MOD.3 UK COVID INQUIRY

CLOSING SUBMISSIONS

For the SCOTTISH TERRITORIAL AND SPECIAL HEALTH BOARDS

INTRODUCTION

1. The Scottish Health Boards (whom we refer to throughout these submissions as 'the health boards') have listened carefully to the evidence in this module of the Inquiry. Given the health boards' role within the system of healthcare in Scotland, the module has been of considerable significance to their operation.

2. As the Inquiry knows, each of the health boards within this grouping are independent boards, with direct links to the health directorates within the Scottish Government. There is not, for the avoidance of any doubt, a body in Scotland that has the same role as NHS England has in England. At times, the papers before this Inquiry refer to 'NHS Scotland', but that is used as a point of reference, or terminology, depending on the context. There is no body called NHS Scotland and we will avoid use of that term in these submissions.

3. The health boards therefore occupy an interesting space within the context of this Inquiry. They were not the creators of national policy, nor was any one of them responsible for the overall direction or strategy of national healthcare in Scotland during the pandemic. They were, however, each accountable directly to the Scottish Government for the implementation of its policies and, thereby, for many of the operational decisions that were undertaken.

4. Indeed, the health boards' usual independence from the Scottish Government was reduced during the pandemic, due to the NHS in Scotland being placed on an 'emergency footing'. The Inquiry has heard that the then-Cabinet Secretary for Health and Sport, Jeane Freeman, placed the NHS in Scotland on an emergency footing from 17 March 2020

until 30 April 2022.[1] The power to do so is given to the Cabinet Secretary in terms of s.78 of the National Health Service (Scotland) Act 1978, although the provision does not spell out precisely what impact such emergency powers have.

5. Mary Morgan, on behalf of NHS National Services Scotland (NSS), has described the meaning of the emergency footing in the following terms:

> *"This meant that Scottish Government was responsible for all key decision making in relation to the pandemic in Scotland and worked with other organisations, such as NHS NSS, to establish national programmes of work to deliver Scotland's response to the pandemic."*[2]

6. Jeane Freeman explained that the rationale for placing health boards on an emergency footing was first, to ensure that every part of the health service was "facing in the same direction", and secondly, to make it clear that she was accountable to the Scottish public for decision-making and the performance of the health service. It meant that decision-making at board level was "superseded" by her decisions.[3]

7. The implications of this emergency footing were described by Humza Yousaf MSP, former Cabinet Secretary for Health and Social Care, Scotland. He told the Inquiry that:

> *"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."*[4]

In his written statement, Mr Yousaf states that it was the expectation of the government in Scotland that national guidance would be followed by health boards.[5]

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[1] Caroline Lamb, DG Health & Social Care, Inquiry Transcript 14/11/24, p.41, line 1.
[2] Mary Morgan, NSS (INQ000226464), para.49.
[3] Jeane Freeman, former Cabinet Secretary for Health & Sport, Inquiry Transcript 19/11/24, p.3, line 14 – p.4, line 4.
[4] Humza Yousaf MSP, former Cabinet Secretary for Health & Social Care, Inquiry Transcript 19/11/24, p.98, lines 4-9.
[5] Humza Yousaf MSP (INQ000480774), para.60.

8. Nonetheless, the health boards remained responsible throughout for implementing national strategy and direction. They worked closely with the Scottish Government. Importantly, they also remained responsible for their employees, without whom the national response would not have been possible. It follows that, in advancing these submissions, the health boards consider that there are certain aspects of the evidence which fall to them to discuss and explain, with a view to assisting the Inquiry in writing its report. We deal with this in Section A. The health boards also consider, bearing in mind what Counsel to the Inquiry has described as the 'forward looking' aspect of this module, that they should discuss some of the potential recommendations that the Inquiry may be considering, and which would fall squarely within the ambit of implementation by the health boards. We deal with this in Section B.

Acknowledgement

9. Before turning to these substantive matters, the health boards wish again to acknowledge publicly the extreme hard work and dedication of their employees throughout the course of the pandemic. The sacrifices you made are what enabled the NHS to respond to such extraordinary threat. The health boards recognise that such sacrifice often came at a cost, including moral injury due to the way in which healthcare workers were required to work just to provide basic care. Of course, sympathy goes particularly to those healthcare workers who lost their lives, or who still suffer from the after-effects of Covid. The health boards are more than aware that things have not yet returned to 'normal', and that considerable effort is continuing to be asked of employees.

10. Separately, the health boards wish to express their sympathy to all those who lost loved ones or who have suffered serious injury due to Covid-19. Healthcare was, during the period under examination, often being provided in extreme and sub-optimal conditions. Care was often delivered in such a way that healthcare workers would not have wanted. Once again, care has not returned to normal. Waiting lists remain long and some people, who could have had a better outcome, will suffer for that.

11. Finally, the health boards also wish to thank the Inquiry Chair, counsel, solicitors and staff at Dorland House for the sensitive and efficient way in which this module has been handled.

SECTION A

A1. IMPLEMENTATION OF NATIONAL GUIDANCE

12. A central theme of this module has been the content of national guidance. In Scotland, that guidance was created both by the Scottish Government and, insofar as in relation to Infection Prevention Control (IPC) measures, by Antimicrobial Resistance & Healthcare Associated Infection (ARHAI). We do not address the underlying discussion around the content of that guidance. However, to set out the health boards' position on a number of matters that follow, we start from the following proposition: in implementing policy, the health boards were bound to follow national guidance insofar as possible.

13. We have already set out the emergency footing upon which the NHS in Scotland was placed, which had as its very purpose reducing local variation. Beyond that, the reasons for following national guidance are clear and logical: its purpose is to draw on the expertise available to the country as a whole, rather than relying on the expertise available only to one health board. For example, in the dispute surrounding airborne or droplet transmission, this was a new respiratory pathogen. Research was developing, at pace, around the world. That research was analysed and compiled at a national level, with guidance as to the steps needed to address the risk.

14. Witnesses who have provided evidence on behalf of the health boards have confirmed that all national guidance was followed during the relevant period.[6] That said, the dilemma in which this placed healthcare managers was well described by Professor Colin McKay, giving evidence on behalf of one of the Inquiry's "spotlight hospitals", Glasgow

[6] Professor Emma Watson, Raigmore Hospital (INQ000480949), para.115; Professor Colin McKay, Glasgow Royal Infirmary (GRI) (INQ000478114), para.83; Paul Bassett, Scottish Ambulance Service (SAS) (INQ000335968) para.137; Stephanie Phillips, NHS 24 (INQ000474258), paras.1.15 & 9.2.

Royal Infirmary (GRI). His evidence was that, early in the pandemic, he was concerned regarding potential airborne transmission. However, had he taken steps to completely disregard the national guidance, that could easily have led to a severe loss of confidence in healthcare workers. That issue, namely the confidence of healthcare workers in the guidance that was being issued, has been raised frequently. Rapid changes and conflicting guidance often led to a sense amongst workers that national leaders were not getting it 'right'.

A2. HEALTHCARE CAPACITY

Critical care

15. The health boards were directed to increase critical care capacity in March 2020.[7] As part of the steps to increase capacity, the health boards were also instructed to reduce the number of delayed discharges from hospital.[8]

16. The health boards took rapid and innovative steps to respond to these directions. Wards were reconfigured, with physical spaces and ventilator equipment repurposed. Intensive Care Unit (ICU) beds were expanded into theatre areas. Staff were redeployed into critical care with the provision of additional training.[9] In accordance with national direction, retired staff, final year medical, nursing and midwifery students, and non-clinical staff who retained professional registration were deployed into the clinical workforce across health boards, which was facilitated by NHS Education for Scotland.[10]

17. There were occasions in the early stages of the pandemic when hospitals had difficulties securing equipment, such as in relation to CPAP,[11] and experienced drug shortages[12] but these issues were resolved.

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[7] Jeane Freeman, Inquiry Transcript 19/11/24, p.38, line 19 – p.39, line 3.
[8] Professor Colin McKay, GRI (INQ000478114), para.41.
[9] Professor Emma Watson, Raigmore Hospital (INQ000480949) paras.67, 82-83 & 97; Professor Colin McKay, GRI (INQ000478114), paras.76-79.
[10] As detailed by Karen Wilson, NHS Education for Scotland (INQ000480770).
[11] Professor Emma Watson, Raigmore Hospital (INQ000480949) paras.97.
[12] Professor Colin McKay, GRI (INQ000478114), para.80.

18. The exceptional hard work, dedication and flexibility to adapt shown by the staff working within health boards meant that capacity was successfully increased in Scotland. Professor Colin McKay of GRI told the Inquiry that the measures were in place, and there was close contact with other ICUs in the West of Scotland, which meant that the hospital was well positioned to respond to further increase of capacity, should it be required.[13]

19. The rule 9 responses provided to the Inquiry on behalf of the fourteen territorial health boards show that there were occasions in some health boards where baseline critical care capacity was either maximised or exceeded. Additional surge capacity was not breached in any health board in Scotland. There were a very small number of occasions in some hospitals where patients required to be transferred or diverted to other hospitals due to ICU capacity issues. There was never a need to utilise private hospitals for the treatment of Covid patients.[14]

20. The Inquiry will note that the evidence of the experiences in Scottish hospitals during the pandemic does not wholly reflect the harrowing descriptions provided by Professor Kevin Fong of some of the hospitals he visited in England which suffered the greatest capacity issues, and the devastating consequences that stemmed from that.[15]

21. However, whilst it might be said that – in light of the above – the NHS was not 'overwhelmed', that would be to oversimplify the issue. As Professor Summers and Dr Suntharalingam noted, it is "*vital to avoid misperceptions that ICU as a speciality 'coped' and needs no further investment – that is not the reality.*"[16] Some of the key difficulties caused by the need to increase capacity are set out by Professor McKay in his statement.[17] He describes that "*the volume of information that staff had to digest and process was*

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[13] Professor Colin McKay, Inquiry Transcript, p.6, lines 9-17.
[14] Written statements on behalf of the territorial health boards: INQ000492648; INQ000492649; INQ000492650; INQ000492651; INQ000492652; INQ000492653; INQ000492654; INQ000492655; INQ000492656; INQ000492657; INQ000492658; INQ000492660; INQ000492669; INQ000494741.
[15] Professor Kevin Fong, Inquiry Transcript 26/09/24, p.1, line 16 – p.55, line 23.
[16] Professor Charlotte Summers & Dr Ganesh Suntharalingam (INQ000474255), para.225.
[17] Professor Colin McKay, GRI (INQ000478114), para.65.

almost overwhelming."[18] The success of upscaling critical care capacity across Scotland came at a significant sacrifice to both the wellbeing of staff, and the quality of care that could be provided during the relevant time. Its impact is still being felt.

Staffing & care provision

22. Limitations on staffing and the physical NHS estate in Scotland brought challenges to health boards in upscaling capacity. This problem was accurately summarised in the evidence of Dr Stephen Mathieu on behalf of the Intensive Care Society:

> *"[S]pace is one thing, equipment is one thing, but the staff is fixed, and intensive care staff, many of the other speciality staffs, they can't - we can't just generate them quickly. They take years and years of training, and those staff were not available*."[19]

23. Witnesses in this module have rightly pointed that the availability of an intensive care bed requires not simply the bed itself, but the equipment and staff to operate it.[20] The ability to increase capacity rapidly and effectively therefore relies on human resource.

24. Significant workforce pressures were experienced by health boards for many years prior to the pandemic, and these problems are ongoing. The problem is exacerbated in rural areas such as NHS Highland due to its complex geography.[21] The health boards had difficulty recruiting and retaining experienced critical care staff for the additional funded beds provided during the pandemic. These staffing challenges meant that critical care units could not open all funded beds in the later part of the pandemic.[22]

25. During the pandemic, workforce capacity was further affected by a lack of onsite Covid testing at the outset of the pandemic, meaning that staff had to self-isolate for several

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[18] Professor Colin McKay, GRI (INQ000478114), para.65.
[19] Dr Stephen Mathieu, Intensive Care Society, Inquiry Transcript 09/10/24, p.130, line 19 – p.131, line 3.
[20] E.g. Dr Daniele Bryden of the Royal College of Anaesthetists, Inquiry Transcript 08/10/24, p.178, line 22 – p179, line 2.
[21] Professor Emma Watson, Raigmore Hospital (INQ000480949), para.48.
[22] Public Health Scotland (INQ000479816), para.6.1.1.

days to await test results.[23] Staffing numbers further depleted because of absences due to sickness, shielding or self-isolating.[24]

26. The focus of redeployment into critical care was primarily on those with critical care experience, or anaesthetic staff who had experience in ventilator and airway management.[25] Beyond critical care there was a need to redeploy staff throughout the healthcare workforce, including non-clinical administrative staff. The health boards took steps to ensure that deployed staff members were as comfortable as they could be through training and support.[26]

27. Notwithstanding these efforts, redeployment of staff into unfamiliar and highly pressured environments with high levels of mortality had a profound effect on staff physically, mentally and emotionally.[27] Upskilling staff without any critical care experience required supervision by skilled ICU staff, which placed additional burden on those staff.

28. There were a number of occasions in Scotland when there were more patients than critical care staff to enable care on a 1:1 basis.[28] Witnesses of the Scottish Government have confirmed to the Inquiry their awareness of the dilution to staff ratios that took place during the pandemic.[29] Professor McKay told the Inquiry that in the GRI during the first wave of the pandemic, one ICU nurse was supervising up to four non-ICU nurses caring for ICU patients. He considers that had there been any further expansion, this would have led to the inability to provide safe levels of cover.[30]

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[23] Professor Emma Watson, Raigmore Hospital (INQ000480949), para.32; Professor Colin McKay, GRI (INQ000478114), para.62.
[24] Professor Colin McKay, GRI (INQ000478114), paras.8, 30 & 62.
[25] Professor Colin McKay, Inquiry Transcript, p.3, line 19 – p.4, line 7; Professor Emma Watson, Raigmore Hospital (INQ000480949), paras.67 & 74.
[26] Professor Colin McKay, Inquiry Transcript 14/11/24, p.4, lines 14 – 23; Professor Colin McKay, GRI (INQ000478114), para.69; Professor Emma Watson, Raigmore Hospital (INQ000480949), para.37.
[27] Public Health Scotland (INQ000479816), para.6.1.1; 'Article by Catherine M Montgomery et al, titled Critical Care Work During COVID-19: A Qualitative Study of Staff Experiences in the UK, dated 12/04/2021' (INQ000477590).
[28] Public Health Scotland (INQ000479816), para.6.2.4.
[29] Caroline Lamb, Inquiry Transcript 14/11/24, p.96, lines 20 – 24; Humza Yousaf MSP, Inquiry Transcript 19/11/24, p.133, lines 4-17.
[30] Professor Colin McKay, GRI (INQ000478114), para.34.

29. The quality of care and communication that staff were able to provide to patients and families was undoubtedly impacted by the pressure and demand placed on the workforce. In consequence, staff suffered from stress and moral distress when they felt that they could not deliver the quality of care and supervision normally expected.[31] Jeane Freeman accepted during her evidence the change to staff ratios had a potential impact on quality of care but considered that people were working to the best standard they could in the circumstances.[32]

30. The significant pressures faced in hospitals during the pandemic, and the move to increase critical care capacity, had a knock-on effect on other NHS services across Scotland, many of which were stretched themselves.

Impact on other services

Emergency departments

31. During the initial lockdown, the numbers of patients requiring unscheduled care, including in emergency departments, fell. However, the Inquiry has heard from Caroline Lamb and Humza Yousaf MSP that one of the periods of most significant pressure in hospitals was around the winter of 2021/22, due to increased presentations and issues with delayed discharges, not only in ICU but also in other departments such as Accident & Emergency (A&E).[33]

Scottish Ambulance Service

32. The Scottish Ambulance Service (SAS) was impacted during the pandemic by the pressures in some hospitals, as well as an increase of crew absence and increased call demand. Response time standards were met by SAS in the early stages of the pandemic due to reduction in demand in the initial lockdown period and maintenance of pre-pandemic

[31] Professor Colin McKay, Inquiry Transcript 14/11/24 p.5, lines 8 – 13; Professor Colin McKay, GRI (INQ000478114), para.65.
[32] Jeane Freeman, Inquiry Transcript 19/11/24, p.48, line 10 – p.49, line 1.
[33] Caroline Lamb, Inquiry Transcript 14/11/24, p.115, lines 1-13; Humza Yousaf MSP, Inquiry Transcript 19/11/24, p.138, line 24 – p.239, line 2.

crew levels. There was, however, a significant increase in call volume from May 2021 onwards, compounded with high levels of staff absence. A number of innovative and effective measures were taken by SAS to respond to the demands, as detailed in the written statement of Paul Bassett.[34] Notwithstanding these efforts, the pandemic pressures affected ambulance response times, particularly from around spring 2021.[35]

33. One specific aspect to note in respect of the ambulance response is that Scotland does not have a framework for the regulation of private ambulance providers. As such, there is no governance mechanism for such provision, meaning that SAS does not ordinarily contract with private providers.[36]

NHS 24

34. In accordance with national direction, NHS 24 took rapid steps to transform its 111 service to aid the response to capacity pressures across the NHS in Scotland. Stephanie Phillips sets out in her written statement the rapid transformation of the service during the pandemic. NHS 24 transformed quickly from an out of hours service to a 24/7 service. A single national pathway was created for those with Covid symptoms. Covid assessment hubs were set up across health boards to accommodate remote and in-person consultations following initial triage through 111. A national Coronavirus Non-Clinical special helpline was also set up in collaboration with a third-party provider to respond to general non-clinical questions and direct those away from the 111 service. New national 111 triage and referral pathways were rolled out in winter 2020 to respond to the increased demand with the aim of reducing the self-presentations to A&E.

35. NHS 24 worked extremely hard to implement these new services and pathways in a very short timescale. However, it was necessary to scale up its workforce and expand its physical estate to accommodate additional staff.[37] There was a significant increase of 111 calls during the relevant period which, coupled with ongoing Covid demand, impacted on

[34] Paul Bassett, SAS (INQ000335968) paras.84-88.
[35] Paul Bassett, SAS (INQ000335968) paras.64, 69, 93 & 108-109.
[36] Paul Basset, SAS (INQ000335968), paras.74 & 75.
[37] Stephanie Phillips, NHS 24 (INQ000474258), paras.6.5 & 7.1-7.7.

call answering performance.[38] Challenges recruiting experienced clinicians combined with continued high levels of demand, continue to impact on 111 call time performance.[39]

Non-Covid conditions

36. The Scottish Government directed health boards to pause non-urgent services, including screening programmes.[40] All plans to re-start screening programmes required ministerial approval.[41] Treatment prioritisation was coordinated in line with national guidance,[42] and treatment decisions continued to be made on an individual risk/benefit analysis.[43]

37. Emergency treatment and management of patients presenting with symptoms of ischemic heart disease was continued during the pandemic.[44] Urgent cancer services for diagnosed patients were also maintained and continued to be prioritised in Scotland, and national guidance on cancer treatment was followed.[45] However, pausing of screening and restricted use of diagnostic tests led to delays in diagnosis and treatment.[46]

38. Some health boards were able to maintain some elective care during the pandemic, though that depended on local circumstances. The Golden Jubilee hospital (operated by the National Waiting Times Centre Board) was designated as a non-Covid hospital to allow some elective work to continue.[47] Humza Yousaf MSP commended NHS Forth Valley as being "standout" when it came to elective care, as the board successfully maintained a degree of elective care provision throughout the pandemic. Mr Yousaf told the Inquiry that re-starting of elective care varied across health boards, again depending on the local

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[38] Stephanie Phillips, NHS 24 (INQ000474258), paras.3.7-3.8, 3.22-3.24, 3.26, 4.1-4.11, 5.1-5.17, 6.1, 12.3-12.4.
[39] Stephanie Phillips, NHS 24 (INQ000474258), para.12.7.
[40] Jeane Freeman, Inquiry Transcript 19/11/24, p.38, lines 19 – 24.
[41] Mary Morgan, NSS (INQ000475249), paras.31-34.
[42] Professor Colin McKay, GRI (INQ000478114), para.147; Caroline Lamb, Inquiry Transcript 14/11/24, pp.164-165.
[43] Dr David Dodds, Beatson West of Scotland Cancer Centre (INQ000479064), para.13.
[44] Professor Emma Watson, Raigmore Hospital (INQ000480949), para.176.
[45] Dr David Dodds, Beatson West of Scotland Cancer Centre (INQ000479064), paras.11 & 16; 'Guidance titled Guidelines For Cancer Treatment During COVID-19 Pandemic, dated 20/04/2020' (INQ000479062).
[46] Dr David Dodds, Beatson West of Scotland Cancer Centre (INQ000479064), para.25.
[47] Jeane Freeman, Inquiry Transcript 19/11/24, p.72, lines 13-17.

circumstances. Re-starting elective care was more challenging for the health boards which had had to fully pause elective care in the early stages of the pandemic.[48]

39. Mental health services in Scotland were also impacted by the pandemic. The Inquiry has heard of the significant increase in mental illness suffered by the population during the relevant period.[49] In efforts to respond to the increased demand, NHS 24 developed a national mental health hub which remains in place. Online mental health advice was also enhanced through NHS Inform.[50] The impact of the pandemic on the provision of CAMHS care, discussed in the report by Drs Northover and Evans, is noted by the health boards. In particular, the health boards note the experts' discussion on the increase in eating disorder presentations.[51] Such presentations are potentially very harmful to children and young people. This is an issue upon which greater planning is needed for any future pandemic, a point to which we return in Section B.

40. Despite significant efforts from the health boards to respond to the increase in demand across a range of services, there is an ongoing backlog and waiting lists remain high. The continuing pressure on service delivery across the health boards has impacted on their ability to recover from the pandemic.

A3. INFECTION, PREVENTION & CONTROL (IPC)

Challenges implementing the national guidance

41. During the pandemic, the health boards followed national IPC guidance. The implementation of this guidance was, at times, challenging. The content of the guidance was frequently changing, and often framed in a way that would be difficult to translate into local guidance that would be easily understood and implemented by frontline staff.[52]

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[48] Humza Yousaf MSP, Inquiry Transcript 19/11/24, p.156, line 18 – p.157, line 17.
[49] E.g. Dr Sarah Hughes, MIND (INQ000479887) paras.13-14; 'The mental health emergency: how has the coronavirus pandemic impacted our mental health' 2020 (INQ000471282).
[50] Stephanie Phillips, NHS 24 (INQ000474258), paras.3.14 - 3.20.
[51] Dr Guy Northover & Dr Sacha Evans (INQ000474300), paras.164 & 165.
[52] Professor Colin McKay, GRI (INQ000478114), para.189.

42. The guidance of the UK IPC cell was being followed by those producing the national guidance in Scotland until October 2020.[53] Chief Nursing Officer, Fiona McQueen, told the Inquiry that the guidance of the IPC cell was confusing to staff and not always relevant to Scotland.[54] Rosemary Gallagher of the Royal College of Nursing stated during her evidence that those implementing the guidance felt, *"as if the guidance had been written for IPC specialists but not necessarily for clinicians implementing it at the frontline."*[55]

43. Often the guidance was being sent out on a Friday, with short timeframes for implementation. Fiona McQueen told the Inquiry that she was aware of fifteen occasions where Scottish Government officials issued guidance on Friday afternoons.[56]

44. Whilst both Fiona McQueen and Caroline Lamb indicated in their evidence that it was not expected that boards would disseminate the guidance at a local level immediately,[57] it must be borne in mind that the health boards have responsibilities for the health and safety of staff and patients. The boards were required therefore, or at the very least reasonably felt required, to review and implement the latest guidance at pace to comply with their legal duties.[58]

45. The health boards disagree with Fiona McQueen's suggestion that issuing guidance on a Friday to the NHS was "kind of immaterial" to them because they were working seven days a week.[59] The reality on the ground was that the short timeframes for implementation were at times very challenging for health boards,[60] so much so that concerns about this were raised by boards to the Scottish Government.[61]

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[53] As set out by Laura Imrie, ARHAI, Inquiry Transcript, 05/11/24, p.114, line 14 – p.115, line 8.
[54] Fiona McQueen, CNO Scotland, Inquiry Transcript 17/09/24, p178, line 17 – p.179, line 1.
[55] Rosemary Gallagher MBE, RCN, Inquiry Transcript 04/11/24, p.106, lines 10-20.
[56] Fiona McQueen (INQ000474225), para.68.
[57] Fiona McQueen, Inquiry Transcript 17/09/24, p.180, lines 11-21; Caroline Lamb, Inquiry Transcript 14/11/24, p.48, line 24 – p.49, line 1.
[58] Professor Emma Watson, Raigmore Hospital (INQ000480949), para.112.
[59] Fiona McQueen, Inquiry Transcript 17/09/24, p.179, lines 12-16.
[60] Professor Emma Watson, Raigmore Hospital (INQ000480949), para.103; Professor Colin McKay, GRI (INQ000478114), paras.65 & 87.
[61] Caroline Lamb, Inquiry Transcript 14/11/24, p.49, lines 4-7; Fiona McQueen (INQ000474225), para.68.

46. Communicating constant changes to staff in health boards effectively was difficult in the circumstances.[62] The health boards did their best to communicate the frequently changing guidance and information to staff using a variety of methods. Those included regular team meetings and briefings, staff intranet, email communication, organised training sessions and an App used by SAS.[63]

47. Professor Sir Gregor Smith, Chief Medical Officer Scotland, has acknowledged in his evidence the practical consequences of the challenges of implementing the guidance:

> *"The complexity and rapidity of asks falling on clinicians and healthcare settings means that interpreting IPC guidance at speed was difficult and as a result IPC guidance was at risk of being inconsistently applied across different settings."*[64]

48. The content of the guidance did not always align with the understanding of those implementing it, nor with guidance being issued by other professional organisations and Royal Colleges, for example, in relation to the definition of aerosol generating procedures or the mode of transmission of the virus.[65]

49. This was particularly challenging where health boards were not able, or at the very least reasonably felt unable, to deviate significantly from the national guidance as deviation would have brought further angst and uncertainty to staff. It was therefore necessary to reinforce to staff that the national guidance must be followed, even if it was not always felt instinctively that it was correct.[66]

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[62] Professor Colin McKay, GRI (INQ000478114), para.65.
[63] Professor Emma Watson, Raigmore Hospital (INQ000480949), para.192; Professor Colin McKay, GRI (INQ000478114), paras.85-86; Stephanie Phillips, NHS 24 (INQ000474258), para.8.17; Paul Bassett, SAS (INQ000335968) paras.128-130.
[64] Professor Sir Gregor Smith, CMO Scotland, para.173.
[65] Professor Colin McKay, GRI, Inquiry Transcript 14/11/24, p.8, line 17 – p.9, line 18 & p12, lines 3-18; Professor Colin McKay, GRI (INQ000478114), para.127; Professor Emma Watson, Raigmore Hospital (INQ000480949), para.107.
[66] Professor Colin McKay, GRI, Inquiry Transcript 14/11/24: p.9, line 24 – p10, line 6; p.10, lines 18-21; & & p.13, lines 7 – 11; Professor Colin McKay, GRI (INQ000478114), para.180.

50. The national IPC guidance did not always reflect the wide variation of healthcare settings across the NHS estate in Scotland. Witnesses have provided examples to the Inquiry of practical challenges that arose in attempting to implement IPC guidance in certain settings – for example, in ambulances,[67] NHS 24 contact centres,[68] psychiatric wards,[69] maternity settings,[70] and pharmacy departments in acute settings.[71]

51. The age of parts of the NHS estate in Scotland also created a barrier to the implementation of the national IPC guidance. Great efforts were made by health boards to reconfigure wards in attempt to achieve physical spacing, and to separate out Covid and non-Covid patients.[72] There were times when health boards created local guidance to supplement gaps in the national guidance. For example, some issued guidance around the management and cohorting of patients based on risk profile to reflect the hospital having many open wards with few single rooms.[73]

52. However, the lack of physical space and single rooms in some hospitals caused difficulty for health boards in effectively implementing the measures.[74] The need for physical space did not only apply to the placement of patients and the spacing between them. Consideration needed to be given as to how staff could safely use the communal areas of wards, where clinical tasks and necessary communication require to be undertaken. Jeanne Freeman acknowledges in her written evidence that it was also not always possible in practice to prevent staff movement between wards.[75]

53. Ventilation measures were also challenging to implement due to the physical infrastructure of older estates. The health boards took steps where possible to achieve

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[67] Mark Tilley, Inquiry Transcript 01/10/24 p.2, line 19 – p.29, line 17.
[68] Stephanie Phillips, NHS 24 (INQ000474258), para.6.5.
[69] Dr Elaine Lockhart, Royal College of Psychiatrists Faculty of Child and Adolescent Psychiatry (INQ000472876), para.92.
[70] Dr Edward Morris obo RCOG (INQ000470853), paras. 68 & 95.
[71] Josh Miller, Clinical Pharmacist in acute sector of NHS Scotland (INQ000421862), paras.4 & 16.
[72] Professor Emma Watson, Raigmore Hospital (INQ000480949), paras.62-65; Professor Colin McKay, GRI, paras.49-52.
[73] Professor Colin McKay, Inquiry Transcript p.11, lines 5 – 16; Professor Colin McKay, GRI (INQ000478114), para.173; Professor Emma Watson, Raigmore Hospital (INQ000480949), para.108
[74] Professor Colin McKay, GRI (INQ000478114), paras.90-91.
[75] Jeane Freeman (INQ000493484) para.176.

adequate ventilation, for instance, by separating areas with screens, opening windows, providing portable HEPA filters, and installing extractors.[76]

54. Humza Yousaf MSP told the Inquiry of that there were occasions where health boards had to seek formal permission from government officials to derogate from the national IPC guidance on the basis that the infrastructure of the estate meant that it was not possible to follow, and there were no alternative options.[77]

55. The health boards followed Scottish Government guidance on Covid testing of staff and patients.[78] It is widely accepted that there was a lack of testing facilities available to all healthcare staff in Scotland in the early stages of the pandemic. This created additional challenges to IPC in healthcare settings, particularly as the patients with the virus could be pre-symptomatic or asymptomatic.[79]

Personal Protective Equipment (PPE)

56. Most of the PPE in health boards was sourced nationally.[80] In the early stages of the pandemic there were widespread issues with the availability of PPE, with limited supplies of fluid resistant surgical masks (FRSM), visors, long sleeved aprons, gowns and respiratory protective equipment (RPE).[81] The Inquiry has heard evidence of the wide-scale global shortages of PPE,[82] which it is understood will be explored further in Module 5.

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[76] Professor Colin McKay, GRI (INQ000478114), paras.37 & 93; Professor Emma Watson, Raigmore Hospital (INQ000480949), para.109.
[77] Humza Yousaf MSP, Inquiry Transcript 19/11/24, p.121, line 18 – p.122, line 3.
[78] Professor Emma Watson, Raigmore Hospital (INQ000480949), para.114; Professor Colin McKay, GRI (INQ000478114), paras.109-111.
[79] Jeane Freeman (INQ000493484), para.284; Paul Bassett, SAS (INQ000335968), para.77; Fiona McQueen, Inquiry Transcript 17/09/24, p.174, lines 10-11.
[80] As detailed by Gordon Beattie, NSS (INQ000417097).
[81] Professor Emma Watson, Raigmore Hospital (INQ000480949), para.116; Professor Colin McKay, GRI (INQ000478114), para.115 & 122; Dr David Dodds, Beatson West of Scotland Cancer Centre (INQ000479064), para.40; Paul Bassett, SAS (INQ000335968), para.167; 'Report from Audit Scotland titled Covid-19 Personal Protective Equipment, dated June 2021' (INQ000108737).
[82] E.g. Gordon Beattie, National Procurement (INQ000417097), para.4.

57. Professor McKay of GRI described to the Inquiry times when there appeared to be only one or two days of supply remaining. This caused great anxiety to those running the boards who had a responsibility for the protection of the health and safety of their staff. Notwithstanding these anxious moments, the hospital was always able to supply staff with the necessary PPE in line with the national guidance.[83]

58. The evidence of Professor McKay reflects the feedback that Fiona McQueen told the Inquiry she was getting from a nurse director, who informed her that there was enough PPE, but that, *"there's a palpable sense of relief when a new supply comes into the hospital."* She also stated that, *"at one time, for gowns, I think there was less than a full day's supply within Scotland."* [84]

59. The evidence of the position in Scotland in respect of PPE supply and distribution does not appear to reflect the extremity of the challenges faced in England.[85] Fiona McQueen nevertheless accepted in her evidence that early in the pandemic, *"we would have been much better to have a better supply of PPE."* [86]

60. The Inquiry has heard evidence of problems with the adequacy and suitability of PPE that health boards in Scotland were receiving from national stock. There were occasions when stock had expired. PPE which had passed its expiry date was never issued to staff unless it was approved as safe to do so by the manufacturer. This nevertheless caused great anxiety for staff. There were times when PPE was locally sourced, but this could not be used unless it complied with national guidance, which was a further source of frustration for staff.[87]

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[83] Professor Colin McKay, GRI: Inquiry Transcript 14/11/24, p.16, lines 18 – 23; Professor Colin McKay, GRI (INQ000478114), para.115.
[84] Fiona McQueen, Inquiry Transcript 17/09/24, p.201, lines 10-19 & p.205, lines 2-3.
[85] Comments of Daisy Sandman, clinical nurse manager in Edinburgh Royal Infirmary, referred to Professor J S Bamrah CBE, FEMHO, FEMHO (INQ000427706) para.15.
[86] Fiona McQueen, Inquiry Transcript 17/09/24, p.202, lines 9-11.
[87] Professor Emma Watson, Raigmore Hospital (INQ000480949), paras.120, 123-125 & 129; Paul Bassett, SAS (INQ000335968), para.173; Professor Colin McKay, Inquiry Transcript p.15, lines 5 – 16; Professor Colin McKay, GRI (INQ000478114), para.121 & 181.

61. Significant efforts were made by health boards to step up fit-testing for FFP3 masks, with additional staff trained to fit-test.[88] However, supplies that were coming from the national stockpile were different to those masks which staff had been fit-tested to use. This meant that staff had to be fit-tested again, and there was a high failure rate with the new stock.[89] The significance of this wasted time and effort, and the frustration it caused to hospital leaders, is difficult to overstate.

62. Jeane Freeman told the Inquiry that the national stock of FFP3 masks was modelled for the average male face.[90] This created difficulties for health boards in successfully fit-testing staff with smaller faces (predominantly women, who make up the majority of the healthcare workforce) or those with facial hair.[91] If it was not possible for staff to shave for religious reasons, or if staff could not otherwise be successfully fit-tested, then they were redeployed to low-risk environments for their own safety,[92] or where possible provided with alternative suitable RPE.[93] Where suitable alternative RPE was not available, this resulted in some highly skilled and specialised staff having to be removed from the frontline.

63. It is, of course, recognised by the health boards that asking staff who do not shave for religious reasons to do so, places them in a difficult position; essentially faced with a choice of participating in the healthcare response versus adhering to their religious beliefs. Professor McKay's evidence was that the policy at GRI (which the Inquiry will likely understand sits within one of Scotland's most ethnically diverse cities) of asking staff to shave did not cause difficulty. However, a choice of this nature is not something that ought to be imposed on healthcare workers in future; and will require to be accounted for in future pandemic planning. Such planning requires, of course, to have full regard to the public equality duty. That duty is something upon which each of the health boards has

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[88] Paul Bassett, SAS (INQ000335968), para.169.
[89] Professor Colin McKay, Inquiry Transcript 14/11/24, p.13, lines 19 – 25; Professor Colin McKay, GRI (INQ000478114), para.124.
[90] Jeane Freeman, Inquiry Transcript 19/11/24, p.35, lines 10 – 20.
[91] Professor Emma Watson, Raigmore Hospital (INQ000480949), paras.138 & 140.
[92] Professor Colin McKay Inquiry Transcript p14, lines 23 – 25; Professor Colin McKay, GRI (INQ000478114), para.170; Dr David Dodds, Beatson West of Scotland Cancer Centre (INQ000479064), para.41.
[93] Paul Bassett, SAS, para.172; Humza Yousaf MSP (INQ000480774) para.178.

published policies.[94] It also requires better access to data on equality impacts, upon which the health boards note the position taken by Public Health Scotland.

64. It is important to note that wearing PPE/RPE for long periods of time was incredibly difficult for many staff. Concerns were raised within health boards in relation to the discomfort, heat stress, physical exhaustion, heat-related illness, and facial trauma caused by prolonged wear.[95] Witnesses have also spoken of the communication difficulties that arose from mask wearing, for example, for individuals who rely on lipreading,[96] and for women during labour.[97]

65. At present, all staff in health boards can have access to an FFP3 mask, following an individual risk assessment, in line with their personal preference.[98] There are, however, ongoing issues with fit-testing FFP3 masks to people with smaller faces or beards.[99] There appears to be little doubt that the Covid pandemic has awakened the healthcare sector to a range of issues regarding PPE and RPE that were, quite simply, not on the radar before it. It is to be hoped that better research in the years to come[100] will increase the safe, workable options available to healthcare workers and their employers.

Visiting restrictions

66. Due to the risks of infection transmission, it was necessary to restrict visiting in hospitals during the pandemic. Such visiting restrictions are a common aspect of the way in which hospitals respond to periods of increased infection risk (for example, a vomiting bug in a

[94] An example can be found at https://org.nhslothian.scot/equality-human-rights/wp-content/uploads/sites/36/2023/06/NHS-Lothian-Equality-and-Human-Rights-Strategy-2023-2028.pdf.
[95] Professor Emma Watson, Raigmore Hospital (INQ000480949), para.132; Professor Colin McKay, GRI (INQ000478114), para.160.
[96] Dr Sarah Powell, Disability Charities Consortium (INQ000421866) para.5 & Inquiry Transcript 28/10/24, p.6, lines 11-15 & p.14, lines 14-17.
[97] Dr Edward Morris, RCOG (INQ000470853), para.100; Gill Walton CBE, RCN, Inquiry Transcript 07/10/14, p128, lines 7-14.
[98] Alex McMahon CNO Scotland (INQ000480975), para.27; Caroline Lamb, Inquiry Transcript 14/11/24, p.65, line 17 – p.67, line 15.
[99] Professor Emma Watson, Raigmore Hospital (INQ000480949), paras.138 & 140.
[100] As suggested by Professor Clive Beggs, Inquiry Transcript 11/09/24, p.176, line 13 – p.177, line 3.

ward), however the rules around visiting became complex and rigid and were changing frequently in line with national guidance and local circumstance.[101] The difficult position in which this placed relatives was described – with considerable balance and clarity – by Margaret Waterton of the Scottish Covid Bereaved in her oral evidence to the Inquiry.[102]

67. In implementing visiting rules during the pandemic, an extremely difficult balance had to be struck between minimising the risk of infection to staff and patients (many of whom were vulnerable) and enabling patients the benefit of a supporter from outwith the hospital.[103] Fiona McQueen explained to the Inquiry that, *"someone's benefit could be harming someone else."*[104] Similarly, Professor Sir Stephen Powis pointed out in his evidence that, *"it would have been almost impossible to come up with visitor guidance that would have satisfied everybody's concerns equally."*[105]

68. The health boards recognise the importance of a person-centred approach and the benefits of visitors to all patients. Enabling essential visitors or supporters for women giving birth, children, those at the end-of-life, those with mental health issues, dementia, disabled people, and autism all avoid unnecessary distress.[106] There is a particularly high value for some patients of being accompanied by a supporter, for example, in cases of learning disability or dementia.[107]

69. The requirement to follow national guidance placed healthcare staff in a very difficult position: having to turn away relatives in extremely challenging circumstances, even at times when they believed it could have a positive impact on care. On the other hand, when national guidance was not in place, decisions of staff could at times feel arbitrary.[108]

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[101] Professor Emma Watson, Raigmore Hospital (INQ000480949), para.147 & 183.
[102] Margaret Waterton, Scottish Covid Bereaved, Inquiry Transcript 26/11/24, p.41 onwards.
[103] Professor Colin McKay, GRI (INQ000478114), para.137; Gill Walton CBE, RCN, Transcript 07/10/14, p85, lines 5-16.
[104] Fiona McQueen, Transcript 17/09/24, p.213, lines 24-25.
[105] Professor Sir Stephen Powis, NHS England, Inquiry Transcript 11/11/24, p.13, lines 21.
[106] Professor Emma Watson, Raigmore Hospital (INQ000480949), para.149.
[107] Julia Jones, John's Campaign, Care Rights UK & the Patients Association, Inquiry Transcript 29/10/24, p.17, line 22 – p.18, line 2.
[108] Professor Colin McKay, GRI (INQ000478114), para.136.

There were occasions when health boards elevated concerns about the rigidity of national visiting guidance to Scottish Government officials.[109]

70. In some cases, the visiting restrictions impacted on communications between staff and families. Staff who were already facing pressures on the ground were required to telephone families each day – a manner of communication with which they were not necessarily familiar.[110]

71. There were variations and changes to the implementation of visiting rules across healthcare settings. In striking the appropriate balance, those implementing the restrictions required to consider the rates and prevalence of the virus in their area at the time. The decisions were not easy, nor were they a "one size fits all". Professor Emma Watson of "spotlight hospital" Raigmore Hospital in NHS Highland indicates in her written statement that the effects of Covid were felt differently in different parts of the country.[111] Different estates also faced varying degrees of challenge in implementing the IPC measures, as described above.

72. The health boards acknowledge and accept the distress, upset and lasting impact that those restrictions caused to many patients, families and healthcare staff. They understand the frustration felt by patients and families about the inconsistent approaches taken to visiting in different places at various stages of the pandemic. Restrictions to visiting were, however, necessary to protect both staff and patients from the virus, particularly given the high rates of community prevalence and the barriers to implementing IPC measures as set out above.[112] Consistency across health boards is not, however, always possible or desirable given the unique pressures and challenges faced in different areas and different points in time.

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[109] Caroline Lamb, Inquiry Transcript, p.158, line 2 – p.159, line 7.
[110] Professor Colin McKay, GRI (INQ000478114), para.132.
[111] Professor Emma Watson, Raigmore Hospital (INQ000480949), para.19.
[112] Professor Colin McKay, GRI (INQ000478114), para.128.

Access to services

73. Digital technology was used in primary and secondary care settings in Scotland to allow services to continue whilst reducing the risk of infection transmission.[113] Remote appointments had advantages and benefits, for instance, convenience for patients who would otherwise have to travel a distance to receive care,[114] and the avoidance of patients having to be physically present in healthcare settings.[115]

74. The evidence before the Inquiry has, however, highlighted that remote healthcare provision is not appropriate for all patients. It can create barriers for those who have difficulties using technology effectively such as some older patients or those with learning disabilities, autism or dementia.[116] Lack of face-to-face contact can also make it more difficult for clinicians to carry out physical assessments and tests on patients.[117]

A4. STAFF HEALTH & WELLBEING

75. Deficits in national pandemic preparedness meant that boards were required to develop systems and assessments from scratch, at the cost of significant time and administrative burden and (at times) a loss of staff confidence.

76. There has been much discussion in this module of the 'precautionary principle' when assessing the risks posed to healthcare workers by the virus. Health boards are of course responsible for assessing the risk to their employees, although the Scottish Government set the policy around this.[118] The Scottish Government published a tool to support health

[113] Professor Emma Watson, Raigmore Hospital (INQ000480949), para.204.
[114] Professor Emma Watson, Raigmore Hospital (INQ000480949), para.117.
[115] Dr David Dodds, Beatson West of Scotland Cancer Centre (INQ000479064), para.48.
[116] Matt Stringer, Disabilities Charities Consortium, Inquiry Transcript 10/10/24, p76, lines 5-13; Caroline Abrahams, Age UK, Inquiry Transcript 28/10/24, p35, lines 7-20.
[117] Dr Michael Mulholland, Royal College of General Practitioners, Inquiry Transcript 23/09/24, p.138, lines 3-7 & p.141, line 19 – p.142, line 17.
[118] Fiona McQueen (INQ000474225), para.136.

boards in carrying out staff risk assessments on 27 July 2020.[119] An updated version of the tool was published in September 2020 which accounted for ethnicity in the calculation of risk.[120] To supplement government guidance, SAS adopted a Risk Assessment tool developed by Disability Equality Scotland.[121]

77. There was some concern amongst health boards regarding the time it took for a national risk assessment tool to be provided.[122] Looking forward, maintenance of risk assessment tools for adaptation is an aspect of pandemic preparedness and we return to it in Section B. However, an assessment of risk (however it is undertaken) relies on a true understanding of the nature of the risk. Professor Sir Stephen Powis told the inquiry that for a risk assessment to be effectively carried out, the nature of that risk needs to be properly understood.[123] In the absence of a clear understanding on the risks associated with the virus transmission, and the particular risks to certain groups, the health boards were ill-equipped to conduct effective risk assessments in the early stages of the pandemic.

78. The risks which the health boards were assessing during the pandemic were being informed by the content of the national IPC guidance. Barry Jones of the Covid-19 Airborne Transmission Alliance told the Inquiry that it was impossible properly to undertake risk assessments where there was a lack of clear understanding about the transmission route of the virus. He told the Inquiry: *"If you're going to do a risk assessment, you have to know what the risk is."*[124] It is against the background of this knowledge of the risk that the 'precautionary principle' must be understood. The 'precautionary principle' did not require the health boards to undertake their own

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[119] 'Letter from Gregor Smith, Sean Neill, Fiona McQueen and Jason Leitch to Chief Executives and Directors of NHS Health Boards, titled Publication of Covid-19 Occupational Risk Assessment Guidance, undated' (INQ000429263).
[120] 'Guidance from the Scottish Government titled Coronavirus (Covid-19): Guidance on individual occupational risk assessment, dated 04/09/2020' (INQ000429279); 'Report from Scottish Government titled Annex A Covid-19 Occupational Risk Assessment Tool, dated 04/09/2020' (INQ000401082); Professor J S Bamrah CBE, FEMHO, Transcript 08/10/24, p.43, lines 1-12; Professor J S Bamrah CBE, FEMHO (INQ000427706), para.24.
[121] Paul Bassett, SAS, para.142.
[122] Professor Colin McKay, GRI (INQ000478114), para.167.
[123] Professor Sir Stephen Powis, NHS England, Inquiry Transcript 11/11/24, p.24, line 20 – p.25, line 2.
[124] Barry Jones, CATA, Inquiry Transcript 12/09/24, p.45, lines 7-25; Barry Jones, CATA (INQ000273913), para.399.

freestanding assessment of the virus's transmission routes, only the steps necessary to minimise the risks in line with national guidance.

79. The health boards took steps to carry out and implement risk assessments in line with government guidance, and staff assessed as being at higher risk were redeployed as appropriate.[125] Vipin Zamvar, a cardiothoracic surgeon at Edinburgh Royal Infirmary, has described a *"proactive and understanding approach towards staff"* in his health board, commenting that, *"nobody was forced to do anything they were not comfortable with. If you were anxious, then you could leave, so be it."* He considers that, *"we never felt the problems that took place in England."*[126]

80. The health boards reported and continue to report Covid death and illness of staff under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) in accordance with the guidance issued by the Health and Safety Executive (HSE). Richard Brunt of the HSE told the Inquiry that during the pandemic, the HSE considered employers in healthcare settings to have taken appropriate measures to protect healthcare workers from risks of Covid if the UK IPC guidance was being implemented and PPE specified in that activity was being provided to healthcare workers.[127] Mr Brunt also confirmed that there was no requirement to report cases of Long Covid.[128]

81. There is no doubt that the pandemic had a devastating impact on the physical, mental and emotional wellbeing of the NHS workforce in Scotland. There were no national plans in place at the outset of the pandemic to prepare health boards for the sheer scale in which the health and wellbeing of the NHS workforce would require to be supported.

82. The health boards acted rapidly with the available tools to scale up staff support during the pandemic. In addition to the national support which was available to staff, such as the NHS 24 wellbeing helpline,[129] several local staff support initiatives were implemented by

[125] Professor J S Bamrah CBE, FEMHO (INQ000427706), para.24.
[126] Professor J S Bamrah CBE, FEMHO (INQ000427706), para.24.
[127] Richard Brunt, HSE, Transcript 12/09/24, p.73, line 14 – p.74, line 9.
[128] Richard Brunt, HSE, Inquiry Transcript 12/09/24, p.106, lines 10-20.
[129] Stephanie Phillips, NHS 24 ((INQ000474258), para.3.18.

territorial health boards during the pandemic. Examples include assistance with food and drinks, access to safe and comfortable rest spaces, the provision of a range of online resources, psychological and wellbeing support provided by Occupational Health services, hospital chaplaincy services, and accommodation support where required.[130] Local staff support measures have continued post-pandemic. Doubtless with increased planning and preparation, these measures could be enhanced in any future pandemic.

83. Several staff employed by health boards suffer and have suffered from Covid and Long Covid.[131] The health boards are fully committed to supporting these staff to return to work. Long Covid support services and ongoing Occupational Health support are available to help and support staff, for instance, through arrangements to reduce working hours or adjust normal duties.[132]

A5. CLINICAL DECISION-MAKING

84. The processes behind clinical decision-making were unchanged during the pandemic. There was no national guidance on clinical prioritisation or escalation of care in Scotland.[133] Rather, a network of local and national ethics committees were set up to assist clinicians in health boards with making difficult treatment decisions.[134] The absence of a national decision-making tool potentially for rationing care was not considered by health boards to be problematic, nor would it have necessarily been welcomed by clinicians who make these clinical decisions on a day-to-day basis.[135]

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[130] Emma Watson, Raigmore Hospital (INQ000480949), para.190; Professor Colin McKay, GRI (INQ000478114), para.165; Paul Bassett, SAS (INQ000335968), paras.136-147.
[131] Paul Bassett, SAS (INQ000335968), para.145; Professor Colin McKay, GRI (INQ000478114), paras.35-36; Emma Watson, Raigmore Hospital (INQ000480949) paras.49 – 51.
[132] Paul Bassett, SAS (INQ000335968), para.145; Emma Watson Raigmore Hospital (INQ000480949), para.190; Professor Colin McKay, GRI (INQ000478114), para.166.
[133] Caroline Lamb, Inquiry Transcript p.119, lines 15 – 19; Professor Sir Gregor Smith, Inquiry Transcript 25/09/24, p.140, lines 14 – 21.
[134] Professor Sir Gregor Smith, Inquiry Transcript 25/09/24, p.142.
[135] Emma Watson, Raigmore Hospital (INQ000480949), para.185; Professor Colin McKay, GRI (INQ000478114), Inquiry Transcript p.25, lines 13 – 21.

85. Professor Sir Gregor Smith explained to the Inquiry that Anticipatory Care Planning is part of a wider process of how a patient expresses preferences in the care they receive. Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Orders may, but do not have to, form a part of an Anticipatory Care Plan. Professor Sir Gregor Smith highlighted the importance of consultation with the patients or family members in clinical decision-making and described this as "shared decision-making".[136] A DNACPR Notice is intended to guide clinicians in the event of cardiac arrest and is not applicable to decisions regarding other treatments or escalation of care.[137]

86. Professor Jonathan Wyllie of the Resuscitation Council UK has described the benefits of using the ReSPECT process in achieving full and informed discussions between clinicians and patients around in Anticipatory Care Planning and clarifying that DNACPR decisions are not applicable to decisions regarding other treatments or escalation of care. He did, however, clarify that ReSPECT was a *"form of just embedding best practice. It isn't to say that people not using ReSPECT were not using best practice because many of them absolutely were."*[138]

87. Health boards approached Anticipatory Care Planning and escalation of care in the same way they had done before the pandemic, continuing to reflect normal clinical practice and ethical decision-making principles. We are unaware of any blanket policies on clinical decision-making and treatment escalation having been applied in Scotland.

88. The ReSPECT process is utilised by some health boards,[139] whereas others use more general Treatment Escalation Plans which reflect the same general principles as ReSPECT.[140] The two are not mutually exclusive, with some boards using a combination of Treatment Escalation Plans for acute episodes of care and ReSPECT or other anticipatory care plans for longer-term planning. Professor McKay described to the Inquiry the Treatment Escalation Plan used within GRI. The version which was used during the

[136] Professor Sir Gregor Smith, Inquiry Transcript 25/09/24, pp.166-167.
[137] Witness Statement Professor Andrew Steven Lockey, Resuscitation Council UK (INQ000343994), para.66.
[138] Professor Jonathan Wyllie, Resuscitation Council UK, Transcript 10/10/24, p.15, lines 15-18.
[139] Professor Jonathan Wyllie, RCUK, Inquiry Transcript 10/10/24, p.20, lines 3-7.
[140] Emma Watson, Raigmore Hospital (INQ000480949), para.188.

pandemic contained the same principles which were already in place. Staff are encouraged to continue to use these Treatment Escalation Plans at the point of hospital admission for all patients.[141]

89. Professor McKay considered that GRI's alternative to the ReSPECT form worked well as it involved multidisciplinary discussions which gave clinicians the confidence to make consistent and ethical, evidence-based decisions on a day-to-day basis. [142] There were occasionally complaints around failures in communication or documentation, but these were substantially the same as those which arise occasionally in normal circumstances.[143] As mentioned above, it was challenging for staff to achieve effective communication at all times during the pandemic due to the pressures they were facing, and relatives not always present to consult with in person.

90. The principles of informed discussion and consent are fundamental to the clinical decision-making process. Patients should never feel pressured into signing DNACPR Notices, and informed consent is crucial in any Anticipatory Care Plan. The processes currently adopted by health boards across Scotland, whether that be ReSPECT or the alternative equivalent such as a Treatment Escalation Plan, clearly reflects these principles and encourages best practice amongst clinicians. The health boards note the again clear and balanced evidence of Margaret Waterton on the concerns of the Scottish Covid Bereaved regarding the use of DNACPR notices.[144] It is difficult, standing the evidence available to the health boards, to understand fully the extent of those concerns, but that does not detract from the issue of principle as stated; namely that individualised and properly informed consent are an essential aspect of such planning.

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[141] Professor Colin McKay, GRI, Inquiry Transcript p.25, lines 3 – 9.
[142] Professor Colin McKay, GRI, Inquiry Transcript p.17, line 14 – p18, line 20 & p24, lines 6-22 & p.25, lines 3 – 9; 'Guidance from Glasgow Royal Infirmary, titled A Clinician's Guide to COVID-19 Management, dated April 2020' (INQ000477554).
[143] Professor Colin McKay, GRI, Inquiry Transcript 14/11/24, p.20, line 19 – p.21, line 2.
[144] Margaret Waterton, Scottish Covid Bereaved, Inquiry Transcript 26/11/24, p.39, line 13 – p.43, line 9.

A6. LONG COVID

91. The devastating impact that Long Covid has had on many individuals, including some who are employed by health boards in Scotland, is clear from the evidence.

92. Strategic decisions in relation to the provision and treatment of Long Covid were made by the Scottish Government.[145] Humza Yousaf MSP stated the following in his evidence during this module:

> *"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."*[146]

93. The Long Covid condition was not fully understood in the early stages of the pandemic and continued to evolve as the pandemic progressed. Patients were presenting to clinicians with a wide range of complex and difficult sequelae at a time when understanding of the condition was limited at a national level. A National Institute for Health and Care Excellence UK-wide guideline on managing the long-term effects of Covid-19 was published in December 2020.[147] An implementation support note for clinicians was produced by the Scottish Government during 2021.[148] These helped to support clinicians in the assessment and treatment of Long Covid.

94. A £10m Long Covid Support Fund was announced by the Scottish Government in September 2021 to support health boards with the provision of Long Covid services.[149]

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[145] Professor Sir Gregor Smith (INQ000484783), para.94.
[146] Humza Yousaf MSP, Inquiry Transcript 19/11/24, p.142, lines 6-16.
[147] 'Document from the National Institute for Health and Care Excellence titled Covid-19 Rapid Guideline: Managing the Long-term Effects of Covid-19 (NG188): Methods, dated December 2020' (INQ000398880); Search History Record, dated December 2020' (INQ000398882).
[148] 'Report from Scottish Government titled Managing the long-term effects of COVID-19, dated between 05/05/2021 and 30/06/2022' (INQ000232014); Caroline Lamb (INQ000485979), para.772.
[149] Caroline Lamb (INQ000485984), para.241.

The health boards were required to apply for this funding and were invited to do so and conduct a gap analysis in March 2022. Funding allocations were confirmed and provided to boards in May 2022. Humza Yousaf MSP accepted in his evidence that the support to health boards could have been provided sooner, through explained that the reason for the delay largely due to the significant pressures faced by the healthcare system in the winter of 2021 into 2022.[150]

95. The responsibility was delegated to health boards to implement Long Covid services at a local level. Caroline Lamb told to the Inquiry that local flexibility is important to enable different areas to respond to the distinct needs of their own demographics.[151] This was also highlighted by Jeane Freeman, who provided the example of the rural Highlands being very different in terms of geography and population distribution to more urban areas on the central belt of Scotland.[152]

96. The flexibility that attaches to local discretion is preferable as it enables health boards to manage their own local services. It does, however, have the consequence of some inevitable variation in the services provided across different areas of the country.

97. The support of the central funding enabled health boards to enhance Long Covid treatment and support to their local population. All territorial health boards now have Long Covid pathways in place which are operational.[153] Whilst only one health board has a single pathway for Long Covid in children and young people, the other boards also provide Long Covid services and rehabilitation to this group.[154] The health boards are committed to the ongoing treatment and support of those who suffer from Long Covid.

[150] Humza Yousaf MSP, Inquiry Transcript 18/11/24, p.144, line 20 – p146, line 8.
[151] Caroline Lamb, Inquiry Transcript 14/11/24, p.133, line 16 – p.134, line 8.
[152] Jeane Freeman, Inquiry Transcript 19/11/24, p.4, line 21 – p.5, line 6.
[153] Caroline Lamb, Inquiry Transcript 14/11/24, p.137, lines 19 – 24.
[154] Humza Yousaf MSP, Inquiry Transcript 19/11/24, p.183, lines 4-8.

A7. FINAL OBSERVATION

98. As we hope is clear from the foregoing, the health boards welcome examination of all the issues raised in this Inquiry. Before passing from this section, however, we wish simply to observe the extreme conditions under which healthcare workers and managers were working during the pandemic. Whilst this Inquiry will proceed with the benefit of hindsight, that was not available to those making decisions under extremely trying circumstances. It is right that actions are examined, and lessons learned, but the Inquiry must take care, when reaching its findings, not to deter a future generation of healthcare leaders by judging too harshly those actions taken under extreme circumstances.

SECTION B

99. Turning to the future, in this section we address some of the directly applicable recommendations that the Inquiry likely will consider. The health boards appreciate that the Inquiry will consider a wide and extensive range of recommendations. We focus here on areas in which recommendations would require to be implemented, in Scotland, directly by the health boards. This is not to detract from those that will be aimed at national bodies, but which will have a significant impact on the health boards.

100. In some respects, work is already underway in these areas, which may be an important factor when considering recommendations which would inevitably carry a resource burden. Where that is the case, we have given the current state of play. The health boards' overriding position is that any recommendations must be specific and workable. The hazards of unspecific recommendations, particularly in an organisation of the size of the NHS, are well understood. There is also a need to avoid fighting yesterday's war.

B1. INCREASED CAPACITY

101. The health boards consider that without increased capacity, any future pandemic is likely to run into many of the same issues in the healthcare response as were felt in relation to Covid-19. Whilst the Independent Investigation of the National Health Service in England by Lord Darzi[155] concerned only England, its findings regarding the numbers of patients attending A&E departments and the slow flow through hospital (see section 5) are, in the health boards' experience, equally applicable to Scotland. The system of care in Scotland is running at or beyond capacity, with the result that there is little headroom within which to expand without significant knock-on effects.

102. The issue of capacity is, however, not simply an issue of providing more space, more beds and more staff; there is a question of how capacity ought to be used and the occupancy levels at which acute hospitals ought to operate. For example, the occupancy of ICU ought to be lower than a general ward, at around 70 - 75%. If occupancy at recommended levels was able to be maintained, there would be greater headroom within which to expand without the need to disrupt significantly other areas of care. The reasons for occupancy above recommended levels are complex and involve a far wider range of care providers than just acute hospitals. Reference is again made to the discussion in the Darzi report.

103. If greater headroom is not found, then the creation of significant additional capacity in any future pandemic would again likely mean elective care having to cease to allow anaesthetists and theatre trained nurses to be redeployed. The difficulties will again primarily be around staffing a significant increase, although upgrades in the basic space and equipment will also be required.

104. The need for increased capacity does not relate only to emergency and critical care. Hospital occupancy is running at too high a level, with the result that the flow through hospitals is slow. This leads to blockages throughout acute hospitals, impacting all aspects of care. Slow flow existed before Covid, particularly over the winter months/flu season,

[155] 'Report from Professor Lord Darzi, titled Independent Investigation of the National Health Service in England, dated September 2024' (INQ000474367).

and has been exacerbated since. NICE guidelines suggest that hospital occupancy (outwith critical care) should run at around 85%, but hospitals have routinely been occupied above that level long prior to the Covid pandemic. Capacity of course affects all aspects of the healthcare system beyond the numbers of acute hospital beds. It affects, amongst other things, testing and diagnostics, IPC measures and the public health strategies designed to reduce morbidity.

105. Occupancy at higher levels than recommended has a long understood knock-on effect on ambulance provision and waiting times, the reduction of which Professor Snooks described as an urgent priority[156] (a characterisation the Scottish Ambulance Service would agree with completely). Solving the slow flow through hospitals is, for the reasons discussed in the Darzi report, a complicated issue, involving community and primary care as well as acute hospitals. All the other recommendations which we discuss below rely, to some extent, upon having increased capacity within the healthcare system.

B2. FLEXIBILITY IN THE HEALTHCARE WORKFORCE

106. Even with increased capacity there is a need for flexibility in the healthcare workforce. This need for flexibility applies within hospitals, between hospitals, and outwith hospitals, depending on local demand. It is not possible to maintain, for example, a critical care workforce that would have been able to withstand the pandemic alone. In addition to the wasted resource in trying to maintain excessive capacity, keeping nursing skills honed requires nurses to care for sufficient numbers of critically ill patients. In reality, the healthcare system has to rely on the ability to create surge capacity.

107. Throughout the pandemic, some areas of the country were hit 'harder' than others, usually those with higher population density and/or greater levels of social deprivation. Most of Scotland's healthcare staff (with doctors in training being the main exception) are contracted to work within specific health boards. This created challenges as health boards tried to work on a more regional or "Once for Scotland" basis during the pandemic. There

[156] Professor Helen Snooks (INQ000474285), para.175.

is a need to create more flexible conditions in which staff can work across administrative boundaries, subject of course to appropriate regulation and oversight and to health protections being in place. There is a need for that flexibility to take account of local circumstances and to make adaptations accordingly. The need for flexibility in the workforce was emphasised by Professor McKay in his oral evidence to the Inquiry.[157]

108. Consideration should be given at national, regional and local levels to enabling flexible employment and deployment of the workforce. It is anticipated that this would enable the healthcare system to deploy staff more flexibly in emergencies, whilst enabling staff to have greater personal opportunities to work in diverse settings during business as usual. Such a step could be allied to local training and risk assessment preparedness, discussed below (at B4), such that flexibility can be used appropriately and safely. Of course, flexibility comes with a need to consider and act to support staff and to take steps to ensure their wellbeing, all of which would require to be addressed in response to any recommendation.

B3. SEPARATION OF ELECTIVE AND UNSCHEDULED CARE

109. Beyond the initial need to cancel elective care to allow for the creation of ICU capacity (see Section A), concern about transmission of Covid-19, requirement for strict infection control pathways, limitations of the NHS estate, and workforce constraints meant that elective care was reduced for much longer than would have been desirable and to a greater extent than other comparable systems[158]. This has had a profound impact on access and waiting times for patients.

110. In order to better protect elective care, there is an opportunity to consider further the benefits from ring-fenced elective sites and centres. This was considered by both

[157] Professor McKay, GRI, Inquiry Transcript 14/11/24, p.29, line 15.
[158] 'Report from Professor Lord Darzi, titled Independent Investigation of the National Health Service in England, dated September 2024' (INQ000474367), p.13.

Professor Bhangu and Dr Nepogodiev in relation to colorectal cancer care,[159] and by Professor Metcalfe and Ms Scott regarding hip replacement.[160] In Scotland, work is already proposed through the initial creation of National Treatment Centres. These centres were originally proposed in 2015, although funding constraint is slowing progress. There is a requirement to further scale this up and move elective activity away from hospitals with unscheduled care pathways. There is further opportunity to transition outpatient and diagnostic activity from main acute hospital sites to community hubs and/or elective centres, provided they are appropriately staffed and resourced.

111. The health boards recognise that the creation of separate care pathways is likely to take time and resource. An interim solution may be the one proposed by Professor McKay, that greater use is made of private hospital sites to provide this type of care in pandemic conditions. Whilst not a complete answer, due to the relatively small amount of private capacity in Scotland, it may be part of an interim solution. Increased flexibility of the workforce (see B2, above) could, within the limits of capacity (see B1, above), support the creation of designated elective centres by being able to utilise workforce from across multiple health boards.

B4. PLANNING AND PREPAREDNESS

112. Whilst pandemic planning and preparedness was and will largely be undertaken on a national level - and while for the reasons given above, the health boards consider they will always be bound to follow such plans - it is recognised that improved local site and workforce-specific planning is needed.

113. The need for local planning is highlighted in several places in the evidence before the Inquiry. For instance:

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[159] Professor Aneel Bhangu & Dr Dmitri Nepogodiev (INQ000474244), para.78; Inquiry Transcript 31/10/24, p.35, line 7 – p.37, line 5.
[160] Professor Andrew Metcalfe & Chloe Scott: (INQ000474262), para.179 & Inquiry Transcript 31/10/24, p.93, line 18 – p.95, line 6.

- Professor Summers and Dr Suntharalingam highlight the benefit of a "*library of site-specific critical infrastructure and surge information.*"[161]
- Dr Shinn, Professor Gould and Dr Warne point to the benefit of resources being maintained so that staff are trained in identifying the threat posed and the steps necessary to reduce that threat, including by wearing PPE and RPE.[162]
- Professor Watson (Raigmore Hospital) highlights the need to monitor and test hospital ventilation systems and to create and maintain staff knowledge of donning and doffing PPE.[163]
- Professor McKay (GRI) highlights the need for pandemic preparedness plans "for each acute hospital site".[164]
- Paul Bassett (SAS), highlights that, "*forecasting and planning arrangements are now embedded*" and that external modelling allows demand and capacity to be better understood.[165]

114. Local planning of this nature is likely to assist with training and risk assessment requirements such that, in any future pandemic, it will be easier for health boards to apply national planning and guidance at a local level. It will allow for better early assessment of risk to employees, including based on their protected characteristics, and for the provision of suitable control measures, based on the hospital estate at each site. Professor McKay's evidence was, of course, that at times it was particularly difficult for national guidance to be applied at GRI due to the nature of the hospital estate there.[166]

115. A separate aspect of local pandemic planning would be to consider in advance the consequence of the shut-down of services where there is crossover with primary care or social care. As the Inquiry knows, the health boards in Scotland form Health and Social Care Partnerships with local councils. This is likely to be examined more fully in Module 6, however an example in the present context was the restriction of access to eating disorder

[161] Professor Charlotte Summers & Dr Ganesh Suntharalingam (INQ000474255), para.226.
[162] Dr Gee Yen Shin, Professor Dinah Gould, & Dr Ben Warne (INQ000474282), Recommendations A(v) and E(i) & (ii).
[163] Professor Emma Watson, Raigmore Hospital (INQ000480949), paras.200-201.
[164] Professor Colin McKay, GRI (INQ000478114), para.187.
[165] Paul Bassett, SAS (INQ000335968) paras.178-180.
[166] Professor Colin McKay, GRI, Inquiry Transcript 14/11/24, p.27, line 20.

clinics. The harms to children and young people requiring CAMHS care has been well set out for the Inquiry in the report by Drs Northover and Evans, with the position of eating disorder clinics being a particularly stark example of an important service that was lost at times during the pandemic. Better planning, at a local level, as to how such services can be maintained in the event of a future pandemic would help to alleviate such harms.

B5. DIGITISATION

116. The health boards continue to engage primarily through traditional methods of communication such as letters and telephone. There is a requirement to modernise. The Covid pandemic has shown the extent to which such plans can be progressed. For example, as vaccine plans were emerging there was a rapid roll-out of Covid-19 immunisation passports which enabled people to readily demonstrate their Covid vaccine record on their mobile phones. Current priorities for the NHS in Scotland include the concept of single digital record and a 'digital front door'.[167] Greater use of digital records would, for example, allow for better tracking of Anticipatory Care Planning including, where appropriate, DNACPRs. It should allow for better communication, both between staff and with patients and for better data collection to improve clinical outcomes.

117. Investment and roll-out of improved digital systems, and associated ways of working, would in any event support patients' self-management in 'normal' times. It would provide improved infrastructure for healthcare services to engage with the population in future pandemics in a quicker more efficient way; both on scale and in relation to one-to-one care.

[167] The current strategy is set out in the Scottish Government's Digital Health and Care Strategy: https://www.gov.scot/publications/scotlands-digital-health-care-strategy/pages/5/.

CONCLUSION

118. As we set out in opening, the health boards are grateful to the Inquiry for its consideration of all the foregoing issues. They look forward to receiving the Inquiry's report on the matters raised by this module in due course.

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Edinburgh, 19 December 2024

NHS Central Legal Office