Tuesday, 19 November 2024

(10.00 am)

LADY HALLETT: Ms Price.

MS PRICE: Good morning, my Lady. May I please call Jeane Freeman, who will take the oath.

MS JEANE FREEMAN (sworn)

Questions from COUNSEL TO THE INQUIRY

LADY HALLETT: Welcome back, Ms Freeman.

THE WITNESS: Good morning, my Lady.

MS PRICE: Would you give us your full name, Ms Freeman.

A. Yes. It's Jeane Tennent Freeman.

Q. You have prepared a witness statement for this module of the Inquiry dated 18 July 2024, and the reference to that is INQ000493484. I understand you're familiar with that and have a copy in front of you; is that right?

A. I do.

Q. I'd like to start, please, with the role of Cabinet Secretary for Health and Sport and some particular features of that role during the pandemic.

You became Cabinet Secretary for Health and Sport, it was a role that you held until May 2021; is that correct?

A. That's correct.

Q. Is it right that you had no involvement in the Scottish Government's response to the pandemic after that date?

A. That's correct.

Q. As Cabinet Secretary for Health and Sport, your responsibilities included the NHS in Scotland and its performance, staff and pay?

A. Correct.

Q. Health and social care integration?

A. Yes.

Q. Patient services and patient safety?

A. Yes.

Q. National clinical strategy?

A. Yes.

Q. Quality strategy and national service planning?

A. Yes.

Q. Allied healthcare services and child and maternal health?

A. Correct.

Q. And in this role you were supported by relevant junior ministers; is that right?

A. That's correct.

Q. From January 2020 until May 2021, you were primarily responsible for health and social care policy?

A. Yes.

Q. In your statement you draw a distinction between responsibility for setting strategic direction on the one hand and responsibility for operations, which lay

with your officials?

A. That's correct. Although I should say, if I may, while the responsibility lay with officials, accountability for all of it rested with me.

Q. Can you explain, please, to what extent that changed, that divide between strategy for you and operations for your officials, during the pandemic?

A. So the change occurred when I used the emergency powers of the 1978 Act which allows a cabinet secretary for health to direct directly, if you like, the National Health Service in Scotland.

Q. And why did you take the step of putting the NHS in Scotland on an emergency footing?

A. Because -- for two reasons. One, I wanted to ensure that every part of the health service, if you like, was facing in the same direction. And two, given that it was a global pandemic, I wanted it to be crystal clear that I was accountable to the Scottish public for the decisions made and the performance of the health service.

Q. What did it mean in practice once the NHS in Scotland was on an emergency footing?

A. So in practice it in effect meant that decision-making at a board level, individual -- we have 14 territorial boards, as I'm sure you know, and the national boards --

that decision-making at board level was superseded by my decisions.

Q. The NHS in Scotland was on this emergency footing from 17 March 2020, and it was still on this footing when you left your role in May 2021; is that right?

A. Yes.

Q. At paragraph 8 of your statement you describe the NHS in Scotland as being well equipped to operate as a single unit in the event of an emergency as a result of its structure. Can you explain, please, why you consider that to be the case?

A. For a little bit of context, in I think just before 2014, in the early 2000s, we in Scotland, the government, abolished the internal market for the NHS. So whilst we have individual boards, they do not compete with each other for funds or in terms of their performance. That meant, in addition to the fact that Scotland is a small country -- there are just over 5 million of us -- you can effectively get everyone who makes decisions on delivery or on policy into the same room. For those reasons, NHS Scotland is structured to operate as a single unit, where the board's discretion, the individuals board's discretion, is to apply the national strategy to local circumstances.

So, for example, you would expect in some

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

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

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

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

I don't believe NHS in Scotland requires

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

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

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

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

A. I believe it did, yes.

Q. How?

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

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

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

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

A. Mm-hmm.

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

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

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

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

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

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

Now, the nature of the relationship established

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

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

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

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

enough beds. That, in normal times, tells you that either your capacity in general isn't sufficient or you have a clinically unnecessary delay in discharge.

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

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

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

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

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

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

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

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

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

MS PRICE: Thank you, my Lady.

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

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

And you say:

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes, I do.

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

A. I don't have the exact date to mind but it would be very early in the emergence of that debate. I think you have heard from our CMO that we never wrote out the possibility of aerosol distribution of the virus. Whilst the focus was on droplet transmission, aerosol was never ruled out as a definite no in our minds, so we were open to that.

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

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

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

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

A. Yes.

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

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

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

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

A. Well, they are healthcare staff.

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

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

A. Not that I recall.

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

A. Yes.

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

A. That's right.

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

not been identified pre-pandemic?

A. No, I can't.

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

A. I believe they had.

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

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

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

A. It would have done, yes.
Q. At paragraph 174 of your statement you say you were aware of the fact that nosocomial infection in Scotland was increasing prior to the pandemic. What was your understanding for the reasons of this increase in nosocomial infection pre-pandemic?
A. My understanding was that it was inconsistent application of basic infection prevention and control measures in a hospital setting.
Q. What was done to address that?
A. So the Chief Nursing Officer would, with her nurse directors from each board, would reference, again, the national manual, which I think had been in place since 2012, which sets out very clearly the procedures to be followed, and asked them to ensure that in their board area that that was being followed, including, kind of, on-the-spot checks to be sure there was a big piece of work undertaken about hand washing and the use of basic-level PPE in particular settings to try and remind everyone of what should be habitual infection prevention and control.
Q. How did this pre-pandemic rise in nosocomial infection inform your approach to the healthcare response to the pandemic? Was it a relevant factor?
A. Well, the awareness that nosocomial infection occurred

informed an expectation on my part that we may well see it in the context of the Covid pandemic.
Q. With that particular consideration in mind and going back to the discussions before about whether anyone proposed to you a discretionary policy for access to FFP3s, did it ever occur to you to propose a wider discretionary use of respiratory equipment, particularly bearing in mind that knowledge that there might be an increased risk of nosocomial infection?
A. So, nosocomial infection, by and large, occurred in the ward setting not in ICU or high dependency where those masks were worn.

The debate around CPR came from clinicians to me. No other concern came from clinicians to me about other settings, and including from the CNO or her office which, of course, was the lead office on infection prevention and control. And as I've said, as a non-clinician, whilst I might ask what are we doing about nosocomial infection, it did not feel to me that as a non-clinician I would start making clinical judgments about PPE.
Q. The Inquiry has received evidence that concerns were raised by clinicians and staff about the adequacy of ventilation at the Glasgow Royal Infirmary in November 2020, linked to problems with complying with

IPC guidance in older parts of the hospital estate in Scotland. Do you recall that issue?
A. I do.
Q. What steps were taken to deal with ventilation problems relating to older parts of the Scottish hospital estate?
A. In relation to ventilation I believe that a number of HEPA filter machines were used.
Q. Did you understand the concerns about ventilation problems to have been resolved?
A. I think it's probably fair to say that I did, inasmuch as they did not come back to me. And certainly in terms of other concerns at various points throughout that period where a resolution was not reached, then it would come back on to my desk, either directly from my own advisers or policy officials, or indirectly through social media, or directly through the unions, and I had regular meetings with healthcare unions.
Q. I'd like to come, please, to PPE supply and access issues. You explain in your statement at paragraph 190 that as cabinet secretary you were ultimately responsible for ensuring that the health workforce in Scotland had access to appropriate PPE. With that in mind, I'd like to ask you, first, please, about PPE stock at the outset of the pandemic.

Could we have on screen, please, INQ000380849.

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

And going to the second page, please, under "Purpose" we see the submission was:

"Seek[ing] your approval to release/make available to Boards the use of FFP3 respirator mask, which has recently passed its expiry date, but has passed stringent Quality Assurance tests."

The timing is:

"Immediate -- given the current position with FFP3 masks."

And then under "Background" it is explained that:

"You are aware of the current challenges in the supply chain for clinical consumables, particularly in relation to PPE and specifically the FFP3 respirator. This is most often used in intensive care units but will be used in all areas where aerosol-generating procedures are carried out ..."

And then at paragraph 4 there is a reference to an earlier submission, noting:

"... the fragile position in relation to the current FFP3 stock and in relation to new supplies."

And some figures are given there for the national stockpiles now only holding 16,000 after distribution to

the boards of 73,000 the week before.

And the position was that the time-expired stock, which had been held, the position had been reached where consideration needed to be given to using it.

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

A. Yes, I do. Yes, I do.

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

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

So in terms of thinking ahead to a future

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

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

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

Q. Not at all.

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

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

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

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

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

A. No, I was -- sorry.

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

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

royal colleges but also discussion with the unions.

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

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

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

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

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

A. Mm-hm.

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

A. Yes, please. I don't.

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

A. Yes, I do.

Q. -- passing on those survey results.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

on behalf of their members early in the pandemic, including issues relating to adequate supply of PPE, and she drew a distinction between how the position may have looked to those involved in procurement in government and the experience of healthcare workers on the ground. Is that a distinction you recall being raised with you in the early months of the pandemic?

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

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

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

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

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

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

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

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

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

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

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

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

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

A. I don't believe so.

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

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

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

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

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

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

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

A. That's correct.

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

A. No.

Q. They were different?

A. Yes.

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

A. There may have been.

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

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

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

First Minister and the CMO?

A. No.

Q. No?

A. No. You'd need to go a step back or earlier in the day. So, every day we had, as I described, the directors meeting, and the key person in that -- two key people in that meeting would be John Connaghan, as our chief operating officer, at one point also interim chief exec, and our chief exec, and DG. And prior to that meeting, Mr Connaghan will have spoken to every health board chief executive or medical director about the status report in their hospitals that morning, and he would feed that into that directors meeting.

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

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

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

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

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

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

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

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

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

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

amount of capacity, I've got this amount instead.
Q. Just focusing on the information from the Chief Nursing Officer about staffing ratios. The Inquiry has heard that staffing ratio data was not being reported by individual hospitals or health boards to SICSAG, the Scottish intensive -- I'm going to get my acronym wrong, but do you know the organisation I'm referring to?
A. Yes.
Q. So that data wasn't being reported and held centrally in a way that could be looked at, you know, over time, for example. So how was the Chief Nursing Officer providing you information on staffing ratios across all those hospitals and health boards?
A. Through her daily conversations with nurse directors.
Q. Turning, please, to the steps that were taken to address expected hospital demand and how effective those steps were. You say at paragraph 57 of your statement that you took a number of decisions to ensure that the health service in Scotland was ready to deal with those modelled high numbers you've referred to. Can you explain, please, what the key steps you took were?
A. So this is very early and then followed up by that letter in early March from Mr Connaghan that I mentioned. So it was a pausing of elective care, which then frees up not only beds but staff to redeploy.

And it was the pausing of the screening programmes, cancer screenings but also the -- I can't recall what it is -- the two screening programmes we retained was for maternity and newborns but all other screening programmes were paused. The steps taken to begin discussions with the relevant regulatory bodies about permitting the entry into the hospital setting on a full-time basis of final year medical constitute departments and final year nursing students that would allow them to still complete their qualification in the time frame they had anticipated pre-Covid. The work to ask recently retired healthcare professionals to return. And the establishment of the community Covid pathway, which was an attempt to retain some primary care provision for patients who did not have Covid. That was replicated a little bit in the red and green pathways in hospital where you delineated from the Covid areas and the non-Covid areas. That was a difficult position to maintain but it was done. And all the PPE work, around increasing the distribution routes of PPE and the supply of PPE to all parts of the healthcare service, whether or not they were private, that we had not done before, and of course to social care.
Q. Setting aside the permanent ICU bed uplift, which was decided upon in Scotland in 2021, what efforts were made

at the outset to ensure that ICU-trained staff could treat patients in the expanded surge capacity beds?
A. I'm not quite sure I understand your question.
Q. Well, there was going to be a surge of beds, and in terms of the recommended staffing ratios that would be one ICU-trained nurse to a patient. When that was surged there would be a greater requirement for ICU-trained nurses. Were any steps taken at the outset of the pandemic to increase the numbers of people so trained to increase the chances that you would have ICU-trained nurses treating those patients?
A. Yes, thank you. Thank you, I understand.

So, pausing of elective work meant that we freed up theatre teams, not only the surgeons but the entire theatre teams. The advice that I received was that those teams could be trained to operate in an ICU capacity more quickly than any other staff because of the skill set that they already had and practised, so that work was undertaken to increase the number of appropriately trained staff to work in an expanded intensive care.

MS PRICE: My Lady, would that be a convenient moment for the mid-morning break?
LADY HALLETT: Yes, I shall return at 11.30.
(11.12 am)

(A short break)
(11.30 am)
LADY HALLETT: Ms Price.
MS PRICE: Thank you, my Lady.

Ms Freeman, it's your written evidence to the Inquiry at paragraph 92 that the key decisions taken by the Scottish Government, which we were talking about just before the break, were effective in protecting the NHS from being overwhelmed during the pandemic.

What did you understand NHS overwhelm to look like or mean?
A. So that would be if we -- if you go back to the modelling of worst-case scenario this would be -- and, of course, those numbers would not all appear at once, but if we were ever in a position where we did not have the capacity to care for patients presenting at hospital or requiring intensive care because -- as a consequence of the virus, that would be us overwhelmed and, of course, as an additional precaution to that, was also why we took the decision to create NHS Louisa Jordan.
Q. At paragraph 128 of your statement you say you were not made aware that intensive care capacity had been reached in Scotland at any point from March 2020 onwards. What definition of intensive care capacity are you using when you say that?

A. Our commitment to quadruple, from baseline, our intensive care.
Q. Just thinking in terms of whether capacity had been reached, so your understanding that capacity had not been reached --
A. That's right.
Q. -- when you're referring to intensive care capacity --
A. Yes.
Q. -- are you referring to baseline capacity or surge capacity? What is your definition of the intensive care capacity?
A. So my definition of intensive care capacity for the purposes of the work that we undertook to respond to the virus is the quadrupling of intensive care capacity, so we had not reached that.
LADY HALLETT: Ms Freeman, a question I suspect we're going to put to various health ministers. If a system has had to close down cancer screening, a potentially fatal disease, if it's had to cancel elective surgery where people can suffer in huge pain for years, why does that not mean the NHS is overwhelmed?
A. In terms of responding to the pandemic I think overwhelmed means your capacity to respond to those cases that come to you as a result of the virus, people contracting the virus. There are other non-health harms

that you've just rightly highlighted, my Lady. Probably the most critical of those is the pausing of screening programmes, and I think I've said before most likely the most difficult decision I made.
LADY HALLETT: So that is really -- you're saying the NHS isn't overwhelmed if you can cater for all the Covid cases. But if by catering for the Covid cases you have to stop people being cancer screened, surely on one definition that might say the NHS was overwhelmed?
A. "Overwhelmed" is not a word I would agree with, I don't think it was overwhelmed as a consequence of that, but undoubtedly non-Covid harm was created as a consequence of that particular set of decisions and, longer term, the pausing of elective care, yes.
LADY HALLETT: Sorry to interrupt.
MS PRICE: Thank you, my Lady.

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

A. Yes, I understood that.
Q. How did you make sure you knew what was happening on the ground?
A. As I've said already, my directors, including clinical advisers, had that morning meeting. Feeding into that was the overnight update report from each health board, and the update from that meeting was fed to me directly, almost always by the chief executive, walking along the corridor and briefing me, and then followed up in writing.
Q. At the time did you fully appreciate that when baseline capacity was breached, even if surge capacity was technically not, this had consequences for the quality of care being received by patients?
A. I would have a concern that it would have consequences for the quality of care, because as you, I think, have alluded to before, it's not simply about the number of beds you have, it's also about the staffing levels you have.

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

some of the others returning to frontline work, they return, and also bringing in final year medics and nursing students. And so you're trying to move people with the highest level of skill to operate at that level of skill, and back-filling them from the staff that you are securing by other means. In that way you're trying to make sure that the quality of care in areas of the hospital in addition to high dependency or intensive care is as good as it can be.
Q. The Inquiry has heard evidence from Professor McKay that during the first wave instead of one ICU-trained nurse to one patient there was, in effect, one ICU-trained nurse supervising four non-ICU-trained nurses each caring for a patient. Were you aware of this kind of change in the standards for staffing ratios during the first wave at the time?
A. Yes.
Q. And did you have any concerns about that?
A. Well, yes, I did, but equally I was conscious of the limitation of choice. So people were not actively choosing to staff those beds in this way in the face of a better choice. They were choosing to do this to the best standard they could, with the highest level of supervision that they could, to secure equal quality of care in circumstances where they were dealing with

higher numbers than in peak Covid times.
Q. Do you consider that entering the pandemic with low ICU bed numbers and high bed occupancy put hospitals in Scotland under even greater strain?
A. I think entering the pandemic with fewer beds capable of modification to be ICU beds, as -- for example, there was a case, I understand, in Germany where more beds in a hospital setting are equipped, for example, with an oxygen supply for use if needed. So entering the pandemic without that circumstance put greater pressure on our system, and it would be one of the lessons I would hope we would learn, that we have greater capacity to increase that level of care, not just in the beds we have but also in the trained staff that we have.
Q. Did this also have a knock-on consequence for the ability to restart non-urgent elective care?
A. I don't believe so.
Q. You say at paragraph 88 of your statement that you had no specific discussions about the rationing of healthcare. What type of healthcare are you referring to there?
A. Any type of healthcare.
Q. Do you mean --
A. There were no discussions at all about rationing of healthcare. Where decisions are made in a hospital

setting about the care that a patient should receive, the appropriate care, those are clinical decisions.
Q. Turning, please, to NHS 24 and ambulance capacity issues. In December 2020 there was a redesign of the urgent care pathways which saw NHS go from being an out-of-hours service to a 24-hour service. Written evidence from NHS 24 received by the Inquiry suggests that NHS 24 additional workforce requirements equated to a 43% increase in staff and that around 2 million patients have accessed the pathway since it was launched. So this was a significant operational change for NHS 24, wasn't it?
A. Yes.
Q. Was there a clear plan for how extra staff would be sufficiently trained and supervised, given the emergency nature of the expansion and the complexity of providing the service to caller patients?
A. My recollection is that NHS 24 had devised such a plan, and certainly that would have been over seen by Mr Connaghan, and challenged by him if he did not think that that met what was required.

I do recall a discussion within NHS 24's chief executive and chair about physical location. They needed to expand the physical footprint that they had in order to accommodate additional staff.

Q. Did you receive any reports of the scale of the change impacting the quality of the service when capacity was first increased?
A. I don't recall any specific reports but inevitably that level of increase and change would not go as smoothly as you might wish.
Q. Is there any learning that can be taken from that quite dramatic change to the pathways and is it something that you would do again?
A. If I had the same advice again, then I would do the same again, yes. But you don't know what any future circumstance might be like so it's impossible to be certain of the answer to a question like that.

I can't recall the second part of your question.
Q. Just whether there had been any learning identified?
A. So I believe NHS 24 have undertaken reviews of how that increase in capacity and resultant demand and what the lessons learned for them are, and they will have fed that into the NHS as a whole.
Q. The intention behind the change was to reduce emergency department self-presentation; is that right?
A. Yes.
Q. How successful was the change in achieving that?
A. My understanding is that that was reasonably successful. Of course this happened after a trial of the approach,

which took place in Ayrshire, in advance of that, and very much was a modification of the model used in Denmark.
Q. In relation to the level of 111 calls in the first wave and wait times for those calls, could we have on screen, please, page 32 of INQ000474258.

This is a statement provided for the Inquiry by Stephanie Phillips on behalf of NHS 24. It provides some data for calls offered, calls answered, and average time to answer, on this page for the week beginning 24 February 2020. And we can see that in that week 31,182 calls were offered, 25,807 were answered, so that's just under 83%, and the average time to answer was 6 minutes and 31 seconds.

And then the table over the page gives the same data for the month of March 2020 with the calls offered for the entire month, showing at the bottom there, of 235,660, with 119,201 being answered, so that's just over 50%. And the average time to answer being 32 minutes and 14 seconds.

What consideration was given by the Scottish Government to the need to increase 111 capacity prior to March 2022 -- apologies, March 2020. I'm struggling with my years today.
A. So I think it would be fair to say that the

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

Q. Given that the public were being urged to use 111 services as a first port of call, what steps were taken to monitor the efficacy of 111?

A. So there would be data produced similar to what we're looking at on screen now where the key number is -- you're certainly interested in calls offered/calls answered because if you see a dip there, then you know that either people feel they're waiting too long and they give up on the call, but also the time it takes, the average time it takes to answer in the first instance. Some calls will take longer to deal with than others, but the initial pickup is a key number that you want to look at.

So, that would be being monitored by the

directorate.

Q. In relation to the pressures on the Scottish Ambulance Service, the Inquiry has received evidence that the SAS conducted a voluntary review of private ambulance providers which indicated that they would be willing to support the NHS if required. But that was not taken forwards because Scotland does not have a legislative framework in place for regulation of private ambulance providers. Were you ever asked to consider the merits of making legislative or policy change which might have allowed for the use of private ambulances to support the Scottish Ambulance Service during the pandemic?

A. I don't recall being asked that.

Q. In relation to private hospital providers, you refer at paragraph 164 of your statement to the decision in March 2020 to make use of private hospital capacity for the treatment of urgent elective procedures and urgent cancer cases. In your view, would it be beneficial in anticipation of a future pandemic to put in place a protocol in consultation with private sector providers to plan for the provision of emergency capacity and surge support by private providers?

A. So the use of private providers in Scotland at that time, the capacity of private providers was relatively small but the use of them had been made prior to the

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

Whether or not a protocol for future use makes sense, I can see advantages for that but, of course, it's a decision for a future health secretary.

Q. Turning, please, to Long Covid. You refer in your statement to a submission dated 15 December 2020 informing you that a clinical guideline on the management of people with Long Covid was to be published on 18 December.

A. Yes.

Q. Were you advised at any point before this of long-term consequences of Covid-19 in the Scottish healthcare system or the potential for this?

A. So the first indication I recall, and it was not at that point put to me or discussed as "Long Covid", but was what appeared to be, for some patients, impact of the virus on their heart functioning. Generally speaking, if I'm correct in my memory, young men. So otherwise fit people who contracted the virus being left with a difficulty in their heart function. I can't be clearer than that.

So I recall that and I recall the Chief Medical Officer at the time saying this is something we need to watch out for, and reminding me that viruses can leave a longer-lasting impact of a different kind so we should reasonably keep an eye out for whether Covid did, whether it was going to be -- sorry -- in the cardiac area or whether it was going to be something else.

Q. Can you recall even roughly when that was?

A. I think that would probably be late spring, summer of 2020. But you're relying on my memory at this point and I should caution you against that.

Q. Apart from deciding to keep an eye, were you advised to take any other steps?

A. At that point, no. At that point, no, because I think it's reasonable to say at that point across the UK, and elsewhere, there was an aware -- well, there was an awareness anyway in the clinical community that viruses can do that. So there was no reason to think that Covid would be different. So it might, I think is the -- keep on open mind approach: let's keep an eye on it, let's see what comes through, what might be emerging, through our -- "our" being our clinical advisers' -- relationships, particularly in Europe, and in Italy, and see what they are identifying as emerging in their area.

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

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

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

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

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

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

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

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

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

A. It was financial.

Q. And was that forthcoming?

A. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. That's right.

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

A. Yes.

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

A. I do.

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

A. Yes.

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

fulfilled after shielding was paused?

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

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

so on.

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

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

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

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

decision that should be reached and by whom around DNACPR.

So, I wanted to ensure that those concerns were addressed as quickly as possible. I did not -- I knew that there was no blanket instruction or requirement emerging from Scottish Government and I wanted to ensure (a), that we looked in detail at the concerns that were being raised, and was that localised, was it in more than one place in Scotland, what was this, and sought to make it crystal clear what should happen, and if that isn't what was happening, what we were going to do about it.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Scotland?
A. So there was a look at where it was alleged these blanket DNACPRs were being imposed to see whether or not that was the case, but there was no more than that done. We were, after all, in the middle of a pandemic.
Q. Moving, please, to non-Covid care. In March 2020 you decided to pause five adult screening programmes, including the cancer screening programme, and you've referred to that already. You describe in your statement that decision as one of the hardest decisions you've had to make?
A. Mm-hm.
Q. What was done to ensure that the screening programmes could get back on track as soon as possible?
A. So, two things. When we paused the screening programmes we -- so the screening programmes operate on the basis that you are called for screening with a frequency. I think it's every three years for breast screening, for example. So we had to make sure that when we restarted them that the people who had not been called were called at the start but equally anyone due to be called at that point was called as well. So you needed to look at whether or not you could resource up in order to be coping, if you like, with two streams of demand, and that applied in the other programmes as well. So that

work was undertaken to see how best we could do that.
Q. Non-urgent elective activity was also paused; is that right?
A. Yes.
Q. Is it right that the decision to restore elective surgery capacity was left to individual health boards, who could decide to prioritise other services in preference to restoring elective surgery?
A. So the decision to restart elective care was national across Scotland. If individual boards wanted to veer from that in any respect, that had to be approved. And obviously they had to have reasons for that.
Q. Taking the examples of hips, the Inquiry has received evidence the number of hip replacements done in Scotland dropped by 50% in 2020 in comparison to 2019, and by 2022 that had not returned to 2019 levels. It has also received evidence that in Scotland patients were waiting 18 months to two years for hip replacements during and since the pandemic in Scotland.
When were you made aware of the increasing backlogs and what steps were proposed to tackle the issue?
A. So it was not difficult to know the backlog that you were creating at the point when you pause it, because those numbers are held. So someone like Mr Connaghan

has at his fingertips what the waiting times and lists are, and so he can tell you, and did, if you pause these -- if you pause it for this amount of time this is the backlog you create, for this amount of time this is the backlog you create, and so on.
So I was aware that I was, by my decision, creating a backlog.
The additional element we put in which does matter is that people did not drop to the bottom because their procedure had not gone ahead. They stayed there. And so there needed to be decisions about, when you restart, how you're prioritising this. Are you going to prioritise it on the basis of those who have waited the longest or are you going to prioritise it on the basis of a clinical judgment about need, in other words how badly deteriorated a hip might be?
We went for clinical judgment, balanced against length of time, and actually looked to begin that in the winter planning work that was underway in the summer of 2020.
Q. What were the key challenges in dealing with the backlogs which had been built up for elective care in Scotland?
A. So, one of the key challenges would be that, just as you're about to do that, the virus mutates and you enter

another period of significant transmission and additional lockdown, so that sets you back.
In addition, you have NHS workforce as you go towards the end of 2020, into 2021, who itself, whatever area they have been in, is physically and mentally exhausted. And so you can't flick a switch and say we're going back to where we were in 2019. That would be to completely deny the impact of what has happened on your workforce.
So -- and we were very clear in our public -- I was very clear in our public statements that it needs to be a phased return to normal working, partly for that reason but also, in some instances, you still have high levels of sickness absence, either for physical reasons or because people are mentally exhausted and they are suffering in that way, and also staff who, towards the end of the pandemic period, are deciding that now is the time to leave the health service. And so there are workforce challenges there. So you cannot say, "We're through the virus, the transmission levels are such that they're low enough we can carry on now and restart", and flick the switch and think you can restart it in 2019 level from day one. That's simply not reasonable to expect.
Q. What use was made of the independent sector to help deal

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

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

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

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

A. So there would be a guidance support and there would be financial support.

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

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

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

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

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

Q. Was that the only elective hub in Scotland?

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

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

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

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

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

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

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

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

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

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

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

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

infection prevention.
Q. Looking back at both the things that went well in Scotland in terms of the Scottish healthcare system response and things that went less well, are there any key lessons learnt which we've not already covered which you would like to raise?
A. So I think it's one and the same. I think the things I would single out that went well are -- is that, first of all, the response of our healthcare workforce across the piece. I think it was extraordinary.
We introduced some level of well-being support for those staff and particularly wanted it to be as close to where they were clinically practising as possible. Very simple, simple things like the availability of microwaves and kettles, a few steps away from -- safely, a few steps away from your clinical area rather than schlepping it all to the canteen. It is a matter of regret to me if those have been removed now because I think the well-being of our staff and the mental health support is a lesson we should learn and incorporate in standard practice.
So I think that was a good thing we did and it's a lesson we should learn and continue to do.
The other main, and it came from staff feedback to me, also in social care, we can come to that on another

day, but in healthcare, was the removal of a number of layers of decision-making in a health board and the devolution of decision -- greater decision-making to frontline staff.
And, again, if you take this in the sense in which I mean it, nothing bad happened as a consequence of devolving decision-making to frontline staff, and so I would believe that that is a practice that should be continued.
MS PRICE: My Lady, those are my questions.
LADY HALLETT: Thank you.
We'll carry on and try and get you done before lunch if that would help you, especially given the weather conditions.
Ms Mitchell, who's over that way.

Questions from MS MITCHELL KC

MS MITCHELL: I appear as instructed by Aamer Anwar & Company on behalf the Scottish Covid Bereaved.
At the beginning of the pandemic after the declassification of Covid-19 as a high consequence infectious disease, consideration was given by those responsible for infection prevention and control guidance as to whether to recommend that all healthcare workers in the NHS dealing with Covid-19 patients should wear FFP3 masks on a precautionary basis.

Was it brought to your attention at that time that the two main considerations when deciding not to recommend were: the logistics of fit testing everyone -- a necessary step for FFP3 masks -- and the level of stock of FFP3 masks available at that time?
A. I don't recall that being brought to my attention, no.
Q. If that wasn't brought to your attention and by your recall it wasn't, should it have been?
A. So, I think there is a balance to be struck between clinical advisers and experts in a particular area making those assessments and judgments, and being allowed to do that and those judgments and assessments being followed by a politician who isn't a clinician, and the politician, ie me, who is directly accountable for what happens, having all the information that they need.
I am not sure, if it had been brought to my attention, whether I would necessarily have disagreed with the final decision. What I may have done, if it had been brought to my attention, was ask for a timeline of how quickly if, for example, stock was a problem, how quickly we could secure the necessary volume of stock or, if fit testing was a problem, and I can see that as a greater difficulty because it is individualised, it takes time, it takes people away from delivering care,

how could we do that?
And I gave the example, I think earlier, of the ambulance service --
Q. Well, we don't need to go further into that. I think we have your answer in relation to that.
A. Okay.
Q. You've explained that as a non-clinician earlier on you wouldn't start making clinical judgments about PPE and you've also explained that as part of your role you were the person who would set out to resolve any issues with PPE. So a clinical decision being made in part based on the stock levels of FFP3, am I correct in saying that you would have liked to have known about that and had you known about it you would have put things in place to find out how to resolve that?
A. Yes.
Q. Moving on. In December 2020, further consideration had been given at a UK IPC cell meeting to the wider use of FFP3 masks in healthcare settings on a precautionary basis in light of the evolving evidence on aerosol transmission of Covid-19. Following discussion, this was not recommended.
Again, was this brought to your attention?
A. I believe that was, yes.
Q. And that being so, what was then done about it?

A. So I'm not sure if the timing is right here, and whether or not that relates to what I was asked earlier about CPR. No?

Q. No, it's in general, December 2020, at a UK IPC cell meeting, it was advocated that a wider use of FFP3 masks in healthcare settings on a precautionary basis, as aforementioned, in light of the evolving evidence about aerosol transmission of Covid-19.

A. Presumably, though -- I do recall this, but I presume that whilst those concerns would be raised inside that cell meeting, there would be counter views and those counter views would prevail. So as the health secretary, I am in a situation where the expert advice is X. I do not necessarily have the evidence or the basis to contradict that.

Q. I see that. Had you been made aware, as we've already identified first of all, that the initial advice but for the levels of stock and but for fit testing, where the FFP for healthcare workers would have been used, and you said that you would have taken action upon that, would, then, had you known that in December 2020 it was being advocated for a further reason, namely that emerging information about aerosol transmission, had you known all those things, would that have spurred you to action at that time?

"... simply ... not [enough] time to go through the processes required to undertake [equality impact assessments] given the rapidly changing nature of events."

How, in those circumstances, did you ensure that a rights-based approach was taken to the decisions made during this time?

A. So the simple answer is: as best I could, bearing in mind that -- formal equality impact assessments are important and are critical for governments to undertake in normal course, but it shouldn't be taken to imply that only through a formal equality impact assessment does a government minister understand equalities, protected characteristics and the likely impact of any decision on particular groups. Particularly when decisions are being made collectively or discussed collectively where you have different government ministers with different areas of portfolio expertise.

So, in those very early days, as I said, the pace of response of emerging understanding of the virus and of decisions and actions that needed to be taken limited our capacity to undertake formal EQIA assessments. You will see that others took place retrospectively and, as we moved through the pandemic, they were more part of policy and decision-making as time allowed.

A. It would certainly have made me have a long discussion with the Chief Nursing Officer to try and understand what were the various views being expressed and the evidence behind those views, which is critical, that then led to the IPC cell's decision and whether or not we had any options around that.

Q. But the fact is that none of this information was known to you?

A. No.

Q. Moving on. You have mentioned in your statements equality impact assessments. And for those perhaps listening, the equality impact assessment is a process that evaluates the potential impact of a policy on people with protected characteristics. And of course some of them were very important during Covid, such as age, disability, race, and pregnancy and maternity.

And the purpose of such equality impact assessments are, amongst other things, to ensure that policies don't unlawfully discriminate against people with protected characteristics or remove -- sorry, and remove or mitigate negative or adverse impacts.

Now, at paragraph 66 of your statement you say that in the early stages of the pandemic you did not carry out formal equality impact assessments as there was, and I quote:

Q. But what --

A. But in those early days I think my personal understanding, and the understanding of my senior advisers, allowed us to make some assessment of the impact of our decisions on the groups you're talking about.

Q. If these are important and critical as you've identified, and likely impact upon groups, the issues of age, disability, pregnancy and maternity, race, were all ones that were critical in those early days and indeed throughout the entire pandemic. Wasn't it all the more critical to ensure right from the outset the rights-based approach was focused on to ensure that you might remove or mitigate negative or adverse impacts on those specific groups?

A. There was undoubtedly important but I'm trying to help you understand the volume of work, the pace of work, the pressures to ensure that our NHS was realigned to be capable of dealing with the numbers that were projected in the worst-case scenario. That meant not only the NHS was focused on that, but my entire directorate of civil servants was focused on that. So in those early days -- and by early days we are talking about late February, into March -- it was not possible to formally conduct a new EQIA assessment before decisions were made,

because decisions were required multiple times in any one day.

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

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

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

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

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

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

A. The answer is yes.

Q. They gave consideration to that?

A. Yes, I did, yes.

Q. And what was done about that?

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

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

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

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

Q. In retrospect.

A. And also in advance.

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

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

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

as a back up to the permanent acute estate.

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

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

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

A. Yes.

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

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

that need.
Q. I see. And will we be able to find therefore somewhere record and reference to that?
A. I think you will need to ask Scottish Government that question.
MS MITCHELL: My Lady, I'm obliged, those are the questions.
LADY HALLETT: Thank you very much, Ms Mitchell.
Mr Burton.
Mr Burton is that way, Ms Freeman.

Questions from MR BURTON KC

MR BURTON: Good afternoon, Ms Freeman. I asked questions on behalf of the Disability Charities Consortium which, as the name suggests, is a consortium of all the main disability charities.
My learned friend has asked you some questions about quality impact assessments and I won't repeat any of those questions. I wanted to ask a couple of bit more specific questions. I perfectly appreciate, however, that this is some time ago and your memory may have been sufficiently taxed already, so if you don't remember, please, of course, just say so.
A. Thank you.
Q. In particular, I'm interested in the equality impact assessment that was carried out retrospectively in relation to shielding, and some observations that were

made in relation to the protected characteristic of disability. And in particular, for those who are following the documents, it's at section 2 on page 7 of that equality impact assessment under the title "Data and Evidence Gathering, Involvement and Consultation". It's said in relation to disability that 42% of households in Scotland contain at least one person who is long-term sick or disabled. This figure covers all household members including children.
However, in relation to the question of shielding, the document goes on to say this:
"The evidence gathered suggests that there is likely to be a number of disabled individuals within the shielding cohort. However, currently, there is no breakdown of that number."
Why was it not possible to obtain a breakdown of that number? Do you recall?
A. I don't recall why that would not be possible.
Q. Okay. That's fine. Just in relation to the sources of that data, the Inquiry has heard quite a lot about the paucity of available data in relation to the prevalence of disability. And that EIA quotes two sources; one was a Scottish household survey of 2016, and the other was the 2011 census.
Now, the EIA, I can tell you, goes on to identify

some gaps in the data that was available but nothing is said about gaps in relation to disability. So can we take it from that that from the Scottish Government's perspective, at least, there weren't any relevant gaps in terms of the data pertaining to disability?
A. No, I don't think you can. Prior to being health secretary, one of my ministerial responsibilities in another portfolio was disability and so I was personally aware of gaps in the data but at that point no work was undertaken to try and fill those gaps or find a way by which we could do that. So that then fed into that situation that the EQIA describes. Whether or not there has been subsequent work undertaken, I cannot tell you.
Q. Do you think that's something that the Scottish Government might be able to tell the Inquiry should a request be asked?
A. It might be able to tell the Inquiry, and equally, the Inquiry might want to suggest that it is work that is done.
Q. I'm most grateful, thank you. I wanted to ask you next a question about the user research directory survey that was done in relation to the shielding programme or, if I can put it more broadly, the overall support that was provided to people who were clinically vulnerable during the pandemic, and you may recall that that survey

demonstrated that about 50% of people who were surveyed thought that not everybody who needed protection had in fact received protection during the pandemic. And one of the groups identified was people who were disabled and it was said in particular, at page 5 of that document, those with disabilities, was the group, people who normally cope well had routines disrupted, lost support services and faced health difficulties and reduced social contact.
I just wondered if you were able to help the Inquiry with this question: did the findings of that survey inform policy considerations thereafter in terms of what was done or wasn't done to help people who were clinically vulnerable but were otherwise identified as not receiving the support that perhaps they might have needed?
A. So one of the areas I can recall is in the area of adult social care and the support to individuals who were disabled in order to help them live as independently as possible, and in my opinion, despite significant additional resource, some parts of our country, of Scotland, withdrew elements of those care packages and that had a significant impact on people with disabilities being able to live independently even in abnormal times. And that was a situation raised very

directly with me from the Glasgow Disability Alliance and Inclusion Scotland and we sought to resolve those issues with the relevant local authorities.

Q. If I could just have one follow-up question. Can you remember roughly when that process began?

A. I would think it would be the summer of 2020, perhaps a little earlier than that.

Q. So certainly ahead of the second wave?

A. Yes.

MR BURTON: I'm very grateful, thank you, Ms Freeman.

My Lady, those are our questions.

LADY HALLETT: Thank you, Mr Burton.

Mr Jory.

He's over that way, behind you, but could you make sure, please, that your answers go into the microphone.

Questions from MR JORY KC

MR JORY: Ms Freeman, two quick areas, please, I hope they're quick. But just way of introduction, I ask questions on behalf of the Independent Ambulance Association, and I wonder if you can just help me with this, please. In your statement at paragraph 43 you mention your role in seeking guidance to reflect Scottish Government policy.

Given the specific challenges of working in the ambulance sector, including the constrained working

conditions, paramedics were often the first to come into contact with patients, and they often had no knowledge of any pre-existing conditions of those patients, do you agree that any future guidance should include specific and clear guidance for the ambulance sector addressing the unique working environment in which they operated?

A. I think that is reasonable. I would hope that guidance like that would be developed in conjunction with the ambulance service.

Q. Thank you, that's very helpful.

One other area, please. You mention in your statement at paragraph 42 about lateral flow testing and then PPE, at paragraph 44, being made available for NHS and primary healthcare staff. You were -- you said within questioned this morning by Ms Price, Counsel to the Inquiry, that in your opinion the professional views of healthcare workers needed to be respected. That if they wished to have additional PPE or FFP3 masks, for example, then they should be made available when they're requested and it's appropriate.

Just this, do you agree that in any future pandemic anyone working as a frontline healthcare worker, so, for example, as a paramedic in an ambulance, whether employed by the NHS or someone else, should be provided with the same access to testing and PPE?

A. Yes, I do agree with that.

MR JORY: Thank you very much indeed.

LADY HALLETT: Thank you very much, Mr Jory.

Right, that completes the questions we have for you, Ms Freeman. Thank you very much for your help. I don't know whether I can say it's the last time. As you know, I've been trying to make sure that the burden we place on people like you is limited, but sometimes I'm afraid it's just necessary.

THE WITNESS: I understand that, my Lady, thank you.

LADY HALLETT: Anyway, thank you very much for your help so far, and if you're going back to Scotland, I hope you have a safe journey.

THE WITNESS: Thank you.

(The witness withdrew)

LADY HALLETT: I shall return at 2 o'clock.

(12.57 pm)

(The short adjournment)

(2.00 pm)

LADY HALLETT: Ms Price.

MR HUMZA YOUSAF (sworn)

Questions from COUNSEL TO THE INQUIRY

LADY HALLETT: Mr Yousaf, thank you for joining us again. I'm sorry to have to ask you to keep coming back.

THE WITNESS: No problem.

LADY HALLETT: Ms Price.

MS PRICE: Can you give us your full name?

THE WITNESS: I'm afraid I am not hearing you at the moment.

LADY HALLETT: Ah, okay. Did you hear me?

THE WITNESS: That's better. I can hear you now, yes.

LADY HALLETT: Try again, Ms Price.

MS PRICE: Could you give us your full name, please, Mr Yousaf?

A. Humza Haroon Yousaf.

Q. You've prepared a witness statement for this module of the Inquiry, dated 16 August 2024, and the reference for that is INQ000480774. I understand you're familiar with that and you have a copy with you; is that right?

A. That's correct.

Q. Starting, please, with your role as Cabinet Secretary for Health and Social Care during the pandemic.

You held this position between 19 May 2021 and 28 March 2023; is that right?

A. That's correct.

Q. And in that role you held primary responsibility for the health and social care directorates and NHS Scotland?

A. Correct.

Q. Whilst you were in that role, is it right that the health boards across Scotland were accountable to you?

A. Correct.

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

In terms of the answer to your question, you're absolutely correct. Of course, the NHS was already on an emergency footing by the time I was Cabinet Secretary for Health and Social Care. That meant that the NHS understood the severity of the emergency that was in front of us, and they also understood that any direction that was given by the Cabinet Secretary was then to be followed pretty much to the letter of that direction, and as it was in statute.
In terms of the practical difference it made when I was Cabinet Secretary for Health and Social Care, it meant that the NHS, despite the change in Cabinet Secretary, still understood that we were in the emergency phase of the pandemic and of course that then means that priority is then given to emergency care, different to of course non-emergency elective care and that also helped to inform the decision to then take the NHS off emergency footing as well.
And, of course, as Cabinet Secretary, the powers of direction were available to me as to my predecessor although I didn't have any cause to use them at the time I was Cabinet Secretary.
LADY HALLETT: Mr Yousaf, your audio isn't great, it's okay, but if you could please speak as slowly and deliberately as possible. At the moment I can follow because the

stenographer I think is picking stuff up, but if you could speak slowly and deliberately it might make the audio better. And I see you've moved in closer, thank you.
A. I will endeavour to do that, your Ladyship.
LADY HALLETT: Thank you.
MS PRICE: It was your decision to take the NHS in Scotland off the emergency footing in April 2022. Can you explain why?
A. Yes, I'm happy to. The emergency footing of the NHS was reviewed every six months and it was due to end actually at the end of March, from my recollection, March 2022. However, the number of cases, Covid cases at that point was going in the wrong trajectory and we were seeing an increase in cases and I felt it was the wrong time to do it and it was extended until the end of April, so another month, and at that point a submission came to me from my officials and I had discussions with my officials to remove the emergency footing status from -- on the NHS.
And that was done primarily for two reasons: one, of course, there were still an overwhelming pressure on the NHS but we were out of, at that point, I would suggest, the immediate emergency phase of the pandemic. But also it was an important signal to our NHS boards

that we needed to put a significant greater focus on non-emergency care, particularly elective care, and elective care, I would suggest, had been one of the biggest victims in terms of prioritisation during the emergency phase of the pandemic. Some health boards completely stopped elective care altogether. Some, of course, continued but at a much reduced scope.
So this was also a signal, a clear signal to the health boards that I expected a resumption or scaling up of non-emergency care.
Q. You refer in your statement to a further mechanism which was available to you. The NHS Scotland Support and Intervention Framework, or the escalation framework. Can you explain, please, what that is.
A. So the escalation framework exists for cabinet secretaries to escalate or de-escalate an NHS board. There's five levels of escalation. The most severe effectively results in, usually, the termination of the -- termination of position for the board and senior management of a health board and the government directly intervening. And the levels below that have various different degrees of intervention and support from government and from officials.
And therefore, if, through our regular engagement with an NHS board on a particular issue or set of

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

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

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

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

A. A range of well publicised issues. There had been

issues around infection into wards, in, particularly, a very new hospital, the Queen Elizabeth Hospital on the south side of Glasgow, and had been significant concerns of infection, including in wards where children had been as well. These were well publicised at the time and my predecessor took the decision rightly to escalate Glasgow. There is also a public inquiry ongoing into some of these issues as well. But for me, the decision to de-escalate was taken when I was assured that the recommendations of the oversight group had been implemented and therefore de-escalation was appropriate.

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

A. I would certainly lean more towards Jeane Freeman's view of this. I have a tremendous amount of respect and had

a very good relationship with the Chief Medical Officer, Sir Gregor Smith, but in my experience as Cabinet Secretary for Health and Social Care, given the size that we are in Scotland, the direct relationship with health board chief executives and chairs is a relationship that is a good one, is one where you can meet with frequency. You build up good personal relationships where necessary and at the same time, if you need to make your views clear on what should happen, there's a variety of ways of doing that, through national guidance and then, of course, through, as we've already discussed, if necessary, a power of direction.

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

But also in a sense you -- it could allow a Cabinet Secretary to feel like, in some respects, they're somewhat off the hook when they should never be off the hook. Being Cabinet Secretary for Health and Social Care, and I can say this from my own experience, you should be held accountable, not operationally, in

terms of the operational decisions that are made day-to-day by health boards, but you should absolutely be held to account if there are failures of progresses not being made on certain issues in health boards. And if you have an overarching Scotland structure, that could dilute the responsibility as well as the accountability. So I would lean more towards Jeane Freeman's view on this as opposed to Sir Gregor Smith's.

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

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

I met with John Burns, I would say, more frequently than I would have met with Caroline because John and I, during our regular discussions, usually multiple times a week, John would have the view of what

was going on on the ground. He would speak to each of the chairs and chief executives of both the territorial and the national health boards with great regularity, sometimes daily he'd be speaking to most of them, and therefore, he was able to give a view on the ground of what was happening.

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

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

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

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

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

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

Q. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

But, you know, there's some progress that was made. When I came in to role in May 2021, one of the areas or gaps that we had was the ethnicity question was still not asked when it came to vaccine uptake. Certainly no mandatory question was asked. So in the

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

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

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

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

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

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

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

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

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

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

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

A. Yes, please.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

levels and orders received from health boards.

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

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

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

for staff, some of whom felt more comfortable wearing it. Can you recall when, roughly, this was?

A. The visit to the Royal Alexandra Hospital, I don't recall exactly when it was but I should say that that was just one example of the issues that were being raised by trade union groups quite regularly by that point, so in kind of early 2022, even the end of 2021 to be honest. At the end of 2021, towards the beginning of 2022, the issue around FFP3 masks, having them more widely available or even, as some groups wanted, mandated for health and social care workers, that was an issue that was brewing during that time, so the visit to the Alexandra Hospital was just one example that I had to say was being communicated more regularly -- and quite publicly, I should say -- by trade union groups and staff working with -- some staff working within the NHS.

Q. Before that period, so before the end of 2021, had it been brought to your attention that healthcare workers wanted FFP3 masks to be routinely available? As in, how early on did you become aware of that debate?

A. I'm afraid I couldn't recall exactly when was the first time that it ever came to my attention. I should say, for all of those who understandably were proposing and advocating for greater availability and use of FFP3,

there was also a number of healthcare workers who did not -- and were very vociferous in their opposition to FFP3 masks being mandatory. And therefore that's why we landed on the discretionary side of things.

As you can imagine, I'm sure you'll recall seeing some of the bruise marks that a number of healthcare workers had across their faces and so on wearing FFP3. They are not comfortable for long periods of time, and therefore if the evidence, a clinical device, was suggesting that they weren't required, then the government and I, in my role, is not going to mandate them but simply allow them to be used on a discretionary basis.

But, forgive, me, the direct answer to your question is I couldn't recall when the very first time the issue of FFP3 masks was brought to my attention.

Q. Did you understand at the time that FFP3 masks were more protective than fluid-resistant surgical masks?

A. Yes. Yes, I think that was well understood.

Q. Could we have on screen, please, page 43 of INQ000480774. And at paragraph 187 you say:

"During my time as Cabinet Secretary ... there was some lobbying by opposition parties, trade unions including the BMA, staff side, the media, Fresh Air (an NHS lobby group), healthcare workers, and

infection prevention control specialists to change from using Fluid Resistant Surgical Mask Type IIR ('FRSM') to FFP3 respirators ('FFP3s'), in the light of emerging Covid-19 variants. I requested an evidence paper on the topic on 13 January 2022, given the concerns voiced by trade unions and professional organisations about the psychological safety of their members in relation to not being permitted to wear an FFP3 rather than a FRSM in settings where they were not performing aerosol generating procedures ... on patients."

You go on:

"In light of that evidence paper, and further to discussions with stakeholders, discretionary access to FFP3 masks was introduced on 19 April 2022 -- not as an IPC measure per se, but to improve the confidence and wellbeing of health and social care staff. Discretionary access guidance ..."

And you have exhibited that.

Discretionary access was based on healthcare worker preference; is that right?

A. Yes.

Q. Why did you decide as a matter of policy that there should be such discretionary access?

A. Because first and foremost the clinical advice that we

were receiving from the IPC cell, from CNRG, the Covid Nosocomial Review Group was saying although we have the latest understanding of the epidemiology of the virus, the latest understanding of how it is transmitted -- so well-known by this point that the virus could also have airborne transmission as well as through droplet -- that even with -- in light of all of that evidence and our latest understanding, the advice was not to make FFP3 masks discretionary.

However, there was, as I referenced in the statement and as you have just exhibited on the screen, a number of those who represent staffing groups within the NHS, well respected professional bodies, RCN, BMA, a number of colleagues in Parliament, now saying that they were hearing directly from staff that they would like access to FFP3. Not all staff. I have already mentioned that a number of staff did not want to wear FFP3 masks and did not think that they were necessary or needed. And therefore if it helped a healthcare worker have confidence to go into their workplace by having access to FFP3, then it certainly, in my view, didn't do any harm to give that discretionary access, particularly when, frankly, we needed every single healthcare worker that was able to work in work and performing to the best of their abilities, which I'm pleased our healthcare

workers did and continue to do right to this day.
Q. This was not an IPC measure per se, but a step taken to improve the confidence and well-being of staff. So it wasn't led by the science, or the transmission -- the epidemiology when it came to transmission per se. Do you think that this policy should have been introduced sooner, whether by you or your predecessor?
A. As I say, it was an issue that largely came to light in my time as health secretary towards the end of 2021. Certainly it may well have been raised prior to that. But the head of steam around the issue, the momentum around the issue really came to a head towards the end of 2021 and the beginning of 2022. I couldn't at all speak for my predecessor on whether this was raised with her with great regularity or not but it certainly -- although it may have been raised, as I say the momentum behind the campaign to have FFP3 masks in healthcare really took a different -- really came -- had a lot of momentum towards the 2021, beginning of 2022, hence why the submission was taken first to get an evidence paper and then, ultimately, ministerial decision to allow discretionary access was taken.
Q. Turning, please, to hospital capacity issues and the response to that. And starting with the question of what information was available to you at the time to

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

Could we have on screen, please, INQ000372596. This is a spreadsheet and it's dated 29 December 2020, and I'd just like to check whether this was still the type of report that was being produced for the cabinet secretary for Scottish Government relating to bed occupancy when you were cabinet secretary.

A. Forgive me, it's not appearing on my full screen but I do think I know the document. I think I have a hard copy of it here, it's a spreadsheet.
Q. I can describe it. It's the spreadsheet which provides for each hospital grouped by health board and network a number of things. So there are a figures for the day and the previous day, providing empty, full, and closed beds, the number of patients at each level of care and the number of suspected and positive Covid cases.

Is that the report you're thinking of in your hard copy papers?
A. Yes. Yes. And that data are available, regularly available to Scottish Government.

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

How easy did you find it, at a glance, from the reports you received to understand how well hospitals were coping with demand?
A. First of all, if there was a -- just to be clear, if there was a breach in baseline capacity, so (*audio distortion*), a breach of baseline capacity of ICU beds then I was notified, and it only happened on one occasion from my recollection --
Q. If I can stop you there a second, to be clear what we're talking about. That's national baseline capacity that you're referring to, is it?
A. No, no, if there was a breach in baseline capacity of a particular -- in a particular health board but I was also very clear that the work done, in fairness, by my predecessor and was being done by the Scottish Government, meant that there was adequate surge capacity of ICU beds and therefore protocols were in place that should there be a breach of the baseline then there

would be measures in place to increase ICU beds should that ever be required.
Q. Just being clear about the one occasion you say that baseline capacity was breached, we can bring it up on screen if you like but one of the SICSAG reports, I think the Public Health Scotland statement containing a graph breaks things down by network. So by North and East and West, and it appears from that, at least, that individual health boards or -- apologies, individual networks did experience a breach of baseline capacity on more than one occasion. Is that your understanding, that the one occasion relates to a national baseline as opposed to any particular network or any particular health board?
A. Yes, yes, that's my understanding.
Q. Okay. Did you have an adequate understanding of staffing ratios and the extent to which the standards for those staffing ratios were being maintained when you were cabinet secretary or was that something you felt was not full in terms of the data?
A. From my, again, recollection, there's no doubt that there could have been a greater level of data around staffing ratios but can I just say should we have required that, it could have also been quite intensive on individual staffing teams if we had it by hospital,

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

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

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

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

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

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

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

overwhelmed.

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

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

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

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

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

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

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

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

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

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

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

vaccine programme in the world at one point.

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

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

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

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

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

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

LADY HALLETT: Yes, certainly. I shall return at 3.25.

(3.08 pm)

(A short break)

(3.25 pm)

LADY HALLETT: Ms Price.

MS PRICE: Thank you, my Lady.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

the service that had been provided.

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

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

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

A. Yes.

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

A. That's correct.

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

A. Right.
Q. Why was it that it took until March 2022 for health boards to be invited to conduct that exercise and to apply?
A. I think that's a fair question to ask, and if I was looking back as a lesson learned there is perhaps a question as to whether we could have invited territorial boards to submit that gap analysis quicker but, of course, as the Inquiry knows very well, we were under considerable pressure with new waves of the virus causing real challenges and of course in the period before March 2022, February, January, December, November '21, still very much within the winter pressures and I think I've already stated my contribution up until that point, I think winter 2021-2022 was the most difficult winter the health -- the NHS has ever experienced in its existence.

So there was already huge amounts of pressure to then have to do a gap analysis and then submit those gap analyses, so the gap analyses were submitted in March 2022 but were -- of course, they take a considerable period of time to do properly. The winter pressures were undoubtedly one of the reasons why they were -- why they took as long as they did, but I have to say I accept, perhaps an implied criticism,

but certainly a criticism from -- I know organisations that represent Long Covid -- those with Long Covid, that perhaps that should have been done at a quicker pace.
Q. The health boards had funding allocations confirmed on 19 May 2022. So is it right that that was the point at which they would have actually got the funding that they applied for?
A. Yes, that would have been the time.
Q. Health boards could use the funds to strengthen existing services or to establish dedicated services such as dedicated Long Covid clinics; is that right?
A. Yes, that's correct.
Q. And you refer at paragraph 207 of your statement to there being political and public pressure for specific Long Covid clinics. Why were health boards not instructed or encouraged to set up dedicated services?
A. As the rest of that paragraph makes clear, there was obviously nothing stopping health boards from developing specific Long Covid clinics. There was a lot of pressure, I think it continues in some part today, to have a nationwide network of Long Covid clinics but the feedback that we were hearing and the anecdotal evidence, particularly from clinical colleagues in Scotland who were talking to their clinical colleagues in England, was that the Long Covid clinics were

essentially creating a middleman where people would go to a Long Covid clinic for assessment and generally be seen with relative speed and ease, they were then being referred on to the appropriate department within an acute site, maybe respiratory, maybe neuro, and maybe occupational therapy, maybe physio. Whatever it was, they were being referred on. And to me, that was just creating an additional stage and step, somebody has to go through in order to get treatment.

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

The Long Covid clinic model now in England, I've noted in recent times a number of those Long Covid clinics have now completely closed and are no longer taking referrals or assessments. So it always seemed to me a better, a more logical approach to take to allow a local health board to analyse where the gaps were, and what they had to do in order to mitigate those gaps in service and then take a nuanced and local approach and that could have been a Long Covid clinic, if they thought that was the best model, or it could have been, as I think for most -- I should not say most, a number

of health boards, it was that they didn't have that single point of access for those who suffered from Long Covid in their local health board area.
Q. You refer in your statement to an aim of the funding being to ensure there was no postcode lottery. Would you agree that before central funding was actually provided in May 2022, there was a postcode lottery in Scotland when it came to access to Long Covid services?
A. Yes, I would accept that. And I would accept to this day that there is still feedback from those with Long Covid that they feel there is still not as consistent a level of service as they would like to see. But certainly I accept that was the case prior and I certainly, you know, accept that there's a feeling that an element of that still may be true to this day, that we still have to work hard to ensure a consistency of service being provided.
Q. Should the decision that central funding for Long Covid services should be provided, should that decision have been taken sooner?
A. I think with a lot of these questions, with the gift of not just hindsight, I think with the evidence in front of us that we had at the time, we could always look to see if we could have done things sooner, earlier, quicker, and I never try to be defensive, overly

defensive about that position. I just simply provide the context that we were, of course, stating the obvious, dealing with some extreme pressures and most of the focus, particularly the winter 2021-2022, was on the emergence of Omicron and the significant impact that that was going to have on what was already going to be a very, very difficult winter.

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

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

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

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

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

by local nuances. So I hope that helps.

LADY HALLETT: Yes, it does. Thank you.

MS PRICE: Thank you, my Lady.

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

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

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

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

Q. Coming, please, to primary care.

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

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

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

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

So the accessibilities issues could range from physical accessibility issues right the way through to, as I say, issues around digital and telephone accessibility.
Q. And did that investments in and those measures improve matters in relation to accessibility issues?
A. I think they certainly helped. It was an issue of regular concern, and I've referenced the kind of litmus test, unscientific I accept, but the litmus test of what was raised with me and what wasn't raised with me by members of the public in correspondence. GP access was probably -- if not the issue, one of the issues that was raised with me with incredible frequency and regularity by members of Parliament and correspondence from members of the public.

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

so on, and you can see as the months and years have gone on that kind of steady improvement. So I think it certainly will have helped but it was certainly an issue at the time of great concern amongst a great number of people.
Q. You refer at paragraph 157 to significant investment which was made in general practice during your tenure as cabinet secretary. Did the need for this reflect an underfunding of general practice prior to the pandemic?
A. No, I wouldn't accept that characterisation. I think investment in the NHS and general practice was good. We increased our investment within the NHS as a government over the years. Prior to me becoming cabinet secretary there was investment in what was known as golden hellos, a kind of bursary scheme particularly incentivising GP posts to the more rural areas of Scotland, again before my time, investment in the ScotGEM programme, four-year graduate entry medical programme as well for those who were interested in becoming generalists within the NHS with a focus on rural medicine. And there was continued focus and investment in GP, direct funding to GPs as well.

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

IPC controls in place, because of the nature of the work that GPs do, a very difficult situation where people are -- because of the pressure on our acute sites, a very difficult position where people are really struggling, I felt they were struggling to get face-to-face appointments with their GPs, which many people still wanted, so this investment was a recognition of that challenge and trying to work collaboratively with GPs as opposed to necessarily targeting them publicly, which was done, I know, by (inaudible) we tried, where we could, to work collaboratively although I must confess there was, no doubt, tensions at times.
Q. In relation to non-Covid care and NHS recovery, what were the key challenges in dealing with the backlogs which had built up for elective care in Scotland during your tenure?
A. Capacity. It's as simple as that. There was a finite resource in terms of beds and in terms of staff and there was such a pressure on emergency care and in an acute setting you have a few pressure valves that you can try to release and if you want to increase the flow of throughput for elective care, you've obviously got to naturally decrease the flow elsewhere and that usually meant around emergency care, particularly at a time when

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

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

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

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

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

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

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

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

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

LADY HALLETT: Thank you very much, Ms Price.

Mr Wagner.

Mr Wagner is over there -- oh no, end of the day. Sorry, I was looking to the witness box and pointing.

Mr Wagner.

Questions from MR WAGNER

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

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

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

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

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

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

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

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

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

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

A. So generally most of the communication with those in the Highest Risk List, for example, would have been done by the CMO and the engagement and communication from the

feedback and the surveys that we carried out was seen as relatively helpful, useful. Whether there was a precise communication from the CMO about higher-grade masks in healthcare settings I couldn't tell you with absolute certainty but certainly our own communication around wearing of masks, particularly in relation to anybody engaging with those who may be clinically vulnerable was a message that we disseminated often.

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

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

A. I think it's a fair point to make that there may well have been a gap there in that communication. I would hope, if I went back, if I went to the surveys and

feedback and response we received from those that we were communicating with and that predominantly our CMO was communicating with regularly, who were at the highest risk and therefore a number of them clinically vulnerable, the feedback generally tells us that the engagement was good, helpful, and very useful.

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

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

A. Yes, very much so. Very much. So a number of organisations that represent those who are clinically vulnerable tell us their fears about those they represent accessing healthcare, and the absolute dread that they would have of potentially contracting the virus in visiting a healthcare setting, usually a

hospital. And therefore we certainly not just took that message on board, but that's why we reinforced the importance of IPC within a hospital setting and of course if that necessarily needed to be nuanced for those who were clinically vulnerable then we would expect that to happen.

All that being said, throughout the course of my time as Cabinet Secretary for Health and Social Care, generally the message we were getting from those who were clinically vulnerable was of fear, as society opened up and IPC measures may well become diluted, may well be withdrawn altogether in some circumstances, the concern they had, and therefore we were always keen to stress and to assure those who were clinically vulnerable that they were not being forgotten and that we would continue to reiterate the message that their needs also had to be put at front and centre by healthcare workers, and by the whole of society, it's not just about accessing healthcare settings, as important as that is, going to a restaurant for a meal, being able to go out and enjoy a coffee when society opened up, these were all settings whereby I was hearing, we were hearing those who were clinically vulnerable had a real fear should they contract the virus at a time where the virus was still prevalent.

Q. Just sticking with healthcare settings, obviously the other settings are extremely important but would you agree that not only were those fears being reported but given how many people were contracting Covid-19 in healthcare settings, their fears were, to an extent, justified?

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

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

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

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

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

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

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

than perhaps other settings.

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

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

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

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

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

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

MR WAGNER: Thank you.

LADY HALLETT: Ms Mitchell.

Questions from MS MITCHELL KC

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Forgive me, could you repeat the question.

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

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

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

(Unclear: multiple speakers)

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

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

for other purposes.

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

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

MS MITCHELL: I'm obliged, my Lady.

LADY HALLETT: Mr Burton.

Questions from MR BURTON KC

MR BURTON: Thank you, my Lady.

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

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

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

MR BURTON: Indeed.

LADY HALLETT: Very well.

MR BURTON: Mr Yousaf, you talked very eloquently how

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

Do you think that some of that happened in Scotland because of an existing practice prior to the pandemic of that sort of direct engagement with, for example, disabled people's groups, et cetera?

A. Yes, in short, I think the ethos of the government is to try to be as engaging as possible with those with lived experience. We know that policy is far better formulated at the conception stage with those who it impacts as opposed to being done to them. So the general ethos of government, you know, and I've served under two first ministers, as well as being a First Minister myself, and serving under of both of my predecessors, it's certainly the ethos of the government to have that direct engagement, and not with representative organisations, don't get me wrong,

I think they do a phenomenally good job, but actually going beyond the representative organisations directly to the people with lived experience is really important.

I suppose I would say the point you've emphasised a couple of times correctly is that was done ad hoc. I think, for me, if we are thinking about a preparedness for a future pandemic, we should perhaps be looking at -- we should be looking at how that is not done on an ad hoc basis but a far more structured basis and one that involves the entirety of Cabinet as opposed to just one or two cabinet secretaries who may well have a direct portfolio responsibility for a particular issue that affects a particular demographic, so instead of doing it ad hoc I think it should be far more structured.

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

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

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

letter was sent out in accessible formats for disabled people?

A. Forgive me, I don't know. I'd be astonished if it wasn't sent out in accessible format and also in various languages as well, but I would have to look back to give you an answer with absolute certainty, and I can obviously provide the Inquiry with a certain answer in writing if so wished.

Q. Thank you. My last question is this, that my clients have a concern that disabled people in particular may have been the ones who were less likely or unable to access hospital treatment unrelated to Covid-19 during the pandemic. Do you know if any evaluation was done of the Right Care Right Place programme to see how it impacted on disabled people positively or negatively, I should say?

A. There was absolutely a valuation done of that campaign, and highlighting some of the successes but also where we could improve upon the campaign.

Again, you will forgive me if I can't recall whether the evaluation looked specifically at the issue of those with disabilities and with accessibility issues.

So, again, if it so pleases the Inquiry, I can ensure that a written response is provided.

MR BURTON: Thank you very much, Mr Yousaf.

I am most grateful for the indulgence, my Lady.

LADY HALLETT: Thank you, Mr Burton.

Ms Iengar.

Questions from MS IENGAR

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

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

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

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

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

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

A. Yes.

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

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

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

with Ms Price, I mentioned in reference the fact that winter 2021-2022 was extremely difficult for NHS. But no, I accept fully the criticisms and critique from those with experience of the long-term effects of Covid that they felt that the government just didn't move at a quick enough pace and that's something we have to reflect on.

Q. So, looking back at what happened, the first infections were in 2020, you first met with the families of children and young people with Long Covid in autumn 2021, yet by early 2024 my client's children still had no access to specialist Long Covid care, which left one parent with no alternative but to pursue legal action against their NHS board.

So, Mr Yousaf, my question is, why wasn't more done to ensure children and young people with Long Covid could access care before you left your role? The debilitating impact on children should have prompted more urgent action, shouldn't it, notwithstanding other demands on the healthcare system?

A. Where I perhaps differ from the characterisation is the suggestion that virtually nothing was done in that intervening period. So you're absolutely correct to state -- when the meetings took place, you're absolutely correct to state when the first pathway came into being

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

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

Q. Mr Yousaf, the reality is that in the summer of 2024, as Ms Caroline Lamb told us quite clearly, the first and only clinical pathway for Long Covid in children and young people was published. So prior to now, my clients have had no access to care. I note the points you make about communication et cetera. That's not what my question is. My question is, in relation to the provision of care for children and young people whom you

met, who have become newly disabled by Long Covid, why wasn't more done before you left your role?

A. Again, I think there was if not clinical pathways, I accept a clinical pathway being established in summer 2024, there would have been, for example -- there could have been referrals made by GPs when they first saw a young child that was presenting with the long-term effects of Covid to particular rehabilitation services, to particular services within their local health board area.

What government did, what I did, was to ensure for the first time that there was funding available to local health boards so that when they investigated the gaps that existed that funding would be available. Not just for one year, because services can always fall over after one year given -- if they are not funded for longer, but funding provided and guaranteed for three financial years was to ensure -- was, I would hope, at least a step in the right direction.

The criticism from Long Covid Kids, who I think are an exceptional organisation, do an important amount of work, is that there are not enough clinical pathways, needs to be further investment and needs to be better communication and consistency across the country, are, I think, ones the government must reflect on and I hope

we can give Long Covid Kids and children more reassurance than they perhaps have at the moment.

LADY HALLETT: Thank you, Ms Iengar, that's as far as we're going to go, I'm afraid.

MS IENGAR: Thank you.

LADY HALLETT: Thank you very much indeed, Mr Yousaf. You've helped me once before. I have no idea whether we're going to have to ask you to help us again. But in the meantime, thank you for the help you've given so far and I hope that the current bout of snow isn't too disruptive in Scotland. I think it's been pretty disruptive, as you'd expect, in England, but there we go, you're more used to it than we are, I think.

THE WITNESS: Thank you. I'm just pleased that I'm not Transport Secretary when the snow falls, I have to say. But, no, thank you very much, my Lady, and of course I'll always make myself available, should you require in future modules.

(The witness withdrew)

LADY HALLETT: Thank you very much. 10 o'clock tomorrow, please.

(4.32 pm)

(The hearing adjourned until 10.00 am on Wednesday, 20 November 2024)

INDEX