 In terms of the impact, I know from my
12 conversations with a number of disabled people,
13 organisations and, indeed, those who have a disability
14 themselves, they communicated to me that they often felt
15 afraid that decisions that were made didn't fully
16 understand the impact on them, particularly when we were
17 opening back up, when we were removing NPI, for example,
18 non-pharmaceutical interventions, and while that was
19 welcomed by a lot of people, I know that a lot of people
20 with disabilities and their carers felt that that
21 situation could make them even more vulnerable.

22 We were always conscious of that but I think
23 hearing directly from disabled people in Cabinet as
24 a Cabinet, so all of us, whether you're the finance
25 secretary, the health secretary, transport secretary,

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1 justice secretary, all of us, hearing directly from
2 those with lived experience would have helped to inform
3 some of our decision-making.

4 **Q.** You provide an example of a practical step which could
5 have been taken to engage with people with disabilities
6 in relation to healthcare decisions, namely
7 a post-Cabinet discussion with organisations
8 representing those with a disability. What practical
9 difference do you think taking that step would have
10 made?

11 **A.** It's hard to say because I couldn't tell you exactly
12 what it was a disabled person's organisation might say
13 to us as a Cabinet at that particular time, and I do
14 want to emphasise that every time we discussed our
15 approach to tackling the virus, every time we considered
16 an NPI and whether we ought to remove
17 a non-pharmaceutical intervention or, indeed, impose
18 one, then a discussion about those with vulnerabilities
19 was always had and, of course, appropriate EQIs were
20 done, equality impact assessments were done at the time.

21 So it's really hard for me, in truth, to say
22 whether or not that would have led to a different
23 decision being made but there's absolutely no doubting
24 that nothing could have been lost and I suspect much
25 could have been gained from hearing directly as

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1 So that feedback was often given at Cabinet but,
2 as I say, there would have only been benefit and
3 certainly no harm done at all for appearing directly as
4 a Cabinet from disabled people's organisations.

5 **Q.** In terms of the lived experiences of those from minority
6 ethnic communities, you refer at paragraph 65 of your
7 statement to having met with the group Black and Ethnic
8 Minority Infrastructure in Scotland's Ethnic Minority
9 National Resilience Network. How did meeting with that
10 group inform your understanding of the impact of
11 Covid-19 in terms of health, in particular, on those
12 they represented?

13 **A.** Well, to state the obvious, I come from one of
14 Scotland's ethnic minority communities and a lot of my
15 own friends circle, family circle, were certainly
16 obviously feeding back their own experiences that it
17 would always be wrong for somebody to assume just
18 because you come from that group, I'm an ethnic minority
19 myself, with ancestry from the sub-continent, to assume
20 that that was every ethnic minority person's experience,
21 of course it wasn't. There will be intersections,
22 ethnic minorities that are not of course from the
23 sub-continent that have different socioeconomic
24 circumstances than I do and, therefore, being able to
25 link in with the likes of BEMIS, Black and Ethnic

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1 a Cabinet, because we all would have engaged, I think,
2 in various different roles and portfolios and we would
3 have engaged -- I would have, of course, engaged with
4 disabled people's organisations as Cabinet Secretary for
5 Health, but I think the whole of Cabinet hearing
6 directly from those with disabilities, that could only
7 have been to benefit.

8 **Q.** Were there any barriers to implementing that kind of
9 step during the pandemic? What prevented it from
10 happening?

11 **A.** No, I don't think so. We could have done it remotely,
12 for example. I think most of our Cabinet meetings
13 during that period, as you can imagine, were remote so
14 it could have been facilitated remotely. I think you
15 are just so in the absolute thick of it trying to act
16 with as much urgency as you can, given the nature of the
17 pandemic and especially when there was spikes in cases,
18 new variants, so there was no particular barriers but
19 also I should say, the First Minister at the time, she
20 rightly expected that cabinet secretaries would be
21 engaging, particularly the Health and Social Care
22 Cabinet Secretary and junior ministers would engage with
23 disabled people's organisations and those with lived
24 experience of being a disabled person. And that did
25 happen.

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1 Minority Infrastructure in Scotland and the Ethnic
2 Minority National Resilience Network brought together
3 people of different nationalities, different races,
4 religions, backgrounds and, again, cut across the
5 intersectionality.

6 So people from an ethnic minority and also from
7 areas of higher deprivation or ethnic minority people
8 from areas of higher deprivation and who had
9 a disability, so to be able to engage with those groups
10 was extremely helpful and particularly in the absence of
11 the level of data I would have hoped that we had on the
12 ethnic minority communities' experience of the
13 healthcare system and the impact of the pandemic on
14 ethnic minorities, the level of data we had, I'm afraid
15 was sub-optimal.

16 **Q.** During the pandemic how did stakeholder engagement
17 inform plans to mitigate disparities in health outcomes
18 among ethnic minority communities?

19 **A.** That feedback that we were getting from the likes of
20 BEMIS, from CRER, from CEMVO, these are all
21 organisations in Scotland that represent ethnic
22 minorities to a large degree, and the feedback really
23 helped inform us of differences or changes, forgive me,
24 that we had to make to address all the disparities that
25 existed.

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1 So, for example, we were hearing some feedback
2 that vaccine uptake was lower among some ethnic minority
3 groups. That then allowed us to use our mobile vaccine
4 assets to go to gurdwaras, to go to mosques, to go to
5 churches that had a large Scottish African population in
6 them. We were able to find even more or greater
7 nuances, for example when it came to Ramadan, one month
8 of the year observed by Muslims, and there were some
9 concerns around whether or not the vaccine could be
10 given during that time amongst some members of the
11 Muslim community. We were able to work with, I think
12 the organisation was the British Islamic Medical
13 Association, BIMA, from memory we were able to work with
14 them and they created a video with ethnic minority
15 doctors, clinicians who were able to explain and answer
16 some of those questions.

17 So the feedback was really important and helped us
18 to therefore nuance what we were doing in terms of
19 a response to the pandemic. But what would have helped
20 even more would have been actual, not just anecdotal
21 evidence but data.

22 **Q.** On that point of data, one of the recommendations of
23 a report dated 18 September 2020 published by the expert
24 group established to consider the impact of Covid-19 on
25 ethnic minorities in June 2020, and if it helps you,

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1 next iteration of the Covid vaccine programme, in
2 November 2021, a mandatory question on ethnicity was
3 introduced when people were asked ethnicity at their
4 appointment. Of course, people could refuse to answer
5 the question if they so wished but that then provided us
6 with a really helpful dataset on vaccine uptake.

7 But it is plainly obvious to the government that
8 the level of data that we have in relation to ethnic
9 minorities in Scotland, not just across health but
10 across portfolios, is not where we want it to be, it's
11 not good enough, hence why the government agreed to
12 establish the anti-racism observatory to work across the
13 public sector and across portfolios in government to
14 say, well, where are the gaps and where do we have to
15 make sure that we have much greater access to data that
16 concerns ethnic minorities in Scotland and not just rely
17 on, for example, English data and say, well, we can just
18 transpose that across Scotland. It's better to have our
19 own data.

20 **Q.** Were any further improvements to the recording,
21 collection and monitoring of ethnicity data in the
22 healthcare system introduced during your tenure?

23 **A.** Well, I referenced the vaccine -- uptake in terms of
24 vaccine. I don't know if there was anything else in
25 particular at that time. I would have to look back over

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1 this is the report you refer to at paragraph 173 of your
2 statement.

3 One of those recommendations was that data
4 relating to the NHS workforce and the use of healthcare
5 services should be accurate, comprehensible, accessible,
6 capable of being ethnically disaggregated and regularly
7 monitored and reviewed.

8 What progress had been made in terms of
9 improvements to recording, collection and monitoring of
10 ethnicity data within the NHS by the time you took up
11 the role of Cabinet Secretary in May 2021?

12 **A.** So, some progress had been made, for example ethnicity
13 recording became mandatory for hospital admission
14 datasets in February 2021. If I pause on that point.
15 That's obviously progress, but that's almost a year into
16 the pandemic, and it's only a year into the pandemic
17 that we're finally getting ethnicity recording datasets.
18 I think, and I may be -- I stand to be corrected, but
19 that level of data I think existed in some other parts
20 of the UK primarily in England.

21 But, you know, there's some progress that was
22 made. When I came in to role in May 2021, one of the
23 areas or gaps that we had was the ethnicity question was
24 still not asked when it came to vaccine uptake.

25 Certainly no mandatory question was asked. So in the

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1 my notes. I don't recall anything further was done to
2 the vaccine question that I referenced.

3 **Q.** More widely in terms of data and monitoring, when you
4 were Cabinet Secretary, was any department or
5 organisation or directorate monitoring the deaths of
6 healthcare workers from Covid-19?

7 **A.** Forgive me, are you asking if it was monitored by
8 ethnicity or overall?

9 **Q.** No, more widely, just simply the question of whether the
10 deaths of healthcare workers from Covid-19, whether data
11 was being collected looked at, monitored, by any
12 particular department, directorate or organisation,
13 whether broken down by ethnicity or not?

14 **A.** Certainly it wasn't broken down by ethnicity, and
15 forgive me, I don't recall whether it was collected by
16 healthcare worker. I certainly do remember reports
17 coming in giving us detail of deaths of NHS workers but
18 I'm trying to struggle to remember whether that was done
19 with any regularity or was ad hoc at the time. So,
20 forgive me, I cannot recall if it was done with
21 regularity.

22 **Q.** I'd like to turn, please, to infection prevention and
23 control and PPE issues. The recommendations made in the
24 18 September 2020 expert group report, which we've just
25 referred to in the context of ethnicity data, included

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1 a recommendation on fair work practices. And in
2 particular the recommendation was that Scottish
3 Government, NHS Scotland and other partners must
4 demonstrate and -- would it help if I put this on screen
5 so you can see what I'm referring to?

6 **A.** Yes, please.

7 **Q.** INQ000241567. And it's page 7, please.

8 So it's recommendation 4 here, on fair work
9 practices. And in particular, in the second half of
10 this:

11 "The Scottish Government, NHS Scotland and other
12 partners must demonstrate how they will ensure that fair
13 work practices are in place in health and social care
14 settings, particularly in relation to PPE, and other
15 workplaces."

16 Was this recommendation drawn to your attention
17 when you took up the role of cabinet secretary?

18 **A.** Yes, I was certainly aware of the recommendation and it
19 was important that we had in place particular guidance
20 for black, Asian and minority ethnic health and social
21 care workers, which we did. We ended up having guidance
22 that included the -- all minority ethnic staff with
23 underlying health conditions and disabilities. Or if
24 they were over 70 or pregnant, they had to be
25 individually or should be individually risk-assessed.

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1 of the Scottish Parliament, although he worked in
2 a different health board at the time, and he came with
3 that particular issue and -- and was working through it.
4 And obviously, as his local member of the Scottish
5 Parliament, I was able to also work on that case through
6 the appropriate channels and where necessary.

7 But I also have a number of friends and family who
8 work in the NHS and worked in the NHS at the time and
9 there was other issues that were also raised with me.
10 For example, for those that did require an FFP3 mask,
11 which is obviously face fitted and tested, the
12 challenges that some women who chose to wear the hijab
13 experienced sometimes with that face fit.

14 And that was early on in the pandemic and I think
15 those issues were very quickly ironed out so sometimes
16 these issues would come up anecdotally to me directly.
17 Sometimes they would come in through the discussions we
18 had with BEMIS or other stakeholders that we've already
19 touched upon.

20 **Q.** In relation to ill-fitting PPE, the Inquiry has heard
21 evidence that some women were affected by PPE fit issues
22 as well. Were any Scotland-wide steps taken to address
23 the range of PPE available for the range of healthcare
24 workers in Scotland?

25 **A.** Can I say that that was probably dealt with by my

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1 So I was aware -- also aware of the subsequent actions
2 that were taken thereafter.

3 **Q.** And what did you understand the recommendation here
4 relating to PPE to mean?

5 **A.** Well, again, that risk assessment should absolutely
6 include whether or not there should be adjustments made
7 to additional PPE or different types of PPE, if that is
8 what a risk assessment ends up resulting in. But it was
9 really important that the impact of Covid, the
10 disproportionate impact of Covid on ethnic minorities,
11 particularly in a health and social care space, was
12 understood, and it was within Scottish Government, and
13 that resultant action was taken.

14 **Q.** You explain at paragraph 178 of your statement that you
15 were made aware during the pandemic of issues with PPE
16 which affected some members of Scotland's minority
17 ethnic communities, and in particular you give the
18 example of a Sikh healthcare worker who required bespoke
19 PPE to accommodate his beard.

20 How did you become aware of the issues you refer
21 to in that paragraph, and what steps did you take to
22 address them?

23 **A.** Well, the individual concerned, without giving any kind
24 of identifying markers, was a constituent of mine and
25 therefore came directly to me as a constituency member

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1 predecessor in far greater detail. At the time when
2 I became Cabinet Secretary for Health and Social Care,
3 although there were issues of PPE raised as I've just
4 referenced, very kind of individual nuanced issues. At
5 that point, issues around supply, test, durability of
6 PPE, those were not issues that came up with any great
7 frequency at the time I was health secretary. As I say,
8 they were largely dealt with in the early days of the
9 pandemic and therefore by my predecessor.

10 **Q.** In terms of compliance with IPC measures, you refer at
11 paragraph 182 of your statement to well-documented
12 concerns in the early days of the pandemic that IPC
13 measures could not be complied with in some parts --
14 some older parts of the Scottish hospital estate. And
15 again this may be something that you consider was
16 resolved before your time, but during your time was
17 inadequate ventilation in some hospitals a concern which
18 continued to be raised?

19 **A.** It would certainly have been raised because, of course,
20 some of our hospital estate was older, and I think you
21 have taken evidence from clinicians at the GRI (Glasgow
22 Royal Infirmary), for example, and that was a very well
23 publicised challenge at the time, but most of these
24 challenges around the hospital estate, its
25 infrastructure, the challenges around ventilation, for

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1 example, or bed spacing because of the limitations on
2 space, these were issues that were largely aired, again,
3 at the beginning of the pandemic. And certainly when
4 greater understanding of the pandemic -- of the virus,
5 forgive me, and the nature of the spread and
6 transmission of that virus, as that began to evolve and
7 our understanding evolved, then we were able to make
8 adjustments at that point. But that was, I think, more
9 of an issue in the earlier days of the pandemic.

10 **Q.** You refer at paragraph 183 of your statement to the
11 difficult balance which had to be struck between
12 maintaining robust IPC measures and the need to use
13 every bit of hospital capacity you could.

14 Did you receive reports during the pandemic of IPC
15 measures not being complied with or varied, for example
16 by reducing bed spacing because of stretched hospital
17 capacity?

18 **A.** There was, on occasion, a request for derogation from
19 national guidance, and usually that derogation or that
20 request for derogation was accepted because, as you say,
21 the space, the infrastructure of some of the hospitals
22 meant that it -- very limited derogation was required,
23 so there was occasion when that would happen, and there
24 was a process whereby an NHS board would engage with my
25 officials, the CNO, the Chief Nursing Officer, usually

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1 to be satisfied that all the appropriate measures were
2 taken ahead of agreeing to any derogation that took
3 place.

4 It was my experience most certainly that hospital
5 chief executives and their boards would not take such
6 decisions to derogate from national guidance at all
7 lightly and usually every single possible avenue to
8 avoid that would be taken. But sometimes it was simply
9 necessary.

10 **Q.** In terms of PPE supply, what progress had been made with
11 boosting domestic production of PPE by the time you
12 became cabinet secretary?

13 **A.** It was a -- very significant progress had been made
14 and -- and credit goes to my predecessor but also the
15 minister at the time, Ivan McKee, he's not minister in
16 the government, in a slightly different role, but the
17 minister at the time, Ivan McKee made significant
18 progress in order to, well, ensure there was a domestic
19 manufacture and supply chain so we wouldn't be so
20 reliant -- the pressures of a global supply chain in the
21 future. So this was already, in fairness, well
22 developed by the time I was cabinet secretary.

23 **Q.** You describe a range of reports and dashboards which you
24 received, depending on the relevant time period, whether
25 it was a report or a dashboard, which addressed stock

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1 around any derogation and, if it was significant, of
2 course, it would be brought to my attention. If it's
3 a relatively minor derogation, the Chief Nursing Officer
4 would be delegated to make that decision.

5 **Q.** Was there any way of flagging up hospital capacity
6 issues that might be causing the need to derogate from
7 guidance so that they could be addressed at a national
8 level?

9 **A.** We received regular data -- I received regular datasets
10 from my officials on hospital occupancy, and --

11 **Q.** I mean specifically in the context, if someone had felt
12 it necessary, a health board or a hospital, to change
13 the IPC measures being applied or to vary them, because
14 of, for example, capacity issues, was there a method
15 through the application to derogate, if I can put it in
16 that way, of raising a concern about the capacity aspect
17 and addressing that?

18 **A.** Yes, I mean, there would be -- that would be the nature
19 of the conversation that undoubtedly took place between
20 the Chief Nursing Officer -- or, indeed, if it was
21 flagged to my attention, the focus of the discussion
22 would be: well, why is this being done? So, for
23 example, bed space being decreased due to lack of space.
24 What has been done to address the capacity issues of
25 that particular hospital or health board? And we'd have

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1 levels and orders received from health boards.

2 When pressures on hospitals and the ambulance
3 service in Scotland increased from around September 2021
4 due to the Omicron variant, did you receive reports,
5 whether formally or informally, of any PPE supply or
6 access issues?

7 **A.** Not as Omicron set in. I think by that point the supply
8 of PPE was adequate. There no doubt would have been the
9 odd occasion where perhaps there was a disruption within
10 the supply chain. Those were usually very localised and
11 could be resolved very quickly, given the amount of
12 stock that we held at that point. More of a challenge
13 around PPE when I was Cabinet Secretary for Health
14 was -- and I think I reference this in my witness
15 statement -- a kind of ongoing discussion, particularly
16 from trade union representatives, around the greater
17 availability and use of FFP3 masks and some of the back
18 and forward between the trade union organisations and
19 staff members and perhaps clinical advisers and clinical
20 bodies that were there advising us on the use of
21 FFP3 masks.

22 **Q.** You refer at paragraph 192 of your statement to concerns
23 raised when you met staff and trade union
24 representatives during a visit to the Royal Alexandra
25 Hospital that FFP3 masks were not routinely available

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1 for staff, some of whom felt more comfortable wearing
 2 it. Can you recall when, roughly, this was?
 3 **A.** The visit to the Royal Alexandra Hospital, I don't
 4 recall exactly when it was but I should say that that
 5 was just one example of the issues that were being
 6 raised by trade union groups quite regularly by that
 7 point, so in kind of early 2022, even the end of 2021 to
 8 be honest. At the end of 2021, towards the beginning of
 9 2022, the issue around FFP3 masks, having them more
 10 widely available or even, as some groups wanted,
 11 mandated for health and social care workers, that was
 12 an issue that was brewing during that time, so the visit
 13 to the Alexandra Hospital was just one example that
 14 I had to say was being communicated more regularly --
 15 and quite publicly, I should say -- by trade union
 16 groups and staff working with -- some staff working
 17 within the NHS.
 18 **Q.** Before that period, so before the end of 2021, had it
 19 been brought to your attention that healthcare workers
 20 wanted FFP3 masks to be routinely available? As in, how
 21 early on did you become aware of that debate?
 22 **A.** I'm afraid I couldn't recall exactly when was the first
 23 time that it ever came to my attention. I should say,
 24 for all of those who understandably were proposing and
 25 advocating for greater availability and use of FFP3,
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1 infection prevention control specialists to change
 2 from using Fluid Resistant Surgical Mask Type IIR
 3 ('FRSM') to FFP3 respirators ('FFP3s'), in the light
 4 of emerging Covid-19 variants. I requested
 5 an evidence paper on the topic on 13 January 2022,
 6 given the concerns voiced by trade unions and
 7 professional organisations about the psychological
 8 safety of their members in relation to not being
 9 permitted to wear an FFP3 rather than a FRSM in
 10 settings where they were not performing aerosol
 11 generating procedures ... on patients."
 12 You go on:
 13 "In light of that evidence paper, and further to
 14 discussions with stakeholders, discretionary access to
 15 FFP3 masks was introduced on 19 April 2022 -- not as
 16 an IPC measure per se, but to improve the confidence
 17 and wellbeing of health and social care staff.
 18 Discretionary access guidance ..."
 19 And you have exhibited that.
 20 Discretionary access was based on healthcare
 21 worker preference; is that right?
 22 **A.** Yes.
 23 **Q.** Why did you decide as a matter of policy that there
 24 should be such discretionary access?
 25 **A.** Because first and foremost the clinical advice that we
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1 there was also a number of healthcare workers who did
 2 not -- and were very vociferous in their opposition to
 3 FFP3 masks being mandatory. And therefore that's why we
 4 landed on the discretionary side of things.
 5 As you can imagine, I'm sure you'll recall seeing
 6 some of the bruise marks that a number of healthcare
 7 workers had across their faces and so on wearing FFP3.
 8 They are not comfortable for long periods of time, and
 9 therefore if the evidence, a clinical device, was
 10 suggesting that they weren't required, then the
 11 government and I, in my role, is not going to mandate
 12 them but simply allow them to be used on a discretionary
 13 basis.
 14 But, forgive me, the direct answer to your
 15 question is I couldn't recall when the very first time
 16 the issue of FFP3 masks was brought to my attention.
 17 **Q.** Did you understand at the time that FFP3 masks were more
 18 protective than fluid-resistant surgical masks?
 19 **A.** Yes. Yes, I think that was well understood.
 20 **Q.** Could we have on screen, please, page 43 of
 21 INQ000480774. And at paragraph 187 you say:
 22 "During my time as Cabinet Secretary ... there
 23 was some lobbying by opposition parties, trade unions
 24 including the BMA, staff side, the media, Fresh Air
 25 (an NHS lobby group), healthcare workers, and
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1 were receiving from the IPC cell, from CNRG, the Covid
 2 Nosocomial Review Group was saying although we have the
 3 latest understanding of the epidemiology of the virus,
 4 the latest understanding of how it is transmitted -- so
 5 well-known by this point that the virus could also have
 6 airborne transmission as well as through droplet -- that
 7 even with -- in light of all of that evidence and our
 8 latest understanding, the advice was not to make FFP3
 9 masks discretionary.
 10 However, there was, as I referenced in the
 11 statement and as you have just exhibited on the screen,
 12 a number of those who represent staffing groups within
 13 the NHS, well respected professional bodies, RCN, BMA,
 14 a number of colleagues in Parliament, now saying that
 15 they were hearing directly from staff that they would
 16 like access to FFP3. Not all staff. I have already
 17 mentioned that a number of staff did not want to wear
 18 FFP3 masks and did not think that they were necessary or
 19 needed. And therefore if it helped a healthcare worker
 20 have confidence to go into their workplace by having
 21 access to FFP3, then it certainly, in my view, didn't do
 22 any harm to give that discretionary access, particularly
 23 when, frankly, we needed every single healthcare worker
 24 that was able to work in work and performing to the best
 25 of their abilities, which I'm pleased our healthcare
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1 workers did and continue to do right to this day.

2 **Q.** This was not an IPC measure per se, but a step taken to
3 improve the confidence and well-being of staff. So it
4 wasn't led by the science, or the transmission -- the
5 epidemiology when it came to transmission per se. Do
6 you think that this policy should have been introduced
7 sooner, whether by you or your predecessor?

8 **A.** As I say, it was an issue that largely came to light in
9 my time as health secretary towards the end of 2021.
10 Certainly it may well have been raised prior to that.
11 But the head of steam around the issue, the momentum
12 around the issue really came to a head towards the end
13 of 2021 and the beginning of 2022. I couldn't at all
14 speak for my predecessor on whether this was raised with
15 her with great regularity or not but it certainly --
16 although it may have been raised, as I say the momentum
17 behind the campaign to have FFP3 masks in healthcare
18 really took a different -- really came -- had a lot of
19 momentum towards the 2021, beginning of 2022, hence why
20 the submission was taken first to get an evidence paper
21 and then, ultimately, ministerial decision to allow
22 discretionary access was taken.

23 **Q.** Turning, please, to hospital capacity issues and the
24 response to that. And starting with the question of
25 what information was available to you at the time to

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1 **Q.** You explain in your statement that the daily reports did
2 not explicitly flag breaches of baseline capacity, and
3 we can see that from this spreadsheet. There are no
4 figures for bed occupancy as a percentage of baseline or
5 surge capacity, and the report doesn't give any
6 information about whether ICU staffing ratios were being
7 maintained, whether at all or to recommended standards.

8 How easy did you find it, at a glance, from the
9 reports you received to understand how well hospitals
10 were coping with demand?

11 **A.** First of all, if there was a -- just to be clear, if
12 there was a breach in baseline capacity, so (*audio*
13 *distortion*), a breach of baseline capacity of ICU beds
14 then I was notified, and it only happened on one
15 occasion from my recollection --

16 **Q.** If I can stop you there a second, to be clear what we're
17 talking about. That's national baseline capacity that
18 you're referring to, is it?

19 **A.** No, no, if there was a breach in baseline capacity of
20 a particular -- in a particular health board but I was
21 also very clear that the work done, in fairness, by my
22 predecessor and was being done by the Scottish
23 Government, meant that there was adequate surge capacity
24 of ICU beds and therefore protocols were in place that
25 should there be a breach of the baseline then there

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1 help you respond to capacity issues. You've already
2 referred to some of the data on occupancy which you
3 received, and you refer in your statements to reports
4 you received as part of your daily Covid-19 data
5 briefings.

6 Could we have on screen, please, INQ000372596.

7 This is a spreadsheet and it's dated
8 29 December 2020, and I'd just like to check whether
9 this was still the type of report that was being
10 produced for the cabinet secretary for Scottish
11 Government relating to bed occupancy when you were
12 cabinet secretary.

13 **A.** Forgive me, it's not appearing on my full screen but
14 I do think I know the document. I think I have a hard
15 copy of it here, it's a spreadsheet.

16 **Q.** I can describe it. It's the spreadsheet which provides
17 for each hospital grouped by health board and network
18 a number of things. So there are a figures for the day
19 and the previous day, providing empty, full, and closed
20 beds, the number of patients at each level of care and
21 the number of suspected and positive Covid cases.

22 Is that the report you're thinking of in your hard
23 copy papers?

24 **A.** Yes. Yes. And that data are available, regularly
25 available to Scottish Government.

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1 would be measures in place to increase ICU beds should
2 that ever be required.

3 **Q.** Just being clear about the one occasion you say that
4 baseline capacity was breached, we can bring it up on
5 screen if you like but one of the SICSAG reports,
6 I think the Public Health Scotland statement containing
7 a graph breaks things down by network. So by North and
8 East and West, and it appears from that, at least, that
9 individual health boards or -- apologies, individual
10 networks did experience a breach of baseline capacity on
11 more than one occasion. Is that your understanding,
12 that the one occasion relates to a national baseline as
13 opposed to any particular network or any particular
14 health board?

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

16 **Q.** Okay. Did you have an adequate understanding of
17 staffing ratios and the extent to which the standards
18 for those staffing ratios were being maintained when you
19 were cabinet secretary or was that something you felt
20 was not full in terms of the data?

21 **A.** From my, again, recollection, there's no doubt that
22 there could have been a greater level of data around
23 staffing ratios but can I just say should we have
24 required that, it could have also been quite intensive
25 on individual staffing teams if we had it by hospital,

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1 even by health board, but you would probably need it
 2 broken down by acute site. It would be quite onerous,
 3 I think, at a time when we couldn't afford to place
 4 an additional burden. Because ultimately, it was well
 5 understood by me as Cabinet Secretary for Health and
 6 Social Care that our -- we were having significant
 7 capacity issues within our hospitals and therefore we
 8 were told with regularity particularly from the likes of
 9 the RCN, the Royal College of Nursing, that the staffing
 10 ratios were far more than they should be, there's not
 11 enough staff to patients as there should be, and it's
 12 one of the reasons that the RCN in particular pushed me
 13 very hard for a timetable for the implementation of the
 14 Health and Care (Staffing) Act, to which I eventually
 15 agreed with them to a timetable. The Act had been
 16 passed many years prior but we'd not got
 17 an implementation timetable.

18 So it was well understood within government that
 19 the staffing ratios were not where they needed to be and
 20 we were hearing quite publicly as well as privately the
 21 concerns being flagged by staff groups, professional
 22 bodies and trade unions.

23 To answer your question directly, did we have data
 24 broken down, kind of, by level, by acute site? No, we
 25 didn't. Certainly not that I saw, again, with any

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1 overwhelmed.

2 **Q.** At the time what advice did you receive about what
 3 resources were required for an ICU bed because,
 4 of course, it's not just the bed itself?

5 **A.** No, indeed, it's the staff that are required so,
 6 obviously, any advice around ICU beds would have made
 7 the point that it required specially-trained ICU staff.
 8 I should say that on this issue of ICU beds, it was not
 9 an issue that was raised again with great regularity.
 10 There were protocols in place in terms of going from
 11 baseline to surge capacity if required and if I think
 12 back to all of the very legitimate questions that
 13 Members of Parliament asked me weekly, if not multiple
 14 times a week, most of those issues concentrated on
 15 emergency care, in terms of people waiting too long in
 16 A&E for example, they focused on delayed discharge and
 17 high levels of delayed discharge and the resumption of
 18 elective care and people waiting too long on waiting
 19 lists while that happened.

20 ICU capacity was rarely an issue of questioning
 21 from Members of Parliament, and -- you know, I don't
 22 recall all of the correspondence that came to me,
 23 of course, but was not a theme that was raised regularly
 24 in correspondence either.

25 **Q.** In terms of a particular crunch point when you were

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1 regularity. Should we have, it certainly possibly could
 2 have aided our deliberations but I don't know if there
 3 was a way to do that that wouldn't have been burdensome
 4 or onerous on staff groups.

5 **Q.** In your statement prepared for Module 2A of the Inquiry,
 6 you said you believed the measures you took in Scotland
 7 were effective in avoiding the NHS being overwhelmed.
 8 What did you understand "NHS overwhelm" to mean or look
 9 like?

10 **A.** That is a big question because it is a subjective term.
 11 I accept that somebody who had been waiting and has been
 12 waiting two years for a hip replacement might well feel
 13 the NHS is being overwhelmed but essentially the reason
 14 why I made that statement, and stand by it, is that the
 15 NHS at a time of extreme pressure was able to focus and
 16 deliver an adequate level of emergency care.

17 Now, that doesn't mean that there wasn't
 18 an impact. There clearly was, particularly on elective
 19 care. There was, for a period, no cancer screening for
 20 example as well. But the NHS, and this is thanks to,
 21 of course, the NHS staff, that they were able to step
 22 up, work their absolute socks off to ensure that people
 23 received an adequate level of emergency care, so even
 24 with a pandemic, were able to provide that service and
 25 stop the NHS from completely collapsing or being

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1 Cabinet Secretary, is it right that the hospitals in
 2 Scotland were under particular pressure after
 3 September 2021 with, in particular, the effects of the
 4 Omicron variant?

5 **A.** Yes, that's correct, it's one of the biggest points of
 6 pressure I think when I was Cabinet Secretary for Health
 7 and Social Care.

8 **Q.** And thinking about that time in particular, did you
 9 fully appreciate that when baseline capacity was
 10 breached, even if surge capacity was technically not,
 11 this had consequences for the quality of care patients
 12 were receiving, at least potentially?

13 **A.** Well, without a doubt. The Royal College of Emergency
 14 Medicine has some reports on this issue in terms of
 15 people waiting longer than they should for emergency
 16 care, what the resultant impacts are of that and very
 17 serious impacts of that could be, and of course, we also
 18 knew from meeting with specialists in orthopaedics, for
 19 example, the detrimental impact of not resuming fully on
 20 elective care was having on those that they cared for,
 21 the deconditioning, for example, that was taking place.
 22 So there's no doubt at all in my mind, and certainly not
 23 in the government's, that the increased challenge in
 24 capacity and occupancy within our hospitals was
 25 undoubtedly having a detrimental impact on members of

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1 the public, and it's why, as I think I referenced
 2 earlier on during my contribution, that the biggest
 3 chunk of portion of my time, if any issue dominated my
 4 time as Cabinet Secretary for Health and Social Care,
 5 would have been trying to alleviate the pressure that
 6 our acute sites were under.

7 **Q.** And in that particular period of pressure from
 8 September 2021, what steps were taken to mitigate the
 9 pressures on the hospitals in Scotland?

10 **A.** Quite a number of steps, both from the front door and
 11 the back door of the hospital estate, but I suppose,
 12 first and foremost, when Omicron became a variant of
 13 concern, when it -- when we were concerned about its
 14 transmissibility, its possible immune escape, and we
 15 were still learning about Omicron and its
 16 characteristics. The number 1 defence against it and
 17 against our hospitals being completely overwhelmed was,
 18 of course, the vaccine programme and therefore I was
 19 leading our vaccine programme, winter programme, and we
 20 had the "boosted by the bells" campaign to have as many
 21 people boosted with the vaccine before the Hogmanay
 22 bells, before the bells for New Year, and although we
 23 didn't quite meet our 80% target, we had record numbers
 24 of vaccinations delivered at one point, I think,
 25 according to the world data, we had the second-fastest

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1 one of the most difficult winters that our NHS has ever
 2 faced in its over seven decades of existence.

3 **MS PRICE:** My Lady, would that be an appropriate moment for
 4 the afternoon break.

5 **LADY HALLETT:** Yes, certainly. I shall return at 3.25.
 6 (3.08 pm)

(A short break)

8 (3.25 pm)

9 **LADY HALLETT:** Ms Price.

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

11 I'd like to come, please, to hospital visiting
 12 policy in Scotland. You explain at paragraph 200 of
 13 your statement that between May 2021 and June 2022
 14 official guidance on hospital visiting from the Scottish
 15 Government recommended that visiting restrictions should
 16 vary in accordance with local levels according to
 17 a route map.

18 Can you explain, please, the rationale behind this
 19 change?

20 **A.** Yes, I think it was to allow for local variation where
 21 there was good epidemiological reason to do so. So it
 22 would make little sense for Orkney and the population of
 23 Orkney to have to have the level of severe restriction
 24 around hospital visiting policy if their R number was
 25 low, if their number of cases was low in comparison to,

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1 vaccine programme in the world at one point.

2 So we had the vaccine programme as the first line
 3 of defence to stop our NHS from being completely
 4 overwhelmed.

5 There was also significant efforts being made on
 6 messaging around the other avenues people could go to as
 7 opposed to emergency services acute sites, for example
 8 ensuring that people knew that NHS 24 was available,
 9 that the GP was still available, that Pharmacy First was
 10 available, and all these other avenues before going to
 11 an acute site and we made sure we raised the level of
 12 that messaging when Omicron hit.

13 There was also a number of conversations at that
 14 point that were taking place with an increasing
 15 frequency around alleviating pressures in the back door,
 16 so trying to get those who were ready for discharge,
 17 didn't have to clinically -- for any clinical reason be
 18 in our hospitals to get them out the back door and that
 19 involved quite intense discussions with particular
 20 health and social care partnerships to find out where
 21 there was any available staffed beds in social care
 22 where we could help to alleviate the pressure from
 23 hospitals.

24 So a number of actions were taken but there's no
 25 doubt at all that the winter of 2021-2022 was probably

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1 for example, Glasgow. So the change allowed that local
 2 variation and local nuance.

3 **Q.** Were decisions about visiting taken at a local level on
 4 a person-by-person basis or was it, instead, that it was
 5 taken at a local health board level and to be applied
 6 across the board?

7 **A.** So we always, always stressed to our local health boards
 8 that ultimately the emphasis should be on
 9 a person-centred compassionate approach and therefore
 10 there may well be slight variation even between hospital
 11 sites or even within a hospital because the situation
 12 required it, particularly when it came to essential
 13 visits which, of course, we were very clear about, but
 14 there was a level of discretion which we trusted health
 15 boards with.

16 There was, obviously, even within the official
 17 guidance, there was broad parameters that were set out
 18 at local levels in the route map and, as I say, some
 19 broad parameters set out for each level in the guidance
 20 but we did emphasise a local approach, flexible approach
 21 and a person-centred compassionate approach.

22 **Q.** How was learning from national visiting policy and
 23 guidance from the early stages of the pandemic, so for
 24 example learning about the harm which might have been
 25 caused where women and pregnant people were not

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1 permitted to have a partner attending maternity
2 services, for example? How was that captured once
3 visiting restrictions were left more to local health
4 boards?

5 **A.** Well, in terms of the learning it was very clear from
6 a number of circumstances, and you've referenced
7 maternity, I would also mention, perhaps, neonatal
8 visiting policy at the time, that there was some very
9 considerable hurt, anxiety and anger towards the initial
10 visiting policy and that was understood by government
11 and therefore changes were made to be -- especially
12 around essential services and of course neonatal and
13 maternity would fit into those essential visits, forgive
14 me.

15 And then when it came to the route map and the
16 various levels there and that hopefully captured --
17 I think it did adequately capture that learning and if
18 I go back, and it's not an absolute test or litmus test
19 and certainly not an exact measure, but if I go back to
20 issues that were raised with me regularly in
21 correspondence or by members of the opposition, or
22 indeed by members of the press corp, hospital visiting
23 policy dropped further and further down the agenda, and
24 that, to me, suggests -- again, it's not an exact -- a
25 litmus test, at all, but it certainly suggests that the

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1 it would be in terms of the impact of the long-term
2 effects of Covid on children and I must at this stage
3 pay tribute to organisations like Long Covid Families
4 but also Long Covid Kids, I think they did a remarkable
5 job raising the issue of awareness of Long Covid and the
6 impacts on children, and fair to say, they had
7 frustrations, I suspect, and maybe continue to have
8 a level of frustration at the level of service being
9 provided but my understanding was that this was still
10 very much -- our understanding of Long Covid was
11 evolving and presented with a range of symptoms and, I'm
12 afraid, without any direct cure or treatment for
13 Long Covid.

14 **Q.** What prompted the mapping exercise which was conducted
15 in July 2021 by NHS NSS to identify how NHS boards were
16 supporting people with Long Covid?

17 **A.** Essentially I wanted to ensure that we had some -- what
18 we understood as a government, nationally, where there
19 were gaps in services, where services -- what services
20 were being provided and that would help to identify what
21 funding and resource we could allocate towards the
22 treatment of Long Covid but also where that money should
23 be focused, because it was only through doing that
24 mapping exercise and a kind of gap analysis, I suppose,
25 do we truly understand where did -- our deficiencies in

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1 policy we had in place was working adequately for most,
2 I suspect not necessarily everybody.

3 **Q.** Turning, please, to Long Covid. What were you told
4 about the state of knowledge in relation to Long Covid
5 when you became Cabinet Secretary in May 2021?

6 **A.** Long Covid was still a condition we were learning about,
7 I would suggest it's still a condition we are learning
8 about, and therefore the clinical advice that I was
9 given was that, first and foremost, always prefaced
10 with: Cabinet Secretary, this is still -- we're still
11 evolving our understanding of Long Covid, and that's not
12 just true in Scotland or the United Kingdom but globally
13 we're still learning about the long-term effects of
14 Covid. So that was always the starting point from
15 clinicians. I think that was a very fair starting point
16 from them.

17 There was clearly a range of symptoms. Those
18 symptoms could range -- there were many -- but were
19 often presented with issues around fatigue, often issues
20 that could affect diet, often issues that would present
21 similar to other conditions such as ME, for example. So
22 a range of symptoms associated when I first became
23 cabinet secretary.

24 There was also some evolution of our understanding
25 as well and I should -- if I give one example of that,

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1 the service that had been provided.

2 **Q.** You decided in September 2021 to create a £10 million
3 Long Covid fund. Was this decision informed by the
4 results of the mapping exercise?

5 **A.** There would have been a range of measures that would
6 have helped to inform that. Certainly the mapping
7 exercise would have been a part of it and it may even
8 have been interim results from that mapping exercise.
9 But also it was very clear to me from all of the
10 conversations with those who were experiencing
11 Long Covid, and I have family members who still suffer
12 the impacts of long-term effects of Covid, that the --
13 there was not a consistency of service being provided
14 across -- actually even within the health board area
15 sometimes, certainly between health board areas.

16 **Q.** And the purpose of the funding was to give health boards
17 additional financial resource to support local services
18 in supporting those with Long Covid; is that right?

19 **A.** Yes.

20 **Q.** Is it right that health boards had to apply for funding
21 from that fund?

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

23 **Q.** It was March 2022 before they were instructed to conduct
24 a gap analysis exercise and submit an application based
25 on that; is that right?

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1 A. Right.

2 Q. Why was it that it took until March 2022 for health
3 boards to be invited to conduct that exercise and to
4 apply?

5 A. I think that's a fair question to ask, and if I was
6 looking back as a lesson learned there is perhaps
7 a question as to whether we could have invited
8 territorial boards to submit that gap analysis quicker
9 but, of course, as the Inquiry knows very well, we were
10 under considerable pressure with new waves of the virus
11 causing real challenges and of course in the period
12 before March 2022, February, January, December,
13 November '21, still very much within the winter
14 pressures and I think I've already stated my
15 contribution up until that point, I think winter
16 2021-2022 was the most difficult winter the health --
17 the NHS has ever experienced in its existence.

18 So there was already huge amounts of pressure to
19 then have to do a gap analysis and then submit those gap
20 analyses, so the gap analyses were submitted in
21 March 2022 but were -- of course, they take
22 a considerable period of time to do properly. The
23 winter pressures were undoubtedly one of the reasons why
24 they were -- why they took as long as they did, but
25 I have to say I accept, perhaps an implied criticism,
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1 essentially creating a middleman where people would go
2 to a Long Covid clinic for assessment and generally be
3 seen with relative speed and ease, they were then being
4 referred on to the appropriate department within
5 an acute site, maybe respiratory, maybe neuro, and maybe
6 occupational therapy, maybe physio. Whatever it was,
7 they were being referred on. And to me, that was just
8 creating an additional stage and step, somebody has to
9 go through in order to get treatment.

10 That being said, we never once gave neither
11 an instruction nor, I would hope, the impression that if
12 a health board wanted to create a Long Covid clinic they
13 were instructed not to. That was never the case. They
14 were never instructed not to do that.

15 The Long Covid clinic model now in England,
16 I've noted in recent times a number of those Long Covid
17 clinics have now completely closed and are no longer
18 taking referrals or assessments. So it always seemed to
19 me a better, a more logical approach to take to allow
20 a local health board to analyse where the gaps were, and
21 what they had to do in order to mitigate those gaps in
22 service and then take a nuanced and local approach and
23 that could have been a Long Covid clinic, if they
24 thought that was the best model, or it could have been,
25 as I think for most -- I should not say most, a number
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1 but certainly a criticism from -- I know organisations
2 that represent Long Covid -- those with Long Covid, that
3 perhaps that should have been done at a quicker pace.

4 Q. The health boards had funding allocations confirmed on
5 19 May 2022. So is it right that that was the point at
6 which they would have actually got the funding that they
7 applied for?

8 A. Yes, that would have been the time.

9 Q. Health boards could use the funds to strengthen existing
10 services or to establish dedicated services such as
11 dedicated Long Covid clinics; is that right?

12 A. Yes, that's correct.

13 Q. And you refer at paragraph 207 of your statement to
14 there being political and public pressure for specific
15 Long Covid clinics. Why were health boards not
16 instructed or encouraged to set up dedicated services?

17 A. As the rest of that paragraph makes clear, there was
18 obviously nothing stopping health boards from developing
19 specific Long Covid clinics. There was a lot of
20 pressure, I think it continues in some part today, to
21 have a nationwide network of Long Covid clinics but the
22 feedback that we were hearing and the anecdotal
23 evidence, particularly from clinical colleagues in
24 Scotland who were talking to their clinical colleagues
25 in England, was that the Long Covid clinics were
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1 of health boards, it was that they didn't have that
2 single point of access for those who suffered from
3 Long Covid in their local health board area.

4 Q. You refer in your statement to an aim of the funding
5 being to ensure there was no postcode lottery. Would
6 you agree that before central funding was actually
7 provided in May 2022, there was a postcode lottery in
8 Scotland when it came to access to Long Covid services?

9 A. Yes, I would accept that. And I would accept to this
10 day that there is still feedback from those with
11 Long Covid that they feel there is still not as
12 consistent a level of service as they would like to see.
13 But certainly I accept that was the case prior and
14 I certainly, you know, accept that there's a feeling
15 that an element of that still may be true to this day,
16 that we still have to work hard to ensure a consistency
17 of service being provided.

18 Q. Should the decision that central funding for Long Covid
19 services should be provided, should that decision have
20 been taken sooner?

21 A. I think with a lot of these questions, with the gift of
22 not just hindsight, I think with the evidence in front
23 of us that we had at the time, we could always look to
24 see if we could have done things sooner, earlier,
25 quicker, and I never try to be defensive, overly
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1 defensive about that position. I just simply provide
2 the context that we were, of course, stating the
3 obvious, dealing with some extreme pressures and most of
4 the focus, particularly the winter 2021-2022, was on the
5 emergence of Omicron and the significant impact that
6 that was going to have on what was already going to be
7 a very, very difficult winter.

8 **LADY HALLETT:** Mr Yousaf, sorry to interrupt, could I, for
9 a second, challenge something -- and I hope Ms Price
10 will forgive me -- where you agreed with her, about the
11 point about postcode lottery.

12 Because on the one hand you have the importance of
13 local discretion, is something that Jeane Freeman or
14 Ms Freeman told me about earlier today, and she
15 obviously believes very strongly in it, and one can see
16 how the local conditions, particularly in a country like
17 Scotland, will vary enormously. Are you on a Scottish
18 isle, are you in the Highlands or in the middle of
19 Glasgow? There are going to be very different
20 conditions. And so I just wanted to challenge your
21 agreement that it would be a good thing to get rid of
22 postcode lottery when local conditions are going to vary
23 enormously and it may not suit a local health board to
24 have something as specific as Long Covid. I just wanted
25 to get your thoughts on that.

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1 by local nuances. So I hope that helps.

2 **LADY HALLETT:** Yes, it does. Thank you.

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

4 At paragraph 229 of your statement you set out the
5 lessons you have taken from the Scottish response to
6 Long Covid and they relate in the main to communication.
7 Could you explain, please, what you think, on
8 reflection, should have been done in relation to
9 communication.

10 **A.** Yes. That communication is both national and local. So
11 on a national level we were doing a lot behind the
12 scenes, so we've already in this exchange spoken about
13 the mapping exercise, we've spoken about the gap
14 analysis. These are all things that are done relatively
15 behind the scenes. They're not communicated necessarily
16 very publicly, maybe not necessarily always be of the
17 greatest interest to people, but what I think -- because
18 you had this gap of public communication in what we were
19 doing, I think the message to those who were suffering
20 the long-term effects of Covid was that the government
21 wasn't taking action when we were, and health boards
22 weren't taking action but we were. And we could have
23 been much more proactive in our communication. Because
24 I do remember speaking to somebody who suffers the
25 long-term effects of Covid, she still does to this day,

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1 **A.** Yes, happy to give my thoughts on that.

2 So I am much aligned with Jeane Freeman that
3 I believe that as much as possible we should allow local
4 nuances in terms of the healthcare that's provided, and
5 we do that to great effect. There are many examples,
6 that I won't give because of time but there are many
7 examples I could give, of that local nuance suiting its
8 local population. As you say, remote rural and island
9 communities in comparison to urban health boards.

10 There's difficulty, I think, in challenges that
11 you would expect consistently and nationally and minimum
12 standard. And the feedback we were getting from those
13 who suffer the long-term effects of Covid was: Look,
14 that minimum standard of having, for example, a point of
15 contact -- at the very minimum, we should have a point
16 of contact per health board. We were getting feedback
17 to say: Look, we don't even know where to go. We
18 present to the GP and the GP says, "You have a range of
19 symptoms and here's three referrals to three different
20 specialisms in three different departments". Whereas
21 what would have made life better nationally, across the
22 picture, was having one point of contact. Now, at that
23 one point of contact in Orkney or one point of contact
24 in Glasgow, at least you have a single point of contact.
25 What happens thereafter should be absolutely determined

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1 and I was explaining to her what we were doing and she
2 said to me, "All of that makes sense, why are you not
3 telling us? Why are you not telling people?" So
4 I thought there was a national piece of communication.

5 Locally, the communication there were some health
6 boards who did have single points of contact, for
7 example, or did have some services running that could
8 have been communicated better, and I don't know if some
9 of that was fear of being overwhelmed as a service, for
10 example, or simply because of the other pressures that
11 health boards would have been under, for example, during
12 the winter of 2021 and 2022. But all of this, both
13 nationally and locally, I heard from those with
14 Long Covid and their representative organisations in
15 Scotland that that led to the impression that not enough
16 was being done and that we were being far too passive
17 when it came to the issue of Long Covid. Which was not
18 the case but certainly the impression that was being
19 given because we weren't communicating of what we were
20 doing adequately.

21 **Q.** Coming, please, to primary care.

22 In November 2021 you announced a £17 million
23 investment in GP surgeries. And you say at
24 paragraph 110 that it was hoped that this would help
25 with accessibility issues for those with disabilities.

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1 What were these issues and how and when were they
 2 brought to your attention?
 3 **A.** So there was issues that were raised around
 4 accessibility, when we would meet with Disabled People's
 5 Organisations for example, and forgive me if I can't
 6 recall the exact date on when those conversations took
 7 place, but those accessibility issues would often centre
 8 around the fact that GP surgeries were often in
 9 relatively small spaces. They were in local
 10 communities, which meant they were often in quite tight
 11 residential areas, and therefore, when it came to
 12 infection prevention and control measures, particularly
 13 distancing and spacing, that created some accessibility
 14 issues, capacity issues. And for example, if you had to
 15 move surgery rooms to an upstairs in a building where
 16 there were no lifts because you had to use the
 17 downstairs for additional waiting rooms because of IPC
 18 control, then that created some issues around
 19 accessibility for those in a wheelchair, for example.

20 There was also accessibility issues in relation to
 21 those who were perhaps less confident of using digital
 22 methods such as Near Me, the video service that was used
 23 for video appointments with the NHS and general
 24 practice. And there was just those who didn't want or
 25 didn't feel confident in terms of telephone

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1 so on, and you can see as the months and years have gone
 2 on that kind of steady improvement. So I think it
 3 certainly will have helped but it was certainly an issue
 4 at the time of great concern amongst a great number of
 5 people.

6 **Q.** You refer at paragraph 157 to significant investment
 7 which was made in general practice during your tenure as
 8 cabinet secretary. Did the need for this reflect
 9 an underfunding of general practice prior to the
 10 pandemic?

11 **A.** No, I wouldn't accept that characterisation. I think
 12 investment in the NHS and general practice was good. We
 13 increased our investment within the NHS as a government
 14 over the years. Prior to me becoming cabinet secretary
 15 there was investment in what was known as golden hellos,
 16 a kind of bursary scheme particularly incentivising GP
 17 posts to the more rural areas of Scotland, again before
 18 my time, investment in the ScotGEM programme, four-year
 19 graduate entry medical programme as well for those who
 20 were interested in becoming generalists within the NHS
 21 with a focus on rural medicine. And there was continued
 22 focus and investment in GP, direct funding to GPs as
 23 well.

24 But what we were dealing with, virtually
 25 overnight, is a situation where our GPs because of the

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1 consultations as well. And there was some issues
 2 with GPs' telephony services and therefore some of the
 3 funding we provided was to upgrade the telephony
 4 services.

5 So the accessibilities issues could range from
 6 physical accessibility issues right the way through to,
 7 as I say, issues around digital and telephone
 8 accessibility.

9 **Q.** And did that investments in and those measures improve
 10 matters in relation to accessibility issues?

11 **A.** I think they certainly helped. It was an issue of
 12 regular concern, and I've referenced the kind of litmus
 13 test, unscientific I accept, but the litmus test of what
 14 was raised with me and what wasn't raised with me by
 15 members of the public in correspondence. GP access was
 16 probably -- if not the issue, one of the issues that was
 17 raised with me with incredible frequency and regularity
 18 by members of Parliament and correspondence from members
 19 of the public.

20 So although these measures undoubtedly helped, and
 21 eventually we got to a place where we have a dashboard,
 22 and I think it still -- it should -- exists to this
 23 day -- or, forgive me, if it's dashboard or regularly
 24 published statistics around access to primary care, to
 25 GP services by telephone, by in-person appointments and

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1 IPC controls in place, because of the nature of the work
 2 that GPs do, a very difficult situation where people
 3 are -- because of the pressure on our acute sites,
 4 a very difficult position where people are really
 5 struggling, I felt they were struggling to get
 6 face-to-face appointments with their GPs, which many
 7 people still wanted, so this investment was
 8 a recognition of that challenge and trying to work
 9 collaboratively with GPs as opposed to necessarily
 10 targeting them publicly, which was done, I know, by
 11 (inaudible) we tried, where we could, to work
 12 collaboratively although I must confess there was, no
 13 doubt, tensions at times.

14 **Q.** In relation to non-Covid care and NHS recovery, what
 15 were the key challenges in dealing with the backlogs
 16 which had built up for elective care in Scotland during
 17 your tenure?

18 **A.** Capacity. It's as simple as that. There was a finite
 19 resource in terms of beds and in terms of staff and
 20 there was such a pressure on emergency care and in
 21 an acute setting you have a few pressure valves that you
 22 can try to release and if you want to increase the flow
 23 of throughput for elective care, you've obviously got to
 24 naturally decrease the flow elsewhere and that usually
 25 meant around emergency care, particularly at a time when

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1 we were feeling significant pressure, and that was the
 2 biggest challenge when it came to elective care was
 3 trying to restart that, and restarting it is probably
 4 the most difficult part, I have to say. Once it starts
 5 and once the health board begins to have some momentum
 6 behind elective care, it generally becomes much easier
 7 to scale it up, but restarting it from a stop and that's
 8 why health boards like -- if I gave you the example of
 9 Forth Valley, who were generally probably the standout
 10 when it came to elective care, they were able to, in
 11 some element, protect that right throughout the pandemic
 12 or for most of the pandemic and therefore when it came
 13 to scaling up were able to do that quite effectively,
 14 whereas those health boards who had virtually stopped
 15 all elective care, restarting it was the real challenge
 16 and then once you were able to scale it up, once it was
 17 established, then they were able to scale it up.

18 But forgive me if I didn't give you a direct
 19 answer to your question, but it's the resource in terms
 20 of bed capacity and staff capacity.

21 **Q.** In your statement at paragraph 230 you say you believe
 22 the government could have done more centrally to help
 23 co-ordinate and support the resumption of elective care.
 24 What specifically do you think could have been done?

25 **A.** I think we could have better centrally co-ordinated

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Questions from MR WAGNER

1 **MR WAGNER:** I'll look towards the witness box as well, just
 2 for somewhere to look to. Thank you very much.

3 My name is Adam Wagner and I ask questions on
 4 behalf of the Clinically Vulnerable Families. I want to
 5 ask you first about engagement and feedback with the
 6 clinically vulnerable.

7 You say at paragraph 66 of your statement that
 8 Cabinet, more widely the Scottish Government, would have
 9 benefited from hearing more of people's lived
 10 experience. You've already been asked about that in the
 11 context of ethnic minorities. Just thinking about the
 12 clinically vulnerable, CVF members frequently felt that
 13 they didn't have a voice and that the government policy
 14 was something that happened to them, leaving them
 15 without a sense of confidence in their needs and
 16 concerns being heard, understood and prioritised.

17 Are you aware of these concerns or those kind of
 18 concerns being expressed by the clinically vulnerable,
 19 the clinically extremely vulnerable, or the immuno
 20 suppressed at the time?

21 **A.** Yes, even before my time as Cabinet Secretary for Health
 22 and Social Care, so as a member of the Cabinet, and --
 23 you would meet people who were clinically vulnerable,
 24 immunosuppressed, you would meet their carers as well,

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1 where there may have been theatre space in one health
 2 board, potential staff availability and better centrally
 3 co-ordinated that so we had something -- we had
 4 a service like that run from the centre for sustainable
 5 delivery far later than perhaps we should have had, kind
 6 of central co-ordinating, kind of, national elective
 7 co-ordination unit far sooner than we had.

8 There -- I think also, if I look back and think
 9 about some of the lessons we could have learned, could
 10 we have set targets sooner? And I'm not always one to
 11 suggest, and I certainly won't suggest that targets
 12 alone can help to alleviate the problem but it might
 13 have helped to focus some of the minds in terms of
 14 health boards around priority.

15 And then also just being clearer about potentially
 16 ring-fencing funding for elective care as well, would
 17 that have helped?

18 So there's a few things centrally that I think we
 19 could have given greater deliberation to.

20 **MS PRICE:** My Lady, those are all my questions.

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

22 Mr Wagner.

23 Mr Wagner is over there -- oh no, end of the day.

24 Sorry, I was looking to the witness box and pointing.

25 Mr Wagner.

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1 and the message coming back from a number of them was
 2 they felt that often when it came to questions about
 3 reopening society, removing NPIs, that they felt that
 4 their health was not given enough consideration. We
 5 obviously tried to do our best to give them assurances
 6 but that was often a criticism from clinically
 7 vulnerable families and indeed their carers that we were
 8 alive to.

9 **Q.** And picking up on that, and looking to the future, what
 10 systems, in your view, need to be put in place to make
 11 sure that clinically vulnerable people, some of whom
 12 don't have a disability, so wouldn't necessarily be
 13 represented by established disability rights
 14 organisations, might not come under the Equality Act,
 15 how can we make sure they can engage with government in
 16 relation to the issues that continue to affect them, for
 17 example, accessing healthcare safely?

18 **A.** I think there's a couple of ways to do it. First and
 19 foremost, I think government, you've got to --
 20 of course, this is said often but we need to get away
 21 from working within our silos, so it may be that the
 22 health secretary or the social justice secretary will
 23 often meet with clinically vulnerable people, not just
 24 the representative organisations but the clinically
 25 vulnerable people, throughout the course of the visits

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1 that they do and the engagements that they have, but the
2 whole of government could benefit from those
3 conversations. And that is why one of my suggestions is
4 that it's regularly incorporated, not just in the midst
5 of a pandemic, but perhaps regularly incorporated into
6 both Cabinet sessions and government, and I was
7 First Minister, certainly, we had some post-Cabinet
8 sessions with people of lived experience, not in
9 relation to clinically vulnerable families but on other
10 demographics within society, and they've always been
11 greatly valuable, not just to the cabinet secretary that
12 may have direct responsibility but actually all of us
13 who usually one way or another had indirect
14 responsibility.

15 **Q.** Just asking about masks. Was any consideration given to
16 providing information to clinically vulnerable patients
17 about the benefits of wearing higher-grade masks such as
18 FFP3 when they were accessing high-risk settings,
19 particularly healthcare, in light of their heightened
20 risk and the difficulties that we all know about in
21 certain healthcare settings of protecting people from
22 Covid-19?

23 **A.** So generally most of the communication with those in the
24 Highest Risk List, for example, would have been done by
25 the CMO and the engagement and communication from the
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1 feedback and response we received from those that we
2 were communicating with and that predominantly our CMO
3 was communicating with regularly, who were at the
4 highest risk and therefore a number of them clinically
5 vulnerable, the feedback generally tells us that the
6 engagement was good, helpful, and very useful.

7 But I take the point there may well have been
8 a gap in terms of those who were clinically vulnerable
9 and accessing healthcare settings.

10 **Q.** And just staying on that subject of accessing healthcare
11 for clinically vulnerable, this is an issue which
12 continues to be a concern for the clinically vulnerable
13 but obviously was a big concern at the time. Was any
14 particular consideration given to the risk that
15 clinically vulnerable patients faced in healthcare and
16 the fact that -- and their concerns, which continue,
17 that healthcare simply wasn't safe for them to attend
18 and avoid the risks of -- the very high risks to them of
19 contracting Covid-19?

20 **A.** Yes, very much so. Very much. So a number of
21 organisations that represent those who are clinically
22 vulnerable tell us their fears about those they
23 represent accessing healthcare, and the absolute dread
24 that they would have of potentially contracting the
25 virus in visiting a healthcare setting, usually a
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1 feedback and the surveys that we carried out was seen as
2 relatively helpful, useful. Whether there was a precise
3 communication from the CMO about higher-grade masks in
4 healthcare settings I couldn't tell you with absolute
5 certainty but certainly our own communication around
6 wearing of masks, particularly in relation to anybody
7 engaging with those who may be clinically vulnerable was
8 a message that we disseminated often.

9 I can think of the former First Minister herself
10 making that point during the daily briefings, but in
11 terms of the direct communication with clinically
12 vulnerable families, that probably would have more
13 likely been done by the CMO and I couldn't tell you for
14 sure if that was a point that was made directly.

15 **Q.** So you mentioned that there was communications to
16 healthcare workers to encourage them to wear masks when
17 dealing with the clinically vulnerable. Do you think
18 maybe there was something missing in that there wasn't
19 an equivalent policy of providing masks to the
20 clinically vulnerable or encouraging them to wear masks
21 where -- obviously where it was -- where it would fit
22 with their healthcare needs?

23 **A.** I think it's a fair point to make that there may well
24 have been a gap there in that communication. I would
25 hope, if I went back, if I went to the surveys and
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1 hospital. And therefore we certainly not just took that
2 message on board, but that's why we reinforced the
3 importance of IPC within a hospital setting and
4 of course if that necessarily needed to be nuanced for
5 those who were clinically vulnerable then we would
6 expect that to happen.

7 All that being said, throughout the course of my
8 time as Cabinet Secretary for Health and Social Care,
9 generally the message we were getting from those who
10 were clinically vulnerable was of fear, as society
11 opened up and IPC measures may well become diluted, may
12 well be withdrawn altogether in some circumstances, the
13 concern they had, and therefore we were always keen to
14 stress and to assure those who were clinically
15 vulnerable that they were not being forgotten and that
16 we would continue to reiterate the message that their
17 needs also had to be put at front and centre by
18 healthcare workers, and by the whole of society, it's
19 not just about accessing healthcare settings, as
20 important as that is, going to a restaurant for a meal,
21 being able to go out and enjoy a coffee when society
22 opened up, these were all settings whereby I was
23 hearing, we were hearing those who were clinically
24 vulnerable had a real fear should they contract the
25 virus at a time where the virus was still prevalent.
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1 **Q.** Just sticking with healthcare settings, obviously the
2 other settings are extremely important but would you
3 agree that not only were those fears being reported but
4 given how many people were contracting Covid-19 in
5 healthcare settings, their fears were, to an extent,
6 justified?

7 **A.** Again, I'm not going to say to somebody who is
8 clinically vulnerable that their fears were not
9 justified. If those were the fears they had, given
10 their life experience, then we have to be mindful,
11 listen to those and try to act on those fears that
12 existed. But what I would say is that's why it was so
13 important for us to ensure that we had a successful
14 vaccination programme as the first line of defence in
15 order to protect people including those who were
16 clinically vulnerable. And that's why, of course, those
17 who had vulnerabilities were at the front of the queue
18 when it came to the vaccine programme.

19 So I would never be dismissive of anybody's fears.
20 At the same time, we took what I would consider to be
21 appropriate and robust measures to try to allay some of
22 those fears where we could.

23 **Q.** If you'll excuse me for just going back on the question.
24 Do you agree that the rates of infection in healthcare
25 settings was at times high?

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1 than perhaps other settings.

2 **MR WAGNER:** I'm out of time, my Lady. Unless I can get
3 another 30 seconds I'll sit down. You tell me.

4 **LADY HALLETT:** You're asking for another 30 seconds? You're
5 pushing your luck. You may, Mr Wagner.

6 **MR WAGNER:** A final question on shielding and the end of
7 shielding. Many CVF members report feeling abandoned
8 once the shielding programme came to an end, with little
9 practical support to assist in the transition. What
10 concrete steps were taken by your government at the time
11 to achieve the important aims set out in the submission
12 at the end of shielding which said that there had to be
13 physical and mental health recovery as well as
14 addressing any social and economic impacts?

15 **A.** I think communication was really important. And this
16 probably goes into the kind of "lessons learned" basket.
17 Where we probably could have done more, I think, as
18 a government is making sure that there was still
19 regular -- more regular communication -- there was
20 an element of communication, but more regular
21 communication with those who were on the Highest Risk
22 List, who were -- some who were previously shielding.

23 And I think the challenge was that they were
24 getting such a degree of communication or regular
25 communication that there had to be a bit more of

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1 **A.** Yes, given the nature of hospitals, given that sick
2 people obviously go to hospitals, and sometimes very ill
3 and very sick people go to hospitals, then -- you know,
4 the rate of nosocomial infection of course we tried to
5 reduce but we always knew that they would be
6 particularly high, and higher in healthcare settings
7 than in most other settings.

8 **Q.** And so those fears weren't just coming out of the blue
9 they were justified; would you agree?

10 **A.** I've answered that question by saying I'm certainly not
11 dismissing that, anybody clinically vulnerable or
12 otherwise frankly but especially those who were
13 clinically vulnerable. If they had concerns about
14 nosocomial infection in a hospital then they were
15 justified in terms of those concerns.

16 But what I would try to do to reassure them, on
17 the flip side, if I may, is to say that there were very
18 strict IPC measures that were in place. There were very
19 strict measures taken in terms of the vaccines. So, for
20 example, again, healthcare workers and social care
21 workers were, again, near the front of the queue when it
22 came to being vaccinated. So measures were taken to try
23 to reduce that. But given the very nature of hospitals
24 and the sick people who often attend them, then clearly
25 healthcare settings were more of high-risk environments

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1 a transition period. But we also tried to reassure them
2 where we could. Obviously, a number of those in the
3 Highest Risk List would have been prioritised for
4 vaccination where possible and we continued to stress
5 the importance of face coverings, mask wearing, IPC
6 measures, as well but I think communications is one area
7 where we possibly could have been better in terms of
8 a transitional approach.

9 **MR WAGNER:** Thank you.

10 **LADY HALLETT:** Ms Mitchell.

11 Questions from MS MITCHELL KC

12 **MS MITCHELL:** I appear as instructed by Aamer Anwar &
13 Company on behalf of the Scottish Covid Bereaved.

14 In your statement you indicate that by the time
15 you came to be Cabinet Secretary for Health and Social
16 Care in 2021 that DNACPR, do not attempt cardiopulmonary
17 resuscitation, notices were less of an issue. What were
18 the issues that remained in relation to "do not attempt
19 cardiopulmonary resuscitation" at that time and what
20 steps did you take to address them?

21 **A.** Can I begin my answer to this question by putting on
22 record, as I did the previous module, my sympathies and
23 genuine condolences for those who have lost loved ones
24 to Covid and continue to lose loved ones to Covid. The
25 pain is still felt by far too many families and we have

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1 a duty, I have a duty, to ensure that my answers of
2 course are not just honest and truthful but hopefully
3 insightful as well and give at least a modicum of
4 reassurance that lessons have been learned where
5 appropriate.

6 To answer Ms Mitchell's question directly, yes,
7 DNACPR was less of an issue, certainly an issue that got
8 greater -- there was greater concern raised at the early
9 stages of the pandemic. Notwithstanding that, when
10 I met with some of those families who were Covid
11 bereaved -- and I think from recollection Mr Anwar would
12 have been at some of those meetings too -- the issue of
13 DNACPR was still an issue at the forefront of their mind
14 and concerns were absolutely still raised and there was
15 still a level of upset and anger at the situation in
16 terms of what we did.

17 That is one of the reasons why we took the
18 decision, different to some other devolved governments
19 of course, to set up a Scottish public inquiry, and one
20 of the terms of reference of that Scottish public
21 inquiry was to look specifically at this DNACPR issue.
22 And I think that's probably the right forum, as opposed
23 to, for example, the government doing a review on
24 itself, of its own health boards. Conducting a review,
25 a kind of statutory public inquiry and looking at this

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1 writing that due to the rapidly developing nature of the
2 pandemic it wasn't always possible to carry out
3 equalities impact assessments prior to certain decisions
4 being taken, and we've heard evidence this morning also
5 from your colleague Jeane Freeman to say that in the
6 early days of the pandemic no formal equality impact
7 assessments were carried out. And in your written
8 evidence you also say that the equality impact
9 assessment process has limitations in a fast-paced
10 environment, and again that was echoed by your colleague
11 giving evidence this morning.

12 Given the importance of these decisions that are
13 being taken and the effect it can have on such groups as
14 those who are older or disabled, do you think that the
15 Scottish Government can improve on taking a rights-based
16 approach to government decision-making? And if so, what
17 can be done in that regard to ensure that those equality
18 duties are recognised and dealt with even in
19 circumstances where there's a fast-paced pandemic?

20 **A.** Yes, it's an excellent question, and the short answer to
21 that has got to be yes, there's more we can do. By
22 embedding, for example, human rights principles and
23 legislation -- international human rights best practice
24 into statute in law here in Scotland. And we've done
25 that a number of occasions around incorporation of

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1 issue independently is one of the reasons why it's in
2 the terms of reference.

3 **Q.** Were there any practical steps taken by you at that time
4 when the concerns were raised, rather than the Inquiry,
5 which is to deal with what's going to happen in the
6 future?

7 **A.** Yes, I think already the steps that were taken, were
8 taken by my predecessor Jeane Freeman, because this
9 issue was an issue that was raised in her tenure more so
10 as Cabinet Secretary for Health and Social Care, and she
11 of course clarified what the situation should be to
12 health board chairs and chief executives at the time.
13 So, as I say, when I became Cabinet Secretary for Health
14 and Social Care -- although I referenced an occasion
15 when that issue was raised in the context of a meeting
16 where Covid bereaved families were wanting a Scottish
17 public inquiry and were ensuring that we co-operate with
18 the UK inquiry as a government, the issue was not raised
19 very often -- I'm sure there will be occasions, but not
20 raised very often at all -- at the time when I became
21 Cabinet Secretary for Health and Social Care. That is
22 not to dismiss, I should say, at all, the very real
23 concerns I'm sure that Scottish Covid Bereaved Families
24 would have.

25 **Q.** Moving on to my next question. You gave evidence in

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1 UNCRC, for example, and so on and so forth. So there's
2 absolutely more we can do and it's an issue I know the
3 government is actively looking at at the moment.

4 EQIAs absolutely have their limitations. They
5 have their uses, purposes. I think in a fast-paced
6 environment like the pandemic they have a very limited
7 use, utility.

8 What we have to do, and I've said this already in
9 initial exchanges with Ms Price, is far greater
10 engagement and deeper engagement directly with those who
11 are affected. So it could be with DPOs (disabled
12 people's organisations), it could be with ethnic
13 minority representative organisations, it could be with
14 the likes of Age Scotland, for example, and other
15 stakeholders. But in a place where we're not able to
16 have that deep analysis over weeks or even months --
17 or weeks I'm told it would be for an EQIA, we are, as
18 a country, at least small enough to gather people
19 relatively quickly -- be it online or in person,
20 relatively quickly in terms of understanding from our
21 key stakeholders some of the equalities challenges that
22 exist. So I think deep, quick engagement is necessary
23 as well as embedding human rights legislation in statute
24 here in Scotland as best we possibly can.

25 **Q.** Moving on to my next question. In your statement you

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1 said that you're firm in your belief that the NHS Louisa
 2 Jordan provided value for money. Was there an analysis
 3 carried out of whether or not the NHS Louisa Jordan was
 4 value for money?

5 **A.** There wasn't a valuation done of NHS Louisa Jordan, and
 6 given all of which -- all of what Louisa Jordan did over
 7 the period that it was established, it's my opinion that
 8 it was value for money and I think it is -- it will be
 9 quite a subjective question to ask. And at the time
 10 of course people, rightly, particularly members of our
 11 opposition, they have every right to do this, of course,
 12 were questioning whether or not the Louisa Jordan was
 13 value for money but once I think they saw the detailed
 14 analysis of all of the procedures and vaccinations and
 15 so on that had been carried out by Louisa Jordan,
 16 I think there was generally, I can't speak for members
 17 of the opposition of course, but generally an acceptance
 18 that it had been useful to have established that
 19 additional capacity.

20 **Q.** I appreciate that that's what you say, that is your
 21 belief in that regard. But my question was, was there
 22 an analysis carried out, financial, of the
 23 Louisa Jordan?

24 **A.** Oh, I couldn't recall. I'd have to look again at the
 25 Louisa Jordan evaluation to see whether or not there was

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1 was a sensible thing to do. Ultimately, we know that
 2 Louisa Jordan was used for other procedures and for
 3 example for vaccinations but we had no concerns, I have
 4 to say, about the level of training of our healthcare
 5 workers when it came to certain particular IPC
 6 restrictions that Covid-19 --

7 *(Unclear: multiple speakers)*

8 **Q.** Indeed -- my apologies. My question, I would prefer to
 9 focus really on capacity of staffing rather than
 10 training. Can you help the Inquiry with that?

11 **A.** Yes, sure. Sorry, forgive me if I misunderstood your
 12 question. In terms of capacity that was always going to
 13 be a challenge. I think that was clearly our, if not
 14 our biggest challenge when it came to providing care not
 15 necessarily for Covid-19 patients, I think there was
 16 a particular focus on providing emergency care but still
 17 capacity was an issue, and I think we referenced earlier
 18 on in exchanges between myself and Ms Price that the
 19 staffing ratios in certain sites, and I talked about
 20 Glasgow, were very challenging indeed. So it would have
 21 been a challenge, I don't doubt. And that was one of
 22 the reasons why Louisa Jordan wasn't necessarily used
 23 for Covid-19 patients because of the IPC restrictions
 24 that are necessarily in place, so that probably wasn't
 25 the best use of the Louisa Jordan, hence why it was used

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1 a kind of value for money exercise by the pounds and the
 2 pennies. So forgive me, I couldn't recall that.

3 **Q.** No doubt if the Inquiry wants that it can make further
 4 investigation in that regard.

5 Moving on to another issue if I may. You -- you
 6 state in your written submissions that you were sure
 7 that the NHS Louisa Jordan could have treated Covid-19
 8 patients if they had been required to do so, and in
 9 a similar question that I asked to your colleague this
 10 morning, how was it anticipated that properly trained
 11 medical and nursing staff would be available to provide
 12 the appropriate level of care to patients in the
 13 additional beds if that eventuality were to have
 14 happened?

15 **A.** Forgive me, could you repeat the question.

16 **Q.** Yes, certainly. How was it anticipated that properly
 17 trained medical and nursing staff would be available to
 18 provide the appropriate level of care to Covid patients
 19 in the additional beds that Louisa Jordan provided?

20 **A.** We have absolute faith in the training that our nurses
 21 and healthcare workers go through, so if Louisa Jordan
 22 had been used for Covid patients then I don't doubt that
 23 we would have had the appropriate staff who were
 24 trained, redeployed from other hospital and healthcare
 25 settings to Louisa Jordan, if that is what we thought

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1 for other purposes.

2 **MS MITCHELL:** My Lady, I wonder if I might be allowed to ask
 3 a question of clarification as to the use of retired
 4 people at Louisa Jordan?

5 **LADY HALLETT:** I think you've taken far enough, thank you
 6 very much.

7 **MS MITCHELL:** I'm obliged, my Lady.

8 **LADY HALLETT:** Mr Burton.

9 **Questions from MR BURTON KC**

10 **MR BURTON:** Thank you, my Lady.

11 Thank you, Mr Yousaf. My learned friend on behalf
 12 of Bereaved Families Scotland has already asked some of
 13 the questions about quality impact assessments.

14 And, my Lady, I wondered if I could ask just one
 15 follow-up question in relation to that that is slightly
 16 different from the one I was previously given permission
 17 for, which is just to ask Mr Yousaf about the
 18 alternative he talked about, which was through ad hoc
 19 quick engagement with DPOs and other people with lived
 20 experience.

21 **LADY HALLETT:** Well, it's sounds as if you've asked it. So
 22 this is instead of the question you have permission for?

23 **MR BURTON:** Indeed.

24 **LADY HALLETT:** Very well.

25 **MR BURTON:** Mr Yousaf, you talked very eloquently how

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1 sometimes the EIA process is not well suited to the
2 fast-paced environment of a pandemic, but then you also
3 spoke equally eloquently about the power of talking to
4 people directly in perhaps a more ad hoc way, quickly,
5 with those who have lived experience, and clearly it
6 seems some of that was done by the Scottish Government
7 during the pandemic, and I think it's fair to say that
8 my clients would suggest that the level of engagement in
9 Scotland was, relatively speaking, good in relation to
10 some of these issues.

11 Do you think that some of that happened in
12 Scotland because of an existing practice prior to the
13 pandemic of that sort of direct engagement with, for
14 example, disabled people's groups, et cetera?
15 **A.** Yes, in short, I think the ethos of the government is to
16 try to be as engaging as possible with those with lived
17 experience. We know that policy is far better
18 formulated at the conception stage with those who it
19 impacts as opposed to being done to them. So the
20 general ethos of government, you know, and I've served
21 under two first ministers, as well as being a
22 First Minister myself, and serving under of both of my
23 predecessors, it's certainly the ethos of the government
24 to have that direct engagement, and not with
25 representative organisations, don't get me wrong,

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1 letter was sent out in accessible formats for disabled
2 people?
3 **A.** Forgive me, I don't know. I'd be astonished if it
4 wasn't sent out in accessible format and also in various
5 languages as well, but I would have to look back to give
6 you an answer with absolute certainty, and I can
7 obviously provide the Inquiry with a certain answer in
8 writing if so wished.
9 **Q.** Thank you. My last question is this, that my clients
10 have a concern that disabled people in particular may
11 have been the ones who were less likely or unable to
12 access hospital treatment unrelated to Covid-19 during
13 the pandemic. Do you know if any evaluation was done of
14 the Right Care Right Place programme to see how it
15 impacted on disabled people positively or negatively,
16 I should say?
17 **A.** There was absolutely a valuation done of that campaign,
18 and highlighting some of the successes but also where we
19 could improve upon the campaign.
20 Again, you will forgive me if I can't recall
21 whether the evaluation looked specifically at the
22 issue of those with disabilities and with accessibility
23 issues.
24 So, again, if it so pleases the Inquiry, I can
25 ensure that a written response is provided.

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1 I think they do a phenomenally good job, but actually
2 going beyond the representative organisations directly
3 to the people with lived experience is really important.
4 I suppose I would say the point you've emphasised
5 a couple of times correctly is that was done ad hoc.
6 I think, for me, if we are thinking about a preparedness
7 for a future pandemic, we should perhaps be looking
8 at -- we should be looking at how that is not done on an
9 ad hoc basis but a far more structured basis and one
10 that involves the entirety of Cabinet as opposed to just
11 one or two cabinet secretaries who may well have
12 a direct portfolio responsibility for a particular issue
13 that affects a particular demographic, so instead of
14 doing it ad hoc I think it should be far more
15 structured.

16 **Q.** Thank you very much. I just have another of couple of
17 very quick questions about the NHS Scotland's Right Care
18 Right Place guidance and campaign.

19 Mr Yousaf, if you don't know the answer to these
20 questions then of course please do say so.

21 In relation to that, I think a letter was sent out
22 in December 2021 effectively reminding every household
23 that they should continue to access NHS services if they
24 needed them despite, for example, some concerns about
25 protecting the NHS, et cetera. Do you know if that

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1 **MR BURTON:** Thank you very much, Mr Yousaf.
2 I am most grateful for the indulgence, my Lady.
3 **LADY HALLETT:** Thank you, Mr Burton.
4 Ms Iengar.

Questions from MS IENGAR

5 **MS IENGAR:** Thank you, my Lady. My Lady, I am pleased to
6 say that in light of the evidence given, I only need to
7 cover one of the two topics I have been given permission
8 on.
9

10 Mr Yousaf, I appear on behalf of the Long Covid
11 groups and I want to pick up on the interactions you
12 mention having with Long Covid Kids Scotland.

13 Firstly, some points of simple chronology which
14 I hope we can take quite quickly. It's right, isn't it,
15 that in those meetings with Long Covid Kids Scotland,
16 the first of which was in November 2021, the parents and
17 carers of children with Long Covid shared their concerns
18 with you of being disbelieved by medical professionals,
19 of delays in obtaining a diagnosis, of being refused
20 referrals to specialists, and of the absence of accurate
21 public information on the risk of Long Covid to children
22 and young people. That's right, isn't it?

23 **A.** Yes, yes, and I should start my responses, again, to
24 re-emphasise and put on the record just how valuable
25 those interactions with Long Covid representatives and

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1 those with lived experience were to me, both as health
2 secretary and I know continue to be to my colleagues who
3 have succeeded me thereafter.

4 **Q.** And taking that chronology a bit further, in June 2022
5 you also met with several of the children themselves,
6 several of -- and saw firsthand previously healthy
7 children who had become disabled by Long Covid. And at
8 that time you made a very public promise to continue to
9 raise awareness of Long Covid in children; is that
10 right?

11 **A.** Yes.

12 **Q.** And it wasn't until a year later, April 2023, that the
13 Strategic Network's Children and Young People's Group
14 met for the first time and, as Caroline Lamb has told
15 us, it's only now in the summer of 2024, after your
16 tenure, that one clinical pathway for children and young
17 people in one NHS board has been published.
18 Caroline Lamb, in her evidence to the Inquiry, accepted
19 that there was a delay in Scotland responding to the
20 needs of children and young people with Long Covid.

21 Mr Yousaf, do you agree that there was a delay?

22 **A.** Yes, I've already accepted that in my exchange with
23 Ms Price that there could have been -- we could have
24 acted with greater speed and there was often reasons why
25 that wasn't always possible and, again, the exchange

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1 in existence. But of course the message to our health
2 boards at a local level was, one, the funding was
3 available and existed. You have to do an investigation
4 of where the gaps exist. And although there might not
5 be, for example, one single pathway, there should be
6 services available, rehabilitation services available
7 where necessary for young people and children that are
8 suffering the long-term effects of Covid.

9 I fully accept the criticism that Long Covid Kids
10 have made that there was not enough public communication
11 around the pathways that existed and that they felt that
12 it took and it takes too long to access some of those
13 services, and I know those are the some of the
14 challenges that my successors and colleagues still
15 continue to work on to this day, but a suggestion that
16 there was nothing effectively done until summer 2024
17 I would suggest is somewhat unfair.

18 **Q.** Mr Yousaf, the reality is that in the summer of 2024, as
19 Ms Caroline Lamb told us quite clearly, the first and
20 only clinical pathway for Long Covid in children and
21 young people was published. So prior to now, my clients
22 have had no access to care. I note the points you make
23 about communication et cetera. That's not what my
24 question is. My question is, in relation to the
25 provision of care for children and young people whom you

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1 with Ms Price, I mentioned in reference the fact that
2 winter 2021-2022 was extremely difficult for NHS. But
3 no, I accept fully the criticisms and critique from
4 those with experience of the long-term effects of Covid
5 that they felt that the government just didn't move at a
6 quick enough pace and that's something we have to
7 reflect on.

8 **Q.** So, looking back at what happened, the first infections
9 were in 2020, you first met with the families of
10 children and young people with Long Covid in
11 autumn 2021, yet by early 2024 my client's children
12 still had no access to specialist Long Covid care, which
13 left one parent with no alternative but to pursue legal
14 action against their NHS board.

15 So, Mr Yousaf, my question is, why wasn't more
16 done to ensure children and young people with Long Covid
17 could access care before you left your role? The
18 debilitating impact on children should have prompted
19 more urgent action, shouldn't it, notwithstanding other
20 demands on the healthcare system?

21 **A.** Where I perhaps differ from the characterisation is the
22 suggestion that virtually nothing was done in that
23 intervening period. So you're absolutely correct to
24 state -- when the meetings took place, you're absolutely
25 correct to state when the first pathway came into being

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1 met, who have become newly disabled by Long Covid, why
2 wasn't more done before you left your role?

3 **A.** Again, I think there was if not clinical pathways,
4 I accept a clinical pathway being established in
5 summer 2024, there would have been, for example -- there
6 could have been referrals made by GPs when they first
7 saw a young child that was presenting with the long-term
8 effects of Covid to particular rehabilitation services,
9 to particular services within their local health board
10 area.

11 What government did, what I did, was to ensure for
12 the first time that there was funding available to local
13 health boards so that when they investigated the gaps
14 that existed that funding would be available. Not just
15 for one year, because services can always fall over
16 after one year given -- if they are not funded for
17 longer, but funding provided and guaranteed for three
18 financial years was to ensure -- was, I would hope, at
19 least a step in the right direction.

20 The criticism from Long Covid Kids, who I think
21 are an exceptional organisation, do an important amount
22 of work, is that there are not enough clinical pathways,
23 needs to be further investment and needs to be better
24 communication and consistency across the country, are,
25 I think, ones the government must reflect on and I hope

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1 we can give Long Covid Kids and children more
2 reassurance than they perhaps have at the moment.
3 **LADY HALLETT:** Thank you, Ms Iengar, that's as far as we're
4 going to go, I'm afraid.
5 **MS IENGAR:** Thank you.
6 **LADY HALLETT:** Thank you very much indeed, Mr Yousaf.
7 You've helped me once before. I have no idea whether
8 we're going to have to ask you to help us again. But in
9 the meantime, thank you for the help you've given so far
10 and I hope that the current bout of snow isn't too
11 disruptive in Scotland. I think it's been pretty
12 disruptive, as you'd expect, in England, but there we
13 go, you're more used to it than we are, I think.
14 **THE WITNESS:** Thank you. I'm just pleased that I'm not
15 Transport Secretary when the snow falls, I have to say.
16 But, no, thank you very much, my Lady, and of course
17 I'll always make myself available, should you require in
18 future modules.
19 **(The witness withdrew)**
20 **LADY HALLETT:** Thank you very much. 10 o'clock tomorrow,
21 please.
22 **(4.32 pm)**
23 **(The hearing adjourned until 10.00 am**
24 **on Wednesday, 20 November 2024)**
25

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