responsibilities and accountability of the DAs. Similarly, there was on occasion, a tendency for the UK Government to take decisions with cross border impacts without appreciating their practical implications, as noted by Transport Scotland in their corporate statement. With regards, for example, to decisions taken on international travel, it was not practically possible for Scotland to follow substantially different approaches with any effect, given the ability of people to travel into England and onwards to Scotland without further checks – although these concerns were raised with the UK Government by my ministerial colleagues, it did not result in any significant change. I cannot comment on whether there were challenges in ensuring that data used within the UK Government was UK wide and not driven by an England only understanding of policy issues. However, there were instances where we felt that the data for Scotland indicated a different approach was appropriate and - where possible within our devolved responsibilities – we took decisions accordingly. I did not often have direct dealings with UK Government civil servants so am unable to comment on their understanding and knowledge of devolution.

45. 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 meant (or believed that 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 NPIs 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 DAs discharging our own responsibilities. There was also a sense that the UK government considered itself the senior partner in the four nations context and that the DAs were accountable to it, when the fact is that in devolved matters there is no hierarchy – we are each responsible within those areas of competence and

accountable to our respective parliaments and populations for how we exercise those responsibilities.

46. My understanding of a four nations approach was rooted in the principles and statutory reality of devolution. It was that we would work co-operatively and collaboratively, sharing insight and experience, and where possible adopt a common approach; if our approaches diverged – either because of epidemiological or other health factors, and/or a difference of opinion about the appropriate interventions – we would develop a mutual understanding of the reasons, respect each other's positions, seek to avoid confusion in our communications, and be mindful of creating unintended consequences for other administrations; and discuss areas where reserved and devolved responsibilities intersected, so that the UK government in reaching decisions on reserved matters would understand the DA perspective and any impact on the exercise of our devolved responsibilities.

47. 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 administrations and at other times making decisions that resulted in divergence. Some of the factors underpinning these decisions are set out at paragraphs 158 – 175 of the DG SEA corporate statement provided in June 2023 [NS8/001 - INQ000215495]. 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 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 DAs, and it was the UK government that was an outlier.

48. I was always aware that, however sound our reasons for taking an approach at times that differed from that of the UK government in England, a potential

to take an alternative approach, including in September 2020 when the UK Government announced it was introducing offences for non-compliance with a request to self-isolate and introducing a legal requirement for isolation where an individual was notified. A decision was taken not to follow a similar approach in Scotland as it did not align with the overall strategy of achieving public compliance through encouragement, persuasion and support.

188. International comparisons were received predominantly through UK Government departments and was considered in the advice provided to Ministers.

189. Further detail on the Scottish Government approach to isolation is included within the Module 7 DG Health and Social Care corporate statement.

190. I believe that copies of advice to ministers have been provided to the Inquiry separately.

Equalities

191. 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 a requirement to self-isolate. This may also read across into intersectional considerations, such as the increased risk BAME 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.

Adult Social Care Testing Board consideration is also being given as to whether there are other services that would benefit from being part of the testing programme – these will likely be smaller very targeted niche services.

222. This expansion was agreed and implemented in a phased manner over the following months.

Care homes

223. I set out below testing arrangements for residents in, and visitors to, care homes. Social care workers have been covered along with health care workers in the preceding paragraphs.

224. As I set out in my statement to Module 2A of the Inquiry, the issue of testing residents entering care homes from both the community and acute NHS settings was raised in Parliament in March/April 2020. However, the advice at that time was that the limitations of PCR testing for asymptomatic and pre-symptomatic cases may result in false assurance and therefore the focus should be on infection prevention and control measures. In addition, there was limited availability of testing capacity in March 2020. WHO guidance at the time was clear that testing all hospital discharges was not the best use of available capacity while it was still being expanded. When capacity did allow for it, testing of all care home admissions commenced on 21 April.

225. Although there was not testing of all new admissions until 21 April, there was nevertheless guidance in place that took account of, and was designed to mitigate, the transmission risks in care homes. As set out earlier in this section, guidance was issued in March 2020 advising that there should be clinical screening of all admissions to care homes, alongside a risk assessment to ensure that sufficient resources, including appropriate isolation facilities, were available within the care home to support social distancing and isolation. In effect, therefore, individuals admitted to care homes were to be