UK COVID-19 INQUIRY – MODULE 3
WRITTEN CLOSING STATEMENT FOR PUBLIC HEALTH SCOTLAND ("PHS")

Introduction

1. PHS is grateful to the Inquiry for Core Participant designation. It was represented (on a shared representation basis) throughout the Module 3 public hearing and is in the process of reflecting on the evidence led.

2. PHS has deliberately chosen to focus its submissions on areas where it has direct involvement. PHS makes submissions on the following topics: (1) Challenging issues at UK and international level; (2) Scottish NHS issues; (3) Long Covid; and Whole Genome Sequencing.

Challenging issues at UK and international level

Was the NHS overwhelmed?

3. This question was posed of many witnesses. PHS thinks that it would be helpful to offer some reflections based simply on its own experience. Others will be better placed to comment on how different parts of the NHS fared. Certainly, PHS faced significant challenges particularly at the start of the pandemic around the time of the organisation's launch (see transcript of Professor Phin's evidence page 4, line 6 onwards). Responding to the pandemic, whilst also establishing a new public health organisation for Scotland, was a unique and highly challenging set of circumstances. As Professor Phin commented, governance structures changed, there was a need to create new managerial and finance systems, and there were HR issues that needed to be resolved (transcript at page 4, lines 6 – 23). Overall, however, PHS considers that in large part the organisation met the

challenges and achieved its aims including those of continuing to fulfil the responsibilities of its legacy organisations. This, however, came at a personal cost in terms of the impact on our staff whose dedication during the pandemic was unfailing (PHS Module 2A Opening Statement, page 4). The need to work very long hours and over sustained periods, combined with stressful working conditions, undoubtedly negatively impacted on their health and well-being – as was the case across many parts of the NHS and beyond. In light of these comments, we would, therefore, answer the specific question "Was PHS overwhelmed?" in the negative.

Health inequalities and data

4. Health and healthcare inequalities. The Inquiry has heard from a wide range of groups and individuals on the impact of the pandemic on the wider population as well as identified groups within society. Scotland went into the pandemic with the worst health inequalities in western and central Europe and the lowest life expectancy in western Europe. Throughout the period in scope for Module 3, PHS continued to undertake analysis and reporting of inequalities and continues to do so currently. This included both the ways in which the pandemic was impacting on existing inequalities and the routes through which existing inequalities impacted on morbidity and mortality. Specifically in relation to healthcare inequalities, PHS set out in its corporate statement to the Inquiry (section 8.6) some aspects of how the pandemic affected access to healthcare and also what healthcare bodies can do to improve health and reduce health inequalities, in two broad categories: action to remove barriers to access to services and action that healthcare providers can take on the social determinants of health.

5. Data regarding healthcare and health inequalities. Again, PHS followed the evidence, and contributions from Core Participant groups, with interest. PHS is the provider of official statistics for the NHS in Scotland and will be particularly interested in any recommendations made regarding different (most likely additional) data that should be captured to attempt to allow healthcare inequalities to be more clearly understood. It is appreciated that understanding

the extent and scale of healthcare inequalities is logically anterior to addressing those inequalities. PHS recognises the need to improve the level and quality of data capture and reporting in relation to all forms of health inequalities and to work collaboratively with health and social care partners, academia and others to ensure that we are better prepared for any future pandemic. PHS has already started taking forward this work. For example, PHS is committed to publishing more data which meet the needs of policymakers, service providers, and the patients and communities they serve to monitor and reduce racialised health inequalities. PHS is currently leading a short life working group to review recording of ethnicity data and develop a series of recommendations to improve it. PHS welcomes any direction that the Inquiry is minded to give in this respect.

6. Healthcare workers. Similarly, it may be that the Inquiry will make recommendations about the monitoring of risks to healthcare workers and their families as a result of the pandemic. In his evidence to the Inquiry hearing, Professor Phin noted how work done by PHS and partners in Scotland, such as the REACT-SCOT consortium, was used to identify risks to healthcare workers and apply these risks in occupational health assessment and infection prevention control measures (transcript at page 32, line 12). Going forward there may be data that could be gathered that might be useful in understanding these risks even outside of the pandemic setting – for example, the level of risk posed to healthcare workers and their families by seasonal illness, particularly of the respiratory type. Stretching the data set to include families might be challenging, and given the fact that healthcare workers' families will no doubt have their own exposure risks as individuals, it might be difficult to know how to identify when family members contracted infection via the healthcare worker, and when it was from an external source.

National hospital admissions reports and other data

7. As explained above, PHS is the provider of official statistics for the NHS in Scotland. It did not detect in the evidence any suggestion that there were areas for significant improvement in its work in that regard. PHS notes that Jeane Freeman was complimentary of the information that she was provided with during

her time as health secretary, which information assisted in her decision making. If the Inquiry requires any further information from PHS about its role in this regard PHS would be happy to provide that.

Scottish NHS issues

The structure of the NHS in Scotland

8. The Inquiry heard evidence that there is no Scottish equivalent of NHS England. While "NHS Scotland" is an oft-used term, formally no such body exists.

9. Structurally, the NHS in Scotland is comprised of:

    a. Six national NHS Boards (Golden Jubilee National Hospital, Health Improvement Scotland, National Education Scotland, NHS24, Scottish Ambulance Service and The State Hospital);
    b. One public health body (PHS);
    c. One non-departmental public body (National Services Scotland); and
    d. Fourteen territorial (geographic) health boards.

10. Some witnesses expressed views about the creation of an NHS Scotland. Professor Sir Gregor Smith, the Chief Medical Officer, stated that this would be a useful step; the former health ministers Jeane Freeman and Humza Yousaf MSP disagreed.

11. While recognising that this would be a matter primarily for Scottish Government, PHS would be one of the bodies affected by any such discussion but takes no formal view at this stage, save that of noting its experience that there are merits and demerits in this regard. While there are advantages for example in national direction being applied to many health protection planning and response matters, bespoke local approaches were a core feature of, for example, the pandemic response to which PHS adapted, and this will continue to be a feature of

healthcare delivery whether through a unified NHS Scotland body or through the existing structures.

The location of ARHAI (Antimicrobial Resistance and Healthcare Associated Infection)

12. The location of ARHAI was discussed in the Closing Statement of PHS in Module 2A (at page 3) under reference to the ARHAI Location Review. PHS notes that the Location Review has now reported with the conclusion to retain ARHAI in its current location in NSS. As was explained in Professor Phin's evidence, PHS worked generally well with ARHAI from the start and during the pandemic (transcript at page 18, line 16). PHS is committed to working with NSS to implement the decision, for example to improve clarity around roles and responsibilities including for instance in relation to guidance in a pandemic emergency footing context. From PHS's perspective there is no requirement for any recommendation in this regard.

The timing of the creation of PHS, and the continued use of HPS branding

13. The Inquiry heard evidence about the (coincidental) timing of the creation of PHS at the start of the pandemic, and that PHS continued to use HPS branding for a period (after the creation of PHS and the dissolution of HPS) (transcript at page 14, line 2).

14. This was a decision taken by the Scottish Government to maintain trusted familiarity at a time of uncertainty for the Scottish public and thus avoid causing confusion at a time of considerable uncertainty. Whether or not that aim was realised is not clear on the evidence. PHS suggests though that the timing of its creation and the continued use of HPS branding, and the coincidence between those events and the start of the pandemic, is a unique situation that is highly unlikely to be repeated. For that reason it suggests that no recommendation is required in this regard.

Long Covid

15. The witness evidence seemed close to unanimous – even from non-medical witnesses – in understanding that post-viral syndromes (to use a scientific word not beloved of the Long Covid groups) were an appreciated fact of life before the pandemic.

16. The treatment of Long Covid will not be a matter for PHS. In Scotland that treatment is likely to be provided mainly by General Practitioners and the territorial health boards. That said, it is undoubtedly also the case that Long Covid continues to be a legacy we are all grappling with. PHS continues to be concerned about, and to focus on, the additional pressures that Long Covid (as well as new cases of Covid) place on the NHS in Scotland specifically those arising from the increase in GP presentations and hospitalisations (see PHS Module 2A Closing Statement, pages 1 and 2). To this end, PHS will continue to work with NHS Board Chief Executives and others in a new National Strategic Network agreed by the Scottish Government.

Whole Genome Sequencing

17. Whole Genome Sequencing (WGS) has been used during the pandemic to identify COVID-19 variants from the samples of infected people. WGS helps clinicians in healthcare environments when identifying outbreaks and transmission of the virus, investigating the origins of outbreaks, taking targeted action to reduce the size of the outbreaks, and reducing the chances of repeat outbreaks in similar settings. The Inquiry heard from Professor Nick Phin (transcript at page 24, line 11) how the capacity within Scotland to undertake WGS was rudimentary at the outset of the pandemic but, following work undertaken by PHS and the Scottish Government, funding and resource has been secured to introduce WGS as a sustainable service which will prove beneficial in the event of any future pandemic.