UK COVID-19 Inquiry Before Baroness Heather Hallett

Module 3 Hearings: September to November 2024

WRITTEN CLOSING STATEMENT
on behalf of
THE SCOTTISH GOVERNMENT

The Human Cost

1. Across the UK, the human cost of the pandemic was enormous. Everyone paid a price. The impact on people, families, communities and the workforce was devastating. Across Scotland in hospital settings alone, 9,573 people, workers included, lost their lives. Frankly, we cannot be reminded enough about such statistics. They cannot be forgotten. The Scottish Government expresses its sincere condolences to those who have lost loved ones, and to those who have suffered, and who continue to suffer. It also expresses its sincere gratitude for the many sacrifices that people made, often for the benefit of others, and the herculean efforts of the health and social care workforce, particularly when looking after our most vulnerable. The Scottish Government has made such statements before and we will continue to make them. Because, in truth, there is no limit to the number of times that they can, and should, be made.

Values

2. The Scottish Government talks a lot about the 'core values' that underpin the health and social care system in Scotland. Those values such as care, compassion, dignity, and respect are evident in those who perform the day-to-day job of 'keeping the system going'. The pandemic response was a prime example of those values in action. The quality of care provided, the myriad of ways in which people took on new roles and worked across boundaries, and the distress felt by many at what they witnessed in our hospitals and care homes, are all testament to those values.

3. Importantly, the values were on display across the *whole* of the health *and* social care system, because the response to the pandemic was a *'whole system response'*. There was collaboration across the *whole* system for the benefit of people and their families. The Scottish Government worked to ensure that the workforce was supported. Thus,

terms and conditions were adapted (arrangements were made for staff to have flexibility in carrying forward annual leave that they had been unable to use as a consequence of COVID-19); a bonus was paid (on 30th November 2020 the First Minister, Nicola Sturgeon, announced a £500 pro-rata one off payment for all health and care staff, as a 'thank you' for helping Scotland cope with COVID-19); and a life assurance scheme was created (the NHS Scotland and Social Care Coronavirus Life Assurance Scheme 2020 provided benefits to dependents of staff, who were not already covered by membership of an existing NHS pension scheme).

Public Health capability and the 'Four Harms'

4. We submit that the evidence has clearly shown that during the pandemic in Scotland, there was *public health capability*. That is, there was a strategy, there were plans, and there was guidance. We submit that the evidence shows that the response was comprehensive and effective. Certainly, at times the system was severely tested and stretched but, as Ms Freeman said, it was *not* overwhelmed[1]. Several important decisions were made which, taken together, resulted in an increase in capacity, in expectation of the reasonable worst-case scenario.

5. It is worth reminding readers of the 'guiding light' that steered decision makers through the pandemic, namely the 'Four Harms' approach. The Four Harms Framework identified the four main categories of harm caused by COVID-19, namely: i) the direct health impacts of COVID-19, ii) non-COVID-19 health harms, iii) societal impacts and iv) economic impacts. This allowed for reasonable and proportionate decision making, in a context where no option was risk-free. It allowed for a nuanced approach, which recognised risk 'across the board', and sought to mitigate those risks with a range of measures. It also allowed for an approach that evolved over time, in response to specific developments, and advancements in our knowledge of the behaviour of the virus.

6. In a related context, Prof Sir Chris Whitty explained in evidence that the 'Precautionary Principle' had not always been understood by witnesses[2]. For the principle to be applied correctly, there requires to be an absence of 'downside' to the proposed measure. If there is no downside, the principle can be applied. Otherwise, the issue is one of balancing of risk. Fundamentally, this is what the 'Four Harms' sought to do. That is, it involved the assessment of the merits of a proposed measure or decision, in full

[1] Evidence of Jeane Freeman, Transcript 34/44/4 – 34/46/14.
[2] Evidence of Professor Sir Chris Whitty, Transcript 12/142/3–12.

recognition of the fact that, more often than not, a downside did exist. It understood that no decision was 'good', or risk free. However, it allowed a conscious weighing and balancing of risks, informed by increasing knowledge and experience of how to respond to the virus. For example, the decision to pause non-urgent elective care was one with which, even in hindsight, all the expert evidence has agreed. But it had obvious negative effects. The decision balanced different risks and considerations to arrive at a proportionate outcome, albeit one which did not eliminate all of those risks.

The structure of the NHS and the Power to Direct

7. In our opening statement, we highlighted the absence of an NHS Trust structure in Scotland. The governance and accountability structure in Scotland is significantly different, compared to other parts of the UK. Policy is administered through the Health and Social Care Directorates of the Scottish Government and delivered through the Health Boards. As we believe the Chair recognises, while a local approach can have the effect of regional variation, in a country the size of Scotland, it can also lead to more effective delivery of the services that matter most in a particular area. Further, there is a direct relationship in Scotland between the Health Secretary and the Health Boards that make up NHS Scotland. That relationship is underpinned by the National Health Service (Scotland) Act 1978 (the '**1978 Act**').

8. The evidence showed that there is a strong collaborative working relationship between the Scottish Government and the Health Boards. As Caroline Lamb explained, the approach in Scotland produces a shared understanding of the priorities of Ministers, and consequent alignment of policy planning and delivery[3]. Ms Freeman noted that it is important that the highest spending public service, and the largest employer, is directly accountable to the Cabinet Secretary for Health[4]. Mr Yousaf said that a Trust structure, similar to ones that operate in other parts of the UK, would add a further layer of bureaucracy, for no discernible benefit, and would dilute the "direct relationship" between the Cabinet Secretary and the Chief Executives of the Health Boards[5].

9. The 1978 Act, at section 78, provides emergency powers to the Cabinet Secretary for Health. It provides inter alia that *'If the Secretary of State is of the opinion that an emergency exists, and thinks it necessary in order to secure the effective continuance*

[3] Evidence of Caroline Lamb, Transcript 32/173/19 – 32/175/15.
[4] Evidence of Jeane Freeman, Transcript 34/5/25 – 35/6/9.
[5] Evidence of Humza Yousaf, Transcript 34/103/13-19.

of any service under this Act ….he shall have power to direct that any function conferred by or under this Act …. on any body or person shall, during the period of the emergency, be performed by such other body or person as he may specify in the direction.' This power to direct the NHS in Scotland is a positive feature of the Scottish system, which was not, at the time of the pandemic, available in other parts of the UK. There was no command and control structure in Wales[6]. Counsel to the Inquiry suggested that there was a lack of central control in Northern Ireland[7]. In England, new legislation was introduced post-pandemic to resolve issues experienced during the pandemic, as a result of being unable to direct the NHS due to its statutory independence[8].

10. For completeness, a more restricted power exists in terms of section 78A of the 1978 Act. Thereunder, if it is a function of a body (including a Health Board) or person under or by virtue of the 1978 Act to provide a service, '*and the Scottish Ministers consider that the body or person has failed, is failing or is likely to fail to provide the service, or to provide it to a standard which they regard as acceptable*', that service may be performed by another body (including another Health Board).

11. On 17 March 2020, the former Cabinet Secretary for Health and Sport, Jeane Freeman, made a statement to the Scottish Parliament in which she said *inter alia* "… today, under section 1 and section 78 of the National Health Service (Scotland) Act 1978, I am formally placing our NHS on an emergency footing for at least the next 3 months." Professor Sir Gregor Smith gave evidence that placing the NHS on an emergency footing led to guidance becoming *'more prominent in the minds of people who were receiving it'*[9]. Humza Yousaf said that it meant that the NHS understood the severity of the emergency and that priority was to be given to emergency care[10]. Jeane Freeman's evidence was that it brought greater cohesion and accountability to the healthcare response[11].

Turning now to aspects of the response

Capacity Issues

[6] Evidence of Andrew Goodall, Transcript 30/194/07-15.
[7] Evidence of Robin Swann, Transcript 33/21/11-23.
[8] Evidence of Matt Hancock, Transcript 36/139/22 to 36/140/17.
[9] Evidence of Professor Sir Gregor Smith, Transcript 11/13/24 - 11/14/03.
[10] Evidence of Humza Yousaf, Transcript, 34/98/1-18.
[11] Evidence of Jeane Freeman, Transcript 34/6/23 to 34/7/1.

12. A number of key decisions were taken that increased capacity, allowed staff to be redeployed, and prevented the NHS from being overwhelmed. Crucially, and as mentioned, on 17th March 2020 Ms Freeman put the NHS in Scotland on an emergency footing. Strategic and operational leadership was required in order to determine which areas should be focussed on. Elective and non-urgent healthcare was cancelled. Cancer screening programmes were paused. Retired health staff, final year medical students and nursing students were brought into the workforce[12].

13. There was an urgency that lay behind the aforementioned steps, explained by the Scottish Government's understanding of the 'reasonable worst-case scenario'. On 3 March 2020, Ms Freeman made a statement to the Scottish Parliament, in which she outlined the reasonable worst-case scenario and modelling[13]. A submission to Ministers of 6 March considered inter alia the ability of the NHS in Scotland to 'scale up' both baseline and surge capacity, in view of the estimated percentage of the population that would require hospitalisation. Based on the assumption that 50% of the population would be symptomatic, with 4% of those people requiring hospitalisation, it was predicted that, in the peak week, demand for hospital beds could be around 20,000. At that time, the NHS in Scotland had 13,000 beds and 372 theatres, not all of which would be suitable for COVID-19 patients. This fell considerably short of anticipated demand. A 'tiered' response was thereafter adopted, in which the Scottish Government sought to increase capacity, through key decisions, described in the previous paragraph. On 11 March, the Scottish Government asked each NHS Board to devise 'Mobilisation Plans' [14]. This was an important part of the response. Each Board was urgently required to state the ways in which they would, for example, increase general bed and ITU capacity, scale back elective care, and (working with their local partners) institute a 'whole system response'.

14. As above, on 17 March 2020, Ms Freeman made a statement to the Scottish Parliament. She said that while NHS Scotland was *en route* to double the ICU capacity, to 360 beds, the scale of the pandemic meant the priority was now to quadruple ICU capacity, to more than 700 beds, as quickly as possible[15]. By June 2020, a total ICU Level 3 capacity of 585 (against a 173 baseline) was reached. In August 2020, the 'COVID-19 ICU

[12] Statement of Jeane Freeman #3, INQ000493484 at §88 to 113.
[13] Statement of Jeane Freeman #3, INQ000493484 at §115.
[14] INQ000326477 - Letter from John Connaghan CBE (Chief Performance Officer, NHS Scotland and Director of Delivery and Resilience) to NHS Chief Executives, regarding mobilisation plans, dated 11/03/20.
[15] Statement of Caroline Lamb #8, INQ000485979, at §357.

Expansion Legacy Planning Working Group' reported that equipment was being procured *'with deliveries in tranches by September 2020',* to support the quadrupling of capacity to 714 ICU beds[16]. In a report submitted in March 2021 to the Director General for Health and Social Care, the Working Group noted that consumables and equipment were in place so that Boards could extend ICU capacity to over 700, subject to staffing[17]. In April 2021, a Short Life Working Group considered ICU baseline capacity, uplift capacity, and associated factors in preparation for winter 2021/22. Following this work, the baseline figures for ICU beds was increased from 173 to 203 level 3 beds, with boards retaining the on-site ability to double this capacity (406 beds) and a central stockpile held by NSS to enable up to approximately quadruple capacity, subject to staffing[18].

15. Ms Freeman told the Inquiry that at no stage was the further expansion of capacity (the quadrupling of the baseline) exceeded[19]. She said that there were no discussions *at all* about the rationing of healthcare[20]. She *was* concerned that increase in capacity would have consequences for *quality of care*, since increase in capacity affected the staffing ratios. As Ms Freeman explained, it was in such a situation that retired staff, final year students and staff who were redeployed from paused screening programmes proved to be invaluable. She said that '*you're trying to move people with the highest level of skill to operate at that level of skill, and back-filling them from the staff that you are securing by other means. In that way you're trying to make sure that the quality of care in areas of the hospital in addition to high dependency or intensive care is as good as it can be.*'[21]

16. Prof Sir Gregor Smith was unaware of any resource-based escalation of care decisions being taken. It surprised him to hear, in research conducted on behalf of the Inquiry for Module 3[22], that doctors (some based in Scotland) reported difficulty in escalating care due to lack of resources[23].

17. The evidence of Ms Freeman and Ms Lamb showed that the Scottish Government closely monitored bed and staff capacity. Not *simply* by means of spreadsheets, but

---

[16] INQ000480820 - Submission to Cabinet Secretary for Health and Sport, 3 August 2020.
[17] INQ000480802 - Submission to the DG Heath and Social Care, 25 March 2021.
[18] Statement of Caroline Lamb #8, INQ000485979, at §362.
[19] Evidence of Jeane Freeman, Transcript 34/44/21 – 34/46/14.
[20] Evidence of Jeane Freeman, Transcript 34/49/18 – 34/50/2.
[21] Evidence of Jeane Freeman, Transcript 34/47/11 – 34/48/9.
[22] INQ000499523, Report by IFF Research titled *'Escalation of Care survey findings'*, dated July 2024.
[23] Transcript, 11/139/10 – 11/140/25.

through multiple telephone conversations and meetings throughout the course of a day, with everyone from Health Board CEO's to the Chief Nursing Officer[24].

18. In March 2020, in order to allow GP practices to focus on 'routine' (i.e. non-COVID 19) patient care, COVID-19 'Community Pathways' for primary care were introduced. A 'secondary' but important aim of the Pathways was to control the demand for acute hospital beds, by managing Covid-19 patients in the community, where clinically possible. To that end, Health Boards were asked to implement the Pathways, as a matter of urgency. The aim was to provide local, dedicated and consistent medical advice, triage and treatment for people with coronavirus symptoms. NHS 24 acted as the single point of entry, and conducted an initial triage of the patient. The patient may then be referred to the local 'Covid-19 Hub', where further assessment might result in referral to one of the Covid-19 'Assessment Centres'. The Centres had the ability to carry out face to face consultations.

19. The NHS Louisa Jordan, commissioned on 30 March 2020 and officially opened on 30 April 2020, provided back up to the permanent acute estate, if needed. It had an initial capacity of 300 beds, with physical capacity to increase up to 1,000, including a high-dependency area with up to 90 beds. It is unreasonable to suggest that, had it been required, there would have been insufficient staff to run it. Certainly, there would have been challenges to operating at maximum expanded capacity of *1,000 beds*. However, it is important to note that it was always intended that any expansion of the facility, beyond the initial 300-bed capacity, would be taken on a phased basis, with availability of workforce acting as a key consideration in any phased expansion. Mitigation measures would have been available. Such measures would have included the deployment of healthcare students on pre-registration programmes on paid placement, guidance on the dilution of staffing ratios, and the use of non-clinical staff to provide supervised care. The combined effect would have been to maximise the availability of registered clinicians' time to deliver treatment. As a measure of last resort, a request for Military Aid to Civilian Authorities could have been made, to support staffing needs within the facility.

20. While ultimately not required to treat acute patients, the Louisa Jordan *was* utilised, and ultimately proved very useful. 32,000 outpatient and diagnostic appointments were

[24] Evidence of Jeane Freeman, Transcript 34/40/14 – 34/41/14; Evidence of Caroline Lamb, Transcript 32/86/21 – 32/87/1.

carried out, over 6,900 healthcare staff and students were trained, and 175,000 people were vaccinated. The site also supported the Scottish Blood Transfusion Service, with over 500 donations carried out as well as providing occupational health services for nearly 1000 people.

21. In summary, we submit that the evidence showed a government that had a good grasp of the figures, knew when problems arose, and strove to prevent the NHS from being overwhelmed.

Escalation of Care / DNACPR

22. Prof Sir Gregor Smith confirmed that he was not told at any time during the Relevant Period that resource-based escalation of care decisions were being made in Scotland[25]. Nor did Caroline Lamb receive any reports of critical care being rationed, officially or unofficially[26]. Both noted that Scotland did not breach its surge capacity[27]. Jeane Freeman's evidence was that there were *"no discussion at all about rationing of healthcare"*[28], noting that decisions made in a hospital setting about the appropriate care a patient should receive are *"clinical decisions"*[29]. Ms Lamb did not recall any discussions around the production of national guidance on escalation of care, nor of any requests from Health Boards for such guidance[30]. Like Ms Freeman, her view was that it was clinicians on the ground who were best placed to make such decisions, based on the individual circumstances and wishes of their patients[31].

23. The Scottish Government recognises that the inappropriate use of DNACPR notices was a matter of concern for many of the bereaved, and we noted carefully the evidence of Margaret Waterton of Scottish Covid Bereaved on this topic. We agree that any discussion around DNACPR or wider advanced care planning ("**ACP**") should be based around the principles of care, compassion and a person-centred approach[32].

---

[25] Evidence of Professor Sir Gregor Smith, Transcript 11/140/22-25.
[26] Evidence of Caroline Lamb, Transcript 32/115/22 – 32/116/1.
[27] Evidence of Caroline Lamb, Transcript 32/117/12-13; Evidence of Professor Sir Gregor Smith, Transcript 11/140/18-19.
[28] Evidence of Jeane Freeman, Transcript 34/49/24-25.
[29] Evidence of Jeane Freeman, Transcript 34/50/2.
[30] Evidence of Caroline Lamb, Transcript 32/119/21 – 32/120/13.
[31] Evidence of Caroline Lamb, Transcript 32/120/9-13.
[32] Evidence of Margaret Waterton, Transcript 39/43/8-9.

24. Prof Sir Gregor Smith explained that there was a long-standing policy in Scotland relating to the use of DNACPRs and ACP from August 2016[33]. He very strongly agreed that the policy made it clear that that DNACPRs should be always considered on an individual basis, and there is never a justification for a blanket policy[34]. Sir Gregor noted having heard of some concerns about the interpretation of how ACPs were being conducted in some places, and having written a letter of 10 April 2020 to GP practices and the Health Boards seeking to provide clarification[35]. Sir Gregor confirmed that he did not see any evidence of a correlation between the use of DNACPR notices and the availability of beds, staff, ventilators or oxygen supply[36].

25. Fiona McQueen's view was that, having heard anecdotal evidence of inappropriate DNACPR notices early in the pandemic, mechanisms were put in place to prevent them from happening[37]. She was very clear that *"under no circumstances should it ever have happened"*[38]. She explained that a care home professional advisory group was established to develop comprehensive guidance for social care to address any potential issues in this regard[39].

26. Jeane Freeman's evidence was that she knew there was *"no blanket instruction or requirement emerging from Scottish Government"* in respect of DNACPRs and so she wanted to ensure that concerns being raised to her about this topic were *"addressed as quickly as possible"*[40]. She confirmed that the Scottish Government did look into the detail of these concerns[41]. Her view of Sir Gregor's letter of 10 April 2020 was that it *"made crystal clear that anticipatory care planning is individualised and DNACPR discussions are individualised to each patient"*[42]. Humza Yousaf confirmed that he met with bereaved families and discussed the issue of DNACPRs, but outside of that the issue was not raised with him *"very often at all"*[43] by the time he became Cabinet Secretary.

Health and healthcare inequalities

[33] INQ000429278 - Policy document from NHS Scotland titled Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Integrated Adult Policy, dated August 2016
[34] Evidence of Professor Sir Gregor Smith, Transcript 11/146/10-14.
[35] INQ000429276 - Letter from the Primary Medical Services team to GP Practices and Chief Executives NHS Boards, titled Anticipatory Care Plans for Vulnerable and High Risk Patients, dated 10/04/2020
[36] Evidence of Professor Sir Gregor Smith, Transcript 11/151/14-16.
[37] Evidence of Fiona McQueen, Transcript 6/192/14-15.
[38] Evidence of Fiona McQueen, Transcript 6/192/12-13.
[39] Evidence of Fiona McQueen, Transcript 6/193/4-11.
[40] Evidence of Jeane Freeman, Transcript 34/65/3-12.
[41] Evidence of Jeane Freeman, Transcript 34/65/7 and 34/69/2-5.
[42] Evidence of Jeane Freeman, Transcript 34/66/12-14.
[43] Evidence of Humza Yousaf, Transcript 34/168/21 – 34/170/24.

27. Tackling health inequalities has long been a key mission for successive governments in Scotland. It is correct, as Ms Freeman has accepted, that in the early stages of the pandemic, formal Equalities Impact Assessments were not always performed, due to the emergency nature of the response. Yet, it would be wrong to assume that, even in those early stages, equalities were not a consideration in Scottish Government decision-making. There was *early* recognition in Scotland that measures taken to combat the spread of the virus would affect certain groups more than others.

28. The Four Harms, introduced in April 2020 within the '*Framework for Decision Making*', reflected the Scottish Government's understanding of the importance of the *wider harms* caused by COVID-19. It also understood that the harms were interlinked, and that *equality considerations* cut across all four areas. In other words, assessment of equality considerations was *built into* the Four Harms. It is therefore simply *not* the case, as has been suggested, that there was no reflection, or assessment, as to how decisions would affect the most vulnerable in society.

29. A prime example of Scottish Government decision-making that reflected equality considerations can be seen in the Shielding Programme. Early in the pandemic, there was an appreciation of the need to review the approach in Scotland to shielding. As a submission of May 2020 to Ministers explained[44], emerging clinical evidence suggested that broader risk factors existed, which were not taken into account by the advice to shield. These included age, ethnicity, disability, obesity and diabetes. As the submission stated, the ask to shield should be aligned to the evidence of risk. Instead of asking the whole cohort to shield regardless of personal circumstances or preferences, there was a need to move to a model where people could make informed decisions that balanced their individual risk with quality of life. A further submission later in May set out how the new approach to shielding would be achieved[45].

30. Shielding was paused on 31 July 2020, at which time the advice given to the shielding cohort became the same as that for the general public. The review of the Shielding Programme was *ipso facto* evidence of the Scottish Government's

[44] INQ000261982 - Submission from Orlando Heijmer-Mason (Shielding Team) to the First Minister, Deputy First Minister, Cabinet Secretary for Health and Sport and Chief Medical Officer, regarding the development of a new approach to shielding, dated 20/05/2020.
[45] INQ000261395 - Submission to the First Minister, Deputy First Minister and Cabinet Secretary for Health and Sport titled Shielding: Next steps, dated 29/05/2020.

awareness of equality considerations, and the impact of the virus, and measures taken to curtail its spread, on the most vulnerable in society.

31. Further evidence of such awareness existed in the two Equality Impact Assessments ("**EQIA**"s) that were carried out on the Shielding/Highest Risk List cohort. An interim EQIA in April 2020 highlighted the ways in which people with protected characteristics could be negatively impacted by the shielding policy. It set out recommendations to mitigate such impacts[46]. In November 2020, a retrospective EQIA was performed as a follow up to the interim report[47]. This EQIA discovered that certain negative impacts had arisen across certain groups as a result of the pandemic, whilst others had (potentially) arisen as a consequence of the shielding policies. These impacts included disadvantages for people, who faced challenges with literacy, in accessing communications about the shielding policy; victims of domestic violence who lived in refuges; homeless people; and people with insecure leases who faced changes of address. Thereafter, all shielding communications were made available in 'easy read' versions, British Sign Language, on videos and were translated into a number of languages. People whose domestic circumstances were uncertain or had changed, during the period when they were advised to shield, were made aware of the need to shield by their local authority or by their GP or clinical teams.

32. Acknowledging the point made by Ms Freeman, that it is *not only* through *formal* equality impact assessments that a government minister comes to understand equalities[48], formal assessments *did* become a regular part of Scottish Government decision making. However, as Mr Yousaf candidly recognised, had Cabinet heard *directly* from disabled peoples' organisations, it *may* have helped to inform decision making, particularly in removing NPIs[49]. Nevertheless, Ms Freeman did regularly engage with disability organisations. Such groups advocated for the promotion of the 'Social Model of Disability', which asserts that people are disabled by barriers in society, and not by their disability. This concept was well understood by the Scottish Government. One such engagement was referred to by Ms Freeman in evidence when, in about the summer of 2020 she sought, on behalf of Glasgow Disability Alliance and Inclusion Scotland, to

[46] INQ000256754 - Draft report from Healthcare Improvement Scotland titled An Equality Impact Assessment of the support required by people who are at clinically higher risk of severe illness from COVID-19 (Shielding Programme), dated 01/04/2020.

[47] INQ000147447 - Report from Scottish Government titled Equality Impact Assessment Record - Strategy Policy: People Who Are At Clinically Higher Risk of Severe Illness from COVID-19, undated.

[48] Evidence of Jeane Freeman, Transcript 34/83/8 – 18.

[49] Evidence of Humza Yousaf, Transcript 34/107/17 – 34/111/4.

resolve significant impacts on disabled people caused by the decision of local authorities to withdraw care packages[50].

33. As well as health inequalities arising from socioeconomic factors, the Scottish Government was alive at an early stage to the possibility of health inequalities, relating to COVID-19, arising as a result of ethnic or racial background. The Inquiry heard about some of the work of the 'Expert Reference Group for COVID-19 and Ethnicity' (established in June 2020)[51], the 'Racialised Inequalities in Health and Social Care in Scotland Steering Group', as well as efforts to improve the collection of data on ethnicity undertaken during the pandemic[52]. Ministers *did* engage with ethnic minority stakeholder groups, such as BEMIS[53] and, as Prof Bamrah said, with FEMHO[54]. However, as Mr Yousaf acknowledged, the data available on the experience, and impact, of the pandemic on ethnic minority groups was *"sub-optimal"*[55]. To that end, the Inquiry has heard evidence on the steps taken to improve data collection on ethnic minorities during the pandemic, including the establishment of the Anti-Racism Observatory, which will help to ensure that in the future Scotland has better access to data concerning ethnic minorities[56].

34. The Scottish Government does, however, note the evidence of Public Health Scotland, whose research concluded that although most, but not all, ethnic minority groups were at increased risk of adverse COVID-19 outcomes in Scotland, differences in hospital treatment (that is to say *healthcare inequalities*) did not substantially contribute to any ethnic inequalities[57]. None of the six reports produced by Public Health Scotland found that variations in healthcare quality (including access, effectiveness, and safety) contributed to variations in COVID-19 outcomes by ethnic group[58]. While there have been many explanations for the disproportionate impact of COVID-19 on ethnic minority communities, the Scottish Government is reassured that it does not appear that the operation of the health service in Scotland contributed materially to these impacts (and in fact may have ameliorated them somewhat).

---

[50] Evidence of Jeane Freeman, Transcript 34/91/20 – 34/93/9
[51] Evidence of Professor Sir Gregor Smith, Transcript 11/63/11 – 19.
[52] Evidence of Professor Nick Phin, Transcript 27/45/11 – 27/47/22.
[53] Evidence of Humza Yousaf, Transcript 34/111/13 – 34/119/19.
[54] Evidence of Professor Jaswinder Singh Bamrah, Transcript 18/17/24 – 18/19/14
[55] Evidence of Humza Yousaf, Transcript 34/112/6 - 15
[56] Evidence of Humza Yousaf, Transcript 34/115/7 – 19.
[57] Evidence of Professor Nick Phin, Transcript 27/43/7 – 27/45/9.
[58] Witness statement of Paul Johnston, Scott Heald and Nick Phin, INQ000401271 at §8.8.4.

Transmission Routes and Infection Prevention and Control

35. The Inquiry heard from Prof Beggs that by the end of September 2020, there was enough moderate evidence to suggest strongly that COVID-19 could be transmitted via the airborne route[59]. He conceded however that it was *"not beyond absolute doubt"*[60] at that stage.

36. The Scottish Government did not close its eyes to the possibility of aerosol transmission. From the beginning of the pandemic, Prof Sir Gregor Smith kept an open mind and was alive to the prospect of many potential routes of transmission[61]. He was aware of early observational studies that suggested some contribution from aerosol spread, although it was thought to be less significant than other routes[62]. Aerosol transmission was, from an early stage, considered as a potential route of transmission.[63] He thought the unequivocal statement from the WHO on 28 March 2020, that COVID-19 was not airborne, to be unhelpful[64].

37. As the evidence and understanding of the virus developed, so too did the advice of the CMO and the guidance from the Scottish Government. Sir Gregor gave evidence about his views on the *"less than helpful equivocal statement from WHO this morning on airborne spread"*[65]. This WHO statement, of 7 July 2020, which acknowledged that there was some evidence to suggest aerosol transmission could not be ruled out in crowded, enclosed or poorly ventilated spaces, was raised directly with Ministers at a Cabinet Meeting on 8 July 2020[66]. Sir Gregor explained that his view at this time was still that the contribution of aerosol transmission, on the basis of the available evidence, was very small[67]. However, he noted that *"if it was confirmed it was a significant contributor to transmission"* then there would be a need to emphasise different measures, in particular ventilation[68].

38. This was not a situation, as some have suggested, in which it was appropriate to apply "the precautionary principle". Sir Gregor was clear that it would have been

[59] Evidence of Professor Beggs, Transcript 3/111/3-9
[60] Evidence of Professor Beggs, Transcript 3/111/15.
[61] Evidence of Professor Sir Gregor Smith, Transcript 11/35/4-24.
[62] Evidence of Professor Sir Gregor Smith, Transcript 11/35/19-24.
[63] Evidence of Professor Sir Gregor Smith, Transcript 11/38/15-16.
[64] Evidence of Professor Sir Gregor Smith, Transcript 11/36/15.
[65] Evidence of Professor Sir Gregor Smith, Transcript 11/40/21 – 11/41/21; 11/43/3 – 11/46/12.
[66] INQ000078557 - Minutes of a meeting between Scottish Cabinet colleagues, titled SC(20)28th Conclusions, dated 08/07/2020.
[67] Evidence of Professor Sir Gregor Smith, Transcript 11/47/9-10.
[68] Evidence of Professor Sir Gregor Smith, Transcript 11/48/9-16.

inappropriate[69]. His view was that the *"gains which would be made by applying those additional measures would be so small that it would be a disproportionate response"*[70]. It is submitted that Prof Sir Chris Whitty remains correct to state that the precautionary principle *"is only a useful principle where there are no downsides, otherwise you're talking about balance of risk and balance of risk is a different concept"*[71].

39. Sir Gregor went on to discuss a Ministerial submission of 4 August 2020[72], which specifically acknowledged aerosol as a possible route of transmission. It is simply not the case that the Scottish Government did not acknowledge, or has not acknowledged, this possibility.[73] However, it was thought at the time to be unlikely to be the dominant route.

40. Through 2021, as the evidence in this respect became less uncertain, Sir Gregor explained that there was greater emphasis given to the benefits of good ventilation and meeting outdoors to reduce the risk of aerosol spread[74]. He also noted that this contributed to the *"cautious approach to re-opening more slowly perhaps than other parts of the UK"*[75] and advice with *"a much stronger emphasis on some of the environments that were felt to be at higher risk because of the lack of ventilation and the crowded nature of them"*[76]. Jeane Freeman noted the use of HEPA filter machines to deal with ventilation problems in the older part of the NHS estate in Scotland, and she understood those concerns had been resolved[77].

41. That said, there continues to be scientific disagreement on the contribution made by aerosol spread[78]. Although Prof Beggs' view, on current evidence, is that while he considers there to be more aerosol transmission than droplet, he could not give precise figures[79]. We note Prof Beggs' view that the infectious particles of COVID-19 were mostly generated deep in the lungs and the vocal chords (although this was said to be

[69] Evidence of Professor Sir Gregor Smith, Transcript 11/49/16-19.
[70] Evidence of Professor Sir Gregor Smith, Transcript 11/52/11-15.
[71] Evidence of Professor Sir Chris Whitty, Transcript 12/142/8-12.
[72] INQ000380368 - Submission from the Covid Public Health Directorate to the First Minister, Deputy First Minister, and Cabinet Secretary for Health and Social Care, regarding COVID-19: expanding mandatory face coverings to indoor public premises and updating general public guidance, dated 04/08/2020
[73] Witness statement of Dr Barry Jones, INQ000273913 at §412.
[74] Evidence of Professor Sir Gregor Smith, Transcript 11/58/25 - 11/59/3.
[75] Evidence of Professor Sir Gregor Smith, Transcript 11/60/2-4.
[76] Evidence of Professor Sir Gregor Smith, Transcript 11/60/4/7.
[77] Evidence of Jeane Freeman, Transcript 24/23/4-11.
[78] Evidence of Professor Sir Chris Whitty, Transcript 12/140/3-5.
[79] Evidence of Professor Beggs, Transcript 3/167/7-10.

"not 100% clear cut"[80]), and thus he considered aerosols were more likely to contain COVID-19 than droplets. Dr Lisa Ritchie, on the other hand, considered the opposite[81]. We do not highlight this to seek to engage in a 'battle of the experts'. We simply wish to acknowledge that there remains reasonable and good faith scientific disagreement about this topic.

42. This is an area where research is ongoing. We note that ARHAI produced a "Transmission Based Precautions (TBPs) Definitions Literature Review" in August of this year[82]. The WHO's current position is that maintaining a strict dichotomy between droplet and aerosol transmission, with reference to particle size, is unhelpful. Rather, the descriptor *'through the air'* might be used in a general way to characterise an infectious disease, where the main mode of transmission involves the pathogen travelling through or being suspended in the air. Laura Imrie confirmed that this is a position that ARHAI supports[83]. However, as Prof Sir Chris Whitty noted, perhaps the more practical question for the purposes of IPC measures is whether a pathogen is *"a near field risk or far field risk"*[84].

43. As Sir Gregor noted, throughout the pandemic, IPC guidance was *"kept under continual review"*[85], although it was at first the UK Government and then ARHAI that held and maintained the IPC guidance for Scotland[86]. The Inquiry heard from Laura Imrie about how hard the team at ARHAI worked over the course of the pandemic, in reviewing evidence and ensuring the guidance was up to date and correct[87]. The view of former CNO Fiona McQueen, based on staff feedback, was that the initial use of UK-wide IPC guidance was *"confusing"*[88]. However, as Caroline Lamb noted, Scotland in general adopted the same measures as the rest of the UK but took steps to contextualise some of the advice for a Scottish context[89]. She did note, however, there were some slightly different approaches in Scotland taken in terms of occupational risk assessment and personal preference in terms of PPE[90].

---

[80] Evidence of Professor Beggs, Transcript 3/51/21-24.
[81] Evidence of Dr Lisa Ritchie, Transcript 5/149/18.
[82] Publicly available - https://www.nipcm.scot.nhs.uk/media/2306/2024-08-19-tbp-literature-evidence-review-final-v40.pdf
[83] Evidence of Laura Imrie, Transcript 26/117/2-12.
[84] Evidence of Professor Sir Chris Whitty, Transcript 12/138/19-20.
[85] Evidence of Professor Sir Gregor Smith, Transcript 11/60/4/7.
[86] Witness statement of Caroline Lamb #8, INQ000485979 at §419
[87] Evidence of Laura Imrie, Transcript 26/116/2-20.
[88] Evidence of Fiona McQueen, Transcript 6/178/17 - 6/179/8.
[89] Evidence of Caroline Lamb, Transcript 32/44/10-17.
[90] Evidence of Caroline Lamb, Transcript 32/44/18-22.

44. In terms of the Scottish Government's role with respect to IPC guidance, Caroline Lamb explained that there was a COVID-19 Nosocomial Review Group ("**CNRG**") which was accountable to the Scottish Government through the CNO. The CNRG played a role in advising on specific aspects of IPC, particularly in the hospital context, although Ms Lamb's recollection was that it was ARHAI that was predominantly providing IPC advice[91]. (In fact, while ARHAI supported a review of the evidence, which was considered by the CNRG, it was predominantly the CNRG that provided IPC advice and recommendations to the Scottish Government). Fiona McQueen noted that, as a nurse with a generalist background, she relied on ARHAI's expertise completely.[92] Ms Lamb's evidence was that advice would be given to Ministers about when and why IPC guidance or advice was changing and that they were *"very keen to ensure that they were aware of that"*[93]. This was so that Ministers could make sure their public communications were in line with the latest scientific advice[94]. Rather than having a direct role in formulating or approving IPC guidance, SG's role was more about communicating updates in IPC guidance in a *"consistent and coherent"*[95] manner to stakeholders like Health Boards and trade unions, as well as the general public.

PPE

45. The Scottish Government recognises that the droplet 'v' aerosol debate was not academic or inconsequential, to the extent that it led to some anxiety amongst healthcare workers who felt that they were not being provided with appropriate PPE. Humza Yousaf gave evidence about being lobbied by a variety of groups during his time as Cabinet Secretary to change from using FRSM to FFP3 masks[96]. The Inquiry has heard from witnesses who have advocated for more extensive use of FFP3 masks, as well as those who have argued the contrary. It has been a dominant, and often divisive, topic in these oral hearings.

46. As with the relative importance of aerosol transmission, the efficacy and appropriateness of the wider use of FFP3s remains subject to reasonable and good faith scientific disagreement. Prof Beggs' view, despite his position on the relative importance of aerosol transmission, was nuanced on the topic. He characterised FRSMs as *"good*

[91] Evidence of Caroline Lamb, Transcript 32/45/2-7.
[92] Evidence of Fiona McQueen, Transcript 6/181/7.
[93] Evidence of Caroline Lamb, Transcript 32/45/14-15.
[94] Evidence of Caroline Lamb, Transcript 32/45/15-17.
[95] Evidence of Caroline Lamb, Transcript 32/46/19-20.
[96] Evidence of Humza Yousaf, Transcript 34/126/22 - 34/127/11.

utility but not effective against airborne", while FFP3s were *"very effective but not good utility, they're difficult, they come with baggage"*[97]. He suggested that FFP2 masks might provide a middle ground[98]. Dr Ben Warne's view was that although FFP3 masks would have provided greater protection, the extent to which their widespread use by healthcare workers would have reduced nosocomial infections amongst that group is unclear[99]. Laura Imrie was more emphatic that the use of FFP3 would have had *"no impact whatsoever in nosocomial infections"*[100]. Prof Susan Hopkins considered the evidence that FFP3s protected more than FRSMs to be *"weak"*[101] and she noted the *"significant harms"* that prolonged wearing entailed[102].

47. Given the potential for such significant harms, the simple answer that FFP3s ought to have been mandated on the application of the 'precautionary principle' is not appropriate, as Prof Sir Gregor Smith noted[103]. No Scottish Government witness considered that FFP3s ought to have been mandated in circumstances other than they were. Contrary to the suggestion by some, Caroline Lamb was clear that she did not recall *"any circumstances when supply constraints were part of the conversation about what PPE should be available"*[104].

48. However, the Scottish Government saw the real difficulties this issue was causing for some healthcare workers, who felt that they were not being provided with sufficient protection. As spoken to in evidence by Ms Lamb, there were occasions (the first as early as May 2020) when the Scottish Government recognised the personal preference of health care workers to wear an FFP3 mask and issued guidance accordingly[105]. The CNO and CMO issued a letter on 20 May 2020, which sought to provide a *"pragmatic solution"* to ensure worker and patient safety[106]. This allowed the use of *inter alia* FFP3s when undertaking CPR if the healthcare worker wished. Humza Yousaf explained that on 13 January 2022 he requested an evidence paper on the use of FFP3s, which led on 19 April 2022 to the introduction of a discretionary access policy in respect of FFP3

[97] Evidence of Professor Beggs, Transcript 3/178/21-23.
[98] Evidence of Professor Beggs, Transcript 3/181/22 – 3/182/1.
[99] Evidence of Dr Ben Warne, Transcript 8/46/10 – 8/47/4.
[100] Evidence of Laura Imrie, Transcript 26/193/3-4.
[101] Evidence of Professor Susan Hopkins, Transcript 7/83/1-2.
[102] Evidence of Professor Susan Hopkins, Transcript 7/83/19.
[103] Evidence of Professor Sir Gregor Smith, Transcript 11/52/11-15.
[104] Evidence of Caroline Lamb, Transcript 32/69/24 - 32/70/1.
[105] Evidence of Caroline Lamb, Transcript 32/57/13-20.
[106] INQ000477445 - Letter from the Chief Nursing Officer, Chief Medical Officer, National Clinical Director, providing a position statement on guidance for personal protective equipment (PPE) and aerosol generating procedures (AGP) dated 20/05/2020.

based on healthcare worker preference[107]. Ultimately, however, as CTI noted, this was *"not an IPC measure per se, but a step taken to improve the confidence and well-being of staff"*[108]. Although it was suggested to Mr Yousaf that it was a step that could have been taken sooner, he explained that the issue *"came to a head towards the end of 2021 and the beginning of 2022"*, which prompted his action[109]. For completeness, the use of FFP3 masks by health care workers, according to personal preference, is now included in Chapter 2 of the National Infection Prevention and Control Manual. This states that *'Where staff have concerns, they may choose to wear an FFP3 respirator rather than a fluid-resistant surgical mask (FRSM) when providing patient care, provided they are fit tested. This is a personal PPE risk assessment.'*[110]

49. NHS National Services Scotland ("**NSS**") was delegated the responsibility for procuring and distributing PPE on behalf of the Scottish Government. We recognise that, notwithstanding every effort made by NSS to procure sufficient PPE in the midst of a global shortage, parts of the Healthcare system had, as Ms Freeman put it, concerns about *"getting their hands on PPE that I knew we had"*[111]. At the beginning of the pandemic there were clearly issues for workers on the ground. This was spoken to in evidence, *inter alia*, by Rozanne Foyer from the STUC, and Prof Colin McKay from Greater Glasgow Health Board. Prof McKay confirmed that there was *"never a scenario where we actually ran out of PPE as per national guidance"*, although there were times when they were *"looking at having no more than one or two days' supply"* which, understandably, caused anxiety[112]. Jeane Freeman accepted that *"at times healthcare workers in Scotland treating Covid patients did not have the ease of access to PPE that I would expect them to have, and those were the issues that I set out to resolve"*[113].

50. The Scottish Government reacted quickly to these issues. For example, Jeane Freeman noted her approval of the use of time-expired PPE stock that had passed stringent Quality Assurance tests on 24 March 2020[114]. She explained that she had *"regular meetings with the trade unions"* which allowed any safety concerns to be raised directly with her[115]. She received a daily stock update which allowed her to properly question

---

[107] Evidence of Humza Yousaf, Transcript 34/126/22 - 34/127/22.
[108] Evidence of Humza Yousaf, Transcript 34/129/2-3.
[109] Evidence of Humza Yousaf, Transcript 34/129/12-13.
[110] INQ000413473, Guidance from National Infection Prevention and Control Manual titled 'Chapter 2 – Transmission Based Precautions (TBPs)', undated.
[111] Evidence of Jeane Freeman, Transcript 34/34/16-17.
[112] Evidence of Prof Colin McKay, Transcript 32/16/18-23.
[113] Evidence of Jeane Freeman, Transcript 34/36/20-23.
[114] Evidence of Jeane Freeman, Transcript 34/25/7.
[115] Evidence of Jeane Freeman, Transcript 34/28/8-18.

those handling procurement and supply of PPE[116]. In April 2020, a helpline was set up, so that healthcare workers could report problems themselves directly, but also to ensure there was follow through. Ms Freeman gave a minister the specific task of ensuring issues were being resolved but also to identify trends[117]. This enabled issues to be raised, heard, and quickly acted on. Prof Sir Gregor Smith's view was that this *"helpline appeared to be working well in terms of being able to address some of the concerns"*[118]. As Mr Yousaf noted, by the time he was Cabinet Secretary, any issues around PPE were *"very kind of individual nuanced issues"* and that *"issues around supply, test, durability of PPE, those were not issues that came up with any great frequency at the time I was health secretary"*[119].

51. The Scottish Government also recognised the difficulties with face fit-testing, particularly for women and ethnic minorities[120]. Concerns were listened to, taken seriously, and concerted efforts were made to improve the PPE provided. 'Smaller fit' masks were sought out and acquired. Funding was provided to Boards to allow them to acquire items such as powered respirators, where FFP3s could not be used by an individual. As Prof Sir Gregor Smith noted, in June 2020 the Scottish Government established an *'Expert Reference Group on COVID-19 and ethnicity'*, to understand better not only the impact on Black, Asian and ethnic minority people, but also some of the broader impacts that related to ethnicity across society[121].

52. As Ms Lamb told the Inquiry, in March, May and July 2020, guidance was produced that required Health Boards as employers to ensure that risk assessments were performed for individual health workers who may be particularly vulnerable, including BAME staff[122]. In October 2020 the Scottish Government published a 'PPE Action Plan', which recognised the challenges faced by such individuals, and detailed the ongoing work to resolve this issue[123]. By March 2021, NHS National Services Scotland were providing at least eight different models of FFP3 mask to ensure that the majority of healthcare workers could be provided with a mask that fitted[124].

---

[116] Evidence of Jeane Freeman, Transcript 34/30/3-12.
[117] Evidence of Jeane Freeman, Transcript 34/32/10-22.
[118] Evidence of Professor Sir Gregor Smith, Transcript 11/112/15-16.
[119] Evidence of Humza Yousaf, Transcript 34/120/5-7.
[120] e.g. Evidence of Jeane Freeman, Transcript 34/35/10-16; Evidence of Caroline Lamb, Transcript 32/54/7-13.
[121] Evidence of Professor Sir Gregor Smith, Transcript 11/63/11-15.
[122] Evidence of Caroline Lamb, Transcript 32/50/20 – 35/51/11.
[123] Evidence of Caroline Lamb, Transcript 32/83/20 – 32/85/7.
[124] Evidence of Caroline Lamb, Transcript 32/84/22-24.

53. From 2021, through the 'PPE Futures Programme' and the 'PPE Supply Implementation Project', the Scottish Government sought to learn lessons from the pandemic and to incorporate them into future policy. The work and findings of these bodies is being progressed by National Services Scotland ('NSS') and Scottish Government policy teams. The key lessons to guide future work include the following: effective mechanisms have to exist for collaboration and communication between the Scottish Government and stakeholders (particularly in respect of real time data sharing, stockpile management and prioritisation of PPE supply where it is most needed); a reformed stockpiling and buying approach for pandemic PPE is required; long term and sustainable PPE supply arrangements are required for the primary care sector; and surge capacity needs to be available to ensure that anticipated PPE demand is met during the volatile, early stages of any future pandemic.

54. Caroline Lamb touched on the concrete steps that have been taken in Scotland to learn lessons from the pandemic, and to strengthen the PPE supply situation for the future. Scotland has significantly increased the amount of PPE held, broadened out supply routes, moved away from a 'just-in-time' model, and improved data systems[125]. In her evidence, it was suggested by Ms Freeman[126], and endorsed by Matt Hancock in his evidence[127], that to avoid stock expiring, there ought to be a 'rolling programme'. In fact, the Scottish Government has asked NSS to manage the PPE stockpile in this way.

55. In her evidence, Laura Imrie mentioned a proposal that had been submitted to the Scottish Government by NSS, regarding inter alia 'mandatory face fit testing'[128]. The Scottish Government can confirm that on 9 April 2024, a situational assessment on FFP3s was sent by NSS to the Chief Nursing Officer Directorate. NSS had found that key stakeholders supported a national standardised approach to both frequency of testing and record keeping in secondary care. The report recommended inter alia that the Scottish Government supports a 'Once for Scotland' approach to these matters. The Scottish Government has since asked NSS to carry out further work around their assessment, and to consider a number of issues, including their specific recommendations for face fit testing.

56. The situation in respect of PPE as a whole was well summed up by Fiona McQueen who noted, *"early on in the pandemic we would have been much better to have a better*

[125] Evidence of Caroline Lamb, Transcript 32/82/1-23.
[126] Evidence of Ms Freeman, Transcript 34/26/02 – 14.
[127] Evidence of Matt Hancock, Transcript, 36/119/03 – 05.
[128] Transcript, 26/181/12 – 26/182/5.

supply of PPE"[129] but that *"My understanding that every single person who needed an apron, a mask, a pair of gloves, a gown, got one. And there was a heroic effort from managers moving supply from ward to ward, sometimes from hospital to hospital, so that my understanding is that everyone had the PPE that they needed, but it was complex and challenging"*[130].

Shielding

57. The concept of 'shielding' was a completely new strand of health policy[131]. A timeline of decisions and guidance pertaining to this policy is produced within Caroline Lamb's 8th Statement[132]. As can be seen, it was developed and implemented at pace. Given this pace, as noted above, it was not possible to carry out an EQIA in advance[133]. However, an interim EQIA dated 1 April 2020 was produced[134], as well as a retrospective EQIA in November 2020[135].

58. The clear and stated policy intent was to identify, protect and support people considered to be at highest risk of severe illness or death from COVID-19[136]. By doing this, the programme aimed to reduce the risk of infection, severe illness, and death amongst that group[137].

59. The formulation of the policy was led by the four UK CMOs, with the support of their deputy CMOs and respective teams. This was a good, early example of effective Four Nations working in respect of the healthcare response to COVID-19. As Prof Sir Gregor Smith put it in his statement, the four UK CMOs "*enjoyed exceptionally good and productive professional relationships*"[138].

60. On 18 March 2020, agreement was reached between the four UK CMOs on the initial groups who were to be included on the 'shielding list':

---

[129] Evidence of Fiona McQueen, Transcript 6/202/9-11.
[130] Evidence of Fiona McQueen, Transcript 6/201/10-16.
[131] Witness statement of Caroline Lamb #8, INQ000485979 at §795.
[132] Witness statement of Caroline Lamb #8, INQ000485979 at §879. This statement at §795 – 916 provides considerable detail on both the decisions pertaining too, and operation of, the Shielding/Highest Risk List in Scotland.
[133] Witness statement of Jeane Freeman #3, INQ000493484 at §256.
[134] INQ000256754 - Draft report from Healthcare Improvement Scotland titled An Equality Impact Assessment of the support required by people who are at clinically higher risk of severe illness from COVID-19 (Shielding Programme), dated 01/04/2020.
[135] INQ000147447 - Report from Scottish Government titled Equality Impact Assessment Record - Strategy Policy: People Who Are At Clinically Higher Risk of Severe Illness from COVID-19, undated
[136] Witness statement of Caroline Lamb #8, INQ000485979 at §797.
[137] Witness statement of Caroline Lamb #8, INQ000485979 at §799
[138] Witness statement of Prof Sir Gregor Smith #2, INQ000484783 at §14.

Group 1 - Solid organ transplant recipients

Group 2 - People with specific cancers

Group 3 - People with severe respiratory conditions

Group 4 - People with rare diseases

Group 5 - People on immunosuppression therapies which increased risk of infection

Group 6 - People who are pregnant and have significant heart disease

61. On 21 March 2020, a submission was put to Ministers seeking their agreement to a "*high level approach to the delivery of support to people with the highest risk of severe illness from COVID-19 in taking measures to shield themselves*" [139]. This submission was approved and the 'Shielding Programme' was commenced. By July 2020 a new 'Shielding Division' was created within the Directorate for Population Health, one of the Health and Social Care Directorates ultimately accountable to the Director-General Health and Social Care ("**DG HSC**"). In June 2021, when the 'Shielding List' was renamed the 'Highest Risk List'[140], the division became the 'Covid Highest Risk Division'.

62. One nuance to the early approach in Scotland was the inclusion of a seventh 'Clinician Identified' group, alongside the six groups specified by the 4 UK CMOs[141]. This allowed clinicians, and GPs in particular, to exercise their own professional judgement in adding patients to the list who they felt were at risk, but who did not meet any of the stated criteria. As Prof Sir Gregor Smith noted in his oral evidence, this allowed for a *"greater degree of flexibility"*[142]. Sir Gregor felt this was *"important"*[143], "*worked well for Scotland*"[144] and in particular for those with *"neurological conditions such as motor neurone disease"*[145].

63. Initially around 136,000 individuals were identified and added to the Shielding List[146]. The numbers on the list were not static and for most of its existence there were around 180,000 – 185,000 individuals on the list. At the time that the Highest Risk List was ended on 31 May 2022 there were 175,193 people on it. Over the course of the Relevant

[139] INQ000261358 - Submission from Donna Bell (Director, Covid19 Response) regarding Support for vulnerable people who are shielding, dated 21/03/2020.
[140] INQ000243054 - Paper from Shielding Division to Nicola Sturgeon (First Minister) and Humza Yousaf (Cabinet Secretary for Health and Social Care) titled Post-Shielding Narrative and Groups Requiring Support, dated 21/06/2021.
[141] Witness statement of Caroline Lamb #8, INQ000485979 at §821.
[142] Evidence of Professor Sir Gregor Smith, Transcript 11/116/25 - 11/117/1
[143] Evidence of Professor Sir Gregor Smith, Transcript 11/117/21
[144] Evidence of Professor Sir Gregor Smith, Transcript 11/121/18
[145] Evidence of Professor Sir Gregor Smith, Transcript 11/122/2-3
[146] Witness statement of Caroline Lamb #8, INQ000485979 at §820.

Period there were 216,710 people who were at some point on the Shielding/Highest Risk List[147].

64. The Inquiry has heard contrasting evidence about the effectiveness of the shielding programme. We note that Prof Snooks, in her oral evidence, adhered to her conclusion that she would not recommend a shielding policy in a future pandemic because it was not effective in terms of reduced infections or COVID-19 related mortality.[148] We also note the criticisms of this conclusion advanced via questions by counsel for the UKHSA[149] and the technical and methodological issues identified by Prof Sir Chris Whitty in trying to draw any proper conclusion from the evidence[150]. Leaving aside these technical disputes, the Scottish Government considers that Prof Sir Gregor Smith put it well when he said that, on the basis of the evidence available in March 2020, implementing a shielding programme was a "*rational way of trying to protect people who were recognised as being at additional risk*"[151].

65. As with so much of the healthcare response, the shielding programme was about balancing competing risks and harms. It was not lost on Ministers that strict isolation could negatively affect people's mental health and physical wellbeing[152]. In light of the EQIA in April 2020 and feedback received via early research, by May 2020 these foreseeable impacts appeared to be being borne out in the experience of many who were shielding.

66. In response to this the Scottish Government took a number of actions. The Inquiry heard from Nick Phin who discussed the evaluation framework, published in May 2020, that Public Health Scotland ("**PHS**") was commissioned to develop by the Scottish Government[153]. This work resulted in:
    a. a phase one impact and experience survey carried out between 1 – 14 June 2020, with its findings published on 23 September 2020[154];
    b. a rapid evaluation published on 27 January 2021[155]; and

[147] Witness statement of Caroline Lamb #8, INQ000485979 at §823.
[148] Evidence of Professor Helen Snooks, Transcript 23/151/2 - 23/152/20.
[149] Evidence of Professor Helen Snooks, Transcript 23/154/6 - 23/159/14.
[150] Evidence of Professor Sir Chris Whitty, Transcript 12/129/6 - 12/131/1.
[151] Evidence of Professor Sir Gregor Smith, Transcript 11/130/1-2.
[152] Witness statement of Jeane Freeman #3, INQ000493484 at §260.
[153] INQ000147581 - Report titled, Scottish Government shielding programme evaluation framework, dated 21/05/2020.
[154] INQ000147532 - Report from Public Health Scotland, titled Covid-19 shielding programme (Scotland) impact and experience survey, dated September 2020.
[155] INQ000202564 - Report from Public Health Scotland titled COVID-19 Shielding Programme (Scotland) Rapid Evaluation, dated 2021

c. a phase two impact and experience survey carried out between 25 October – 7 November 2021, with its findings published on 30 March 2022[156].

67. The rapid evaluation published on 27 January 2021 was positive about the fact that a "*comprehensive programme was set up, at speed, despite the logistical challenges involved*"[157]. However, PHS noted that "*Shielding was challenging and at times impossible for people*"[158]. Ultimately, the evaluation considered that "*a repeat of the shielding programme, **in its initial format**, is not recommended for future crisis situations"*[159].

68. However, by May 2020, the Scottish Government had already decided to move away from this initial approach to shielding[160], and after the initial pause to shielding on 31 July 2020, this form of 'strict shielding' was not revisited[161]. Instead there was a move towards *"a more risk-based strategy"*[162], that was more *"person-centred"*[163]. This recognised the potential harms of shielding and was a reflection of a more rights-based approach. As Jeane Freeman put it, *"individuals have a right to make decisions about themselves, and their own lives and how they will live"*[164]. The role of government is to provide advice and information to people, to allow them to make informed decisions.

69. As the pandemic progressed, the Scottish Government aimed to avoid what was described by some as *"cliff edge"*[165], with support ending abruptly. Although advice changed as the situation did, it was not the case in Scotland that shielding was simply "*paused in April 2021 and never resumed*"[166]. Indeed, the Highest Risk List was not closed in Scotland until 31 May 2022.

70. The Scottish Government agrees with Prof Sir Chris Whitty that whether or not a form of Shielding Programme would be appropriate in a future pandemic will depend on the

---

[156] INQ000147531 - Report from Public Health Scotland, titled Covid-19 shielding programme (Scotland) impact and experience survey - part two, dated 30/03/2022
[157] INQ000202564_0070.
[158] INQ000202564_0070.
[159] INQ000202564_0068 (original emphasis retained).
[160] See Ministerial Submissions on 20 May 2020 INQ000261982 and 29 May 2020 INQ000261395, as well as INQ000233328 - Presentation from Scottish Government CMO Advisory Group, titled Shielding Scientific and Behavioural Science Considerations, dated 15/05/202.
[161] Evidence of Professor Sir Gregor Smith, Transcript 11/133/3-4.
[162] Evidence of Professor Sir Gregor Smith, Transcript 11/133/7.
[163] Evidence of Caroline Lamb, Transcript 32/144/24.
[164] Evidence of Jeane Freeman, Transcript 34/63/20-22.
[165] Evidence of Professor Sir Chris Whitty, Transcript 12/207/24.
[166] Statement of Dr Catherine Finnis, INQ000409574 at §4.

situation[167]. Certainly, if there is a situation where a section of the population might rationally require effectively to isolate themselves from wider society in order to protect themselves, then having some form of government backed support framework will inevitably be required. The Scottish Government notes the evidence of Dr Catherine Finnis as to the benefits she saw of the "*passporting aspect*"[168] of the Shielding List, in terms of being able to work from home or eligibility for statutory sick pay. There was also the tangential benefit of the risk stratification exercise, built on by the QCovid tool, which would come to be important when it came to vaccination prioritisation[169].

71. Prof Sir Gregor Smith[170] and Caroline Lamb[171] both agreed in their oral evidence that, were they in the same position again, they would have placed greater emphasis on putting in place additional mental health support. While the Scottish Government submits that it was both reasonable and well intentioned to implement the Shielding Programme as it did, we recognise that it was incredibly difficult for many people. While, and without doubt, there was a need to put in place mechanisms to support those at highest risk of direct COVID-19 harm, the downsides are also well demonstrated, and would be something that policymakers would have to consider very carefully in any future pandemic.

Long Covid

72. It is easy to say with hindsight that different viruses produce different long-term sequelae. But, as Prof Sir Gregor Smith frankly acknowledged, Scotland was not prepared to deal with either the volume or type of long-term sequelae that COVID-19 produced[172].

73. Sir Gregor noted that in July 2020 he first gave advice to the Scottish Government to start work to try to understand the potential different symptoms and syndromes that came to be known as "Long Covid", in order to develop an evidence base that might inform a *"more cohesive longer-term approach"*[173]. It is accepted that it took until December 2020 for a guideline to be produced, but this perhaps reflects the uncertainty and need for further research. Several teams in the Scottish Government were working

[167] Evidence of Professor Sir Chris Whitty, Transcript 12/131/17-20.
[168] Evidence of Dr Catherine Finnis, Transcript 18/90/25,
[169] Evidence of Professor Sir Chris Whitty, Transcript 12/131/7-12.
[170] Evidence of Professor Sir Gregor Smith, Transcript 11/131/4-6.
[171] Evidence of Caroline Lamb, Transcript 32/145/4-6.
[172] Evidence of Professor Sir Gregor Smith, Transcript 11/75/10-12.
[173] Evidence of Professor Sir Gregor Smith, Transcript 11/66/8-16.

on different approaches to supporting people who had ongoing symptoms[174]. As Jeane Freeman noted the guideline *"was largely a non-evidence based… as the evidence on Long Covid was continuing to emerge"*[175]. Indeed, in October 2020 the Chief Scientist Office for the Scottish Government launched a funding call seeking applications which aimed to investigate the longer-term effects of COVID-19, which resulted in nine projects being funded with a total funding commitment of £2.5 million[176].

74. Recognising that Long Covid comprises a number of different syndromes, and that it is consequently not straightforward either to diagnose or to treat, fairly significant steps have been taken to redress the balance in Scotland. Jeane Freeman explained how she met with Chest Heart & Stroke Scotland in January and February 2021, and discussed Long Covid with the BMA[177]. A mapping exercise was undertaken by NSS in July 2021 to identify how NHS boards were supporting people with Long Covid[178]. Humza Yousaf spoke about the *"valuable"*[179] meetings he had with Long Covid Kids Scotland in November 2021 and June 2022.

75. A Long Covid support fund of £10 Million was established in September 2021[180], from which Health Boards can access funds to use as they deem appropriate for their populations, to deliver the best models of care. Prof Sir Gregor Smith's view was that this led to a *"much more consistent approach to the way that these services would be designed and delivered within each of the boards supported by that level of funding"*[181]. Caroline Lamb explained that the Scottish Government considered that central funding would assist the Health Boards in providing services to suit their local circumstances, recognising that *"there isn't a one-size-fits-all in relation to Long Covid provision"*[182]. Humza Yousaf's view was that, while there was nothing stopping individual Health Boards setting up a dedicated Long Covid clinic, the feedback he had received was that these were *"essentially creating a middleman" and "an additional stage and step somebody has to go through in order to get treatment"*[183]. The aim, as Mr Yousaf put it, was to take "*a nuanced and local approach*"[184]. Following a question from the Chair, Mr

[174] Witness statement of Dr Safia Qureski, Director of Evidence and Digital on behalf of the Scottish Intercollegiate Guidelines Network (SIGN), INQ000409591, at §79.
[175] Witness statement of Jeane Freeman, INQ000493484 at §216.
[176] Evidence of Caroline Lamb, Transcript 32/131/21 – 32/132-2.
[177] Evidence of Jeane Freeman, Transcript 34/57/6 – 34/59/17.
[178] Evidence of Humza Yousaf, Transcript 34/143/14 - 34/144/1.
[179] Evidence of Humza Yousaf, Transcript 34/180/24.
[180] Evidence of Professor Sir Gregor Smith, Transcript 11/71/6-12.
[181] Evidence of Professor Sir Gregor Smith, Transcript 11/72/7-9.
[182] Evidence of Caroline Lamb, Transcript 32/133/16 – 32/134/12.
[183] Evidence of Humza Yousaf, Transcript 34/147/1 and 34/147/8-9.
[184] Evidence of Humza Yousaf, Transcript 34/147/22.

Yousaf clarified that although he had accepted that the position prior to the support fund could be described as *'postcode lottery'*, really what he meant was that following the allocation of central funding they were seeking to bring a national minimum standard[185].

76. Mr Yousaf's view was that despite considerable work behind the scenes, more could have been done to communicate that to the public[186]. To that end, we note that all 14 territorial Health Boards in Scotland now have rehabilitation and clinical pathways for Long Covid patient referrals[187]. A pathway has also been published for children and young people[188]. This builds on information that was produced by the Scottish Government for healthcare professionals and NHS Boards on the assessment, management and referral of children and young people with long COVID. That was published in in May 2022, nine months *before* the WHO first published a clinical-case definition for post COVID-19 condition in children and adolescents. However, as Caroline Lamb[189] and Humza Yousaf[190] candidly accepted, these pathways could ideally have come sooner.

Access to and the Use of 999/111/NHS 24 Services

77. In Scotland, during the pandemic there was a significant operational shift within NHS 24. It had to develop a complete system response, and to transform completely its service delivery model, so as to cope with the additional pressures and asks that were placed on it. Since then, the service has expanded from what was largely an out-of-hours service, to one that provides 24/7 access to urgent care, dental advice, a dedicated Mental Health Hub and a national COVID-19 pathway. In addition to this, the service also now plays a key role in the re-design of unscheduled care, in that patients are asked to use NHS 24 as the first point of contact if they feel they need to access A&E, but their condition is not an immediate emergency. This has resulted in a significant increase in demand which has required a correspondingly significant investment in estates, workforce, and infrastructure[191].

78. Prior to the pandemic, the Scottish Government had been looking at a Scandinavian model whereby, rather than individuals presenting to A&E, the person would telephone

[185] Evidence of Humza Yousaf, Transcript 34/149/8 - 34/151/2.
[186] Evidence of Humza Yousaf, Transcript 34/151/10 - 34/152/20.
[187] Evidence of Caroline Lamb, Transcript 32/137/22-25.
[188] Evidence of Caroline Lamb, Transcript 32/138/24-25.
[189] Evidence of Caroline Lamb, Transcript 32/137/25 - 32/138/1.
[190] Evidence of Humza Yousaf, Transcript 34/181/21 - 34/182/7.
[191] Witness statement of Caroline Lamb #8, INQ000485979 at §674.

a number and receive an appointment to be seen. Given the pandemic and the need to keep people away from A&E, and the recognition that there are often other routes for them to receive the necessary care, the implementation of this model was accelerated. NHS24 was moved from predominately an out of hours service to triage 'in hours' as well. 'Flow Navigation Centres' ('FNCs') were also set up, the idea being that you would call NHS24 if your condition was not life threatening, and be given advice on options for care. Since the programme launched in winter 2020, FNCs have been established in every mainland Health Board area to offer rapid access to virtual clinical assessment, or to arrange a scheduled appointment in person. This change was extremely successful in reducing emergency department presentation. There was a reduction of around 10% in those presenting to A&E[192].

79. Prior to the pandemic NHS 24's key performance indicators placed significant focus on the timeliness of response, both in answering the initial call and the subsequent call-back, where clinician input is required and is initially unavailable. While NHS 24 accept the importance of answering calls as quickly as possible, the indicators do not always meaningfully measure either the effectiveness or appropriateness of the NHS 24 response, or indeed the experience of callers. Nor do they offer insight into how effectively NHS 24 supports complete system integration and patient pathways[193]. The measure is now 'care delivered at point of contact', which is important as people may wait longer for the phone to be answered, but once it is answered they can be dealt with at the first point of contact[194].

80. Through the 'Redesign of Urgent Care' ('RUC') programme, NHS 24 capacity has been bolstered. It has seen staffing levels increase by 65% since 2007. As of 31 March 2020, NHS 24 had a total of 1,154.0 WTE (1,676 headcount) staff in post. This is the total staff in post within NHS 24 which includes call handlers, healthcare advisors, management staff and general services staff[195]. As of June 2022, NHS 24 had a total of 1,381.2 WTE in post, an increase of 20% since March 2020[196]. NHS 24 has contributed to an evaluation of the programme, and will be using lessons learned from this evaluation as we move forward into the next phase of implementation[197].

[192] Evidence of Caroline Lamb, Transcript 32/120/21-14/121/19; 32/123/2-4
[193] Witness statement of Caroline Lamb #8, INQ000485979 at §672.
[194] Evidence of Caroline Lamb, Transcript 32/125/15-24.
[195] Witness statement of Caroline Lamb #8, INQ000485979 at §651.
[196] Witness statement of Caroline Lamb #8, INQ000485979 at §666.
[197] Evidence of Jeane Freeman, Transcript 34/51/16-19.

81. In 2020-21, NHS 24 saw a significant increase in demand across its services, with over 1.6 million calls made to the 111 service, and over 77 million page views on NHS Inform. Increased call volumes can be attributed in part to COVID-19. However, the launch of the RUC in December 2020 also led to an expansion in NHS 24's services which in turn resulted in increased call volumes. Call demand continued to increase throughout 2021–22, with just over two million calls made to the service (2,060,976). The months from April through to November 2021 were extremely busy and, in fact, each month received its highest ever volume of calls in 20 years of service history[198].

82. In 2020–21 an additional £2.6 million was issued by the Scottish Government to support the development and implementation of the Mental Health Hub in response to the COVID-19 Pandemic. In July 2020 the Mental Health Hub expanded to a 24/7 service. In 2021/22, through the £120 million Recovery and Renewal Fund, NHS 24 were provided with additional funding of £4.9 million. This was intended to support the NHS 24 Mental Health Hub, and to allow it to provide a 24/7 service, through their 111 service, for anyone experiencing distress or seeking mental health and wellbeing support[199]. NHS 24 also enhanced the provision of information and advice for a range of COVID-19 issues through new pathways, including testing and vaccinations and delivered a consistent access route for those with symptoms of COVID-19 through 111. There were 414,075 calls to the helpline during 2020–21[200].

83. The Scottish Government recognised the increased pressure the pandemic would place on the ambulance service, and liaised with the service as to what further resources they needed to deal with additional pressures. The Scottish Government also provided additional funding of £20m[201]. An official request was made for military assistance which provided over 100 military personnel, who assisted as drivers and support to the mobile testing units across Scotland. The Scottish Ambulance Service enlisted around 100 second-year paramedic students to assist in ambulance control rooms. In addition, the Scottish Government worked with local government as part of the Winter Plan 2021, to provide additional investment in social care to reduce the congestion in hospital, which has an impact on the handover times for ambulances at A&E. The Scottish Government funded the ambulance service to provide nine additional hospital liaison officers (thereby increasing the numbers from 11 to 20) to help improve flow through the system for

[198] Witness statement of Caroline Lamb #8, INQ000485979 at §668.
[199] Witness statement of Caroline Lamb #8, INQ000485979 at §659.
[200] Witness statement of Caroline Lamb #8, INQ000485979 at §669.
[201] Witness statement of Caroline Lamb #8, INQ000485979 at §645.

patients arriving by ambulance[202]. The Ambulance service introduced a 'call before you convey' system, so that ambulance crews would have access to a senior clinician, to help determine whether a patient required conveyance to hospital. This is an ongoing programme which helps to benefit staff and patients[203]. Around 50% of ambulance call-outs every week now result in patients being treated at home or in the community, as a result of the Scottish Government's development of the ambulance service workforce, and initiatives such as 'call before you convey' and the SAS integrated clinical hub[204].

Access to Primary Care

84. The Scottish Government set out its overall guidance for General Practitioners on 17 March 2020[205]. The 'National Supporting Guidance for Scottish General Practice' brought together a range of guidance to support GPs, GP nurses, practice and community nursing teams, other clinicians in the multidisciplinary team, practice management and administration staff, in order to coordinate response activities during the pandemic[206]. The guidance covered a wide range of matters to support GPs in continuing to deliver care, as explained by Caroline Lamb in her statement to the Inquiry[207]. All online appointment systems were suspended with immediate effect. GPs were advised that decisions on whether to continue to bring in some patients for face-to face consultations or use alternatives (such as a telephone or NHS Near Me reviews) should be based on a clinical judgement considering the balance of risk and benefit[208].

85. The use of digital technologies was critical to the Scottish Government's response to COVID-19. The rapid scale up of NHS Near Me is an example of the type of support given by the Scottish Government through use of technology. NHS Near Me (Scotland's public-facing name for the 'Attend Anywhere' platform) was an existing video consulting platform which was rapidly rolled out for use once social distancing and restricted travel came into effect. Prior to the pandemic, NHS Near Me was already in use across 11 of

[202] Evidence of Caroline Lamb, Transcript 32/127/2 – 32/128/17.
[203] Evidence of Caroline Lamb, Transcript 32/123/15-16 and 32/129/5-23.
[204] Evidence of Caroline Lamb, Transcript 32/120/21 - 32/123/18.
[205] INQ000414584 - Letter from the Community Health & Social Care Directorate Primary Care Division to colleagues, regarding National supporting guidance for Scottish general practice, dated 17/03/2020
[206] Witness Statement of Caroline Lamb #9, INQ000485984 at §64.
[207] Witness Statement of Caroline Lamb #9, INQ000485984 at pp 24 – 28.
[208] Witness Statement of Caroline Lamb #9, INQ000485984 at §72.

the 14 territorial Health Boards, along with a range of third sector organisations. Approximately 1,000 video calls per month were undertaken in early 2020[209].

86. An evaluation of the Near Me video consulting service took place between July and September 2020 with a report published in March 2021[210]. A separate public and clinical engagement exercise was also commissioned by the Technology Enabled Care programme from June to August 2020. In addition, a national EQIA of Near me was carried out in September 2020[211]. Survey data from this work indicated wide support among the public and healthcare professionals for the use of video consultations during the pandemic. The EQIA also found that the option of video appointments offered significant benefits in that it i) enabled people to attend appointments safely and without risk of infection; ii) improved access to healthcare as a result of the removal of travel barriers; iii) reduced the amount of time people were required to take off work in order to attend appointments; and iv) supported the attendance of carers, family members and translators at appointments when required[212].

87. However, barriers were also identified in respect of poor internet connectivity, lack of access to technology, lack of privacy and lack of IT literacy[213]. As Mr Yousaf explained at the time of the pandemic a number of programmes to boost internet connectivity were in progress. The SG R100 programme ensured significant investment was directed to remote, rural and island Scotland where internet connectivity has traditionally been poor[214]. Throughout the pandemic there remained a range of ways to access treatment which did not involve internet connectivity. Nevertheless, the Near Me video consulting service was an important tool to access primary care and provided significant advantages to many.

88. The Scottish Government recognised the important role of community pharmacists during the pandemic. Additional funding of £5.5 Million was provided to community pharmacists in Scotland, to help them cope with increased pressures[215]. In April 2020, in announcing the funding Jeane Freeman said: "*I want to thank all community pharmacy*

---

[209] Witness statement of Caroline Lamb #8, INQ000485979 at §917 – 938.
[210] INQ000480806 - Report from Scottish Government titled Coronavirus (COVID-19) Near Me video consulting service evaluation 2020 main report, dated 23/03/2021.
[211] INQ000480807 - Paper from Scottish Government titled Near Me Video Consulting Programme National Equality Impact Assessment, dated September 2020.
[212] Witness statement of Jeane Freeman #3, INQ000493484 at §143.
[213] Witness statement of Jeane Freeman #3, INQ000493484 at §144.
[214] Witness statement of Humza Yousaf #3, INQ000480774 at §111.
[215] Witness Statement of Nick Kaye, INQ000340104 at §125.

teams for their incredible hard work throughout this pandemic. They are doing an invaluable job to ensure people continue to receive vital medicines and care through this period of unprecedented challenge"[216]. Community pharmacy staff were included in the wellbeing guidance issued in Scotland on 9 April 2020[217].

Maternity Services

89. Scottish Government officials from the Maternity and Neonatal policy team, alongside professional advisers from the CMO Directorate and CNO directorate (Midwifery, Obstetric and Paediatric), established weekly meetings with obstetric Clinical Directors and Heads of Midwifery (which were sometimes twice weekly at the start of the pandemic) to discuss a wide range of COVID-19 related maternity service issues[218].

90. On 3 April 2020, the Scottish Government Children and Families Directorate published guidance titled 'Maternity COVID-19 Planned Care/Service Minimum Standards'[219]. This guidance outlined minimum agreed standards for planned maternity and neo natal care. That guidance was developed over time, and all versions of the guidance were developed jointly by the maternal and Infant health policy team and Scottish Government professional advisers, in close consultation with the Heads of Midwifery and Obstetric Clinical Directors through weekly calls and by email[220].

91. In response to concerns from clinical teams, the Scottish Government procured the use of the 'vCreate' system in all neonatal units in Scotland. vCreate is a secure video messaging service that allows clinical staff to communicate with parents via video link to assess premature newborns' development remotely and securely. Clinical teams were concerned about follow-up from neurodevelopmental teams in their assessments of premature infants via virtual clinics. vCreate was already being used in this way in other parts of the NHS, and neonatal clinicians presented a business case seeking to extend the use into neonatal neurodevelopmental follow-up. vCreate has a secondary purpose of allowing clinical staff to record and send videos and photo updates to parents whose babies are on the neonatal unit, but who are not able to visit. This enables parents

[216] Witness Statement of Nick Kaye, INQ000340104 at §174(e).
[217] Witness Statement of Nick Kaye, INQ000340104 at §85.
[218] Witness Statement of Caroline Lamb #9, INQ000485984 at §91.
[219] INQ000414587 - Guidance from the Scottish Government titled Maternity COVID-19 Planned Care/Service Minimum Standards, dated 03/04/2020.
[220] Witness Statement of Caroline Lamb #9, INQ000485984 at §96 – 107.

to be involved, to support family integrated care, reduce separation anxiety and facilitates bonding. It also supports families to share videos with clinical staff, allowing remote neurodevelopmental follow-up post discharge

92. The Scottish Government was made aware of general concerns voiced by maternity services leaders of the impact of withdrawal of face-to-face anti-natal education. In response the Scottish Government purchased and made available a package of online anti-natal education known as the 'Solihull Online Antenatal Course', which was made freely available for all pregnant women to access via advertising on NHS Inform and the parentclub.scot website.

93. The Scottish Government also produced a range of information leaflets for pregnant women on maternity care during the pandemic (which were updated as information evolved), information for families on care of babies, and vaccination advice. It ran a campaign to promote vaccine uptake in pregnant women[221]. Guidance was also provided to pregnant health care staff[222].

94. In June 2020 heads of Midwifery were asked to return a template outlining current maternity service provision including staffing levels and service provision. This template was to be returned on a monthly basis. The decision was taken in summer 2020 to discontinue that requirement[223]. After consultation it emerged that completion of the template was placing an excessive burden on staff, and the information was not adding to what was generally known. As was clear from the evidence of Caroline Lamb, Scotland has a small enough system that there were regular (sometimes daily) meetings where the Scottish Government heard what was happening 'on the ground'[224]. It is necessary to weigh up the value of the information obtained (from innovations such as the template), and the additional demands it places on staff, who are working in a highly pressurised environment[225].

Maternity Visiting

95. Initially guidance on visiting in maternity and neonatal settings was included within Scottish COVID-19 hospital visiting guidance. From 3 April 2020, the guidance

[221] Witness statement of Fiona McQueen #2, INQ000474225 at §182.
[222] Witness Statement of Caroline Lamb #9, INQ000485984 at §137 – 143.
[223] Witness Statement of Caroline Lamb #9, INQ000485984 at §92 – 95.
[224] Evidence of Caroline Lamb, Transcript 32/50/13 – 32/151/8.
[225] Evidence of Caroline Lamb, Transcript 32/154/12-14 and 32/155/11-24.

mentioned in paragraph 90 (i.e. 'Maternity COVID-19 Planned Care/Service Minimum Standards') provided that no visitors were permitted for antenatal appointments, other than advocates for women with autism or learning difficulties. Birth partners were allowed during delivery [226]. On 13 July 2020 service specific guidance was issued to maternity and neonatal services on person centred visiting in those services, titled 'Visiting in maternity and neonatal settings during COVID-19 pandemic'[227]. This allowed one supportive person to accompany women to an antenatal or postnatal appointment/scan, provided that person was not ill or showing any symptoms of COVID-19. Regarding labour and birth, women could be accompanied by a birth partner (as an essential visitor) and a second birth partner if requested, in an obstetric alongside or free-standing midwifery unit; and for a home birth subject to the need to maintain physical distancing where possible. In post-natal care, it outlined that women could identify one designated visitor who would be able to visit them whilst in hospital on the neonatal and post-natal ward in addition to one birth partner. The guidance outlined that parents should not be viewed as a visitor on neonatal care[228]. Further guidance was issued in November 2020 which stated that a birth partner supporting a woman during hospital visits is categorised as an essential visitor and is permitted at all of the five COVID-19 levels[229].

96. Scotland was the first to define the circumstances in which maternity and neonatal services could reduce the level of restrictions[230]. The Scottish Government funded taxi fares to help parents travel to hospital to visit their child[231].

97. Gill Walton suggests things worked well in Scotland as the midwives in Government and senior midwives in the NHS knew each other and worked well together: *"they sat down and worked it out together probably more than England"*[232]. This meant that the guidance was *"clearer for both the public and the staff working in the services"*[233].

---

[226] INQ000414587 - Guidance from the Scottish Government titled Maternity COVID-19 Planned Care/Service Minimum Standards, dated 03/04/2020
[227] INQ000468048 - Guidance titled Visiting in maternity and neonatal settings during Covid-19 pandemic from 13 July 2020
[228] Witness Statement of Caroline Lamb #9, INQ000485984 at §115.
[229] INQ000468049 - Guidance titled Visiting in maternity and neonatal settings during covid-19 pandemic from 2 November 2020 minimum standards, dated 02/11/2020.
[230] Evidence of Jenny Ward, Transcript 17/39/19-21.
[231] Evidence of Jenny Ward, Transcript 17/54/4-8.
[232] Evidence of Gill Walton, Transcript 17/92/8-9.
[233] Evidence of Gill Walton, Transcript 17/92/15-16.

98. Both Jenny Ward and Gill Walton called for there to be a distinction between carers and visitors (with parents of a new born being treated as carers). This proposal was endorsed by Sir Stephen Powis, from NHS England, in relation to carers for those with disabilities. It is, perhaps, simply a different way of describing what was referred to as an "essential visitor" during the pandemic.

99. Caroline Lamb accepted that it would have been helpful for that specific guidance to have been issued at the beginning[234].

Visiting

100. From January 2020 to April 2022 the Healthcare Quality Improvement Directorate led on the development of detailed guidance and principles to support Scottish Health Boards to manage visiting during the pandemic[235].

101. Jeane Freeman expressed the view that the national restrictions did strike the right balance, but she was aware that some of the operational delivery of those restrictions may have been too restrictive, in particular where families were unable to be with a loved one who was dying[236].

102. Humza Yousaf made clear that *"we always stressed to our local Health Boards that ultimately the emphasis should be on a person centred compassionate approach and therefore there may well be slight variation even between hospitals sites or even within a hospital because the situation required it, particularly when it came to essential visits which of course we were very clear about but there was a level of discretion which trusted Health Boards with"*[237].

103. There was learning from the initial policy on visiting. It became less of an issue of concern raised with Mr Yousaf, which suggested to him that the visiting guidance was working[238].

---

[234] Evidence of Caroline Lamb, Transcript 32/159/12-15.
[235] Witness statement of Fiona McQueen #2, INQ000474225 at §201.
[236] Evidence of Jeane Freeman, Transcript 34/76/11-21.
[237] Evidence of Humza Yousaf, Transcript 34/140/7-15.
[238] Evidence of Humza Yousaf, Transcript 34/141/15- 34/142/2.

104. Julia Jones of John's campaign was supportive of the culture of valuing family care and the person-centred visiting culture that prior to Covid 19 had been adopted and taken root in Scottish Health Boards[239].

105. The Scottish Government acknowledges the evidence of Margaret Waterton on behalf of the Scottish Covid bereaved. Mrs Waterton expressed the view that the bereaved understood the need to restrict footfall in hospitals. Her concern was less as to the guidance itself, but the lack of consistency with which it was applied particularly in allowing access to loved ones who were dying. Her view was that the guidance was not applied in the individual and compassionate way that it was intended. That is a matter which those applying the guidance will no doubt reflect on[240].

Healthcare Provision and Treatment

106. Scottish Health Boards, whilst directly accountable to Scottish Ministers, are public bodies in their own right, and each Board is responsible for the delivery of health and care services within its specific geographic area.

107. On 11 March 2020 NHS boards had paused non-urgent elective activity to be able to continue to provide a response to COVID-19 patients and manage the infection control requirements and advice[241].

108. The decision in mid-March 2020 across all four nations to suspend elective surgery was no doubt the right one. Professor Metcalfe[242] considered that the decision was the right one for two reasons. Patients were in danger at the start of the pandemic and their risk of mortality was higher than it would normally be for a routine hip replacement. Professor Bhangu was of a similar view that there were risks to patients with colorectal cancer in acquiring COVID-19 if hospitals had continued with elective surgery[243]. In addition, there was a huge resource burden on the NHS which required to be managed.

[239] Evidence of Julia Jones, Transcript 20/17/22 - 20/18/25.
[240] Evidence of Margaret Waterton, Transcript 39/43/10.
[241] Witness Statement of Caroline Lamb #9, INQ000485984 at §174.
[242] Evidence of Professor Andrew Metcalfe, Transcript 24/60/12 – 24/61/5.
[243] Evidence of Professor Aneel Bhangu, Transcript 24/11/10/23.

109. On 25 August 2021 the NHS Recovery Plan was launched[244]. The central purpose was to create additional capacity within the NHS to aid the resumption of elective care. It committed over £1billion to help deliver necessary reforms and capacity within the health service including significant investment to reduce wating times for elective surgery. On 6 July 2022 the Scottish Government announced targets for the next two years to reduce the number of long waits for elective care. These targets encompassed both inpatient and outpatient cases[245].

110. Ms Chloe Scott was critical of the NHS Recovery Plan in Scotland. She considered that Scotland compared unfavourably with England in terms of its efforts to restart elective surgery and highlighted the lack of specific targets[246]. Humza Yousaf testified that targets *"might have helped focus some of the minds in terms of Health Boards around priority"*[247]. It is submitted that, on account of the different measurement systems used by Scotland and England, a degree of caution requires to be exercised when comparing statistics published by each country on total elective activity.

111. Jeane Freeman was not specifically asked about targets, although she disagreed with the suggestion that the decision to restore elective surgery capacity was left to individual Health Boards. She testified that the decision to restart elective care was national across Scotland, and if individual Health Boards wanted to *"veer from that in any respect"* they had to seek approval[248].

112. Ms. Freeman emphasised the need for a phased return. The workforce was physically and mentally exhausted. It was not possible to *"flick a switch and say we are going back to where we were in 2019"*. That, in the view of Ms Freeman, would be to completely deny the impact of what had happened to the workforce[249].

113. In terms of future planning, it is anticipated that Scotland will have five specialist elective centres in Scotland that have been in the planning for some time. They would allow for delegation to them of non-covid work, and continue elective work which would be taken away from the acute settings[250].

---

[244] INQ000228406 - Report from Scottish Government titled NHS Recovery Plan 2021-2026, dated August 2021.
[245] Witness statement of Humza Yousaf #3, INQ000480774 at §133.
[246] Evidence of Ms Chloe Scott, Transcript 24/66/15 - 24/67/21.
[247] Evidence of Humza Yousaf, Transcript 34/158/8-14.
[248] Evidence of Jeane Freeman, Transcript 34/70/5-12.
[249] Evidence of Jeane Freeman, Transcript 34/72/3-9.
[250] Evidence of Jeane Freeman, Transcript 34/75/1-8.

114. There were no easy decisions taken by the Scottish Government during the pandemic. However, Ms. Freeman described the decision to pause cancer screening programmes as was one of the hardest decisions she has ever had to make[251]. This decision was taken with careful thought. The DG HSC liaised with internal and external stakeholders to seek information, advice, risk assessments and recommendations in relation to initiating a pause to adult cancer screening. Follow up questions by Ministers were responded to before the decision was taken. The Cabinet Secretary requested further clinical advice on the risk of pausing the three cancer related screening programmes, and an assessment of the level of staff resource released, and to where they would be deployed, with evidence that they were needed in the redeployed area[252].

115. The Scottish Government issued a set of Principles on 1 May 2020[253] applicable to all mental health services setting out the expectation that urgent mental health support services would continue to be provided[254].

116. The Scottish Government has set a target and made a commitment to support Health Boards to allocate 1% of their NHS operating budget to CAHMS (approx. £140m at 2021/2022 figures) by the end of this Parliament[255].

Impact on Healthcare Workers

117. It was very evident to the Scottish Government in terms of the response just how flexible, agile, and committed the staff was over the whole course of the pandemic. It became clear to the Scottish Government early on that staff on the frontline were working under considerable pressure, in rapidly evolving conditions with, at time, the additional burden of uncertainty. This inevitably had a huge impact on their wellbeing and resilience. Prior to the pandemic, Dr Dave Ceasar, deputy CMO had been working on staff wellbeing in the NHS in Scotland, and from that work, and his own personal experience as an A&E consultant, was able to offer critical advice and practical options to help staff as they

[251] Evidence of Jeane Freeman, Transcript 34/69/6-12.
[252] INQ000250654 - Submission from Liz Sadler (Directorate of Population Health) titled Covid-19: pausing population screening programmes in Scotland, dated 17/03/2020; Witness Statement of Caroline Lamb #9, INQ000485984 at §157 – 168.
[253] INQ000414579 - Letter from Minister for Mental Health to NHS Board Chairs & Chief Executives, IJB Chief Officers, Local Authority Chief Executives and Local Mental Health Services Leads titled Covid-19- Mental Health Services- Principles, dated 01/05/2020.
[254] Witness Statement of Caroline Lamb #9, INQ000485984 at §216.
[255] Witness Statement of Caroline Lamb #9, INQ000485984 at §208.

coped with the high level of COVID-19 related demand. The introduction of staff breakout rooms close to wards where staff could take time out was a small practical measure which made a positive difference[256].

118. A number of measures were implemented to support health care workers in Scotland. On 10 April 2020 advice was provided to Ministers from senior civil servants in the Health Workforce Division. They recommended the creation of a National Wellbeing Hub. This was scoped as an interactive website that provided a range of resources to the workforce as they responded to the pandemic. It was launched on 11 May 2020. In addition, a National Helpline was established for health care workers[257].

119. On 10 August 2020 the cabinet secretary agreed to the establishment of the Workforce Specialist Service. This offered confidential mental health assessment and treatment for regulated health social care and social work professionals in Scotland. The service launched on 26 February 2021[258]. As Caroline Lamb explained, *"it was established to offer a service that was separate from the general NHS provisions"* and *"designed to offer psychological support and counselling to staff who had been impacted particularly by the pandemic but who might feel uncomfortable seeking support from within their board area"*[259].

120. In September 2020, the Scottish Government provided funding to assist Health Boards in delivering psychological interventions and therapies for health care workers. There was also funding made available for practical support e.g. ensuring staff had access to hot drinks and food and rest areas[260].

121. In the long term, the Scottish Government has been working with Health Boards to appoint wellbeing champions, and there is now a Leadership Culture and Wellbeing Board which looks at measures across the Health Boards, and brings forward recommendations to value and support the workforce[261]. It is the role of government to support boards, to help ensure that a good culture of valuing and supporting staff is in place.

---

[256] Witness statement of Jeane Freeman #3, INQ000493484 at §79.
[257] Witness statement of Fiona McQueen #2, INQ000474225 at §79-80; Evidence of Caroline Lamb, Transcript 32/166/23 – 32/167/6.
[258] Witness statement of Fiona McQueen #2, INQ000474225 at §81.
[259] Evidence of Caroline Lamb, Transcript 32/167/15-22.
[260] Evidence of Caroline Lamb, Transcript 32/166/23 - 32/168/23.
[261] Evidence of Caroline Lamb, Transcript 32/171/5-18.

Conclusion

122. A key learning point from evidence in this and other modules is that *too* rigid a plan for future pandemics is of limited value. All pandemics are different. By contrast, investment in Scotland's health and social care system *is* of value. As too is strength and depth of relationship, trust that permits honest conversations, and decision-making that is un-restricted by organisational boundaries.

123. Counter-intuitively, the pandemic had some positive effects on the health and social care system in Scotland. It has placed us in a stronger position to respond in the future. For example, the detailed planning that went into the roll-out of the vaccine programme; Test and Protect; and the National Treatment Centres has helped to change forever the nature of public sector service planning and design in Scotland. Again, the reality of responding to a global pandemic, at pace, with implications for every aspect of society, has led to improvements in how people are redeployed at speed, and how capacity can be supplemented in creative ways. Further, there is the success of the NHS 24 programme. It has led to a 10% reduction in people presenting at Accident and Emergency. Also, the 'Integrated Clinical Hub', now used by the Scottish Ambulance Service, provides enhanced remote triage to patients who present with urgent care needs, and ambulance crews with access to clinical advice and support whilst on scene. The effect has been to reduce by 50% the number of ambulance call-outs that result in conveyance to A&E.

124. But we end where we began, with the human cost of the pandemic. The Scottish Government *once again* passes its sincere condolences and sympathies to those who have lost loved ones, and to those who continue to suffer. And it *once again* acknowledges the efforts and sacrifices of our health and social care workforce during the pandemic.

20 December 2024

G. D. Mitchell, KC
Julie McKinlay, Advocate
Michael Way, Advocate
Iain Halliday, Advocate

Counsel for the Scottish Government
Instructed by Caroline Beattie, Scottish Government Legal Directorate