Thursday, 29 May 2025

(10.00 am)

LADY HALLETT: Ms Nagesh, just so that everyone following online understands, there are certain problems with the government wi-fi system this morning. We're hoping they won't affect our proceedings -- it's why I've got so many screens on my desk -- but if anything happens, we hope we'll still be able to going with other wi-fi networks.

Welcome back, Dr McMenamin.

MS NAGESH: Thank you, my Lady. As you have identified, the first witness for today is Professor Jim McMenamin.

May the witness be sworn, please?

PROFESSOR JIM MCMENAMIN (sworn)

Questions from COUNSEL TO THE INQUIRY

MS NAGESH: Thank you, Professor McMenamin. You attend today to give evidence on behalf of Public Health Scotland; is that right?

A. Yes, that's correct.

Q. And you've helpfully provided a witness statement to Module 7 of the Inquiry, which is on the screen now, dated March 2025. You've -- you have a copy of that with you, as well, I understand?

A. Yes, I do, thank you.

Q. If we turn, please, to page 122, do we see there at the

bottom your name with the signature, which has been redacted, dated 2 April 2025?

A. Yes.

Q. And is it right that although your name there is listed as Dr Jim McMenamin, since the date of this report you are now Professor McMenamin?

A. Yes.

Q. There are three other signatories; that's because this statement was produced jointly between the four of you?

A. Yes, that's correct.

Q. And at the top there's a statement of truth which says, "I believe that the facts stated in this witness statement are true."

Does that remain the case today?

A. Yes, it does.

Q. Thank you. Now we can take that off the screen, thank you.

Professor McMenamin, you've actually previously provided a number of statements to this Inquiry, or contributed to them, for, I believe, all modules, 1 through 5; is that correct?

A. Yes.

Q. And, in fact, you attended these very hearing rooms back in 2023 to give evidence for Module 2A of the Inquiry.

A. For Module 1 and also, in the surroundings of Edinburgh,

for 2A.

Q. Thank you.

If we can just, then, talk about your professional background and relevant roles during the pandemic. First of all, you have a number of qualifications. You have a -- you hold a Bachelor of Medicine and a Bachelor of Surgery; is that right?

A. Yes, that's correct.

Q. And a Master's in Public Health?

A. Yes, I do.

Q. You're also a member of the Royal College of Physicians and a member of the Faculty of Public Health Medicine?

A. Yes, that's correct.

Q. And you're a fellow of the Faculty of Public Health Medicine and, in fact, hold a diploma in tropical medicine and hygiene?

A. Yes.

Q. Now, in relation to your relevant experience, you're currently the interim director of clinical and protecting health directorate at Public Health Scotland?

A. Yes, that's correct.

Q. And until relatively recently, from January 2020 you were the Strategic Incident Director at Public Health Scotland, the Covid-19, sorry, Strategic Incident Director?

A. Yes, that's correct.

Q. And in terms of your other relevant experience, you have been chair of the Covid-19 National Incident Management Team, also known as NIMT?

A. Yes, correct.

Q. And a member of the UK New and Emerging Respiratory Viral Threat Advisory Group since 2014?

A. Yes.

Q. Thank you. So that's your experience and background.

If we can turn, then, to consider Public Health Scotland, please. It's right that Public Health Scotland was launched in fact in the time period that we're looking at in this Inquiry, it was launched on 1 April 2020?

A. Yes, it was.

Q. And its remit was, broadly speaking, to protect and improve the wellbeing of people in Scotland and to reduce health inequalities.

A. Yes, that's correct.

Q. And then just if we can put on screen, please, INQ000587251, page 7 -- thank you. This image on screen, does that set out the structure of Public Health Scotland at its inception in April 2020?

A. Yes, I can confirm it does.

Q. Thank you. And the chief executive, who at that time

was Angela Leitch, the three directors, and the head of the Strategy Governance and Performance Group together made up the Senior Leadership Team?

A. Yes, that's right.

Q. Thank you.

And if we can, then, put up, please, INQ000587500.

This is a timeline which I believe you've seen before. It's a timeline of the Test, Trace and Isolate response in Scotland.

Now, you say Test, Trace and Isolate, but it's right that at some point Test, Trace, Isolate became Test, Trace, Protect in Scotland?

A. That's correct. It became simplified to just Test and Protect at a later point.

Q. Thank you. So on 4 May, the first blue bubble on the left, 4 May 2020, the Scottish Government published the Covid-19 Test, Trace, Isolate, Support strategy. Is it right that that was a public health approach to maintaining low levels of community transmission in Scotland?

A. Yes, it was, it was an integral component of the emergency response that our Scottish Government colleagues were coordinating.

Q. Thank you. Whilst Scottish Government colleagues were coordinating it, did Public Health Scotland contribute

to the development of this strategy?

A. Yes, very much so, along with a number of our key stakeholders.

Q. And then on 28 May 2020, the Test and Protect strategy was rolled out. In relation to Public Health Scotland's responsibilities during the pandemic and during this Test and Protect strategy's operation, your role included providing expert advice to the Scottish and UK governments; is that correct?

A. Yes, that's correct.

Q. Collaborating with national and local partners to help coordinate the response?

A. Yes.

Q. Supporting work across the UK to agree effective infection prevention, control guidance, including, through its collaboration with the Antimicrobial Resistance and Healthcare Associated Infection Scotland. A mouthful there!

A. ARHAI, correct.

Q. Thank you. And advising on the development of national testing strategy?

A. Yes, that's correct.

Q. As well as various other roles, which included establishment of PCR testing, testing infrastructure and scale-up of testing?

A. Yes, that's correct.

Q. And direct undertaking of contact tracing in the initial stages of the outbreak and then commissioning a national contact tracing function for Scotland?

A. Yes, although I should perhaps clarify that, that last part.

Q. Please do.

A. Because although we might be coordinating that, that was a collaboration between us and our local NHS board partners, who are at the coalface, they were the ones who were doing much of that immediate contact tracing in this initial period.

Q. Thank you. And certainly we'll come on to look at that in some more detail, so thank you for raising it now and clarifying.

On 10 September 2020, the third bubble, the pink bubble, the Protect Scotland App was launched. Now, we've heard a little bit or we've heard quite a bit, I should say, about the NHSX app that was launched in England and adopted by Wales. First of all, did Public Health Scotland have any input into the launch or development of the Protect Scotland App?

A. Yes, we were working collaboratively in a number of areas, this one being a particularly important area, where we were able to work with our colleagues, either

in the commissioning of the app itself and some of the system developments that then were required in the background to enable the sharing of the subsequent information that was to be collected within the application.

Q. So, given that detailed involvement, are you able to assist with the reasons that Scotland launched their own app rather than adopting the NHSX app?

A. Okay. Certainly I can offer a -- perhaps a PHS view, or perhaps a personal one, but really I should preface that to say that of course this was something that was being delivered on behalf of the Scottish population and coordinated by our Scottish Government colleagues.

They in turn, were those colleagues who would be reporting to ministers, and it was ministers who were setting a policy, that policy being, at this instance, that there should be a Scottish application which would reflect some of the challenges that we have for our own local population.

And to answer that a bit more, I have to step back a little bit, because the terms of the devolved settlement, which allowed the delivery of health in Scotland to be controlled by the Scottish Government, there had been significant changes over time that meant that many of the things that were built as a consequence

of that were perhaps some departures from what our colleagues in England were routinely dealing with, and allowed us, from the outset, to be able to have a local collaboration from the ground up, from our local board colleagues and local authority colleagues, to be able to influence what we needed to do.

That was reflected then in what eventually came out of that, because that Protect Scotland App was then going to be utilised to support that delivery in that local area.

Q. Thank you. So effectively, it was -- Scotland developed their own app to be able to meet the needs of the Scottish people specifically?

A. Yes. And having said that, from a PHS perspective, I think from my own personal perspective, that that was a necessary thing that was really going to be very supportive of what our own parochial requirements were for the Scottish population.

LADY HALLETT: Given the open border with England, what consideration was given to making sure that the apps would work together? Interoperable, I think is the expression.

A. My Lady, you ask me something that probably goes above my technical expertise. I can give you my understanding of that, that yes, that there was -- in terms of

interoperability, there were challenges to that, but nonetheless something which we were aware that in the app development and in the subsequent refinements over time, that this was a real consideration that had to be well considered.

I'm not, however, an expert in Test and Protect, so if there are some detailed questions about how on the ground did that work, I think that that might have to be deferred to some of my other colleagues. But I'll be happy to seek any specific commentary about that particular question.

MS NAGESH: Thank you.

Then if we just move on to the next date, which is 12 October 2020, which relates to the £500 Self-Isolation Support Grant, just briefly, did Public Health Scotland have any input in terms of those grants?

A. Well, first, within the evidence that we presented from the early part of the pandemic, we wanted to ensure that, as we have perhaps crassly described as "hard-to-reach" groups but might be better described under different terminology, about marginalised or seldom-heard parts of the population, it was really important that, from what the work of my colleagues, Margaret Douglas and Professor Gerry McCartney had produced, I think from about March 2020 onwards, there

were going to be key groups who had to be well supported: a number of key groups that were identified as part of our inequalities agenda who we thought would likely suffer as a consequence of the implementation of any social restriction. Whether that was older groups, the young, women, East Asians, those with mental health conditions, those who were part of the criminal justice system, and those who were homeless.

But this important aspect here about that self-isolation grant was really to try and address the difficulties that we envisaged would be seen for individuals who were either on a precarious contract or were low income. That meant, then, that there was not just from a PHS perspective, about this is really important, people need to be supported, but for our NHS Board colleagues and local authorities, it was really important that all of us were as one voice saying: this is really important. And delighted, then, that at least there was a recognition here that that Self-Isolation Support Grant was something which, although delivered by government, was well supported in principle by all of us.

Q. Thank you. We then have the Check-in Scotland App launched on 26 April 2021, that's an app that has complemented the Protect Scotland App, isn't it --

A. Yes.

Q. -- that businesses used to allow people to use to check in when they were on site and enable contact tracing that way?

A. Yes.

Q. Then the next date is 9 August 2021, which represents the road out of the pandemic, vaccinated close contacts no longer needing to isolate if they didn't have symptoms and returned a negative test.

A. Yes.

Q. And then, finally, 30 April 2022 is when routine testing came to a close and contact tracing ended, and so the Test and Protect service effectively ended in April 2022.

A. Yes.

Q. Thank you. So that's the broad Test, Trace and Isolate response in Scotland. In your witness statement you produced a very helpful chronology of key decisions taken by Public Health Scotland. We'll take it relatively quickly but I just wanted to ask a few questions about some aspects on that chronology, please.

So if we could please put up INQ000587251, page 129. Thank you.

So at the top, the first row, we can see March 2020: "The Shadow Executive Management Team established

the Covid-19 Response Group to provide leadership to PHS's response to the pandemic."

Was that comprised of the Senior Leadership Team of what would become Public Health Scotland as of April, key members of staff?

A. Yes, that's right, supplemented by individuals like me, who were the chair of the National Incident Management Team or the Strategic Incident directors, of which I was one.

Q. Thank you. And the remit of the group, was that to address issues escalated through the Public Health Scotland response structure, agree issues in relation to resourcing in terms of the pandemic response, and authorise the creation of new programmes of work?

A. I think what's important to reflect here is, coming back to one of the opening lines that you offered, that we were forming on 1 April, but the planning for the creation of PHS had been going on for a number of years. This was just a culmination of that and a recognition that, through the chief executive of the time that we were then going to need to be able to hit the ground running from that first moment of creation on the 1 April.

Q. Thank you. In fact, this Covid-19 Response Group, I believe, met every single weekday --

A. Yes, that's correct.

Q. -- up until March 2021. And even in March 2021, the frequency of the meeting was reduced to three times a week?

A. Yes.

Q. Then we have 1 April, further down the page, 2020, Public Health Scotland was established.

22 April 2020:

"The Scottish Government convened a Deep Dive on Test, Trace and Isolate with public health experts."

Could you just assist us with this particular question: what was the purpose of the deep dive? If you could just describe the deep dive on test, trace and isolate in April 2020.

A. I know it was my other colleagues who were in attendance for this particular reference here. My understanding, having spoken to them, either at the time or from what I've seen subsequent, was that this was a wide-ranging somewhat detailed discussion about what could and should be implemented. Now, I've already offered that from what my colleagues had already offered about the need to protect the Scottish population, and that the differential likely impact going to be in those individuals who might be marginalised, then that would be an important component of any such discussion, but it

would be a free-ranging discussion dealing with the topics of the day, including what did our international awareness, as well as what was developing as any local impact, whether that was in England or Scotland, was now bringing to the table for that discussion, given the early observations that we had about the speed with which the infection was spreading in the population, and the potential impact and the timing of that impact for the societal measures that were being introduced as a consequence of any first lockdown.

Q. Thank you. Then just over the page, please, two days later after that deep dive, on 24 April, Public Health Scotland:

"... proposed and developed a national-local partnership approach to universal contact tracing ... a model described and agreed through a series of meetings with NHS boards and Scottish Government ..."

You mentioned earlier the importance of the local NHS boards in relation to contact tracing, so could you just explain a little bit about the national-local partnership approach, please?

A. Sure. I think that all of this cycles back to what I was saying a little earlier about the parochial nature of what we were offering, because to protect the Scottish population, that we were using a development or

our existing infrastructure in which the tried and tested approach to that would need our local colleagues in the local authorities and the NHS boards to allow us to deliver that. So that truly was a grassroots approach to how we would be able to effectively deliver that. But also supplement it by having a national resource through telephony, that might be able to support that contact tracing arrangement.

So this development was then something which was, from my organisation's perspective, certainly well recognised as really very important for us to deliver.

To give you an example of just what we thought about that, the chief executive was in very many of these kinds of meetings to ensure that the whole of the resource of our organisation was behind this, and that it was seen as a significant priority for delivery by the whole of the organisation.

Q. Thank you. That's very helpful. Thank you.

Just over the page then, please, to page 131, on 17 May, at the top we see the rollout of contact tracing did in fact begin using the local national model.

LADY HALLETT: Just before you go on, can I just interrupt just to explain to anybody who wants to get in touch with me, (a) I've lost my connection and (b), I hope it's just my screen, but the transcript has turned into

gobbledegook. But let's carry on as best we can.
A. Would you like me to slow down? It's not anything I'm doing about speaking too fast, is it?
LADY HALLETT: It's nothing you're doing. It's, I'm afraid, literally the letters are half Chinese, half Roman -- it's a weird combination but it's all to do with the wi-fi system. It's not your fault, Dr McMenamin, I assure you.
MS NAGESH: Thank you.
If we actually go now to page 133 or skip ahead a little bit, between March 2021 and the standdown of the board in April 2022, so about halfway down the page, March 2021 to April 2022, we see that Public Health Scotland:
"... provided public health advice and evidence to the Scottish Government Asymptomatic Testing Board."
It's just showing at the top of the screen. Can you explain a bit about what the Asymptomatic Testing Board was and your role at Public Health Scotland in relation to that board?
A. I can give you my best understanding about that, not necessarily that I was in all of those meetings, but from my understanding of individuals who would be in attendance, the challenge that we had during this time period was a complex area about understanding about

individuals who were in an asymptomatic category, that's to say a combination of two things: one, people who hadn't developed symptoms yet but were going to go on and develop system so that they were pre-symptomatic and, as a consequence, were asymptomatic at the point where they were being considered. The second was truly individuals who did not develop any symptoms who remained completely asymptomatic.
So this was a combined grouping, then, of individuals who would need to be considered.
From the public health advice that we had, which was certainly well developed by this time point in the timeline that you're indicating here, it was much clearer to us that the availability of testing for all individuals should be ramped up to be able to support the identification of any individual if they had Covid-19, or rather, more correctly, the SARS coronavirus that caused Covid-19 to present in individuals with symptoms or, in this instance, for some individuals who were asymptomatic.
That further clarification then was allowing an extension of the testing arrangement where individuals then would be able to identify that they had the infection and would be able to, as a consequence of that, be able to undertake a number of things including

their self-isolation to prevent any further spread to any other individual, and further reduce the spread of Covid-19 in the population.
Q. Thank you. And it seems from this that Public Health Scotland were very closely involved with advising the Scottish Government?
A. Yes, that's quite correct.
Q. Thank you.
Could we then take that off the screen, please, and I want to, if I may, go on and ask you about intergovernmental working.
A. Yes.
Q. Because it's right, first of all, that although, of course, health is a devolved issue, Public Health Scotland collaborated with the public health organisations of England, Wales and Northern Ireland?
A. Yes, absolutely.
Q. Now, I'd like to ask you about some evidence given to the Inquiry by way of a written statement from Nicola Sturgeon, dated 11 March 2025.
A. Yes.
Q. So could we please have on the screen INQ000475142 at page 25. We are looking at paragraph 45 and Nicola Sturgeon says this:
"Throughout the pandemic the Scottish Government

sought to adhere to a four nations approach to formulating our response. However, there was often a misconception about what a four nations approach meant in practice. There were some who assumed that it should mean (or believed it should mean) always adopting a uniform approach across all four nations. I think the UK Government fell into this category. It seemed to assume that the approach it decided to pursue should be the one applied across all four nations. Because of the devolution settlements, many of the decisions it was taking -- on [non-pharmaceutical interventions], for example -- were for England only, but it often communicated these decisions as if they applied automatically across the UK. It acted as if its approach was the orthodox one and any divergence must be wrong or politically motivated, rather than legitimate outcomes of the [devolved administrations] discharging our own responsibilities."
So just pausing there for a moment, do you agree with Ms Sturgeon's characterisation in that statement?
A. I think from a PHS perspective, yes, that seems a reasonable standpoint.
LADY HALLETT: I should say, I have heard evidence giving the other side of the coin.
MS NAGESH: My Lady, just pausing there for a moment, if the

issues with the transcript are still -- on your screen are still persisting, would my Lady prefer to take a short break to resolve those issues or --

LADY HALLETT: No, no, I think I can survive, I just wanted to make sure that everyone knew that they couldn't get in touch with me in case there was a problem.

MS NAGESH: Thank you.

Then moving on, please, to page 26 of the same statement, paragraph 47, Nicola Sturgeon then goes on to say this:

"The Scottish Government, based on our understanding of what it meant -- indeed, what it could only properly mean in the devolution context -- did not at any stage depart from or, to the best of my recollection, reject advice in relation to a four nations approach. We operated within it -- at times aligning our approach with the other three imaginations and at other times making decisions that resulted in divergence."

Then on divergence, she says two lines down:

"At all times -- to Parliament and/or through my daily media briefings -- we sought to explain the reasons for the decisions we took, what the implications were, and if they differed from the decisions of the UK Government for England, why that was the case. It is worth noting again, however, that on many of the

occasions when the Scottish Government would have been described as diverging, our position was closely aligned with the other [devolved administrations], and it was the UK Government that was an outlier."

So --

LADY HALLETT: I'm a bit concerned, Ms -- I'm sorry to interrupt, but I'm a bit concerned -- this relates to overall policy, this. I've heard a lot about this in other modules. I'm also concerned how far Dr McMenamin can assist in the test and trace module, so is there anything you can add in relation to test and trace, which is the subject of this module, Dr McMenamin, in relation to what Ms Sturgeon was saying here?

A. Not that I can see immediately for this particular paragraph. Thank you.

MS NAGESH: Perhaps if I might then ask this more broadly -- if we can take that off the screen, please -- did incidents of divergence in test, trace and isolation policies in Scotland and -- between Scotland and England affect/impact in any way the administration and communication of the test, trace, isolation and support policies in Scotland?

A. I guess the most significant area which was difficult for us was border health, because border health, as it impacted on the two relative systems, was one that led

at least to communication difficulties, because our population were receiving two concurrent pieces of information, one in which the UK daily briefings, for instance may be saying one thing, and the daily briefings from the Scottish Government, which does not have direct control over what the Home Office, et cetera, or border control do, other than for our own airports.

So there were, relatively speaking, in the grand scheme of things, more minor things like that that I can see are immediate but tangible difficulties for the Test and Protect system in Scotland versus what was going on south of the border and the interpretation, and inevitably would have led to confusion for the Scottish population, because if they arrive at London, Manchester or other airport and then come over the border, then the arrangements might be slightly different.

Q. Thank you, that's helpful. Thank you.

If I can move on to another topic, then, which is in relation to the testing of patients discharged from hospital and placed into care homes, I would like to take you to a report which you have been asked about before, so I don't intend to go through it in lengthy detail at all, rather, focus on a very specific point.

First can we put the report up, please, at

INQ000147514.

This is a Public Health Scotland report entitled "Discharges from NHSScotland Hospitals to Care Homes between 1 March and 31 May 2020", and I believe you're very familiar with this report.

The publication date is 28 October 2020.

Just briefly turning to page 5, to understand why the report was commissioned, we see there:

"On 18 August 2020 the Cabinet Secretary for Health and Sport, commissioned Public Health Scotland ... to carry out work to identify and report on discharges from NHS Hospitals to care homes during the first wave of the ... Pandemic."

And then:

"This publication by [Public Health Scotland] presents management information statistics on people aged 18 and over ..."

So then if we can, please, turn to page 42. This is a rather impressive-looking table entitled "Care home characteristics (including different types of hospital discharges) associated with care home outbreaks of COVID-19", and really I'd just like us to turn to the very bottom row, headed "Discharges", and we can see there some figures:

"Discharge Negative ... Reference ..."

And then the last column:
"Reference: 1.00 ..."
"Discharge Untested ... [last column]
Reference: 1.27 ..."
And:
"Discharge Positive ... Reference: 1.45 ..."
Now, for those of us who aren't accomplished statisticians, can we turn, please, to a document which I think may help us to interpret those figures.
INQ000346839, please.
This is a letter sent from Ed Humpherson, the director general for Regulation, on 14 January 2021, to Scott Heald, who was the head of profession for statistics, Public Health Scotland.
And I just want to turn, please, to page 3 and the bottom heading:
"Specific feedback on analysis of associations ..."
And there he says this:
"When looking at the different types of discharge, we see adjusted hazard ratios of 1.00 for tested negative ..."
So these are the figures we've just looked at, is that correct, as you understand it?
A. Yes, that's correct.
Q. Thank you.

"... we see adjusted hazard ratios of 1.00 for tested negative, 1.27 for untested and 1.45 for tested positive. Although the confidence intervals again suggest these findings are not significant, the observed 'dose-response' pattern in the adjusted hazard ratios is consistent with the causal relationship between positivity and outbreak."
So the few questions I have on that, please, are, firstly -- and we can take that off the screen, thank you -- when did Public Health Scotland first become aware of the causal link between testing positive and outbreak? If you can answer that.
A. Okay. First -- well, my understanding of what you just put up, and the subsequent correspondence with Ed Humpherson, was he was broadly complimentary about the report, but was asking for us to be clearer about what a key component of that report was, which you then highlighted on the screen.
My understanding is that that was addressed, and indeed my colleague Scott Heald has previously addressed that in the Edinburgh sessions for modules 2A, I think.
Looking at what you had on the screen -- and this is where I get a bit geeky, to do with epidemiology and statistics -- it is correct there was a clarification of the language around what was meant here, but in the

statistical sense, whenever you have something which says one way or another that a value, in this instance for the statistical reference that was stated, that it spanned the value 1, then that means that none of those observations are statistically significant.
What Ed Humpherson was saying about that was that if you look broadly at the trend, there's a suggestion that, with an increased number of individuals, the confidence interval that you have for something, the precision of your estimate, may shrink and would come -- might then begin to only be above the value of 1, but they did not have sufficient observations for that to take place, so that the statistical association was not proven, it was a non-statistical positive result.
LADY HALLETT: Sorry, you lost me.
A. I know that. That's -- it's -- I know that it's a -- it's a complex area to try to put over. Whenever we talk about any observations, that we have to always ensure that the values that we are describing are accurate, but, more than that, that they are likely to be interpreted in the right way. The interpretation was what our colleague in statistics, as a director general, was asking us to be clear on, and I think that in the subsequent correction that Scott Heald and the team then undertook, they did say something about this. They did

have a clearer language, but the same finding was still evident. It was not a statistically significant set of results.
MS NAGESH: And there was concern that there might be over-reliance on those statistics --
A. That's correct, yes.
Q. -- to indicate that there was a definite causal link between positive test result and outbreak?
Thank you.
Then just moving on, if I may, to the next topic, public communications.
In your statement, if we can put up, please, INQ000587251, at page 29, at paragraph 3.5.11, you've talked here about engagement with third and private sector bodies, including, in the fourth bullet point:
"... [engaging] with the third sector in deploying language services. Public Health Scotland was involved in this to a lesser extent, which also included liaising with faith groups to engage with harder to reach groups to improve access to and use of testing facilities (for example mobile testing unit deployment)."
Can just ask what the steps were taken to engage with these groups you've identified, and also any comments, sorry, you have on the wording "harder to reach", which you've mentioned earlier today.

A. Thank you. And just to reiterate that -- apologies that that use of the term "harder-to-reach" is one that, if we were permitted the opportunity to, that we would obviously be amending. The implication, whenever we used that, it's that it's the fault of those groups, but rather they are groups who are marginalised or seldom heard or underrepresented. They could well be vulnerable groups who have severe or multiple disadvantage.

And we tend in general to use "inclusion health groups" as a terminology to avoid that, but in this instance, in this drafting, and in what's been submitted, that's not been picked up, so apologies.

But you asked a key question, which was: what were we doing? As a demonstration of what we were doing in the background, we were acting either as facilitators to ensure that language services could be made available for key issues that had to be addressed, working collaboratively with the local authority and NHS Board colleagues. But to give you a practical example, the Scottish population, dependent upon each of the every 10 years census, allows us to get some insight into things, so that, across the UK, our populations are somewhat different.

The Scottish population, at least from the census

data, would indicate that around 98% of the Scottish population speak English, but that, in terms of our top six languages, if you take the top eight, then, you know, you get up to something like 98.9 or something that would speak those top eight languages. That would include Scots, Gaelic, English, it would also include Polish, Chinese, Urdu, Punjabi and French.

So we already knew a great deal about what our own local populations were, and where there were population pockets that needed to be appropriately configured, and allowed access, then, to ensure that we were reducing the marginalisation that otherwise we might encounter.

That meant, then, that for the initial information that was in door drops for a number of key outputs that we had leaflets from June '20 that were available in 19 languages, and that by the facts posters that I know that we've spoken about or our colleagues have already spoken about, you know, the face covering, avoiding crowded places, the cleaner hands, the 2-metre distance between individuals and self-isolation facts was available in 38 languages.

So much of this was about facilitation and working to ensure, at a very demanding timeline, often, that we had that information available. I don't think we ever, you know, absolutely nailed that, but nonetheless it was

something which was, with each iteration of what we tried to do, learning from what we had done the last time, and seeing how could we incrementally improve that, including, as you've highlighted here, using faith groups in particular for some of those populations, or looking at the local circumstance that our directors of public health were telling us about to enable them to best communicate with those groupings.

Q. Just on that in fact, the availability of information in different languages and leaflets, I think in fact you sought, am I right, that you sought feedback and received it from ethnic minority groups, and based on that, one of your actions was to attempt to ensure that automated emails and text messages were available in different languages?

A. Mm.

Q. But is it right that you sought a quote from a translation service, but didn't in the end pursue that avenue?

A. Yes.

Q. Can you just explain why?

A. Well, that's -- you and I have, yes, the mutual understanding, that's what we included in this. I don't know, at the time, why, at the point where commissioning could have been undertaken, why there was a decision at

that point not to proceed. That would have been a difficult, I'm sure, decision for the respective groups who would have been coordinating whatever the activity was, but certainly something which outside the hearing today that we might be able to provide some written information about.

Q. Thank you. And then just finally turning to lessons learned and recommendations, you have very helpfully in your witness statement provided, I think it's about, I make it 13 pages of explanation about exercises undertaken to learn lessons and provide recommendations for the Inquiry. These include, don't they, a Public Health Scotland lessons learned report in May 2023? And the NIMT, National Incident Management Team, which you headed, a lessons learned report in September 2024?

A. Yes, that's exactly right, yes.

Q. Thank you. And most recently, a Standing Committee on Pandemic Preparedness (SCoPP) report, dated November 2024?

A. Yes, that's right.

Q. And am I right that in response to in fact Module 1 of this Inquiry, on 16 January 2025, the Scottish Government undertook to accept and act on the recommendations in that Standing Committee on Pandemic Preparedness report. Thank you.

If we can just put up, please, INQ000530949 at page 1, to start with. Thank you.

So this is that Standing Committee on Pandemic Preparedness report; am I right?

A. Yes, that's right.

Q. Then if we just turn to page 8, please.

We have here a helpful summary of recommendations, and so I'll take them relatively quickly, but there's one recommendation in particular I'd like to ask you about. So first, the establishment of a Scottish Pandemic Sciences Partnership. I believe, am I correct, that that partnership is in the process of being set up?

A. Indeed. If I could just pause for a moment, though, given that in the introduction to what you just said, you cited that we had the National Incident Management Team report. It's a privilege of my working life to have worked with such an amazing group of people, and the production of that report has not been discussed in any of the sessions so far because it, unfortunately, came immediately after Module 2A, so apologies that it wasn't possible to complete that until after 2A, and that it's something which obviously has fed into what we are now going on to discuss, and that yes, that pandemic partnership is a really key component of what the SCoPP recommendations were. It's one of those five key

recommendations, I don't know how many you're going to go through.

Indeed, the appointment panel is tomorrow for the director of pandemic partnership, and that one of my roles in my existing role within PHS has been to set up that appointment. So I'm delighted that I'll at least have the opportunity to do that tomorrow.

Q. Thank you. That's very helpful to hear. Thank you.

I'll just run through quickly, then, the other recommendations in this report, and conclude with a couple of questions.

So the second recommendation is in relation to fostering connectedness amongst the academic and wider pandemic preparedness community.

Then over the page, please. 3:

"Identifying and securing the effective use of data for pandemics".

And just pausing there, is it -- in your view, will Scotland have adequate data available immediately in order to provide a contact tracing programme without delay in the event that we face another pandemic?

A. I think it would be best to offer you both a PHS view and one personal view. From a PHS perspective, we can only do what we can within the resource that's allocated to us. And there are complicated things that, as an

organisation, we always have to balance about our strategic needs and that's an inevitable headache for any chief executive and the executive team and the board that supports them.

From a personal perspective, gosh, there are some incredible advances that we've made. The data that we are now receiving has been immensely helpful, and that through programmes that we've spoken about here before, like EAVE, EAVE II, we've been able to demonstrate the utility of when we can use data and the power of it to inform whether things that we're doing are positively helping the population to save lives or to reduce hospitalisations, in particular for the vaccines that we deployed for Covid, where they were so powerful.

My own personal perspective is that yeah, that that's great, but gosh, it's awful difficult to try and continue to see why it's so important to do that, when there are so many competing demands, and it will always come down to the resource available to allow us to do that.

For the specific use of data, fantastic that we've got where we are, but what we hope that we're able to drive ahead now, subject to the appointment of a director of this Scottish Pandemic Science Partnership, is that we will have a PHS statutory duty

to have the data available to be able to help us to do that, but it's over to that director to then help us to achieve what we're trying to do, which is to harness academia and other groups to be able to ensure that yes, we are in that position to be able to do that.

So we're in a great place, but I'd like it to be a greater place.

Q. Thank you. And I think that you've adequately explained what was going to be my next question, which was about the ability to scale testing capacity in the future. But it seems that linked to this new partnership --

A. I think that scaling of testing, I think, is really important. I think that -- we've heard many of our -- of witnesses describing dismantling of the Lighthouse system, et cetera, a reversion to what the NHS testing capacity should be, but what about that surge capacity? How do we best address that? And I think that's going to be something important for the national exercising to be able to help us with, and that one such exercise is coming very soon that may already have been spoken about, that we hope will begin to make us think a little bit strategically, what do we need to have in place to enable that?

LADY HALLETT: Only one problem with the exercise is, as you will know, not everybody implements the recommendations.

A. Absolutely. And it will be really key that we are able to fulfil that. And indeed, that's one of our governance challenges. Whose responsibility are, indeed, many of those recommendations? And I know certainly for our own organisation that we will be championing that with our other stakeholder colleagues, but to be fair, our Scottish Government colleagues have been very open and reflecting on much of what we've said, we hope that that director of that Scottish Pandemic Science Partnership as an independent voice will be able to influence that too.

MS NAGESH: Thank you. Those are all the questions I wanted to ask you about recommendations, and indeed, those are all the questions I have for you today. But there are some more questions for you.

LADY HALLETT: Thank you, Ms Nagesh.

THE WITNESS: Might I have the opportunity to say one thing? Because --

MS NAGESH: Please.

THE WITNESS: -- I'm very clear that often something gets missed, and one thing that often does get missed is I don't know if anyone has offered, on behalf of the NHS in Scotland, the profound thanks that we have to the whole of the Scottish population. They were, throughout all of the time, compliant and, as we've gone through

today, really it was entirely due to the -- their self-isolation and the adherence that they had to the Test and Protect programme that it bought us time to develop, deploy and demonstrate beyond doubt what we then went on to see: the effectiveness of the vaccines that were available to reduce mortality and bring us back out of that restrictive set of things that we implemented for societal response.

So just, if I could, it was just to make that ...

MS NAGESH: Of course.

LADY HALLETT: Thank you.

Professor Thomas.

Questions from PROFESSOR THOMAS KC

PROFESSOR THOMAS: Good morning, I represent, FEMHO, the Federation of Ethnic Minority Healthcare Organisations.

A. Good morning, Mr Thomas.

Q. I've only got a couple of questions for you. At page 57 of your witness statement, it's noted that it was understood that:

"... interventions designed to suppress viral transmission have had an unequal impact across the population with differential impacts most adversely affecting those in more deprived populations, for example, overcrowded housing."

A. Yes.

Q. What specific steps did Public Health Scotland take to address this unequal impact and ensure that the delivery of Test and Protect adequately considered and supported those from ethnic minority backgrounds who were more likely to be living in overcrowded housing conditions?

A. Thank you so much. I would refer you to one thing I've already said about the engagement that we had through our local authority colleagues and in support of them and their NHS Board colleagues, in effecting what would work for them locally.

There were some important champions that we had that were able to do things, for example through faith groups, to support that activity. And indeed, some of our immunisation programmes were, for example, mounted in mosques or in other faith settings.

That's just one set of examples about how that local-national collaboration was then an important mechanism where we were using local leadership and the engagement of third sector to try and improve vaccine uptake, the use of the support mechanisms, one of which Ms Nagesh put up about the grants that were available during the principal part of the pandemic to support that, and assisting people where it was possible to make that offer.

I've also covered that the language availability

that we tried to build on throughout the pandemic, to try and assist that, so that there was a clear communication. But using those local voices and wherever there was identification in the third sector, who might be important influencers of those groups to be able to provide that.

Q. Thank you. At page 92 of your witness statement, you note that Public Health Scotland had identified inequalities early in the pandemic and raised awareness of these issues with policymakers by providing inequality briefings to those involved in the pandemic response.

Can you explain which decision makers these inequality briefings were provided to?

A. Thank you very much. In the main, all of that information that we had was being relayed through a number of different standing structures, that through the National Incident Management Team, Public Health Scotland represented advice to the Chief Medical Officer and to Scottish Government to be discussed as part of a Four Harms agenda within Scottish Government.

That was one conduit to that. Our local board colleagues were in constant dialogue, either through their local resilience partnerships or directly with Scottish Government colleagues about what could or

should be undertaken, and that through COSLA and SOLACE, the local authority groupings, that we were able to try and influence that and share key findings.

So the work that I alluded to earlier by Margaret Douglas and Gerry McCartney would then be escalated up so that everyone had an awareness about key challenges that might arise, as we said, for March and April 2020, but continually revisiting that, and that the PHS role often was to collect the data and openly publish such data so that we could inform, through the use of the metrics that we collect, whether they were making the impact that we hoped that they would.

Q. Well, I think you've touched upon my final question. I'll ask it just to see if there's anything you want to add to it, which is: did PHS establish a mechanism for tracking the outcomes of such briefings to monitor if they had a positive impact on the outcome of the decision making that was being taken?

A. Yeah, I'm not aware of any formal mechanism that we had, other than the very, very frequent National Incident Management Team reviews, because at one point we were meeting three times a week, thereafter perhaps once a week or twice a week, dependent upon what the circumstance was with the different waves of the pandemic.

That allowed us to have a dynamic discussion about: what were we seeing? What, if anything, did we wish to make about that? And, through the periodic deep analysis of either presentation of vaccine uptake by ethnic group or by socioeconomic status, an opportunity to then see: were we seeing the effects that we had? And if we wished to try and generate a reduction in the attainment gap between vaccine uptake or reduction in hospitalisation, et cetera, there was that opportunity to do that through that deeper analysis that was presented on that periodic places.

But we openly published that to make sure that it wasn't just us who then had access to that, but rather to all of our academic colleagues who might wish to be able to use that data for some refinement of that analysis.

PROFESSOR THOMAS: Thank you very much.

Those are all my questions.

LADY HALLETT: Thank you, Mr Thomas.

Mr Weatherby, who is just there.

Questions from MR WEATHERBY KC

MR WEATHERBY: Thank you.

Professor, I ask questions on behalf of the Covid Bereaved Families for Justice UK Group. Just two quick topics from me. We know from the evidence that the

Scottish TUC were very concerned about employees not being supported to follow public health advice and self-isolation arrangements.

And in late May of 2020, following the launch of Test and Protect, we know from the statement of Rozanne Foyer at paragraph 62, and I'll give the reference for the record, it's INQ000103538, that the Scottish TUC wrote to the First Minister raising, and I quote:

"... concerns that some employers may not fully support employees to engage with Test and Protect, identifying those on insecure contracts at further risk."

Can you help us with what particular steps PHS took to ensure that employers did fully support employees, and in particular, employees in precarious positions to fully engage with Test and Protect measures?

A. Thank you very much. I feel as though I need to offer you an apology first. I don't know necessarily whether I can fully answer the question that you've asked, given that it's a policy issue to which we were one of very many contributors, given that sectoral guidance and the implementation of that would be the responsibility of Scottish Government.

But from what I've already covered, you might begin

to have some idea of what I would now go on to say. Our role was then to provide analysis of information to say did we think that there was a likely potential problem of the future in March 2020 and April 2020, which my academic colleagues at the time were then providing information to inform decision making.

Q. Yes.

A. But thereafter, we were also providing, through the periodic analysis of data and presentation by socioeconomic status, some metrics that might allow an examination of that. So we were offering advice to Scottish Government about -- and to our directors of public health and to COSLA and SOLACE in support of this. And as I've already identified, that the individuals who were going to be potentially the most disadvantaged financially --

Q. Yes.

A. -- were in a position to then be as best supported as they could be.

Q. Right.

A. It's not to say that it was ever perfect, because I don't think it ever was.

Q. Yes, okay, just so I understand that and others understand that, you provided analysis of perhaps disparities in the way that people in precarious

situations were. What I'm not quite following is what PHS itself did beyond that.

A. Yeah, we were, along with our directors of public health and local authorities, advocates, then, for what we thought needed to be in place.

Now, I know that we then get into a rather difficult territory about what that financial support should be, because that's the responsibility of Scottish Government --

Q. Yes.

A. -- but all that we could do was offer reflection about what we were observing, and that through the intelligence that our local health protection teams were bringing to each and every National Incident Management Team, a flavour of just how that was playing out for them, where they were documenting individual encounters of difficulty that either were being reported through the Test and Protect programme and escalated through their NHS Board contact tracers for the attention of the local NHS Board. That was a critical bit of this use of local intelligence to inform what we were doing.

Q. Right. Thank you.

And the second point, at paragraph 2.5.4 of your statement, you say and I quote:

"Border control and restricted entry guidance is

a reserved matter. A UK-wide approach to International Travel Regulations was taken at the outset of the pandemic, although this diverged when Scotland applied different entry restrictions to certain countries."

A. Yes.

Q. Unquote. Can you help us with what effect this divergence had on the T&P approach in Scotland?

A. Sure, and I know I've already said something about this, so I can avoid duplication --

Q. Yes.

A. -- because I've already replied to Ms Nagesh about a component of what you're just asking.

Q. Yes.

A. The clear thing that we were trying to do then was ensure where there was a recipe for confusion as a consequence of a difference in what was being provided to the UK population at one set of briefings, where -- compared to what was being presented at the Scottish briefings, try and make that clear -- or as clear as we could -- in that process, to ensure that there was a, at least a consistent voice to try and reduce that confusion, and that for the call handlers, the education and support of them, no matter where they were, whether that was in the national call centres, whether it was in the local boards, or whether it was in our third-party

additional capacity, making sure that it was as clear as it could be in any information that those call handlers would use in managing the Scottish public.

Q. Yes. And just finally on that, should the Scottish Government have taken this divergent approach earlier in the pandemic? Was it something that should have been done from earlier or not?

A. I know how this is going to sound, but that's way above my pay grade, I think, because it's a political question, given that policy is the responsibility of Scottish --

Q. I understand that. I'm asking it because of your role within PHS and the effect of it. I'm not asking you about the policy decision but, from PHS's perspective, would it have been better had that divergent approach have been taken earlier?

A. I think that I've -- I've been asked in -- I'll paraphrase what you've just asked and put it in a slightly different way. I think I was asked in A, another module, about whether -- did we act early enough?

Q. Yes.

A. Was there something that we should or could have done? Of course, in retrospect, that some of the societal things that were implemented could potentially have been

done earlier.

Q. Yes.

A. That, however, was something which is a political decision.

Q. Okay. Is that a diplomatic "yes"?

A. It's my answer.

MR WEATHERBY: Thank you.

LADY HALLETT: Thank you, Mr Weatherby.

Dr McMenamin, that completes the questions that we have for you thank you very much for your help again. I haven't checked whether or not we're calling on you again for Module 7 -- no, 6 --

A. 6.

LADY HALLETT: I'm losing track.

A. As far as I understand, no.

LADY HALLETT: Right. Well, in which case, count your blessings and thank you very much indeed for your help to date. Thank you.

THE WITNESS: Thank you so much.

LADY HALLETT: I'll break now and return at 11.30.

(11.12 am)

(A short break)

(11.30 am)

LADY HALLETT: Ms Cartwright.

MS CARTWRIGHT: Thank you.

My Lady, please can Mary Morgan be sworn in.

MS MARY MORGAN (affirmed)

Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 7

LADY HALLETT: Sorry to keep you waiting, Ms Morgan.

THE WITNESS: That's okay.

MS CARTWRIGHT: Could you please give your full name to the Inquiry.

A. Mary Morgan.

Q. Thank you. Ms Morgan, you've provided a witness statement, if we can turn to page ... sorry, I do apologise. If we could turn to page 92, it's dated 27 February of 2025. And can I ask you to confirm that the contents are true to the best of your knowledge and belief?

A. Yes, they are. Thank you.

Q. Thank you. Now, this is the corporate witness statement that you have provided on behalf of NHS National Services Scotland; is that correct?

A. Yes.

Q. And you similarly have provided a number of witness statements to the Inquiry already to assist earlier modules.

A. Yes.

Q. Can we then, please, start with identifying your role within NHS National Services Scotland. It's right, isn't it, that you are the chief executive officer and have been in that role since February of 2021?

A. Yes, that's correct.

Q. Thank you. And I think prior to that, you were the Strategy Performance and Service Transformation in the directorate for the NHS National Services Scotland from October of 2018?

A. Yes, that's correct.

Q. Thank you. And it's right, isn't it, that as the chief executive officer you are the accountable officer for NHS National Services Scotland?

A. Yes.

Q. And together with the directors of NHS NSS, you are part of the executive management team and, essentially, the key decision makers in the organisation?

A. That's correct.

Q. Thank you. You also tell us in your witness statement that you had responsibility for the NHS NSS Resilience Management Team which had strategic oversight of the organisation's response to Covid-19?

A. From when I became the NSS chief executive, the chair of the IMT and Resilience Management Team would have sat with the then chief executive, Colin Sinclair. But the team was part of the Strategy, Performance and Service Transformation team, the team that administered that.

Q. Thank you.

Well, let's just identify the organisation and what it does in peacetime, and then we'll look at how it evolved during the pandemic.

Could we display your paragraph 2, please, which is on page 1 of the statement INQ000475006. Thank you.

You tell us that:

"Health and social care in Scotland is a devolved matter to the Scottish Parliament and the Scottish Government oversees activities for NHS in Scotland. The Scottish Government sets national outcomes and priorities for health and social care, approves plans with each territorial NHS Scotland Health Board and national NHS Scotland Health Board, and manages performance of all NHS Scotland Health Boards."

You go on to tell us that:

"NHS Scotland consists of 14 territorial Health Boards which are responsible for the protection and improvement of their population's health and for the delivery of frontline healthcare services."

And you also identify that:

"The 14 territorial health boards also meet in three regions. In addition to NHS National Services Scotland, there are seven other health organisations ..."

And you then list those organisations:

"... [which] support the territorial Health Boards by providing a range of specialist and national services."

And can we briefly go to the map that you've helpfully appended to the statement, which gives the layout of those health boards and local authorities.

Can we move forward in the statement, please, to page 93. Thank you.

You've helpfully provided us with the map which identifies those health boards and local authorities, and I think one of the things that's particularly apparent from this map is the islands of Scotland, and can we, using this map at the moment, we're going to come on to look together at testing and the standing up of testing and the partnership that existed between academic institutions. Is there any observation you want to make about that at this stage, particularly because we know that there was a Lighthouse laboratory that was established in Glasgow?

A. Yeah, I think highlighting the geography of Scotland, there are very concentrated areas around the central population, concentrated areas around central Scotland but our island communities are very remote and rural, as are some parts of the mainland of Scotland. I think that posed particular challenges for us in ensuring that

all of these communities were served throughout the pandemic and sometimes took a little bit of time to resolve some of those issues.

So for example, there were partnerships created with the Scottish Fire and Rescue Service to provide testing facilities, testing packs to people, and also opportunities created with local GPs, particularly dispensing GPs and pharmacists, in order that the populations and communities could more easily access tests for them.

Q. Thank you. Well, that can be taken from the screen, please.

Can we then go back in your statement to paragraph 13, please. And please be assured, Ms Morgan, the full chronology that's in this statement will be published and available to view, and so please forgive me for going to disparate topics for the questions.

Can we then display paragraph 13, please, at page 5. Thank you.

You've set out sort of business-as-usual operation of the organisation, but then you tell us:

"At the initial stage of the pandemic, NHS NSS responded to a request from the Scottish Government to identify which of its services could potentially be ramped up or stood down to support the pandemic

response. This was an internal discussion with the Directors and Chief Executive within NHS NSS at this time."

And you tell us that:

"On 11 March 2020, John Connaghan CBE, the Chief Performance Officer ... and Director of Delivery ... requested a list of prioritised services from all Health Boards ..."

And you thereafter identify, at paragraph 14, essentially what was identified as the essential services in Scotland; is that correct?

A. That's correct, yes.

Q. Thank you.

Then perhaps if we move forward a little more, please, to paragraph 32, you give us some particular detail around the Test and Protect then that was stood up in Scotland. Can we move to that now, please.

And do you want to, before doing that, just give some context to, in particular, National Services Scotland's key role in the delivery of Test and Protect, please?

A. Yes, we were responsible for operationalising decisions and requests that came from Scottish Government, and also responsibility for providing national coordination, and some delivery, national coordination of delivery,

but also delivering some aspects of Test and Protect, mainly through coordinating testing, delivering of national contact tracing, and so on.

We did that working very closely with our 14 territorial health boards, and, indeed, with UK Government services located locally but also on a UK national basis, and also working closely with other national health boards, particularly national Education for Scotland, around training for national contact tracing, Public Health Scotland, in terms of data and also decision making, and also testing capability, the Scottish Ambulance Service. But worked with everybody in that space across Scotland.

Q. Now we'll perhaps come on to deal with the Scottish Ambulance Service, but it's right, isn't it, that they played a key role in Test and Protect in Scotland, and they operated 39 of the mobile testing units that operated in Scotland during the pandemic?

A. That's correct, they operated all of our mobile testing unit capability.

Q. Thank you. And just doing that topic at this stage, we know, I think, additionally there were three other mobile testing units that were part of the surge plan, is that correct, that were provided through the national system operated by the private contractors; is that

correct?

A. That's correct. We tried with the Scottish Ambulance Service in deploying mobile testing units as far as we possibly could on a planned basis to communities. We spoke earlier about the island communities; so mobile testing units were at times deployed to our islands, Skye, Shetland and Arran. That took some planning, as you can imagine, getting them across to islands, and created expectations in the community as well, but at times of surges, if there were multiple outbreaks or particular activities that couldn't be accommodated, we did have access to an emergency three further MTUs, if they were required, through requests to UK Government.

Q. Thank you. So we start then at paragraph 32, please. You detail there that:

"At the start of the pandemic the Scottish Government collaborated with multiple bodies, including NHS NSS, to establish national programmes of work to deliver Scotland's response to the pandemic. Under emergency measures the Scottish Government was responsible for making the key decisions. NHS NSS provided subject matter expertise from the services operated by NHS NSS."

A. That's correct, yes.

Q. And then you detail then the Test and Protect and the

aspects of the pillars. I'm not going to go through that. But can we move then forward to your paragraph 37 on page 14. Thank you.

You've already confirmed that essentially NSS had the operational role for the delivery of Test and Protect. And can we start, then, with looking at what was done to scale up testing in Scotland. You detail that in the witness statement but can you give an overview of what was done from January onwards to scale up testing in Scotland, please?

A. Okay, from the January onwards we already had an established National Laboratories Programme which was designed to consider a One Scotland approach and target operating model towards laboratories and laboratory services and other diagnostics within Scotland. The National Laboratories Programme stood up with our Scottish Microbiology and Virology Network colleagues really to establish what testing capability existed already in Scotland, which was one of the key things that one needed to know.

There was found to be gaps in that space, those spaces, but really the NLP stepped up to source additional capacity for the laboratory structure.

In addition to that, in April, the UK Government had started to build the regional testing sites, beginning

in Glasgow and then in Edinburgh. It was quite critical that those services were integrated with the Scottish health care system. At that very early stage they weren't. Our system was different, our digital systems were different, and we wanted to make sure they were integrated fully with the Scottish healthcare system.

So that was one key point for NSS's work.

And the other thing that the NLP did was to seek to identify other laboratories, other than what existed within territorial health boards. So what existed within the Scottish universities, research areas, and others. The reality of that was that we were inundated with requests from people who wanted to help and support, and we're very grateful for all of those, and we -- it was established -- a group was established to assess all of those capabilities of laboratories in Scotland.

So we stood up partner nodes, we called them, in the university, some private sector functions.

Very grateful to them because they did bridge a gap for us while we were building up big, more scaling up.

We found it quite difficult in that equipment for laboratories was in short demand right across the UK and indeed globally. There was demand for that, as with other aspects of the pandemic. So we sought equipment

especially to service our islands from South Korea and brought in Seegene testing equipment to do so in that space.

Q. Thank you. Can you assist then in terms of what you've identified that work had already been done to identify the laboratory network or capacity in Scotland, and is that pre-pandemic?

A. No, no. That was as a result of the pandemic coming just right at the start of when it -- it was on its way, in order to build, begin to build capacity.

Q. Can you give us some idea, you've identified, first of all, the Virology Network in Scotland. Can you give us some idea as to how many laboratories that included?

A. Well, there are 32 hospitals in Scotland, not all of them had their own laboratory services but I can't tell you exactly how many we'd have at that point in time.

Q. Then you've also identified academic institutions. Was there a piece of work done to identify which of those had PCR machines and were able to do testing?

A. Yes, a lot of them stepped forward but some of the criteria was to make sure that they also had capability to do that, to do the testing, that there were reagents available to service them, especially initially, and also that they had the capability of -- with minimal change linking into our digital and reporting laboratory

information management systems.

I think most of the nodes were in the east, and came under also the clinical governance auspices of NHS Lothian at the time, so they were linked into that and that was the conduit by which the results were passed through to patient records.

Q. Thank you. Can we then briefly look at a document.

Now, you've said NLP a number of times. That's the National Laboratories Programme, isn't it?

A. That's correct, yes.

Q. Can we then please look at a paper, which is INQ000291509. And is, essentially this the paper that assists with the work that was done to scale up and identify the laboratory capacity for testing in Scotland?

A. That's correct, yes.

Q. Thank you.

Can we move through the document to page 3, please. I think you've just referenced the liaison with Korea. We can see on the second paragraph there reference to procuring the nine Seegene analysers.

A. That's right.

Q. Are they also for PCR testing?

A. Yes.

Q. Thank you. And can we then move through to page 4,

please, where this document identifies the academic, public and private sector partnerships that were being established. Thank you.

Then over the page, please, to page 5. We've got some tables that give some idea of the volunteers across the academic institutions, but also the volunteers that stepped up.

A. Yes.

Q. We can see in particular the University of Edinburgh, we've got a large number of volunteers.

A. Yes.

Q. And then other universities and what they offered. We know that the first Lighthouse laboratory in Scotland was established, I think through the University of Glasgow, in April of 2020. Is there any other observation you want to make by reference to the assistance from the universities, and I think you've already identified that they were, is that right, mostly on the east coast?

A. So these were staff volunteers. One of the things that the NLP also did was identify volunteers who could come in to support staffing in those established laboratories we had. And I think the total was around 1200 staff that were deployed or could be deployed from universities into NHS laboratory capacity.

We -- I don't know to what extent those staff were actually used. I can't identify that specifically, but we were keen, wherever possible, because the Lighthouse lab was established in Glasgow and it was kind of using the same people. They had laboratories that had been stood down, the research laboratories that had been stood down at the start of the pandemic. Those staff were used in that space. So we were quite keen not to deplete or be seen to be in competition with the Lighthouse lab to make sure that the staffing was reflected across the country in the best way possible.

Q. Thank you. Can you give us some idea in terms of the universities that were linked to medical schools as to how they were utilised in Scotland, please, for testing?

A. I can't answer that question. What I do know is that the University of Edinburgh, the Moredun research unit, which is part of the Edinburgh space, were used actively for testing and linked into NHS Lothian's testing capacity. I think the network of research laboratories where we had genomic testing and also other research pieces were used but I'm not clear about the specific PCR testing.

Q. Thank you. Can we just turn over the page, please, and just to pick up on -- thank you. We'll go to the next page. We can see there is reference to service level

agreement. You've just identified that certainly the Edinburgh University was then able to share the information test results with the local hospital. Was there any identified issue in Scotland when academic institutions were doing the testing linked to medical schools about the transferring of the data and the results?

A. No, we linked the partner nodes that we had through NHS Lothian. Results went directly and they were treated as any other part of that UK, or that Scotland Pillar 1, NHS Pillar 1. The results went through the health board laboratory information management system into the SCI Store, that's SCI, the information store that results are stored in in Scotland, and they would have been accessible by any healthcare professional who has access to SCI Store.

Q. Thank you. So in Scotland there was no impediment for transferring of the data and the results into healthcare records?

A. For PCRs that were undertaken, no, there shouldn't have been.

Q. Thank you. Can we then, please, go back into your witness statement, please. And if we can go to paragraph 39 on page 14, please. We can see that you detail there that it assisted with commissioning three

regional testing hubs, the development of local test sites throughout Scotland, latterly then distribution of lateral flow devices.

Over the page please, then, the procurement aspects of the devices and genomics.

Can I then additionally ask you, please, a question linked to asymptomatic testing and there's a particular reference to this within the Director General's statement from Caroline Lamb that we will be hearing from after you.

And can we briefly display, please, that paragraph. It is INQ000587342. That's INQ000587342, and can we display, please, paragraph 390 at page 126, please.

We can see at paragraph 390 it's detailed about targeted community testing that came in, intended to undertake asymptomatic testing of people who were otherwise not eligible under other testing pathways in areas of highest transmissions, and it details that this programme was led by the Scottish Government with input from territorial health boards, NSS, PHS and local authorities.

So can you just give us clarity about the contribution NSS made, please, to asymptomatic testing.

A. We coordinated the location -- it was a collaborative effort but we coordinated and placed -- did the placing

of mobile testing units as we did with any other testing endeavour, it's just that this was asymptomatic testing. So I think the pilot was undertaken in Renfrewshire council in the first instance, and then rolled out to a further eight local authority areas, and so we deployed the MTUs, and supported the setting up of that.

It was mainly LFDs so there wouldn't really have been that much by way of digital linkages that could have been made.

Q. Thank you. So with identifying the lateral flow devices, that's obviously much later in the pandemic response.

A. Yes.

Q. Would that be almost in the winter, Christmas-time of 2020 --

A. Yes.

Q. -- and through into 2021?

A. Yes, asymptomatic testing I think was first piloted towards the end of November, December of 2020.

Q. Thank you. Can we then, please, move back into your witness statement at paragraph 201, please, at page 59, where you deal with testing of healthcare and social care staff. You tell us that:

"In April 2020 the ... [National Services Scotland's] COVID-19 Testing team supported some health

and social care organisations," and you list them there.

You say:

"The process involved organisations submitting details of staff who required a test via spreadsheets, with these being uploaded to an online secure file system hosted and managed by Deloitte."

Then over the page, please, you detail that:

"In July 2020 the ... NSS COVID-19 Testing teams offered support to care homes managing staff testing regimes. As part of the UK Pillar 2 testing programme care homes could order PCR test kits using an online ordering portal. Tests were delivered directly to care homes and collected on the day of sampling by couriers booked using an online system."

And you detail that:

"... Testing teams were a first line of escalation for care home testing leads when ordering test kits or arranging couriers ..."

So can you give us any more context to that service and how that assisted with testing in care homes?

A. It provided a local -- a more local -- well, a Scottish contact point for care homes. The assistance was broader than that because we also arranged for mobile testing units, for example, as they were being deployed to their site to call into care homes that they were

perhaps passing or close to to drop off testing kits, and to collect them on the way back again, so that increased the turnaround times for tests having been done.

The -- later in that period the National Contact Tracing Centre also would help find tests, for example, that had been lost or results hadn't come back from, and would seek to problem solve and support our care homes in delivering their testing requirements.

Q. Thank you. Can we briefly look at some guidelines that were introduced in Scotland for testing of care home staff.

If we could, please, display INQ000259979. Thank you.

I'm not going to go through this guidance but is this the guidance that came in to assist with the testing in care homes?

A. That's correct, yes.

Q. Thank you. That can be taken from the screen, please.

Can I now ask you some questions, please, about testing capacity specifically.

Now, if we can display your paragraph 172, please, at page 53. Thank you. You detail that:

"During the early stages of the pandemic response ... NSS worked closely with Scottish Government and

other delivery partners to grow testing capacity and focus what capacity existed at the highest priority areas, for example, health and social care, Fire, Police Scotland and SAS".

Then if we go over to the next paragraph, please. 173 -- thank you -- you detail then the work of the National Laboratories Programme was redirected from its transformation objectives to focus entirely on the testing response to the pandemic in March of 2020. And the work with the partners to do so.

And again, if we look at the next paragraph, paragraph 174, please. You detail there the testing capacity expansion that took place.

Now, can I ask you then by reference to that expansion, if we could look at a specific email from March from a Dr Michael Lockhart which, please, is INQ000478143. Thank you.

Perhaps if we can just go to the first page of that document just so we can locate it. Thank you. Have you had an opportunity to review this email exchange, Ms Morgan?

A. Yes.

Q. Thank you. If we move then to page 3 and so we're in March, now, of 2020, we can see specifically Dr Michael Lockhart, the consultant medical microbiologist,

programme lead at Public Health Microbiology, Health Protection Scotland, details as followed:

"... I am worried that the intervention by No. 10 last night may have already impacted on testing service availability in Scotland -- kit that was ordered for rollout in the NHS Fife lab and was due to arrive imminently has now been delayed until middle of next week. This kit can run on Roche machines. I will find out more when our National Procurement colleague liaises with the kit company Thursday, my colleague in NP thought it is most likely symptomatic of the chaotic climate in which we are currently working. However, I thought I should flag up that at this stage we are not working collegiately with NHS England but are instead in direct competition with them for the procurement of some of our planned testing infrastructure. We therefore we need to carefully monitor for the equity of support from the testing industry."

So can I ask you, can you assist us, looking at this email from March 2020 that seems to identify further challenges, and we've looked at the scale-up efforts, are you able to assist what difficulties that you were aware of with conflicting demands between the UK Government and the Scottish Government, especially in the early stages of the pandemic?

A. So, first of all, I would like to say we did work very, very well together, both UK Government and Scottish Government and the agencies, from my perspective. In the very early stages, as with other items of commodities that we needed within the pandemic, there was shortages of equipment. Moreover, some of the pieces of equipment required to be compatible with what already existed. One couldn't just go out and purchase something like you would a games machine that plugs and plays into any television. So they needed to be compatible.

What I would say from my own experience is when we did contact some suppliers, they advised that they were allocating what they had available on a UK basis, and then it would be for UK governments, DHSC, to decide what the allocation within the UK would be.

That was true in the very early stages for reagents, and I think in part, too, around suppliers for equipment at that time.

But I would emphasise this is very early stages in the pandemic, and thereafter we sourced Seegenes from South Korea, and also when we were setting up the regional labs we were able to source the large Hamiltons that were also in short supply in order to do that.

So we overcame these issues. I don't think it was

that we weren't working collegiately; I think it was the state of the supplier market at that point in time.

Q. Thank you. Can you assist, why did it take so long to scale up Scotland's testing capacity at the beginning of the pandemic?

A. So we did everything that we possibly could, and more, in order to scale up our testing. We worked very closely with UK Government but I think there are times -- there are things that needed to happen. So there were constraints around reagents, there were constraints around equipment. Setting up the three regional laboratories required identification of suitable accommodation and fully kitting out a laboratory that also required to meet regulatory standards. So I think we actually did quite well, in fact very well. I think lots of people put lots of effort into doing that in scaling up as rapidly as we did.

We made our own viral transport medium purposefully to deactivate the virus at the point the test was taken in order that testing could move more rapidly through, and we set up really quite innovative solutions at times to very remote and rural areas that had challenges, from our point of view, just purely from logistics of getting tests, test kits, to those areas and back again, and

results.

There was a lot of digital solutions that needed to be sourced through as well, so that the reporting could happen quickly. We needed to make sure they were all in place and okay. So I thought we did remarkably well.

Q. Can I ask you then, would -- was there an issue of lack of planning and preparedness for the pandemic that may have resulted in this slowish scaling up initially of testing in Scotland?

A. I think that Scotland has 14 territorial health boards, and a range of universities, and we don't necessarily all know what each other is doing. So certainly it would have been helpful to have had a single plan -- or not necessarily a plan but to have had a One Scotland approach to how we operated our laboratories, which is what the National Laboratories Programme was in the process of doing. So I think that had been recognised and we were working towards that.

I don't think we -- I didn't realise what was heading our way with this particular pandemic. I had been the director for Health Protection Scotland when H1N1 came to Scotland, and so had some idea of what a pandemic or what arrangements might need to be put in place, but clearly this was much greater than anybody anticipate at an operational level.

Q. Now, you've just referenced the one system that the partnership moved towards; are you able to assist as to whether, in a future pandemic, it would be different for scaling up?

A. So I think a lot of it depends on what it is that's the pandemic. It took a long time for reagents, for the tests, actually to be developed. A long time, you know, weeks and months. I think we were getting allocated very, very few tests and very few quality assurance testing opportunities at the early stages of this pandemic.

There is much of what we have created in this pandemic that remains in place, so all of the equipment that we bought is currently in use in all of the -- in the main territorial boards. We have a large amount of learning. And also, in terms of contact tracing, we still have the national contact centre, so standing things up in a different way will be -- should be easier.

Q. Thank you. Can I next ask you a question, again rooted in care homes and testing in care homes, and to do that, can we please display the statement of Nicola Sturgeon which Module 7 has received, which is INQ000475142, and can we go to her -- the paragraph 224, so it's page 83 of INQ000475142. Thank you.

Now, just to give some context, prior to 21 April 2020, residents being admitted into care homes in Scotland were not tested for Covid-19, including those people being discharged from hospital where there was known to be high rates of nosocomial infection.

And we can see Ms Sturgeon details that this was in part due to limited availability of testing capacity in March of 2020.

Now can I ask you, certainly the Inquiry has heard -- has much evidence from the Covid bereaved groups, and a significant issues for the Covid bereaved and particularly the Scottish Covid Bereaved, are the fact that many of the families lost their loved ones because they contracted Covid-19 in care homes.

Are you able to assist as to what lessons can be learned from this about the need for increased testing capacity and the prioritisation of available testing capacity at the outset of a future pandemic, especially in settings such as care homes.

A. So I don't think I'm the right person to answer that question because the decisions made around prioritisation were made by Scottish Government in accordance with guidance and probably the science that existed at that time. Our role was to operationalise those decisions.

In March 2020 there was a paucity of test reagents across -- coming in from any environment that I could see. I certainly was engaged with one supplier who was making allocations on a UK basis, and we had clinicians who were very much asking for those reagents because they had analysers who could do more tests if the reagents were available, and that's particularly the Roche analyser.

So the constraints were not just necessarily, I think, a point of the ability to scale up and do more; but the tests -- but the constraint of testing was also about the manufacture of testing. And as researchers, as suppliers get better at responding more rapidly to those, then we would be able -- we would have been able to fill our machines with tests.

Q. And can I ask you, in terms of the reagents, where were they then sourced from, and did the universities play a role in the creation of more reagents?

A. Well, we manufactured our own within Glasgow and Edinburgh laboratories initially, until reagents picked up. We sought to secure more reagents from suppliers. And then, as the pandemic increased, lots of suppliers were then making particular tests, or the PCR tests, available.

Q. Thank you.

A. I don't know the precise numbers -- (overspeaking) --

Q. Thank you.

Can we then move back to your witness statement, please, and can we go to paragraph 134 at page 45, please.

Now, you detail within the witness statement the Scottish National Blood Transfusion Service, but particularly I think the testing through that service had identified an issue in respect of asymptomatic transmission.

A. Yes.

Q. And you tell us at paragraph 134 that the samples provided for testing from 17 March 2020 had identified essentially that [between] 2.1% and 7.6% had Covid-19, despite being fit and healthy at the time of donation, which suggested a prevalence of prior infection of around 5% of the healthy Scottish population, which was in excess of the number of people reporting clinical infection and commensurate with what we later learned about the incidence of asymptomatic infection.

Do you agree, first of all, that these findings were a useful data source coming at the early stage of the pandemic that helped inform understanding about the prevalence of asymptomatic infection?

A. Yes.

Q. And can you help us, how were those findings shared and utilised in decision making in Scotland?
A. So they were a published paper. They would have been reported in through the scientific group. They would be one part of decision making, I guess. Again, not for me to make decisions around that space. But would have been one part of the science that would be used in addition to wastewater testing and so on.
Q. Thank you. But in particular, though, this data that was identified from testing, are you able to help as to why that data was not taken more seriously earlier in Scotland?
A. So I don't know that it wasn't taken seriously. If you're -- I'm not quite sure what the inference is there. If you're asking why was asymptomatic testing not commenced on the basis of this data alone, I think there would be other factors to consider, such as at that time the availability of testing overall, the stage of the pandemic, what scientific advice was being given about asymptomatic testing and other factors other than that, than this piece of information.
Q. Thank you. Can we then, please, move to your paragraph 201, please, at page 59.

You've helpfully set out from paragraphs 201 to 208 a section that deals with testing of health and social

care staff.

Can we please move to paragraph 202. You detail there that:

"In July 2020 the NHS NSS COVID-19 Testing teams offered support to care homes managing staff testing regimes. As part of the UK Pillar 2 testing programme care homes could order PCR test kits using an online ordering portal. Tests were delivered directly to care homes and collected on the day of sampling by couriers ..."

Are you able to assist why there was -- whether any -- why the offer was not given in relation to supporting the testing of residents as well at that time?
A. No. Sorry. The decisions are made -- who to be tested and who had access to testing was made by Scottish Government.
Q. But are you able to help us as to what were the advantages of NSS supporting care homes in managing staff testing regimes?
A. We provided a local -- a local support ensuring that the testing kits reached them, but also our local conduit, to answer any queries that they had, or to seek test results that had maybe gone missing. If the care home managers had any questions regarding testing, then we

provided a local support to that -- service we offered.
Q. Thank you. Can you assist whether NSS or you had awareness prior to July 2020 of care homes having difficulties in managing staff testing regimes?
A. They didn't have difficulty; they were given -- they were busy, and sometimes staff perhaps didn't fill out the -- you know, fill out the test properly or they didn't fill a form out properly, or those kinds of things. They didn't have -- there was more staff -- also, we conducted a survey later on, in my statement I refer to it, which discovered that there was actually more staff in care homes than had initially been identified. So it was really day-to-day operational issues that caused them difficulties and challenges rather than anything with the system that was set up. And we gave them a place to contact to discuss those, and also, as I've said, used MTUs who were passing to drop off test kits and pick them up on the way back again.
Q. Ms Morgan, I hope you don't mind me pursuing the topic to see if you can assist us any further, because it's a particular concern and experience of the bereaved, and particularly the Scottish Covid Bereaved, that patients were transferred within hospitals between wards and units without having been tested for Covid.

Are you able to assist as to what, if any, guidance was put in place to ensure that patients were tested before being moved within hospital settings?
A. I'm sorry, I don't have that directly to hand. I know that our ARHAI team were heavily involved in providing guidance on all of these matters, but I don't have that to hand, I'm sorry.
Q. Thank you. And again, please forgive me for pursuing this question also, again linked to the experience of the Scottish Covid Bereaved, that staff also were able to move throughout hospitals without having been tested. Ms Morgan, can you assist at all as to what, if any, guidance was issued to staff to help avoid staff members transmitting Covid throughout the hospital?
A. Yeah, whilst I can't recall the precise details of it, staff in hospitals, as in care homes, were asked to test at particular times. I think it was twice weekly or -- I can't remember what the heightened pace was, but particularly during PCR testing initially, and then LFDs, when they became available, at regular intervals until that was stepped down. So that was the basis of testing.
Q. Thank you.

Can we next move to the section, that deals with contact tracing, please. It's paragraph 232, where it

starts, at page 65. And you helpfully provide much detail about how the National Contact Tracing Centre operated, essentially local contact tracing was essentially the model that operated through Scotland; is that correct?

A. Yes.

Q. And so the detail is in there as to how it operated, particularly in Scotland, using local teams?

A. Yes.

Q. But can I ask you in particular, just a question based on your paragraph 294, please, at page 81. It's linked to the training of the contact tracers. And can you give us some idea about how much recruitment there needed to be to scale up contact tracing in Scotland first, please.

A. Yes, so I don't know how many contact tracers there were in local health boards, but nationally NSS recruited 750 contract tracers onto NHS, I suppose temporary contracts. 800 bank staff were also trained and recruited to support contact tracing to work at times of increased activity or to cover absences. And we also engaged and trained 1,000 contractors. So private sector call handling staff.

Q. Thank you. Can I just ask for clarification, because at paragraph 294 you're dealing with impact assessments and

you say this:

"The training for the newly recruited contact tracers was not in scope for the purposes of the impact assessment and the broader Public Health Scotland Track Equality and Human Rights Impact Assessment of the DHI Tracing Tool Trace Isolate and Support ... programme was reviewed and impact assessed separately."

Could you just help us be clear about what that means? So it says they weren't part of the impact assessment, but then it seems that something was done. Can you give us any clarity around the training, then, of the contact tracers and whether that was pursuant to an impact assessment also?

A. It was part of a wider Equalities Impact Assessment that I think has been entered into evidence. There was two equality impact assessments undertaken, one in July 2020 -- or June 2020 and one in July 2020, that involved focus groups. This particular one was about -- more about the systems that we had in place and particularly the digital systems that we had in place. So not specifically about training people, but how they -- what the forms looked like, what -- you know, what the digital infrastructure was looking like, and so on.

Q. Thank you. Then can I ask you, because you've now

referenced a number of times the training that those recruited contact tracers had, are you able to assist as to whether that training was specific and culturally competent to equip them to perform that unique role as a contact tracer?

A. They had a variety of -- I mean, these are relatively junior people who operated to a script that was prepared by Public Health Scotland and trained by -- trained through by National Education Scotland. They were trained to identify when there was somebody with particular complex or difficult needs. They were trained to collect the details on ethnic minorities, which were reported back to Public Health Scotland. And anything that they felt was out of their particular remit was handed off. There were jump-off points created so they could be handed to a more experienced contact tracer or supervisor, or indeed, if there were particular complexities, to refer the individual they were contact tracing to the local health board, who may have more knowledge of those situations arising.

Q. Thank you. Then, finally for my purposes, can I thank National Services Scotland for the helpful paragraphs and pages that deal with the legacy of the test, trace, isolate system and future development in Scotland from paragraphs 320 to 326.

Is there anything else you wish to say to inform recommendations beyond what's detailed in the witness statement?

A. No, I don't think so. I think they refer to a more One Scotland approach to delivery of services overall. I think that's really, really important, and that, if you like, peacetime engagement with government colleagues, and understanding that the Scottish system is different from the rest of the UK system, and that we need to think about what we can do more to converge.

MS CARTWRIGHT: Ms Morgan, thank you very much. Those are my questions.

THE WITNESS: Thank you.

LADY HALLETT: Thank you.

Professor Thomas -- oh no, Mr Dayle. I've done it again, Mr Dayle.

MR DAYLE: Not at all [inaudible - microphone off].

Questions from MR DAYLE

MR DAYLE: Thank you, my Lady.

Ms Morgan, I ask questions on behalf of FEMHO, the Federation of Ethnic Minority Healthcare Organisations, and I have just one topic that I want to explore with you.

At page 80 of your witness statement you report, following an equality impact assessment focus group

meeting in July 2020, that the NHS NSS had an action to develop useful infographics to clarify that contact with the National Contact Tracing Centre is confidential and that no information will be shared with the police.

It was noted that the infographic produced could be shared with local support groups. However, this action was not implemented.

FEMHO is keen to understand why such a seemingly simple action was not implemented by NHS NSS, given the positive impact that it could have had in raising public awareness and engaging with ethnic minority communities.

A. Okay, thank you for your question. I did explore these actions, there was a few actions that weren't undertaken by NSS. I did look into these in preparation for being here today, so thank you for your question.

But it is seemingly simple, but I don't think it is as seemingly simple. I spoke to our equality and diversity lead within NHS National Services Scotland, and she advised me that on reflection, this was a wider issue than for the National Contact Centre for NSS alone. The development of infographics is something that needs marketing, it needs skill in itself. This was a particular conversation in relation to gender violence, particularly women who are involved in sex trafficking or sex workers. And that's what -- what

surrounded that conversation.

So it wasn't implemented, it wasn't taken forward, simply because it was thought to be much wider, that information governance considerations would be considered in a more broad group, and the fact that there were other actions in relation to national contact tracing that were implemented, such as jump-off points, such as the revision of scripts to reflect some of the pieces that were identified from that particular, or those particular equalities focus groups.

MR DAYLE: Very well, thank you.

LADY HALLETT: Thank you, Mr Dayle.

Mr Weatherby, who is just there.

Questions from MR WEATHERBY KC

MR WEATHERBY: Thank you. I ask questions on behalf of the Covid Bereaved Families for Justice UK Group, and just two short topics.

At paragraph 154 of your statement, you refer to making contact with the 14 territorial health boards in June of 2022, regarding shared learning. And you refer to a number of challenges to patient and staff testing results, including difficulties applying lateral flow device results to patient records, which often involved making annotations to paper files.

A. Yes.

Q. And difficulties of staff reporting LFD results into the national portal. And I know you gave evidence earlier about the PCR results and how the electronic transfer of the information worked apparently well. But in terms of the LFD results, are you able to help us, first of all, with why those issues weren't identified earlier than June of 2022? So that steps could have been taken to address them earlier in the pandemic?

A. Yes, so I mean, more broadly, point-of-care testing is difficult to get into notes unless people would handwrite the outcomes simply because they're at the point of care, they tend not to be linked into the formal information systems that are digital and electronic.

In terms of identifying them earlier, this was an opportunity for lessons learned, so it will have triggered people to have thought about what could be better for them and what could be improved, and one of the recommendations you may have seen later in my statement arising from the clinical group that was looking at assay development was to focus more on point-of-care testing and the issues surrounding that. So we've already appointed a point-of-care lead specifically to do those things.

Q. Okay, but just to go back to the point about earlier,

I mean, the evidence you gave about the PCR test results and the seamless way that the information was transferred, wouldn't it have been more obvious, because of that, that the LFD results, in particular regarding the staff reporting, was a problem well before June 2022?

A. So I don't know about staff but I thought they were talking here specifically about patient care, so staff reporting was reported through the portal, and that's how that was done, and therefore would go into contact tracing and people who looked at that. But for patients, particularly those who were arriving in accident and emergency department, and having their LFDs undertaken, it would be difficult to get that into any information system.

Q. As you have said, yes, okay, I'm just working from the information in your statement. But can you help us generally, if there are difficulties in transferring the information, either in relation to patients or to staff through the national portal, presumably that would have had an impact on the Test and Protect or the TTIS programme, with respect to both patients and staff? The speed in which the information gets on to the records --

A. I don't know how they recorded that. They would have wanted that to have been highlighted on a patient's note

and record so that there was evidence that had been done, in reference to previous questions about patients moving through the system.
Q. Yes.
A. I don't know how point-of-care testing results get included within testing reporting in that way, I'm sorry. I can't help with that.
Q. Thank you. A second topic, briefly. You've been asked a series of questions by Ms Cartwright about care home staff testing, and it's your paragraphs 201 to 208. And you've spoken already about NSS offering support to care home staff testing in, I think, July of 2020.
A. Yeah.
Q. But isn't it -- is it right that it wasn't until December of 2020 that the Social Care Testing Pathway started, and the rollout of those pathways, which took a period of about eight months?
A. Yes. So that coincided mainly with the setting up of the regional, the regional test centres and the decision made to transfer social care, including care homes, staff, patients, visitors, on to that Pillar 1, so away from the UK Pillar 2 and into Pillar 1, and so there was a -- a transition plan was created in that space and social care pathways, I think there were about 14 of them that included women's shelters, homelessness, as

well as care -- home care workers, unpaid carers, and so on and so forth -- (overspeaking) -- space.
Q. Sticking with care home staff, am I right that it was the testing pathways that was the start of routine testing, routine organised testing for care home staff?
A. No, because staff -- the care staff had been identified as key workers so could access the UK Covid testing at the regional UK test sites.
Q. Yes.
A. This was the time that we chose to -- Scotland chose to transfer social care and care homes into that UK -- into our pillar, Pillar 1, into the NHS.
Q. Right. So that's at the point that it then became routine, it went from supporting care home --
A. Our support.
Q. -- (overspeaking) -- doing it -- to actual routine testing of care home staff?
A. I think that's when our support, so I haven't got the timeline in my head for when that became routine, but in July 2020, NSS was supporting care homes to access the UK, whatever was in place with the UK, and in December, we transferred them completely into the NHS system.
Q. Right.
A. So that's not to say that it was routine. It became part of the NHS system rather than the UK testing

pillar.
MR WEATHERBY: Yes.
I'll leave it there. Thank you.
LADY HALLETT: Thank you, Mr Weatherby.
That completes the questions we have for you, Ms Morgan. You've spoken very calmly but I'm sure it was a time of enormous pressure and challenges and I've no doubt that you and your colleagues worked extraordinarily hard to protect the people of Scotland. So thank you for all you did for their benefit, and thank you for your help to the Inquiry.
THE WITNESS: Thank you very much.
LADY HALLETT: And I hope you catch your train.
THE WITNESS: Oh, I will do, yes, thank you.
LADY HALLETT: Safe journey back to Scotland.
THE WITNESS: Thank you.
LADY HALLETT: I've been asked to break now before the next who is remote, but I'm going to lurk outside the door and come back as soon as we are ready.
MS CARTWRIGHT: Thank you, my Lady.
(12.29 pm)
(A short break)
(12.32 pm)
MS CARTWRIGHT: My Lady, the witness over the link is Ms Caroline Lamb. Can I ask for her to be affirmed,

please.
MS CAROLINE LAMB (affirmed)
LADY HALLETT: Ms Lamb, thank you for joining us again and I'm sorry if we've kept you waiting.
THE WITNESS: That's okay.
Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 7
MS CARTWRIGHT: Please could you give your full name to the Inquiry.
A. Yes, I'm Caroline Sarah Lamb.
Q. Thank you. Ms Lamb, you've provided a statement dated 3 April of 2025 to Module 7. Can we turn, please, to page 320 of that statement where we see your signature and statement of truth, and can I ask you to confirm, are the contents of that statement true to the best of your knowledge and belief?
A. Yes, they are.
Q. Thank you. Can we then, please, identify who you are. It's right, isn't it, that you are Director General of Health and Social Care?
A. That's correct.
Q. And you've been in the post since January 2021?
A. Yes.
Q. Prior to that, you were delivery director for contact tracing and isolation from 5 May 2020 until August 2020?
A. Yes.

Q. And in this role you worked with local government representatives who had the responsibility for support for isolation to ensure delivery of end-to-end services?
A. Yes, that's correct.
Q. Thank you. And I think it's right, isn't it, that you also had a role as director of digital health from January 2020 until January 2021?
A. Yes, that's correct, yes.
Q. Ms Lamb, can we thank you on behalf of Module 7 because it's clear you've given much time and energy to the Covid Inquiry. It's right, isn't it, that you provided eight previous witness statements, five of which have been corporate statements, and have given evidence already in four earlier modules?
A. Yes, that's correct.
Q. Thank you. Ms Lamb, accordingly, there is a huge amount of detail in your witness statement that gives the context as to the roles and responsibility of the department, and so can I take it fairly briefly with you, please.

Can we, first of all, go to your paragraph 7, please, at page 3., just to give some context to your evidence, please. You tell us that a Director General manages a number of directorates and agencies which are responsible for proposing legislation and putting

Scottish Government policy into practice.

You are, as we know, the Director General for Health and Social Care, and the direct reporting line for you is to your portfolio DG, but you also report directly to the Permanent Secretary and to ministers; is that correct?
A. Yes, what that actually indicates is the direct reporting line for a director is to me, I'm the portfolio DG, but directors can also report direct to the Permanent Secretary and to ministers. I'm responsible to the Permanent Secretary and to ministers.
Q. Thank you very much.

Can we then briefly look to identify how the directorates changed in the pandemic. Can we move forward to paragraph 16. Thank you. So paragraph 16 at page 7. You detail there of the structural and responsibility changes in the relevant directories (sic) that occurred during the pandemic and I think significantly, the Directorate for Test and Protect that was created in April 2020 and the Directorate for Covid Public Health that was created in June of 2020; is that correct?
A. Yes, that's correct.
Q. Thank you. And you give the full history to the evolution of those.

Can I then briefly, because they're helpful tables, identify the summary of advice that the Health and Social Care Directorate provided.

Can we move to paragraph 72 at page 25. Thank you.

You've helpfully detailed there a chronology of high-level advice provided by the Director General of Health and Social Care in relation to Test and Protect; is that correct?
A. Yes, that's correct.
Q. Thank you. And you've also significantly assisted the work of Module 7, if we turn, then, to page 42, please, and the chronology of decision making in relation to TTI, which starts at page 42, but if we go to the final page, we can see takes us up to, at page 56, the fifth -- sorry, 1 May 2020, and the ceasing of routine contact tracing in health and social care settings, and cessation of population-wide contact tracing.

And so I do that very briefly, Ms Lamb, just to give some context to the evidence, but also the substantial amount of information you have provided on behalf of the Directorate, for which we are grateful.

Before we then get into my next topic, which is preparedness, is there any other context to understand the Directorate and your role that's necessary to understand your role within the Test and Protect system

that operated in Scotland, please?
A. I think it might just be helpful for the Inquiry to understand that the Directorate for Test and Protect was set up in order to be able to give a particular focus and additional resourcing, as we moved into the phase of the pandemic that was going to be very focused on testing and contact tracing, and as you've already identified, I took up the post as director for contact tracing and isolation delivery early in May, and was in that position until August. So it's quite a short period of time which was very much about establishing the systems and the processes at which point, then, that just became part of the ongoing business of the Directorate for Test and Protect.
Q. Thank you very much. Can we then move to my first substantive topic that I seek your assistance, please, Ms Lamb. Can we move to your paragraph 135, please, at page 57. This is a section of your statement where you deal with system readiness and funding.

Now you detail that:

"For many years the Scottish Government has had in place law, policy and practice to prepare for, respond to, and mitigate the impact of emergencies including the management of pandemics and epidemics."

If we could then move to paragraph 136, please, you

say this:

"However, in January 2020, Scotland's national preparedness for a large-scale and rapidly deployable Test, Trace and Isolate ... system was limited, as the concept of comprehensive whole population community testing and contact tracing was not yet central to the pandemic planning. As was the case with other UK nations, Scotland's preparedness plans for an influenza pandemic did not anticipate the scale of speed of testing required for Covid-19."

Can I ask you then, are you able to give any other observations as to why the state of preparedness in Scotland was not ready for this pandemic, please?

A. I think, as with the rest of the nations in the UK, our planning and preparedness was based on pandemic flu planning. I think we had anticipated a shorter wave to the pandemic, and we didn't really have any concept of, as it says here, of comprehensive whole-population testing and the sort of scale of testing and then contact tracing effort that we -- that in the end we ended up rolling out.

So we -- that is one of the things, I think, definitely in terms of recommendations going forward, because we did have to take the time to scale up that whole-population testing and contact tracing.

Q. Thank you. Can we then, please, move to your paragraph 271, which I think gives some idea as to the testing capacity at the beginning of the pandemic in Scotland, please. And if we look at paragraph 271, thank you, we can see that at the outset of the pandemic, Scotland had capacity to process only 350 tests per day, as against a population of over 5 million.

Now, you state that in January 2020 Scotland's national preparedness for a large-scale and rapidly deployable TTI system was limited. But can I ask you, in saying it was limited, would you in fact agree that in fact it, rather than "limited", that's a significant understatement of the state of tests available at the beginning of the pandemic?

A. So I think that is correct, in that we didn't have the platforms for the sort of scale of testing that we ended up needing, but actually, those platforms weren't the only limited factor. A test for Covid had to be developed. We needed -- all the commercial reagents and supplies needed to be developed, as well. But yes, you're right: there was not enough testing capacity. There was not as much as we needed at the beginning of the pandemic.

Q. Thank you. And perhaps just to give, then, some context

to then how this progressed, if we move to your paragraph 348, please, thank you, which is on page 115. Thank you.

You can see that you detail about the scale-up and over March of 2020, laboratory testing capacity increased with a further laboratory commissioned in Dundee, so that by 18 March 2020, Scottish daily testing capacity was 780 PCR tests per day across the three laboratories, Edinburgh, Glasgow and Dundee.

Then you go on to deal with the input of the Glasgow Lighthouse laboratory that we know became operational from 21 April 2020, and you were able to detail that by 1 May 2020, NHS lab capacity was 4,350. In the Glasgow Lighthouse laboratory testing was 4,000, giving a total capacity of 8,350.

Then you detail, then, that by 5 June 2020, this had increased to 8,626, and 20,000, giving the total capacity of 28,626.

So, then, can I just confirm, the NHS lab capacity, was that the tests that were available within hospitals and the Lighthouse laboratory test, was that available for the community testing?

A. So it wasn't quite as defined as that but that's about where the capacity was being delivered from. The Glasgow Lighthouse laboratory did end up being used for

other purposes, as well, but yeah, and that gives an indication, I think, of just how quickly that capacity was being scaled up.

Q. Thank you. Now, can we at this stage then move to one of the lessons learned around the pandemic, and move to your paragraph 880 at page 311. And we're grateful for, in particular, the detail provided as to lessons learned. But you detail in the statement, you agree with the findings of the UK-wide technical report on the Covid-19 pandemic, which includes within it "Limitations in testing capacity and an end-to-end system to effectively use the output of testing were initially a major constraint", and I think you've quoted from the report. I don't think we need to go to it, but it's summarised there.

Can I ask you, given this major constraint that's identified within the technical report that's accepted by the department, do you agree that more should have been done to prepare for a pandemic emergency, including through the availability of greater testing capacity, availability of vital data, as well as measures such as contact tracing?

A. Yes, I do agree that those measures need to be in place and the work we've been doing in Scotland. So, for example, I think we've still got capacity to do about

65,000 tests a week in Scotland, so we've been very concerned to try to retain those platforms and that capacity.

Q. Thank you. And can you assist, what, in your view, were the barriers to scaling up testing capacity in Scotland more quickly at the outset of the pandemic?

A. I think, first of all, was having the right tests, and being clear that those tests had been quality assured, and that they were appropriate. And it was then around recruiting the staff, making sure that we had all the consumables that are needed and putting all the processes in place to make sure that the data flowed in the correct ways.

Q. Thank you. And can I then -- just on the data flow, can I briefly take you to your paragraph 242, please, at page 86. In fact I'll start with paragraph 241. You detail that:

"Available high-level data within TTI was generally provided when required and of sufficient quality to support good decision making. Whilst there were specific technical issues as described [above] other technical challenges were generally short lived."

But then can I just seek the operation of what you tell us at the next paragraph, so:

"As the Four Nations Testing Programme grew in

detail that:

"Operational data aggregation at the national level, until early 2021, limited local authorities and health boards in understanding testing demand in their specific regions. [Public Health Scotland] launched a targeted community testing ... dashboard, with data flowing from the Deloitte dashboard, to enable local partnership areas (local authorities, NHS territorial boards) to prioritise targeted community testing resources and support local decision-making. The data on this dashboard included the number of symptomatic and asymptomatic tests conducted and cases found by TCT mobile testing unit testing, and asymptomatic tests conducted and cases found by community asymptomatic testing using [lateral flow tests]."

Can you, assist and provide an example of how local authorities and NHS boards utilised the data from the targeted community testing dashboard to adapt their testing strategies in response to the specific needs of ethnic minority communities, please.

A. Yes, so the targeted community testing dashboard was intended and did help local authorities and health boards to understand where they were experiencing spikes or whether there was a high prevalence in particular areas. So one example that I would give you was in

complexity, a range of reporting data points became available. Deloitte developed the OMIP (Operational Management Information Platform) dashboard for Pillar 2, (population-wide) testing, providing daily updates on completed test volumes. Positive results from both Pillar 1 ... and Pillar 2 ... were integrated into the Case Management System ... delivering a comprehensive dataset for monitoring case numbers. [Public Health Scotland] contributed verified case data with geographic and demographic breakdowns, supporting the establishment of a twice-daily ministerial Covid-19 briefing."

So can I ask you then, in terms of the OMIP system linked to the Lighthouse laboratory, was there any issue at all in respect of the sharing of data from the testing at the Lighthouse laboratory into the relevant platforms operating within the Scottish systems?

A. My recollection is that there was complete cooperation in terms of making sure that we got those flows into our platforms, particularly into our case management system, alongside the flows that coming were coming from the NHS Scotland laboratories.

Q. Thank you.

Can we then move forward to the next page, please, to page 87, your paragraph 245, and can I ask for some more assistance, please, in respect of testing. You

Glasgow, where we worked together with the central mosque to deliver a testing station within the mosque in order to help minority ethnic minorities to more easily engage with the testing programme.

Q. Thank you.

Can I ask you, did that in any way impact the rollout of prioritised test for healthcare workers?

A. No, the programmes ran alongside each other. So we were focused, we had our priority groups for testing and our targeted community testing was around trying to make sure that we were focusing on areas, as I said, where there appeared to be a high prevalence of Covid.

Q. Thank you. And can I ask, did the targeted community testing dashboard data facilitate more equitable resource allocation across Scotland's diverse communities?

A. So the dashboard was absolutely intended to enable us to shift our testing resource towards the areas that appeared to be experiencing most instances of Covid. So yes, and there was really good, close collaboration between our health boards and local authorities in terms of identifying whether they'd be walk-in sites or mobile units to help to target those areas when they were identified.

Q. Thank you. And are you able to assist as to how the

insight gained from using the targeted community testing dashboard shaped Scotland's long-term approach to targeted community testing, particularly in terms of reaching ethnic minority groups?

A. I think that data, together with other data, helped us to understand the ways in which we needed to ensure that our communications with different groups, particularly ethnic minority groups, were really good and strong, that they were trusted communications that would encourage people to engage with the Test and Protect programme and also -- and the way in which we did that was very much by way of involving community leaders and, you know, another example would be actually just using the mosque as a facility for testing in order to build that confidence in the programme.

Q. Thank you. And are you able to assist whether there was any lasting changes in how data was used to inform testing strategies for vulnerable communities?

A. I think, in terms of lasting changes, we have absolutely, I think, recognised the importance of understanding at a granular level what's happening in communities, and also being able to cut that data in different ways. So being able to identify ethnicity and proportions of people from minority ethnic groups who are testing positive, equally being able to identify age

ranges and gender and other factors as well.

So I think one thing that we all learnt out of Covid was the absolute importance of having good data, getting it joined up really well and using that to gain, to develop insights that help you to improve the services and the response that you're providing.

Q. Thank you.

Ms Lamb, can I now move to a new topic, please, and it's self-isolation support. Can we move to your paragraph 680, please, which is at page 222 of your statement. Thank you.

Now, you indicate at paragraph 680 that the Scottish Government recognised the risk of financial hardship as a barrier to self-isolation, and you say that by 26 March 2020, when it added 45 million to the Scottish Welfare Fund to provide crisis grants. However, it then took until 13 October 2020 to provide more substantial financial support for those earning the real living wage, or less, who had to isolate through the introduction of the Self-Isolation Support Grant.

Do you agree that it was a failure of pandemic planning that provision of such vital financial support was so delayed?

A. I think that it is really important for future pandemics that we further consider how we can provide that

financial support to people who are being asked to self-isolate. I think in terms of what we did in Scotland with the Scottish Welfare Fund, that was a well-established arrangement. We did put an extra 45 million into that fund, as I said, well established, run by local government and has been in place since 2013, and we appointed people who were asked to self-isolate, those people who, when they were contacted either because they'd had a positive test or because they were a contact of an index case, they were asked if they were prepared to share their data with the local authority so that the local authority could proactively contact them, and ask them what financial support was needed.

I think over and above that, it was really important, then, that we looked to make sure that there was a mechanism in place for those people who were on lower incomes, so certainly the real living wage or less than that, and the Scottish scheme was slightly more generous than that in the rest of the UK, because we wanted to make sure that people weren't being put off self-isolating because of the fact that they would be losing income.

Q. Thank you. But can you assist us, and we've examined it with other witnesses as to how the scheme was

implemented, but can you assist in terms of the scheme in Scotland, why it took until 13 October 2020 for Scotland's Self-Isolation Support Grant to be introduced?

A. I am not -- I'm not sure I can help you on that one. My recollection is that it was to do with the overall funding flows, but I'm not absolutely certain on that.

Q. Thank you.

Can I then, please -- if we just look at some more paragraphs on the Self-Isolation Support Grant, you tell us at 681 that:

"The Self Isolation Support Grant ... provided financial support for those who earned the Real Living Wage or less and who would experience reduced earnings as a result of them, their child or the person they were caring for being required to self-isolate, or stay at home, to prevent the spread of Covid-19."

You say:

"It opened for applications on 13 October 2020 enabling claims for those affected backdated to 28 September 2020."

Can I see if you can assist any more in respect of wider context. Can we look briefly, please -- and in fact this will probably take us to the lunch break -- at the statement of Ms Sturgeon, please, which is

INQ000475142. And it's paragraph 191 at page 74, please.

Have you had an opportunity to consider the statement of Ms Sturgeon as part of your preparations, Ms Lamb?

A. I have, yes.

Q. Thank you. We can see that Ms Sturgeon details in her Module 7 statement:

"I understood the impacts of Covid-19 were experienced disproportionately by those with different protected characteristics, as set out to me in briefings and submissions provided by policy colleagues. There was evidence that people on lower incomes or insecure work, without the protections provided by contractual or statutory sick pay, may be impacted the most from requirement to self-isolate. This may also read across into intersectional considerations, such as the increased risk [black, Asian minority ethnic] or disabled people face with regard to being on lower incomes. My understanding and need to ensure this was forefront of our minds in all decision-making remained throughout the pandemic."

Now, that gives us a bit more context, but are you able to assist with that clear statement from Ms Sturgeon as to any other detail you can give as to

why it took so long for the Self-Isolation Support Grant to be implemented in Scotland?

A. I'm sorry, I can't help with that.

Q. Thank you.

My Lady, I'm slightly before the lunch but I wonder whether that's a convenient --

LADY HALLETT: We were planning to sit until 1.15 --

MS CARTWRIGHT: Oh, brilliant, I'll carry on then, thank you. Sorry, the message didn't reach me.

Apologies, Ms Lamb.

Can we then, please, look at another document, please, INQ000119080.

Again, just to give some more context, if we look at page 1 of this document we can see also that even those entitled to Statutory Sick Pay were still at risk of financial hardship, as highlighted in this report from the TUC explaining that Statutory Sick Pay is around one-fifth (or 19%) of average weekly earnings, at £504, and that self-isolating for two weeks on Statutory Sick Pay would mean losing out on £816. And we can see its details, living off just Statutory Sick Pay for two weeks would push many people into financial hardship.

Now can you assist, then, any further, would you agree that financial planning and support for isolation

is a significant issue that needs to be addressed in future pandemic planning?

A. Yes, I absolutely agree with that, and I think that -- so particularly from the perspective as the director general for Health and Social Care, we -- the NHS has a very strong occupational sickness scheme, but we were very conscious that social care workers were not necessarily in the same position, depending on who was their employer.

And so the Cabinet Secretary did actually announce in May 2020 that we would establish a Social Care Staff Support Fund for staff working in social care who may only be entitled to Statutory Sick Pay, and that was absolutely because we wanted to ensure that they were not -- there wasn't a -- the fact that their earnings would be reduced was not a barrier to them actually self-isolating.

Q. Thank you.

Can we then look at another document on the particular impact on social care workers, please.

Can we look at INQ000107206, please. Thank you.

And this is a note of a meeting from 13 May. Again, it was one of your documents in your pack from 2020.

Can we then move in this document to page 4, please. Thank you.

I think we can see there that the issue was a particular concern for those working in care homes. It was raised in that meeting of 13 May 2020, during which essentially the Scottish Government were informed that workers were afraid of being tested in case they test positive and therefore end up in isolation at home on Statutory Sick Pay.

Are you able to assist what lessons can be learned to ensure that care home staff are better supported from the very beginning of a future pandemic?

A. Yes. So I think that for -- I think the lesson learned from that is that we need to be aware that not all employers are paying -- or have in place an occupational sick pay scheme, and that, as a result, we need to be ready, as we did on 27 May 2020, to set up a scheme that provides support that -- so that actually that fear of loss of earnings is not a barrier to people self-isolating.

I think we need to be prepared for that next time, and ready to put such a scheme in place more quickly.

Q. Thank you. Can we then, please, on the issue of what then the Scottish Government did then, please, can we look, please, at INQ000103538. That's INQ000103538, at page 14, please. Thank you.

We can see at paragraph 40, that the Scottish

Government did announce on 24 May 2020 that social care workers would receive enhanced sick pay when they were self-isolating following a positive Covid-19 test.

Can you help as to -- and sorry, this is the statement of Roz Foyer, that was provided in Module 2A. Are you able to assist as to why this approach for enhanced sick pay was not adopted more widely in particular for other key workers in critical sectors?

A. I'm afraid I can't assist you with that, I was focused on what was happening with this -- this DG was focused on what was happening within health and social care.

Q. Thank you.

Now, can we then display another document, please, INQ000589787. That's INQ000589787. Thank you.

We can see there this is the Coronavirus (COVID-19): fair work statement. And can we go to page 2. In December 2020, the Scottish Government issued a Covid-19 Fair Work Statement, which included:

"Our success in managing the virus at this critical stage depends on employers supporting workers to self-isolate and attend for vaccination, when advised to do so without any financial detriment."

And it also details:

"No worker should be financially penalised for following medical advice. Any absence relating to

COVID-19 should not affect future sick pay entitlement or other entitlements like holiday or accrued time."

How was this monitored and enforced in Scotland to ensure that workers were in fact supported to be tested and self-isolate without detriment?

A. So the Fair Work Statement is a statement of the way in which Scottish Government expected and encouraged employers to support fair work forces, but it is a voluntary statement, it's not in regulations. So it was not possible, as a result, to either monitor or report on that.

Q. Thank you. Can we then, please, continue with what you tell us about the financial schemes within your witness statement, please. Can we go back to paragraph 699, please, at page 226. That's INQ000587342, page 226, please.

Thank you.

Now, you tell us, Ms Lamb, within the statement around the Scottish Government being mindful of its duties under the Public Sector Equality Duty, including eliminating discrimination and advancing equality of opportunity.

Can you assist as to how these duties were in fact operationalised in practice during the design and implementation of the Self-Isolation Support Grant in

Scotland, please?

A. Yes, so a full EQIA was carried out on the Self-Isolation Support Grant, and that identified a number of groups who were likely to be adversely impacted by requirements to self-isolate. People -- groups around age, disability, race and gender, particularly. And as a result, there were various changes made to the operation of the Scottish self-isolation grant, including looking to extend eligibility of it, to parents who had to isolate because their child was needing to isolate, to those who had no recourse to public funds due to their immigration status, and we also recognised that if we had stuck to the Universal Credit limits around income then that would have limited the grant to quite a -- to I think around only about a quarter of the Scottish population. So it was -- our eligibility criteria was extended around that as well.

Q. Thank you.

Can we then look at your paragraph 702, which you touched upon in giving that answer, please. You detail that:

"The Scottish Government understood the impacts of Covid-19 were experienced disproportionately by those with different protected characteristics. [The Scottish

Government] also recognised that there were a lot of crossovers between the different groups."

And that:

"[The scheme] was for anyone earning the equivalent of the real living wage or less to get through a period of isolation. [It] was designed and amended to always reflect the needs of these groups and mitigate financial loss wherever possible by providing targeted financial support.

Can I just have clarity about what's meant by "targeted financial support", please.

A. Yes, so this was to target financial support particularly around those people who were earning the real living wage or less. But also to look at some of the circumstances in those groups through the equality impact assessment process and through our learning through that to make sure that the people who needed it most were absolutely eligible for it. So the example I just quoted around people without recourse to public funds would be one example there.

Q. Thank you. But can you assist as to how the Scottish Government assessed whether the grant was reaching the most marginalised groups, including ethnic minority individuals in low-paid or insecure work, or those who had no recourse to public funds?

A. So the grant was distributed through local government, and there was -- we put in place arrangements so that people who were being contacted by contact tracers would be asked if they were happy to share their information and the local government would then get in touch with them. We tried to make it as easy as possible for people to apply by having all the information available on the mygov.scot website. In terms of who was getting it, I think that information would be held by local authorities, but I do know that we awarded around 78.8 million and that impacted 152,000 workers in those low-paid categories.

Q. Thank you.

And can you assist, was specific analysis carried out to evaluate the level of uptake of the grant among the most vulnerable communities? Obviously, you've just given an idea as to how much was issued, but was there specific analysis as to take-up?

A. There was an impact assessment carried out, yes.

Q. Thank you.

And then can we look, please, at your paragraph 703. You detail the development of the discretionary element of the grant to include individuals with no recourse to public funds, many of whom were from marginalised groups. Can you help, given the systemic barriers faced

by this population, including a lack of entitlement to mainstream benefits and potential hesitancy around engaging with government services, how did the Scottish Government address those barriers?

A. So we attempted to address those barriers through communication, so we had self-isolation and facts sheets that were produced, I think in the end, in around 27 different languages. We ensured that they were directed through door drops, using the advice of stakeholders from various groups, local community leadership leaders and our local authorities, who have a good understanding of their communities.

So we tried to ensure that there was information available from trusted sources to people who might feel a bit vulnerable about coming forward to claim something.

Q. Thank you.

And just building of what you've just said about those vulnerable and whether they'd come forward, can you assist with what steps were taken to ensure individuals with no recourse to public funds were made aware of, and able to access the support, particularly in the context of those who had immigration-related potential consequences, so that they could come forward essentially without fear of immigration-related

consequences?

A. Yes. So, again, that would be through the facts sheets and ensuring that groups working with those communities, who were already trusted by those communities, were in a position to provide that support and to help them with the fact sheets.

Q. Thank you. And then perhaps again, can you assist, should there be another pandemic, will the Scottish Government be able to properly financially support people who have to isolate, and are prevented from working, from the very outset of a pandemic?

A. Should there be another pandemic, the Scottish Government would absolutely want to support people and to do that as quickly as possible. Throughout other evidence sessions we have been through some of the limitations on funding in Scotland and some of the constraints in terms of how the level of funding that is available to Scottish Ministers to make those decisions, how that process works. So I think Scottish Government would absolutely want to do that.

We would need to ensure that that was aligned across UK Government to ensure that they asked -- that the right amount of money of funding was available.

Q. Thank you.

And can I ask you, on the topic of funding, please.

If we could please display your paragraph 147, at page 60. Thank you.

You detail the reliance on the UK Government for funding for Test and Protect, and detail that, although Scotland has devolved powers over health spending, initial baseline funding and its growth largely rely on decisions made by the UK Government, and that a lack of clarity over Barnett consequentials made it more challenging for Scotland to swiftly implement and scale a comprehensive TTI system right from the outset of the pandemic.

Can you assist as to how this affect or hampered the Scottish Government's ability to introduce the Test and Protect strategy?

A. So, as I said before, this is about a certainty that -- understanding and having certainty over the financial flows that are going to come to Scotland. And I think in all cases throughout the pandemic, and in fact as I covered in my evidence in Module 5, the Scottish Government took a view that they would proceed sometimes at risk, pending that financial certainty being provided by the UK Government.

I think that, in terms of what we might want to think about for a future pandemic is how we ensure that those conversations and that certainty about funding

happens really, really early on.
Q. Thank you.
And so building on that, can I ask, could the Test and Protect strategy in Scotland have been achieved more quickly or more effectively if it had not been for these funding constraints?
A. I think that actually, in practice, ministers made the decisions that they needed to make and sometimes did that at risk, pending financial certainty from the UK Government, and there was probably not much more. There are other limitations around the actual volume of testing available that were constraints on the strategy rather than just the financial aspect.
Q. Thank you.
And you've mentioned a couple of occasions now, occasions when the Scottish Government essentially took action at risk before the assurances to financials. Can you give us a concrete example of one of those, please.
A. So my most concrete example of that would be in relation to the evidence I gave in Module 5 around personal protective equipment, and the Scottish Government needing to provide NSS with -- as it was, with cover to go ahead and procure equipment before we had certainty of those funding flows from UK Government.
MS CARTWRIGHT: Thank you, Ms Lamb.

My Lady, is that a convenient moment? Thank you.
LADY HALLETT: Very well. I'm sorry we have to break off in the middle of your evidence, Ms Lamb, but we shall return at 2.15.
(1.16 pm)
(The Short Adjournment)
(2.14 pm)
LADY HALLETT: Ms Cartwright.
MS CARTWRIGHT: Thank you.
Good afternoon, Ms Lamb. Ms Lamb, can I start with a new topic, please, international comparisons, and please can we display your paragraph 191, which is at page 72, please.
Now, you detail in the statement:
"In addition to cooperation, the UK has a seat as a member state on international organisations, such as the World Health Organisation ... and the World Health Assembly ... Whilst Scotland is not a member state, information provided by these relevant international organisations was provided to the Health Protection Network and the Chief Medical Officer."
Can I ask then, please, had the Scottish Government undertaken any work relating to international experience and learning relevant to inform its test and protect, isolation and support preparedness prior to the

pandemic?
A. So, prior to the pan -- I'm not aware of what work had been done prior to the pandemic. As the pandemic, as we started to be aware of the existence of Covid-19 in China and -- (overspeaking) --
Q. Sorry, Ms Lamb. Can I just interrupt you, I don't whether you're sat near the microphone, it's quite crackly, whether you sit back -- I am sorry, you might want to start that answer again. I'm sorry for interrupting you.
A. That's quite all right, I think there's something around the connectivity, which is odd because it's been fine so far, but you're a bit broken up for me, as well.
Q. I apologise --
A. -- (overspeaking) --
Q. Please, if you can't hear me, please let us know, but if we're able to just to continue if you can persevere with the slight crackle we'd be very grateful. Thank you.
A. Thank you.
Q. Do you want me to ask the question again or --
A. No, I heard the question.
Q. Thank you.
A. Prior to the pandemic I'm not really aware of how much engagement we had because that would have been around the four nation development of the pandemic flu plan.

As soon as we became aware of the existence of Covid-19 through our Chief Medical Officer and, as it says here, through our Protection Network, colleagues were talking to other colleagues internationally, and in terms of how we specifically looked at how we set up Test and Protect, our establishment of Test and Protect was very much based around the WHO recommendations for a test and protect -- or a testing and contact tracing system.
We also took, through our advisory groups, one of our advisory groups looked at a review done by the University of Edinburgh, of international approaches, that was around asymptomatic testing, and I'm aware, also, of another paper that was considered around how Slovakia went about whole-population testing.
So there was some formal consideration through those advisory groups of other international approaches, and at the same time, our Chief Medical Officer, through the four UK medical officers, but also through his own international links and their international links, kept very close to developments that we thought would be helpful for us overseas.
Q. Thank you. Can I then, please, move to a new topic on communication, please. And can we go, please, to your paragraph 762 at page 266 please. Thank you.
You detail there that:

"The Expert Reference Group in Covid-19 and Ethnicity was asked to provide advice and recommendations by the Scottish Government in relation to data, evidence, risk, and systemic issues ..."

And then you tell us about the two subgroups formed:

"... one to review health data and evidence, and the other to examine systemic issues and risk."

You tell us that the work of both groups was underpinned by evidence of the risks that migrant and minority ethnic communities face in contracting Covid-19.

Can I ask, given your role as director for Test and Protect, how were the recommendations of the Expert Reference Group incorporated into the design and delivery of the Test and Protect programme?

A. Yes, there was a full equalities impact assessment of the Test and Protect programme carried out pretty early on, so we worked through that process to look at the impact on different groups, including ethnic minority groups. The Expert Reference Group I think brought to us that analysis and a recognition that our data wasn't good enough, in terms of ethnicity, and one of their key recommendations, not just for the Test and Protect programmes but for other programmes, was that we needed to improve the collection of ethnicity in our core

health systems so that we were able to really review the data with the lens around ethnicity.

And in fact, one of the things that we took forward as a result from that, not in the Test and Protect programme but in the vaccination programme, was taking the opportunity when people came forward to vaccination to ask them if they were prepared to use that to disclose their -- engagement to disclose their ethnicity that would help us to get a more complete record across Scotland.

Q. Thank you. Can we then move forward to your paragraph 795 please, at page 275, and you detail in this paragraph and the paragraphs that follow the partnership working that existed in the Scottish Government with NHS and Public Health Scotland colleagues and also the Black and Ethnic Minority Infrastructure in Scotland, the Minority Ethnic Health Inclusion Service, and the Minority Ethnic Carers of People Project and the Scottish Public Health Network to develop the content of the factsheet and the translated language list.

And then you further give more detail of the efforts taken, if we look at paragraphs 797 and 798, again around the work done messaging and communication.

And can I ask, then, having looked at those matters,

can you assist or explain how these working relationships developed, and why it was considered essential to convene these specific organisations in response to the challenges posed by the pandemic?

A. So, these were organisations that were trusted by ethnic minority communities who had a really good understanding of the concerns of those communities, and they were bringing to us issues around our -- the extent to which our messaging was reaching those communities and the extent to which those communities had barriers and challenges in complying with that messaging and understanding what we were asking them to do and being able to do that.

And I think some of the benefit that came out of those discussions were around how we were able to tweak our communications, particularly in things like self-isolation factsheet, as we had that evidence that there may be poorer levels of compliance with self-isolation, and bringing to us some of the understanding around cultural norms. So, for example in cultures where it's very much part of the culture that you gather together, that you visit each other, and that it might be considered very unwelcome for people not to -- to stop you doing that, it helped us to be able to translate those messages and assist people to understand

why we were asking people to reduce their gatherings, for example.

Q. Thank you.

And can we look specifically then at paragraph 797, please, on page 275.

You detail that:

"Minority partners highlighted that self-isolation messages were not being understood within Ethnic Minority communities."

You tell us:

"There was evidence that people were still going to work and sending children to school when waiting for test results and also when testing positive. For those in extreme poverty, self-isolation was a huge challenge, and for those with no recourse to public funds, following the rules was extremely difficult and might mean their familiar would not have the essentials."

Can I ask you in that context, can you assist, and I appreciate we've asked a number of questions in the same context, but are there any other additional measures that you want to tell us about that were put in place to specifically address these concerns in Scotland, please?

A. So the first part around self-isolation messages not being understood, the measures that we took to try to

address that was to work with members of those communities to understand how we needed to tweak our factsheets. And that might have been about translating them into more languages; it might have been about slightly changing the way in which we were -- the text that was involved in those, or the visuals that were involved in them. It might have been about presenting more information in a targeted manner through video clips, and those sort of things.

So we worked really hard to make sure that those -- the messages around what you need to do if you're asked to self-isolate were, you know, as clear and -- as possible in the context of the cultural norms within those communities.

And then, in terms of that -- the issues around self-isolation being a huge challenge for those in poverty, as I've already said, we made sure that the Scottish Self-isolation Grant was available to those with no recourse to public funds. We worked with the relevant groups to make sure that people understood that was available. And we also continued to ensure that the eligibility bar for those was lower in Scotland than elsewhere in the UK.

Q. Thank you. You've just referenced the work that was done on the self-isolation factsheets. Perhaps, for

completeness, if we can look briefly at your paragraph 801.

At page 276 thank you.

You detail there the languages in which the self-isolation factsheets were created in and the various formats.

Then if we can just look briefly at the follow-on paragraph, again, touching on what you've told us about the audiovisual information in community languages, I think there's further examples there about how that particular tool was utilised to assist with communication; is that correct?

A. **(Witness nodded)**

Q. Thank you.

A. That's correct, yes.

Q. Thank you.

Then finally to complete the topic on communication, in light of the difficulties in self-isolation compliance, were there any lasting impacts or changes in policy regarding how the Scottish Government collaborated with minority ethnic organisations, especially in terms of communication strategies for future public health crises?

A. Yes, I think we learnt a huge amount about communication strategies for -- in general, but -- for general public

health issues, but also for future public health crises. And I think that comes back to making sure that the messaging is really accessible, making sure that you are building trust and using trusted organisations to communicate with different communities, and really understanding the impact in this -- in the case of this pandemic it was around isolation; in another pandemic we might be asking people to do different things. But it's about understanding the impact on different groups of what we're asking them to do, and then, again, making sure that access to testing was as easy as possible. And that was -- that was around, you know, targeting minority ethnic communities in places where they would feel comfortable to engage with the testing programme, and equally in our remote and rural communities, making sure that we were using mobile units, the Scottish Fire and Rescue Service and others to take tests as close to people as possible.

Q. Thank you.

LADY HALLETT: Ms Cartwright, I'm sorry to interrupt, I've been asked to break so the connectivity issue can be resolved but, for reasons I am not going to go into, I'm reluctant to break this witness's evidence, so I'm just going to encourage everybody to focus their questions, and this obviously applies to those Core Participants

who have permission to ask questions, solely on the issues that really do need to be highlighted.

MS CARTWRIGHT: If it assists, my Lady, I've only got a brief question on scaling back and one question on lessons learned, so we're nearly there with my evidence.

LADY HALLETT: Thank you.

MS CARTWRIGHT: And I think there's been some indication that the TUC questions have either been shortened or reduced completely. So I'm sure that's noted. Thank you.

LADY HALLETT: Thank you very much. Sorry to interrupt.

MS CARTWRIGHT: No.

LADY HALLETT: Your last question was about tests as close to people as close as possible if that ...

MS CARTWRIGHT: Thank you, I think we'd completed that. Thank you.

(Pause)

LADY HALLETT: Ms Cartwright.

MS CARTWRIGHT: Thank you. Ms Lamb, thank you for your patience. Can I then move to my penultimate topic, please, scaling back of Test and Protect and when I started the questioning with you on the very helpful chronology, we saw that being the endpoint of the very relevant chronology of Test and Protect.

Can we contextualise these questions, please, in

your paragraph 206 at page 76. Paragraph 206 at page 76, please. Thank you.

Now, we see detailed there the view of the First Minister at the time, Ms Sturgeon, on 15 March 2022, where she detailed:

"Regrettably, our freedom of manoeuvre here is severely limited by the fact that our funding is determined by UK Government decisions taken for England. However, we have sought, as far as we can, to reach the right decisions for Scotland. It is important to note that we are aiming for the same long-term position as England on testing. However, we consider that the transition should be longer. In England, testing for people without symptoms ended in mid-February, and will do so at the end of this month [that being the end of March] for those with symptoms. We intend the transition to last until the end of April. This is as far as we can go within funding constraints, but this does allow us to take account of current case numbers and better support the shift in our management of the virus overall."

And so can we then, together, please, given the views of the First Minister around that decision, which we touched upon at the outset of your evidence, can we briefly look at the Test and Protect Transition Plan

from March 2022, which is INQ000235186, if we can start on the first page, please, first of all, just to identify it. Thank you.

And if we scroll down a little, just so we can see it's badged as March of 2022. Thank you.

If we could then move to page 9., would you agree Ms Lamb, that certainly the ideal plan that Scotland had hope to have in place for the scaling back of Test and Protect was a plan, if we look at this, this plan intended to have availability of lateral flow devices and PCRs from onwards to July of 2022, had the funds been available to permit the scale back in the way that Scotland would have liked to have done?

LADY HALLETT: I'm not sure we've got the foundation for that question --

THE WITNESS: (Inaudible) is the case that --

LADY HALLETT: I'm sorry to interrupt, Ms Lamb.

It seems to be accepting what Ms Sturgeon says and, as I said earlier, I've had a fair bit of evidence on funding, and I've yet to hear evidence of an actual decision not taken because of what Ms Lamb called the uncertainty of funding.

Was this programme, Ms Lamb, this timeline, affected in any way by the uncertainty of funding?

A. So, my Lady, in this case it wasn't about the

uncertainty of funding. We had certainty, and we knew that the funding was going to come to an end. So Scottish ministers' views was that they would have liked to have had a more gradual transition plan out of the full-scale testing, but took the decision that that was only affordable up through to the end of -- to the end of April.

MS CARTWRIGHT: Then can I ask, please, Ms Lamb, I think to look at the views also of Mr Yousaf.

Can we briefly look at his statement, which is INQ000475071. That's INQ000475071. At paragraph 157 on page 57, please.

Thank you.

Now, we can see there Mr Yousaf details that in early 2022 the UK unilaterally announced it would stop population testing for Covid-19 in England from April 2022 in most circumstances, and he characterised that this significantly reduced the available consequential funding for the Scottish Government, and constrained the Scottish Government's ability to decide on the length and nature of transition of the Test and Protect scheme.

Can I ask you, from your perspective as the director general, do you agree with Mr Yousaf's characterisation of this issue as detailed in his witness statement?

A. So, as director general and accountable officer for the portfolio budget, it is absolutely the case that the decision of the UK meant that Scotland would not be getting consequentials, and therefore that immediately put financial pressure on us in terms of needing to find money from other budgets in order to be able to continue -- to have a longer transition, and in practice, what that meant was that the transition was not as long as ministers would have liked it to have been because of the cost involved.

Q. Thank you. So I suspect you've answered this question, but would you then agree that what this meant for Scotland was that the Test and Protect scheme in Scotland was brought to an end earlier than should otherwise have been the case, as a result of the reduction in consequential funding available?

A. Yes, ministers would have liked to have seen a longer transition available.

Q. Thank you.

Now, you'd again helpfully assisted with giving the latter part of your statement from paragraph 876 over to lessons learned, and so I'm not going to take you through what's helpfully set out from page 310 onwards, but can I ask you then briefly on one aspect that's a little earlier in your evidence, at paragraph 239 on

page 85, linked to lessons learned from data handling, please.

That's INQ000587342, paragraph 239. Thank you.

Now, you detail within paragraph 239 that:

"A wide range of data resources were relied upon by [the Health and Social Care Directorate] in advising and briefing ministers and working with other partners, ([including] NHS boards) to inform policies and strategies at the various parts of [test, trace, isolate] ..."

Can you assist us with what lessons have been learnt by the pandemic by the Scottish Government regarding data shortcomings, data gathering, availability and analysis relevant to Test and Protect, please, and particularly if there's anything you want to say around Test and Protect in the context of isolating also, please.

A. Yes. So I think in terms of lessons learned, we absolutely learnt that we need to have access to multiple data sources, and that we need to be able to join up that data very quickly in order to make sense of it. That meant that we had to work through some of the information governance requirements around use of that data, and actually, that work continues today to enable us to ensure that the data that we have across

Scotland for multiple purposes is being put to the best use in improving of the services that we provide, so we continue to progress that work.

MS CARTWRIGHT: Ms Lamb, those are my questions. Can I thank you for answering them but also persevering with the technical difficulties.

There are some questions from Core Participants. Thank you.

LADY HALLETT: Mr Dayle.

Questions from MR DAYLE

MR DAYLE: Thank you, my Lady.

Ms Lamb, I ask questions on behalf of the Federation of Ethnic Minority Healthcare Organisations, or FEMHO, and I have two short topics I wish to explore with you.

Firstly, in paragraph 781 of your witness statement you mention the Scottish Government's Connecting Scotland's Programme, which aimed to provide laptops devices and wi-fi to individuals who were shielding or needed to avoid outside contact which was introduced to address digital exclusion during the pandemic.

My question is: how do you assess the role of digital exclusion in exacerbating health inequalities, particularly during the pandemic?

A. Thank you for that. So during the pandemic, I think we, as we were moving (inaudible) so much reliance towards

digital, we were really acutely conscious of the impact of this digital exclusion. The Connect Scotland programme was already in place, so that was already up and running, and we used that really to work with partners to try to ensure that we were reaching as many people physically excluded as possible. From the perspective of this portfolio, Health and Social Care, we had a real emphasis on shielding and also on people in care homes, and being able to use digital to connect those people in care homes with their families and loved ones, during the pandemic. Other portfolios such as Education, would have had more of a focus on the requirements for education, but the programme, I think, the programme continues. It's -- it was important during the pandemic, but it pre-dated the pandemic and it continues today, and it's distributed, I think somewhere around 36,000 devices, so iPads and Chromebooks, and also MyFi, so the remote connectivity devices, about 32,000 of them.

And it is, as I said, it's an ongoing programme to ensure that people are not digitally excluded by -- as a result of not having devices or connectivity, which is a bit ironic today, but we also need to ensure all the time that we're making other methods available so that people who are unwilling to, or unconfident (sic) in

engaging with digital, can reach us as well.

Q. Thank you. And it might be obvious, but how did the Connecting Scotland Programme integrate with other initiatives such as Test and Protect, to ensure that individuals who were digitally excluded could still access crucial public health services and information?

A. So the Connect Scotland programme focused on people who were shielding to enable them to access those resources, and also it was a key part of ensuring that people in care homes could continue to remain connected, as well. So those were the two big priorities from this portfolio's perspective, and we engaged with Connect Scotland to make sure that we were able to deliver on those.

Q. Were there any particular challenges in reaching certain communities?

A. I think probably the challenges are the same as we've heard across some of the pieces. Some of this is about understanding where the challenges -- where people are experiencing issues due to not having access to devices, or connectivity. I think we recognised right from the start that care homes were a particular feature, and we had I think about 80 to -- 85% of care homes engaged with this programme in order to improve that connectivity. But yes, there are always challenges in

people understanding what's available to them and getting that message out.

Q. And finally, given your leadership, how do you, stepping back a little bit, how do you or did you assess the impact of connecting Scotland, the Connecting Scotland programme in bridging the digital divide for those in vulnerable and marginalised communities, particularly in terms of access to health service and public information?

A. I think that the Connect Scotland programme was and continues to be, really important in providing an opportunity for those who are digitally excluded by virtue of not having access to the devices or connectivity. So that continues to be really important. I think that our focus -- inevitably we focused on some key groups during the pandemic, and as I've said, 85% of care homes engaged with that. I do not have data as to how well -- what the uptake was compared to what might have been expected in other vulnerable communities.

MR DAYLE: Very well. Thank you.

LADY HALLETT: Thank you, Mr Dayle.

Mr Jacobs, do you have any questions left?

MR JACOBS: (inaudible) my Lady, thank you.

LADY HALLETT: Thank you very much.

And Ms Mitchell.

Questions from DR MITCHELL KC

DR MITCHELL: I appear as instructed by Aamer Anwar & Company behalf of the Scottish Covid Bereaved. It is the experience of the Scottish Covid Bereaved that patients were transferred within hospitals between wards and units without having been tested for Covid. Was there any guidance put in place to ensure that patients were being tested before being moved within hospitals?

A. My starting point here is the Scottish National Infection Prevention and Control Manual which is maintained and kept up to date by ARHAI Scotland, that stands for the Antimicrobial Resistance and Healthcare Associated Infection team, and that manual is the guidance that is used by NHS boards in relation to the prevention and management of infections, whether they're Covid or whether they're other infections.

That -- in, I think, January, around mid-January, 10 January 2020, the UK -- there was a UK-wide Covid Infection Prevention Control guidance issued through Public Health England, and over time, that guidance was, I suppose, brought together and added as an addendum to that Scottish National Infection Prevention and Control Manual, because the guidance that was issued for England used terminology that was unfamiliar in Scotland so we did some work to make sure that was understood.

Within the constraints of the -- that National Infection Prevention Control Manual is the guide. Each NHS Board then needs to accept, facilitate its own risk assessment and operationalise those procedures, taking into account their own specific patient pathways but also the nature of their built infrastructure.

I think that, as well, in terms of that definition -- so we also, within the work -- those working procedures, the UK guidance specified that patients needed to be screened on entry to hospital, and that was screening at the point where we didn't have the testing capacity. And the screening, or indeed then followed on by testings, the screening would stream people into either low-risk, medium-risk or high-risk categories, with low risk being having no confirmed or suspected Covid, medium risk being maybe suspected but not confirmed and high risk being a clinically confirmed case of Covid.

And so those were the pathways that people needed to be managed between those because patients were cohorted within those pathways.

Q. So we've heard about ARHAI and we've heard about the screening on entry, but my question is to do with, once people had entered the system, whether or not thereafter, before they were moved to different places

around different wards, there was testing done or any guidance given on that?

A. So, in line with the Infection Prevention Control manual, again, NHS boards needed to make their own assessment of the risk, taking into account the cohorting arrangements for patients and which pathway those patients have already been -- which pathway those patients were placed in and whether there has been any change that would indicate that they've -- actually need to be moved to a different risk group.

Q. And would your answer be the same in relation to guidance to -- for staff, to avoid staff members who were being placed -- or being used in one ward or deployed in one ward moving to others, would your answer be the same for that?

A. That's right, yes.

Q. Finally, in February, March and April 2020 -- and I appreciate when you came into post -- what, if any, steps were taken to ensure that Covid-positive patients were not being discharged from hospital settings into care homes?

A. Yeah, so in March 2020 the guidance was that patients needed to be screened before they were transferred, and that that should then be accompanied by isolation, so that patients should be screened, and then recognising

at that point the -- that the intelligence and the evidence about Covid was growing all the time, so we didn't yet have a full understanding of how -- whether -- how long before symptoms presented themselves somebody might be infectious or how long somebody might stay infectious after they'd recovered.

So the focus was very much on clinical screening and then on correct infection prevention control measures within care homes, including patients who had transferred from care homes to hospitals needing to be isolated first for seven days, and then the advice I think changed to 14 days. And it was, I think, 21 April when we moved to requiring to negative tests before patients were discharged from hospital.

Q. I wonder if I may, my Lady, ask one follow-up question. The question would be this: did you receive any feedback from care homes that the requests being put on them for isolation simply weren't possible to carry out?

A. I'm sorry, I'm not sure I can -- I don't have an answer to that question, I'm sorry.

Q. Is that simply because you weren't party to -- you wouldn't be party to those sorts of conversations?

A. That's correct. That's correct, yes.

DR MITCHELL: My Lady, that will perhaps be a matter for the next module. I'm obliged.

LADY HALLETT: Thank you very much indeed, Ms Mitchell.

That completes the questions we have for you, Ms Lamb. As you know, I'm particularly grateful for the help that you and your colleagues have been providing to the Inquiry, and especially today for you. So thank you very much indeed for your assistance.

I'm sorry you haven't seen the back of me yet. I think that we're placing further demands on you in the next module, but thank you very much indeed for your help to date.

THE WITNESS: Thank you very much. Thank you.

MS CARTWRIGHT: My Lady, the next witness is Professor Madelynne Arden.

Please could Professor Arden be sworn.

PROFESSOR MADELYNNE ARDEN (affirmed)

Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 7

LADY HALLETT: Professor, you have got the last slot of the day, I hope you haven't been waiting all day.

THE WITNESS: No, no, I travelled this morning. Thank you.

MS CARTWRIGHT: Could you please give the Inquiry your full name.

A. I'm Professor Madelynne Anne Arden.

Q. Thank you. Professor Arden, you were instructed by the Inquiry to provide an expert report. And can we first look at that report, please.

We can see on the front of the report that you were the lead author but you had co-contributors but can I ask you, can you confirm, essentially, the declaration relating to your expert report and everything within it is true and accurate to the best of your knowledge and belief.

A. Yes, absolutely, I can confirm that. And just in terms of my co-authors, I'd really like to thank them, they really enabled this to be a true sort of four nations report with their contributions. So Professor Vivien Swanson from University of Sterling, Dr Rhiannon Phillips from Cardiff Metropolitan University in Wales, and Dr Gillian Shorter from Queen's University Belfast in Northern Ireland, really enabled us to kind of -- they had that experience on the ground so that was incredibly helpful.

Q. Thank you.

Well, if we perhaps move into the report we, in fact, see at page 4 details of the authors and we'll start with your own professional background and expertise, please. Thank you.

It's right, isn't it, that you are professor of health psychology and currently head of the Centre for Behavioural Science and Applied Psychology at Sheffield Hallam University?

A. That's correct.

Q. You're a chartered psychologist and registered health psychologist with 25 years of experience specialising in understanding behaviours and promoting behaviour change and maintenance across a wide range of behaviour domains?

A. That's correct.

Q. Thank you. And then you've already -- I'm only going to deal with that by way of your background, but the full CV of your expertise is detailed there. But if we go back, please, just to see the co-contributors, you've already identified them by name and location, but we can see there the academic and expertise background of Vivien Swanson, Dr Phillips and Dr Shorter, who you've already acknowledged by way of the contribution to this report, which provides an analysis of adherence to behaviours associated with test, trace and isolate system. Thank you.

Now, can we then move to page 6, please, which I think gives an overview and your executive summary but it's perhaps the most useful place to start that really details what the view of you and your co-authors has been by reference to the documents you've considered, the academic research you've undertaken, and so can we start, please, at paragraph 1.

You tell us that:

"[Test, trace isolate] policies across the UK nations was central to the strategy to limit the spread of Covid-19 during the early phase of the pandemic. While there were some differences across the four nations, the approach was broadly similar, focusing on testing, (initial in response to symptom identification), contact tracing and self-isolation."

And I think you then deal with adherence to test, trace, isolate policies was complex. And so can I ask you, then, just to deal with, in your own words, the complexity that you identified in completing this piece of work?

A. So I think adherence, there were lots of different behaviours associated with test, trace and isolate from identifying the symptoms to actually testing, and then engaging with the tracing system, whether that was individuals contacting you or whether that was the tracing app, and then isolating. So there are lots of different behaviours and many of them are pretty invisible. So we can see whether people tested or not although we can't see people who didn't test, they're pretty invisible too. And in terms of adherence, really, we're relying on self-report data because we can't sort of observe people adhering to that.

So there is some real challenges in terms of looking at that data and understanding it. There are things around how we sample -- there's lots of surveys that we drew on in this work, but those methodologies, depending how they sampled participants, reported quite different levels of adherence to self-isolation, for example.

So we haven't got, if you like, the objective facts in terms of how adherence worked. We've got some kind of data that enables us to gather a picture. Just to say that's not unusual in behavioural science, there's lots of behaviours that we can only infer or ask people to tell us about, but it makes the job of working out exactly what was happening quite challenging.

Q. Thank you.

And can we look next under the heading of "Adherence to [test, trace and isolate]", you identify that it requires four behaviours: identifying the need to test, testing, enabling contact tracing, and self-isolating.

And then deal with the fact that:

"Identifying the need to test ..."

In the next paragraph:

"... was inconsistent, with only half of respondents able to correctly identify [the] symptoms. Testing uptake remained low, even with increased testing capacity and latterly the availability of lateral flow

tests ... as part of a Universal Testing Offer."

A. Yes, so even, you know, the first step in that chain of events, if you like, definitely before the Universal Testing Offer came in, was that we asked people to identify when they had symptoms, and use those to go and test. But if we've only got half of people actually knowing what those are, we've sort of fallen at the first hurdle, before we've even gotten to the important behaviours, if you like, and the key important behaviour is self-isolating. That's what all the other ones are for. You know, there's no point testing if we're not getting self-isolation.

So that was, you know -- we're having problems right from the start there.

In terms of the Universal Testing Offer, that improved things, because we weren't so reliant on symptom identification at that point, but then we -- you know, there's other challenges to testing that I know we'll come on to in a moment when we further our discussion.

Q. Thank you. And so it sounds fairly obvious and basic, but really is what you're saying that there needs to be clarity of what the symptoms of the virus is, because if those are known and somebody has them, even before a test, it allows knowledge of the need to isolate?

A. Yes, I mean potentially. I think the symptoms were really challenging because they're similar to so many other sort of infections, colds, flu. And actually the way in which people identify symptoms is related to their motivations around other behaviours. So it's not that that stands alone, but certainly, I think, that not everybody knew what they were in the first place was problematic.

Q. Thank you.

Now, you tell us in the next paragraph:

"Key barriers to testing included misunderstandings of symptoms [as you've just dealt with] and a reluctance to test due to the potential for a positive result, which would necessitate self-isolation."

Is there anything you want to say to expand upon that?

A. Yes. So self-isolation is not an easy behaviour to do, and actually it varies depending on your, sort of, position, your sociodemographic status. So for some people, self-isolation merely means working from home, in a nice house with a garden. For other people, self-isolating is incredibly hard, they haven't got the support, they haven't got the housing to self-isolate, they haven't got the finances to enable them to do that if they're in precarious employment. So we have a kind

of huge difference in terms of how difficult self-isolation is, if you like, and I think -- and we'll talk about this more, I'm sure, as we go through -- reluctance to test is related to whether people felt that they could self-isolate or not.

Q. Thank you.

And then perhaps building on the answer you've just given, can we then briefly move to your chapter three 3, was the lessons learned, which I think perhaps very eloquently expresses your views on self-isolation.

Can we move forward, please, to paragraph 381 at page 112. You say:

"Self-isolation is an altruistic behaviour -- it benefits others rather than ourselves. Self-isolation is fundamentally more challenging for some groups than others and this produces and potentially exacerbates social inequalities. Self-isolation for people with professional/managerial jobs that could be done from home in comfortable houses with space, gardens and the financial security of sick pay and the social support of friends and family is much easier than self-isolation for people isolated from friends and family, in precarious employment without sick pay or job security, living in a small bedsit with no outside space who are worried about the consequences of having to isolate for

their ability to pay the rent and have enough money for food and heating. We need to acknowledge these differences and support people appropriately."

So is there anything you want to build upon what's perhaps quite eloquently expressed there?

A. I think it just illustrates there that -- the hugely different ask that we were putting out there for people in different social situations, and that it's not a behaviour that's easy to do for many people, and I don't think that was sufficiently acknowledged in how we supported people.

Q. Thank you.

Can we then go back to page 6 of your report -- thank you -- and if we can continue, then, in terms of your overview. You detail that:

"Contact tracing faced challenges, with many positive cases and their contacts not being reached."

Is there anything you want to expand upon, on that overview point, please?

A. So, you know, there's evidence that people were reluctant to provide details of their contacts where they were worried that that would have knock-on effects on them, meaning having to self-isolate, if they perceived that it would be difficult for them. So that kind of runs through everything, I think.

There were issues around, kind of, privacy and trust, as well, in terms of sharing contacts.

So there were lots of -- you know, the data would suggest that we only reached a relatively small proportion of the contacts that, you know, ideally we would have done.

Q. Thank you.

You next, then, detail that smartphone apps played a central role but were hampered by low usage due to privacy concerns and mistrust.

Can you perhaps expand on that from your research?

A. Yes. So I think that the aim that was identified was that 60% of people needed to be using the smartphone apps for them to be optimal in terms of tracing but I think it was around 25%, certainly 20-something per cent, I'd have to find the right paragraph, so much lower usage than was hoped for, and I don't think that is particularly surprising, actually. People generally -- I think what was missed here was that the smartphone apps required engagement with them to work. It wasn't just a thing that people had that would just work without people's engaging with them. Another behaviour we're talking about here. And there's lots of evidence not just around Covid apps but digital apps generally that people are concerned about data privacy,

they are concerned about how to use them. So, you know, there was evidence that that might be challenging and I think we saw that play out.

Q. Thank you. And I think the Inquiry has the Every Story Matters record where some of the experiences expressed in that record includes their concerns about information through the app, and deleting it because of their concerns about privacy.

Can we then move, please, to the next point, self-isolation adherence was low, particularly among disadvantaged groups, barriers included inadequate financial and practical support, exacerbating social inequalities.

A. Yes, as I kind of mentioned earlier, I think there were different situations that people were in. Many of the people in kind of key worker roles, for example, were out and about and being exposed to the infection more frequently, and therefore being asked to self-isolate more frequently, actually, and I don't think that's been acknowledged, that actually this wasn't -- as much as it should be -- this wasn't a one-off thing that you did, it was actually something that people were often being asked to do repeatedly. And I think the idea that, you know, actually they needed to maintain this adherence over the course of the pandemic is also something that

needs more acknowledgement and consideration.

Q. Thank you. Now we're going to deal next with the summary of the lessons learned for future pandemics and this is summary. I appreciate that in the report you've gone into a lot more detail under lessons learning and your key recommendations but I think it's a helpful way of looking at these stripped back without the wider detail we see in the full report which will be published. You say this:

"Infrastructure and systems, (eg testing, tracing, personnel, apps) were prioritised over policies and interventions to promote adherence. Behavioural science and health psychology should play a larger role in future pandemic responses."

Could you provide a bit more detail about that.

A. Absolutely. So, I mean, clearly we needed a testing system, we needed tracing to happen and apps were part of that response. There was a huge amount of investment in those things but all of them require people to behave in certain ways, to engage with systems, to self-isolate. So behaviour was absolutely crucial to everything and yet there wasn't, I don't think, sufficient acknowledgement that that was going to be a challenge, that that was something that we needed to focus time and energies on to make that as easy as

possible and to support people to adhere.

And behavioural science and health psychology is, that's what behavioural scientists do, they look at, you know, the causes of behaviour and how we can create interventions and policies to promote behaviour change and behaviour maintenance, and I don't think that was central enough to the response, given the reliance on adherence that everything else was based on.

Q. Thank you. You then identify at paragraph 10:

"Public health messaging must be viewed as an intervention to promote behaviour change, not just information dissemination. Messaging should be grounded in behavioural science and tailored to different population groups."

A. Yes, so in the report we kind of look at one of the key frameworks that we use in behavioural science and health psychology, which is the COM-B framework. And that says that in order for anybody to do a behaviour they have to have the capability, the opportunity, and the motivation.

So public health messaging shouldn't just be about telling people what they've got to do. That's only part of the picture, and that's not sufficient to produce change by itself.

So when we're looking at public health messaging,

actually it could do a lot more. So it could help people to increase their motivation to engage in things, it can help them understand the support that's available to them. So there's lots more things that it can and should do, and I think during the pandemic, it was viewed more as a sort of information tool and not as a behaviour change tool. And I think with more input from behavioural scientists, and particularly, you know, one of the things that behavioural scientists do is think about what do different people need? What do different groups need? And that might be slightly different. That would have been really helpful in the pandemic, and would be really important for any future pandemic response.

Q. Thank you. You detail that:

"Trust is critical to ensuring adherence. Changing guidance, mixed messages and lack of transparency damaged trust during the pandemic, as did instances of non-adherence from prominent public figures."

A. Yeah, I mean, we were -- we were having to rely on kind of trust and what we were being told, and we know that that's really crucial. It was difficult, you know, we had guidance that was changing as new evidence came to light, and, you know, we'd expect that, I guess, if it was a new condition, a new infection, we didn't know

what we knew at the beginning and what we knew at the end.

But what that meant was that the guidance changed frequently, people got confused about what they were supposed to be doing, and it wasn't really clear why things were changing. So that in itself can impact trust.

The other thing that impacts trust or one of the other things that impacts trust is, you know, why are we doing this? It's about us -- we're doing it for everybody else, you know, at the point that you're self-isolating, you're not doing that for yourself because you've already been exposed to an infection, you're doing it to protect everybody else.

And it's really important, then, that we are all doing that, and particularly prominent public figures need to be setting a really good example, being a role model so that everybody can see the value and trust that we are all there doing the same thing for each other.

Q. Thank you.

You then detail:

"Behavioural scientists worked to support the pandemic response, but their advice was not always fully integrated into government policy. Formal channels must be in place for future pandemics to ensure their

insights are used at national and local levels."
A. Yes, absolutely. So there were behavioural scientists in sort of -- that had routes through to government policy, so SPI-B being the obvious one, but I think SPI-B's documentation suggests that they -- they had concerns that their advice wasn't necessarily impacting on policy, and I know there's some research being undertaken at the moment about the extent to which that happened. But there were behavioural scientists working across the board.

So I myself was a member of -- and this is a really long title which I've written down, this group, so I don't get it wrong, it was the British Psychological Society's Behavioural Science and Disease Prevention Taskforce, and this was a group of health psychologists from across the four nations who came together to pool their understanding, their expertise, and to try to be helpful. But it was very difficult to actually be heard.

We had some kind of local response to that, but these kind of channels, there's all this expertise, it needs to reach the right places and to be influential. And there needs to be -- there's no point in working out what the channels are later on; we need those in place in advance.

Q. Thank you. Now, we can see the summary of the key recommendations which are expanded upon later in the report but let's work through these together now. You have recommended to:

"Align policies with barriers to adherence ..."

Detailing that:

"Different groups face different barriers, and policies must be designed to address these specific needs. Fines should only be used when non-adherence is intentional, not when it's due to situational factors."

A. And that comes from the evidence that most people intended to self-adhere, but there was what's called an intention behaviour gap, and lots of the things that stopped them from actually adhering were around opportunity factors. So, whether they had enough money, whether they had enough support, whether they had to care for an elderly relative and therefore leave their home to do so.

So if we're fining people for things that they have to do, that doesn't seem reasonable.

Q. Thank you. Now I think just --

LADY HALLETT: Just pausing there, the trouble is that if I had gone to work because I had to, to feed my family, I had to do it, in my view, do you fine me or not?

A. I think we need to have proper support so that you, if

we're using you as an example, is not being disadvantaged by self-isolating for the benefit of others.

LADY HALLETT: That I accept, but I'm going back to the principle of when you apply fines. Because, of course, when you have a system of fining, any criminal enforcement, you've got to make sure that it has clear application and people know where they stand.

And are you not suggesting that one has to introduce a subjective element as to whether or not I think -- let's take me out of the equation -- that somebody had a good enough excuse not to isolate? Do you see what I mean?

A. I do see what you mean. I mean, I think they shouldn't have been fined at all, because I think, actually, that had some knock-on effects in terms of people's willingness to test and engage in anything. Because if you see that you may end up with a fine because you tested positive, then you avoid testing. And there's certainly evidence for that from the Liverpool Pilot, for example.

LADY HALLETT: So basically your approach would be to stop the problems I've talked about without having any kind of fining system that's subjective, because that's impossible to enforce --

A. Yeah.

LADY HALLETT: -- you're saying move the emphasis to persuasion, messaging and --

A. And support.

LADY HALLETT: -- (overspeaking) --

A. Supporting people to do what they intended and wanted to do but felt they couldn't for various reasons.

LADY HALLETT: Thank you.

MS CARTWRIGHT: So you would adopt the approach of Northern Ireland and Scotland on the self-isolation?

A. Yes, yes.

Q. Now, I think the next two recommendations you've already -- expanded upon already, but you've detailed that:

"Public health communications are behaviour change tools ..."

And also the necessity to build and maintain trust.

I think you've perhaps already spoken to those.

A. Yes, that's fine.

Q. Can we then move to "Invest in behavioural science". You detail that:

"Future pandemic responses integrate behavioural scientists from the outset. Their expertise should guide research, policy, and communications aimed at promoting adherence to health-protective behaviours."

A. Everything we did in the pandemic required behavioural change, and behavioural scientists are the people that know how to do that best, so there needs to be kind of investment in that.

There's so much less money going into research around behavioural science than there is many of the other things. It applies in test, trace and isolate but also things like the vaccination uptake later on. And it's important that behavioural science isn't just a responsive -- in responsive mode, which I think is the kind of mode that it -- was used in the pandemic, because behavioural scientists can also identify areas that we need to look at that perhaps might not occur to policymakers.

So generally, you know, behavioural science -- behaviour is a key and therefore we should be investing in expertise in people who understand those.

Q. Thank you. I think, again, the next three recommendations again we've touched on in looking at the overview.

Then the recommendation of the need for accurate adherence data, support for self-isolation, but also the challenges of symptom identification.

So is there anything else you want to say as to those three beyond what we've already touched upon

together?

A. I think the one thing around symptom identification that we haven't touched on yet is it wasn't just what the symptoms are, but there were lots of misconceptions that the symptoms needed to be really severe and long lasting to warrant testing. So people were really reluctant to test if they had a symptom that wasn't very severe and didn't last very long. And that was about a sort of lack of understanding. And, you know, we know, for example, that there were lots of asymptomatic people, and I don't think there was a sufficient communication that enabled people to properly understand that.

Q. Thank you. You then recommend the need for supportive conversations. You say this:

"Frontline staff and contact tracers should be trained to engage in supportive, behaviour change conversations that enhance motivation and adherence to health advice."

A. Yes, so this is really important, I think. So contact tracers, they're doing a really difficult job, actually, because you're telling somebody something that they don't really want to hear, that they need to self-isolate. And it's not as simple as just saying, "This is what you need to do" and expecting that people after going to stick to that.

And actually, you know, behaviour change conversations, there is a way to have a conversation around kind of adhering to a behaviour that isn't just telling people what to do. There are kind of methods to do that which we talked about in our report.

In Wales, they did train their contact tracers using those kinds of methods, and I think that's really important, that it's -- you know, understanding that there is more sophisticated ways to support people to change their behaviour than just telling them that they need to do it.

Q. Thank you. And you have also recommended the necessity to address equity issues. You detail that:

"Policies should focus on supporting those who find it hardest to adhere due to socioeconomic circumstances, ensuring the response is fair and equitable for all."

A. Yeah, everybody was self-isolating for everybody else. It shouldn't have been so hard for some people to do that.

Q. Thank you. Then you provide your overarching conclusion which is this:

"The UK's [test, trace isolate] strategy during Covid-19 demonstrated the importance of high adherence to health-protective behaviours, but this was undermined by inconsistent communication, inadequate support, and

limited use of behavioural science expertise. Future pandemic responses must prioritise trust, behavioural insights, and tailored interventions to ensure that public health policies are effective, equitable, and sustainable."

A. I've nothing to add to that.

Q. No. Well, then, I've some specific questions that are in the report. So if we can then just work through some of those discrete topics, appreciating hopefully we've given a good overview of yours and your co-authors' views and recommendations.

Can we start, please, at your paragraph 48d on page 13. This is under your theories of maintenance. You outline theoretical themes relating to maintenance and behaviour and we can see those set out at d, including the models and recommendations.

Can I ask you, then, does it follow that you consider this ought to have been recognised by or flagged by advisers to decision makers and factored into the development of TTI systems?

A. Yeah, absolutely. So we weren't asking people to do this once; we were asking people to do this repeatedly whenever they came into contact with an infection, whenever they needed to self-isolate, and there's, you know, there's evidence that we need to, therefore, give

people some feedback on the value of what they're doing, for example, and those kinds of things weren't factored into the Test, Trace and Isolate policy. And, you know, I think we could have foreseen that there would be some people, probably particularly target groups like key workers, who were out and about much more, exposed to more infections, that they in particular might need to do this thing, you know, the self-isolation repeatedly, and so we needed to factor that in more.

Q. Thank you. Can we then move to your paragraph 73, please on page 18, where you detail the review of how people respond to public health messages about managing risks and preventing infectious disease and then, obviously, give the various examples and also the review of the guidance document produced by BPS taskforce.

Can I ask you, does it follow that you consider these steps ought to have been recognised by, or flagged by, advisers to decision makers, and factored into the development of TTI systems?

A. Yeah, I think, you know, the -- how we got those messages out was really important. I think engaging different communities in the development of messages is something that we knew about, you know, in advance of the pandemic, that actually we need to speak the languages of the people that are receiving our messages,

and that means co-designing messages with those communities. I know in Professor Yardley's statement she's been very supportive of that as well, that actually there are recognised ways of making sure that we are listening to and responding to the needs of communities in terms of how we use messages.

So yes, I think this was known, sort of, before and I think this should have been, you know, considered in how we responded and how we developed those messages.

Q. Thank you.

Can we then, please, move forward to paragraph 81, please. You've helpfully provided a table relating to the financial support that was available across the four nations. And then -- thank you.

If we can then just move forward, having identified that table, please, to your paragraph 259, on page 80., that's paragraph 259, please, on page 80. Thank you.

You detail there, in respect of particularly Wales, albeit there's an analysis that's done of each of the four nations, you detail that for Wales the payment scheme did not formally open until 16 November 2020, and that this delay between announcing support and enabling claims to have been made would have been challenging for those who were eligible, given that they would have been on low incomes and in need of timely financial support.

Can you comment on the impact of delay? And I think there's some evidence of that across the other nations but can you comment on the impact of delay in providing financial support on adherence to test, trace, isolate behaviours, for example in relation to identification of the need to test, testing and/or self-isolation, following a positive test?

A. Absolutely. You know, any kind of delay is going to be problematic. There's the actual delay that people experience, you know, for people on low incomes who are relying on a weekly wage, for example. Then having a delay in being able to access that means that, you know, people don't have money for that meek.

But I think there's also an impact on motivation, because if you perceive that, you may not have access to that money, then that's going to mean that, you know, the next time you need to self-isolate you're also going to be less motivated to do so because you, you know, you have less confidence that you're going to receive the support that you need.

So any delays, whether, you know, they -- they're still happening or whether they happened before, you may still be worried that they're got in happen again.

So I think, you know, we needed those support systems in place as soon as possible. And in terms of

thinking about any future pandemic, having a system in place so that we know how we're going to do that in advance would be incredibly beneficial.

Q. Thank you. Can we then move to your paragraph 118, please, on page 36, where you offer an observation on contact tracing. You detailed:

"The extent to which the contact tracing systems were centralised or used existing local systems differed across the four nations with England and Northern Ireland using a national approach and Wales and Scotland using a local system that utilised existing healthcare systems. England moved towards a more local response in summer 2020 following criticism of the national approach, which relied too much on 'inexperienced contact tracers and not enough on public health teams with local expertise'."

Are you able to provide any further detail as to your overall view of how the responses compared between the four nations?

A. I mean, I think, you know, local public health teams have got a great deal of knowledge about their local communities, how to communicate with -- through trusted leaders, things like that. So they have lots of knowledge.

As I mentioned earlier, the job of contact tracing

isn't as simple as contacting people and saying, "This is what you've got to do."

And I think where we used a national system where we were rapidly training people to deliver a really skilled thing is problematic. And so it was much better in places -- and obviously England moved from one to the other, following criticism -- using that kind of local expertise and local skills in having those kinds of conversations.

Q. Thank you.

Can we next move to your paragraph 144, please, on page 43.

You detail, under "Test, trace and isolate as a system of behaviours", that:

"Interventions to increase adherence ... need to consider behaviours as an interconnected system."

And that:

"People are likely to be unwilling to increase testing if there remain substantial barriers/a lack of support for self-isolation given that this is a direct likely consequence. Critically, this lack of support hits those living with deprivation more profoundly than for those who are more affluent."

Would you agree that the barriers you've detailed here were, firstly, foreseeable and, secondly,

predictable?

A. Yeah, I mean, I think that kind of interconnected nature of the behaviours is something that's really important, and I think we can -- we could have foreseen this. And I think this is something about when we are looking at something and considering the motivations of different kind of people within that system.

So, in terms of the motivation of policymakers, clearly, the, kind of, purpose of all of this is to stop the spread of Covid.

But actually, if we think about each individual, they've got a huge number of other things going on in their lives, and I think we'd all accept that the kind of key motivators for human beings is, you know, looking after families, having enough food, having housing over their head.

So I think, you know, we could anticipate that where the system that's being proposed is going to be particularly challenging, then people will withdraw engaging with it. And in this instance that would mean avoiding getting a test because you can foresee that that will have negative impacts on really kind of core values you have as an individual in terms of looking after your family.

So, yes, I think it could have been anticipated, and

I think we need to -- we needed to look at these things a much more joined-up way, and acknowledge that, kind of, across the whole of policy making.

Q. Thank you.

Can we next move, please, to your paragraph 155 on page 47, where you detailed the substantial differences in ability of people to correctly identify the main Covid-19 symptoms, and then referenced the barriers.

Can I ask you, in light of this, would you agree that in circumstances where language barriers or differing cultural behaviours exist, there can be significant benefit in healthcare workers who belong to the same communities as those receiving the information communicating, and helping them understand, in terms and language, that will interpret and explain the information clearly to them?

A. I think yes. I mean, it could be healthcare workers. I think that would be one way to do that. I think we generally needed to think about how we could deliver those messages to different ethnic and cultural groups. In the report there was -- I detail some work done by Atiya Kamal and colleagues looking at how messages needed to be both developed to suit different communities, but also how they were delivered was really important for those different communities.

So that could be by healthcare workers from the same cultural groups. It could be by local leaders in those groups. I think we needed to make use of, you know, all of the kind of community contacts that we had to make sure that those messages were reaching people in a way that they could understand.

Q. Thank you. And I think you've also highlighted there the statistics from the Office for National Statistics, the 5 million people in the United Kingdom speak a primary language other than English.

So, again, using paragraph 155 as the foundation of this question, do you believe that these disparities in symptom recognition suggest that highly important government messaging firstly, lacked nuance and specificity, and was thus not sufficiently tailored or designed to reach all groups in society?

A. Yeah, I think that's absolutely the case. There were certainly some delays between the guidance coming out in English and then it being translated into other languages, and although those won't be like hugely long delays, they're still very important ones, and I think we could have anticipated, at a minimum, that we needed the guidance in the, kind of, key languages. I think there is also other work in terms of making sure those messages are being provided in ways that suit different

cultural groups, and I think co-production, so working with those groups to make sure that the messages work for them is the way to go about doing that.

Q. Thank you. And again, on the issue relating to government messaging, would you also have any views as to whether it failed to be sufficiently accessible to resonate with the lived experiences of some minority communities?

A. Yes, certainly. I think there's lots of evidence that that's the case. There were some kind of messages that were -- so, for example, the messages about why the guidance was changing was missing from most of the public health communications, so unless you were the kind of person who was watching the daily briefings where maybe that information was given, you didn't hear that, and I think we need to acknowledge that actually, that "why" things were changing was really important and there weren't the same kind of efforts made, I don't think, to make sure that was understood across different groups.

Q. Thank you. Can we move, then, to your paragraph 187, please, at page 57.

Again, you give a section on data on the percentage of people requesting a test and, similarly, I think, over the page you give the data in the figure that

assists with self-reported behaviour, intended behaviour, and capacity under Pillar 2.

Can I ask you, then, there's clearly, from your report and this figure, a relationship between testing capacity, compliance with self-isolation and perceptions at play. Can you explain why and how testing capacity issues in the United Kingdom may have impacted upon compliance with self-isolation?

A. So I think this relates to the fact that these are all linked behaviours. So we've got, kind of, testing being linked to self-isolation, but the harder we make something for people to do, the less likely they are to engage with it. So if we're requiring people to go and travel to get a test because that's the only place that they are, then people are less likely to do it. So I think we have those, kind of, you know, logistics, opportunity issues in terms of testing. But I think we've also got the fact that even when -- there's certainly some research studies that we refer to in the report where even when testing capacity had increased, there was still a perception that there was lower testing capacity. So people were still reluctant to, kind of, engage with it even when the capacity issues had been resolved.

So I think there's -- it's important for people to

feel that they are able to access a test in the easiest way possible and that was certainly more challenging for people in some communities, rural communities, for example. I know in Scotland they, kind of, addressed that with things like fire stations offering testing to try and address some of those things.

Q. Thank you.

Can we then move forward to your page 72, please, thank you. And can we specifically look at paragraph 226 where you detail that:

"The low level of adherence to self-isolation in the [United Kingdom] ... compares dramatically to places where support for self-isolation was provided which that higher rates of adherence," and the example you give is New York, "where people were provided with money, hotel accommodation, food and mental health support ..."

And also that there were multiple calls during the pandemic for there to be better support for self-isolation.

So can I ask, do you agree that it's clear that adherence to self-isolation and sufficient support are interconnected?

A. Absolutely.

Q. And the study you cite there which is quoted in paragraph 226 suggests that the sufficiency in the data

makes conclusion equivocal. However, would you accept, nonetheless, that the data in international comparisons do provide valuable insight that should have been used to inform government planning and decision making at the time?

A. Yeah. I mean, I think that particular study was equivocal. I think if we look at the international picture, there is a lot of evidence that was important. If we look at the theory from, kind of, behavioural science, if people, you know, are struggling to do a behaviour then they're not going to do it. And, you know, having sufficient money and support, you know, that may be accommodation, to enable you to self-isolate, or mental health support, are absolutely critical.

I don't think, you know, there were so many different groups calling for self-isolation support, SPI-B were, Independent SAGE were, as well as various, kind of, papers. You know, there were so many calls for it, and I agreed with them.

Q. Thank you.

So can I ask you, would you have views as to whether the United Kingdom did not take sufficient notice of TTI systems in other countries during the pandemic to help inform our responses?

A. I think if we look generally, you know, the comparisons are quite difficult. There are lots of differences around, kind of, different cultures, different ways of doing things but I think if we're talking specifically about support for self-isolation, then I think the messages were clear.

Q. Thank you.

And you say the messages are clear but can I ask you, could those international examples have taught the United Kingdom in respect of the design and adaptation to self-isolation support?

A. Yes, I think so.

Q. Thank you. Can we then move to the next paragraph, please, over the page at 73, paragraph 227. You talk about the evidence of the impact of financial support coming from both other pandemics and international responses to the Covid-19 pandemic, and obviously reference the fear of the loss of income.

And obviously the -- learning from the swine flu outbreak.

Would you agree that clearly these factors were known at the time, and should have been part of the government's planning and decision-making process in relation to self-isolation rules in the United Kingdom?

A. Yes, I think so.

Q. Thank you. Then if we can go to paragraph 229, please. Again, you detail there about the benefits of financial support for self-isolation. Can I ask you, throughout your research, have you identified evidence that explains this omission or how it arose?

A. No, I haven't. I think all of the evidence I've seen in terms of what was being recommended is that people needed sufficient support to be able to self-isolate. Just to be clear, this isn't a reward for self-isolation; this is addressing the kind of shortfall in income that people were experiencing. And I think, yeah, it was really clear that that was needed.

Q. Just two final questions from my perspective, please. Can we then look at paragraph 232, which is there on page 73, where, again, you talk about self-isolation payments. I know you've had an opportunity to review the expert report of Dr Richard Machin who we will hear from tomorrow, and considered his report.

Now, Dr Machin suggests that future self-isolation payment schemes would be more efficiently administered and provide a higher level of financial support if administered as part of a centralised job retention agreements.

Can I ask you, and particularly in light of what you say at paragraph 232, do you consider that financial

support ought to have been universal and paid via the employer, rather than retrospectively, following an application process?

A. So I don't think I've got expertise on how financial support should be paid, but from a behavioural science perspective, in terms of how this might influence adherence, the key thing is that people need to access that support easily, and be really confident that they will get that support. And, you know, universal payments is one way to do that, because then everybody knows they're getting the payment, but I acknowledge there are also downsides to universal payment. The key thing from a behavioural change perspective and adherence perspective is that those payments are really clear, so Dr Machin's report also kind of outlines that the people who most needed that support were the least likely to know about it.

So we need to make sure that that support is really easy to access, that people know they can access it, and we need to use the contact tracing system to make sure that they know that they can access that, and, you know, people can feel confident that they're going to receive that support in a timely fashion. And that's what will impact adherence.

So I don't know how that is best done. I'll leave

that to the experts in that field.

Q. Well, we'll ask Dr Machin his views tomorrow.

Then finally by way of the particulars, paragraphs that I seek your further assistance, can we look at paragraph 340, please, at page 104. And under the banner of "Trust" which we've already touched upon, you detail that:

"Trust is central to engagement with public health policies, and for adherence to protective behaviours to be maintained there needs to be trust in the long termed."

You then detail that:

"Data from a large weekly online panel of UK adults during the first three months of lockdown ... showed that there was a small association between increased confidence in the government to tackle the pandemic ..."

Then can I ask you finally: given it was known that ethnic minority groups generally have lower levels of trust in government and state authorities, do you consider that there ought to have been targeted intervention to build trust within these communities in order to increase chances of adherence to TTI measures?

A. Yes, absolutely. You know, we know that, you know, that's well known, that there are some issues with trust. We also have evidence from kind of other sort of

areas of public health that the best way to build that trust is to work with those communities. So that's around co-designing the approaches, making sure that people have their say in them, and again, Professor -- I mentioned earlier, Professor Yardley's reports details this as a really crucial way to build trust, and that we needed to adopt.

Obviously there's an issue if that takes some time. You know, you obviously can't suddenly co-design a policy, and obviously there were time pressures to do that, but I think some of that work, in terms of things like people's willingness to engage with digital apps, for example, could be done in advance of another pandemic -- that we all hope isn't going to happen -- but, you know, some of that work around how people might feel about those, what kinds of features people might want to be able to turn off, for example, is something that we could do in advance.

But that's certainly the best way to make sure that the policies are more trusted by different community groups.

Q. Thank you.

And I'm just going to give the reference to Professor Yardley's statement now that you've referenced on a number of occasions. So, for completeness, that's

INQ000567607.

Professor Arden, those are my questions.

My Lady, there are some Core Participant questions.

LADY HALLETT: Mr Dayle.

Mr Dayle is over there, Professor.

Questions from MR DAYLE

MR DAYLE: Good afternoon, professor. I ask questions on behalf of the Federation of Ethnic Minority Healthcare Organisations, or FEMHO, and I have two short topics I wish to explore with you.

At paragraph 180 of your report, you note that issues of lack of trust in the Covid-19 app have been identified in a number of research studies:

"... with black and minority ethnic groups reporting particularly low trust in the app ... and [that] trust [decreased further] over time as a result of awareness of the failures in the technological capabilities of the app and lack of evidence of its effectiveness ..."

End of quote.

My short question to you is: do you consider enough was done by way of targeted intervention to address the low trust of minority ethnic groups in the app?

A. I certainly think more could have been done, and I think there was a focus on getting an app that worked functionally in terms of the tech, and not enough focus

on how people would engage with it. And that is really about the kind of trust that people might have in it.

You know, it required a lot of trust in that app to use it. You were trusting that it was working properly, you were trusting that what it told you about whether you were exposed to an infection was accurate. There was things around, kind of, tracking your movements.

We know from other studies of, sort of, digital apps that there are some concerns, and yes, in terms of black and minority ethnic groups, studies have shown that that's particularly the case.

I think that relates to the comment I mentioned earlier that the best way to kind of resolve that would have been to make sure that the apps were co-designed with people. We needed people to use them. People needed to be more involved in the design of them. We needed people to be able to use some but not all of the functionality, perhaps.

So it was a bit of an all-or-nothing kind of app; you either used it or you turned it off. And many people chose to turn it off or not to download it at all. Whereas perhaps if they'd have been able to, kind of, use it in a way that was more controllable.

But we'd have known that if we had properly listened to the voices of different groups and co-produced the

features of those apps, and I think that would be the way to go forward.

Q. And you might have answered this question before -- just now, actually -- but what would you suggest ought to have been done to address this issue?

A. So I think making sure that the groups that we wanted to use the app were involved in its design, making sure that people could say what they would do, what -- would they engage in an app that did this or that? Or you had to scan an IQ -- a QR code -- you know, or the features that the app had, and they changed a bit over time, were people going to find those acceptable? Would they engage with them?

And I think the levels of use of the app would suggest that there were some significant problems there that weren't, sort of, designed in at the beginning. So that -- making sure that people have a say in designing those apps is really important. And behavioural science is a, sort of, way to make sure that we're understanding how people engage, and engagement being a behaviour.

MR DAYLE: Very helpful. Thank you, professor.

LADY HALLETT: Thank you, Mr Dayle.

Mr Weatherby, who sits just there.

MR WEATHERBY: My point has been dealt with, thank you very much.

LADY HALLETT: Thank you very much indeed.

That completes the questions we have for you, professor. I do appreciate the amount of work that went into the report and you may think that we have rather skimmed over a lot of it. Please don't worry, as Ms Cartwright said, it will be published, but also I'll ensure -- I take into account all the material. Some people think it's just the evidence I hear orally, but it isn't, it's all the material. So thank you very much.

THE WITNESS: Thank you.

LADY HALLETT: And please pass on my gratitude to your colleagues for their assistance too.

THE WITNESS: Thank you.

LADY HALLETT: Thank you. That completes today's evidence, I shall return at 10.00 tomorrow.

MS CARTWRIGHT: Thank you.

(3.45 pm)

(The hearing adjourned until 10.00 am the following day)

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