Witness Name: Jane Claire Judson
Statement No.:
Exhibits:
Dated: 29.8.2023

UK COVID-19 INQUIRY

WITNESS STATEMENT OF JANE CLAIRE JUDSON

I, JANE CLAIRE JUDSON, will say as follows: -

1. Chest Heart & Stroke Scotland (CHSS) began life in the late nineteenth century as a charity supporting people living with TB. We support & advocate for people affected by chest, heart & stroke conditions; this includes both people living with these conditions and their families, friends & carers. This now includes people living with the effects of COVID-19 and Long Covid. Our aims are set out in our Articles of Association:

   "3.1 The advancement of health through improving the quality of life for people in Scotland, and elsewhere, affected by chest, heart and stroke Conditions, through medical research, influencing public policy, education, advice & training and provision of healthcare and other support services.

   a. To engage in and to undertake all other similar charitable purposes."

Organisations which Chest Heart & Stroke Scotland co-operated or worked with during the relevant period in response to the Covid-19 pandemic

2. Directors at CHSS and I met with Scottish Government through the Social Isolation & Loneliness Advisory Group, where we were able to raise the impact that lockdown and shielding had on the wellbeing of people with our conditions. We offered our support to Scottish Government in providing practical and emotional assistance to people with our conditions who were shielding or recovering at home. We maintained our business as usual contacts within the Clinical Priorities team, who communicated key public health messages to us. We continued our business as usual work with local NHS health boards, where we have service level agreements to provide support to people living with chest, heart and stroke conditions.

CHSS's communications and work with Scottish Government during the relevant period

3. During the relevant period, CHSS's work focussed on supporting people living with our conditions (chest, heart & stroke), who were more adversely affected by Covid-19 and the lockdown than the general public. Shielding and lockdown significantly impacted on the wellbeing of people with our conditions. We therefore focussed on offering practical and emotional support to people living with chest heart and stroke conditions.

4. Working with the Clinical Priorities Team, CHSS received approximately £461,000 from Scottish Government in the financial year 2021/22 to support digital development of our offer to meet the needs of people with Long Covid and other chest heart and stroke conditions during the pandemic. We also invested significant organisational funding and resource into this project. Senior members of CHSS staff met with members of Scottish Government and the Cabinet Secretary to discuss this project, and the necessary pathways that would be needed for a national Long Covid Service.

5. We also produced a costed proposal for how CHSS could support with NHS pressures via our self-management model. We did not offer advice on the clinical care or treatment offered to patients with ischaemic heart disease.

6. Directors at CHSS met with Scottish Government through the Social Isolation & Loneliness Advisory Group, where we were able to raise the impact that lockdown and shielding had on the wellbeing of people with our conditions. Further, we set up a 'Kindness Caller' programme to match volunteers with people living with conditions who were looking to connect. Over 6,300 volunteers signed up to deliver more than 32,500 acts of kindness in their communities, including 4,191 phone calls to people who are lonely or isolated. We received £100,000 from the Scottish Government's loneliness funding to support this work in the year 2021/22.

7. Our Advice Line (already a telephone service) offered help & support in managing existing conditions during lockdown. We saw an increase in the number of demand and complexity of cases we supported with; the team delivered 2,953 lifeline phone calls to those in need with cases also becoming more complex

Impact of the Pandemic on treatment for heart disease

8. During the relevant period, a lot of information was in the public domain about the impact of the pandemic on NHS treatment and systems. Many news stories ran on the pressure on NHS services, and the lack of staff and ward space available. I was aware that many, including people who were shielding, were potentially less likely to seek medical assistance due to fears of contracting Covid-19, as this information was already in the public domain.

9. Directors shared with me that their staff heard anecdotally from service users that specialist staff and services were no longer available in the community due to redeployment within the NHS. This redeployment could have affected physiotherapists, occupational therapists and other Allied Health Professionals who would normally support patients with our conditions leaving hospital. We had little evidence that this happened in relation to inpatient cardiac treatment. Face to face cardiac rehabilitation sessions were often replaced for many by online sessions. While the availability of digital

solutions was a positive outcome for many, for some people the lack of community based care or difficulties in accessing technological solutions will have been an issue. In their report 'Cardiac Rehabilitation – a patients perspective' (JCJ/01, INQ000252440), the British Heart Foundation outlined the impact of the pandemic on access to cardiac rehab. They acknowledge that staff redeployment, as well as an end to group based sessions and a lack of suitable space led to a swift evolution in the delivery of cardiac rehab.

Impact of the pandemic on CHSS Services

10. During the relevant period, our helpline saw a significant increase in the number of cases as well as an increase in complexity. Many of these cases related to Long Covid, with callers struggling with a new and complex condition and new terminology to go with it. Cardiac and vascular symptoms are common for this condition, and we offered support to people experiencing them. However, we also supported people struggling with multiple co-morbidities, and callers who reported that they could not access help for symptoms elsewhere in the NHS.

11. People with ischaemic heart disease needed to manage their conditions at home. Their calls related to isolation and loneliness as well as looking for symptom advice. Our volunteers also made 4191 phone calls to people who were lonely or isolated. Demand for our direct services also grew significantly.

Issues relating to inequality of access or infection control.

12. I was not aware of any issues relating to infection prevention and control in cardiology departments during the relevant period, or of issues relating to the availability of PPE other than those already in the public domain.

13. I was only aware of inequalities in healthcare in as much as these issues were already in the public domain. For example, there was significant media

coverage of the impact of Covid-19 in ethnic minority communities. I was not aware of inequalities issues other than those in the public domain.

Information on cardiac health gathered after the relevant period

14. Colleagues in our policy team have also gathered information published towards the end of the relevant period and after the relevant period, and informed me on the long term consequences of the pandemic on the diagnosis and treatment of heart conditions. I am aware from academic research that the numbers of statin prescriptions dropped during the pandemic, as people were less able to access blood pressure testing and GP appointments for non-urgent reasons. Sofat et al, 'The impact of the COVID-19 pandemic on cardiovascular disease prevention and management' (JCJ/02, INQ000252441), an academic paper on CVD prevention, highlights "a decline in the dispensing of antihypertensive medications between March 2020 and July 2021, with 491,306 fewer individuals initiating treatment than expected. This decline was predicted to result in 13,662 additional CVD events."

15. Even when it was possible, many people were reluctant to return to visiting their GP. YouGov surveys commissioned for Scottish Government (Public attitudes to Coronavirus March update Societal impacts and wellbeing team, COVID-19 Analysis Division) showed that as late as February 2022, more than a quarter of people said they would avoid contacting their GP for immediate non-Covid-19 health concerns.

16. Academic literature published towards the end of lockdown also suggests that many people avoided visiting hospital during lockdown, including for fear of contracting Covid-19 in hospital. A study by Lyall & Lone (JCJ/03, INQ000252442,) showed that non-Covid-19 acute admissions to hospitals within NHS Lothian were 44.9% lower than expected during the early days of lockdown. Scottish Ambulance data shows a drop of around 40% in ambulance attendance at cardiovascular incidents between early April and

mid July 2020 (JCJ/04, INQ000252443). This data suggests the sad reality that people needing medical attention for cardiac problems chose to stay at home, rather than risk Covid-19 at hospital, and some died as a result. 'Deaths involving coronavirus (COVID-19) in Scotland - Week 52 (JCJ/06, INQ000252445) published by National Records of Scotland, shows that during 2021 in Scotland there had been 1,408 more deaths at home from heart disease and stroke than the five year average, and 698 fewer in hospital.

17. JCJ/08, INQ000252447, is mortality data provided by Public Health Scotland, showing the number of heart attack deaths through 2020 until 2022 was slightly higher than the five year average. JCJ/09 INQ000252448, is hospital admissions data, which shows that despite the higher level of heart attack deaths, heart attack admissions remained lower than average, particularly in the first half of 2020 . JCJ/09 INQ000252448 also shows that heart failure admissions were roughly comparable to previous years, but JCJ/08 INQ000252447 shows there has been significant excess mortality from June 2020 onwards . Again, reading these two together suggests that not everyone who suffered a heart attack or heart failure was admitted to hospital.

18. The data referred to in paragraph 18 demonstrates that interruptions to early detection and screening efforts can have significant impact on the development of non communicable disease. Based on this data, we would recommend that when planning for future pandemics, consideration should be given to how to minimise excess mortality from other causes.

19. Finally, it is worth considering whether more people with underlying health conditions should have been considered high risk. In Scotland, those living with a chronic heart condition were advised they were at high risk but were not advised to shield. 'Rapid Epidemiological Analysis of Comorbidities and Treatments as risk factors for COVID-19 in Scotland (REACT-SCOT)' (JCJ/05 INQ000252444) is a piece of academic research which concluded that both those with asthma and heart conditions were more vulnerable to

Covid-19. Risk of severity was not independently related to ischaemic heart disease, but to other forms of heart disease such as heart failure and cardiomyopathy. This again suggests that these groups should have been asked to shield alongside people who had longstanding respiratory conditions. This study also found that risk was much more complex than having a single health condition and related to multi-factor variables. While it's not clear whether shielding added more benefit than the population level measures already in place, evidence seems to suggest that there were people at risk who were not identified as such. I believe that future crisis planning needs to take a more nuanced approach.

Role of Third Sector providers in times of crisis

20. I also believe that future crisis planning needs to take better account of Third Sector organisations, particularly those who provide health & care support. Throughout the pandemic Third Sector services stepped up to unprecedented strains and challenges. Yet they remain siloed, poorly integrated with national services and underfunded – in the same position they were before the pandemic. Organisations like ours can best support people with our conditions, and our wider health systems, if we are properly considered as part of the health infrastructure.

21. In my opinion, Scottish Government's approach to the pandemic failed to consider Third Sector health organisations and providers as part of the wider health system. For example, while Scottish Government's public communications during the pandemic were clear, impactful and authoritative, they consistently failed to mention Third Sector sources of health support. The public weren't signposted to third sector services and opportunities to relieve pressure on the NHS were missed. This lack of consideration and integration also made it unclear whether our staff were key workers. Staff delivering face to face support did not receive priority access to vaccines, or other systems that supported NHS staff. There was also no opportunity for the Third Sector to access PPE through NHS procurement, which meant that

Third Sector resources were used to buy more expensive alternatives. I believe that being part of NHS procurement would have given far greater value for money.

22. As a national organisation looking to provide support across Scotland, working with multiple different Health Boards to co-ordinate services was a significant challenge. The creation of a national pathway for Third Sector organisations would have significantly simplified our work and increased our reach.

23. Many organisations like ours, who provide services or care, are dependent on year-long grants. Many work year to year, sometimes even quarter to quarter. Loss of income through the pandemic immediately destabilised many Third Sector organisations. As outlined above, our immediate concerns were how best to support existing service users at the time they needed us most, while also dealing with a potentially devastating drop in income. It was simply not possible for many Third Sector organisations to be involved in other streams of work – including advising on government responses to the pandemic. Despite the funding that we applied for through the Clinical Priorities team CHSS faced an immediate financial crisis that led to the loss of 80 jobs in 2020 – almost a third of the staffing resource – a situation not faced by public sector partners we were working with and often supporting. The lack of long term funding for Third Sector organisations removes our ability to contribute to other issues in a crisis.

Statement of Truth

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

Signed: Personal Data

Dated: 29.08.23