Tuesday, 22 July 2025

(10.00 am)

LADY HALLETT: Good morning, Ms Carey.

MS CAREY: Good morning, my Lady. The first witness this morning is Mr Alasdair Donaldson.

MR ALASDAIR DONALDSON (affirmed)

Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 6

LADY HALLETT: Good morning, Mr Donaldson.

MS CAREY: Mr Donaldson, your full name, please.

A. Alasdair Donaldson.

Q. Mr Donaldson, I'd like to ask you some questions about your time working in DHSC's adult social care policy team. And I think in your statement you say you started there on 30 April 2020 through until about October of that year; is that correct?

A. Until 2 October, yes.

Q. Thank you.

By way of background, in your statement INQ000598578, you set out that you had been working as a senior policy adviser at the British Council and then volunteered for Covid response work.

A. That's right.

Q. Thank you. And I can see you nodding occasionally but would you mind just saying "yes" or "no" for the stenographer. Thank you very much.

In your statement you make plain that you have no academic background in science or epidemiology.

A. Correct.

Q. And I think it's right that in preparing your statement you had limited or indeed no access to emails or minutes or documents to refresh your memory now some five years on?

A. That's right.

Q. I'm going to try to ask for a little bit of detail, but, please, I don't want you to guess or speculate and if you genuinely can't remember the answer, please say so.

A. Understood.

Q. I think at paragraph 5, and mainly my questions today will be about the Vivaldi project, you said:

"... I was the official responsible for creating the Vivaldi Project."

And to help you, Mr Donaldson, we have heard from Professor Laura Shallcross, who led Vivaldi.

Can I be clear, what was your precise role or responsibility with the project?

A. Certainly, and I think I may have muddied the waters slightly here in my statement, because when I talk about Vivaldi, I'm talking about three different things, all of which I was the leading, albeit junior, official in charge of.

First of all, the surveillance study led by Professor Shallcross. Secondly, the related work to fix the data, in particular the Pillar 2 testing data that my ONS team was leading. And thirdly, my dashboard, which has also been referred to as the Palantir dashboard or just the Covid care home dashboard, they're all the same thing, which came out of that work. And I move between the three, I realise.

Q. No, well, I'll try to split them up if I may, but please correct me if I get it wrong. I primarily really want to start with the Vivaldi project and Professor Laura Shallcross's involvement in that.

I think Department of Health and Social Care funded the project; is that correct?

A. Correct, yes.

Q. And when you arrived at the department on 30 April, in your paragraph 6 you describe it as being "complete chaos"?

A. Yes.

Q. Hundreds of staff, you say, had been parachuted in, like you, with no relevant knowledge or experience.

Now, to help you, Mr Donaldson, the Department has told us that there was a significant expansion of staff from I think about 90 staff at the beginning to over 320, certainly later on in the pandemic.

Can you help, the chaos, as you describe it, did that help or hinder the setting up of Vivaldi?

A. Both. So the chaos, which was -- as you point out, there were hundreds of people like me coming in, and it slightly overwhelmed the HR systems, but what it did mean is that it wasn't always clear to everyone where people sat in the new structures, and I was able to carve out a degree of operational independence for Vivaldi by virtue of reporting both into the adult social care part of the department and also into the Pillar 4 surveillance part, led by John Hatwell, which was extremely effective and it allowed me to get more done than I probably would have been able to achieve otherwise.

Q. Your actual role in Vivaldi itself Professor Shallcross has described as a project manager. I hope that's not being pejorative. Is that what you really were, is a kind of a middle man between the project and the department?

A. That's exactly right. So I can claim no credit for the intellectual work behind either Professor Shallcross's study or the Palantir dashboard. I was the muscle, if you like, that got that -- that got those products seen by the people who mattered.

Q. Right. Sticking with Vivaldi, you say in your

statement -- obviously we know that April was the month where certainly there was reporting of the huge number of deaths in care homes, particularly related to Covid-19. So that's just where we were in the grand scheme of things.

You say you put together a team of non-civil servants but you were told you needed Public Health England's involvement, and you say in your statement it proved "mysteriously difficult" to get this involvement, nobody knew who was responsible for what, and PHE appeared "deliberately obstructive".

What gave you that impression, Mr Donaldson?

A. Yes, so the way it worked was that Sir Jeremy Farrar effectively put me in touch with the relevant parts of the Vivaldi team and I sort of brought them together and named the project. But I was then told that, in order to unlock the funding, I had to have a PHE senior partner, even if they weren't directly working on the project. We eventually got that in Susan Hopkins, but that was only after several weeks of trying to get other people in PHE to play that role, and getting nowhere.

Q. Why did you form the impression that PHE appeared deliberately obstructive?

A. Because I can't find any other explanation of why it was so difficult, given that we weren't asking for people to

do extra work; we just needed, as it were, a badge, a PHE badge, on the project. And we just couldn't get it. And I wasn't the only person who found that. The team that I joined had said that that had been a problem that had been going on for a couple of weeks already.

Q. Professor Shallcross told us that she thought at the beginning there might have been a feeling that Vivaldi was "treading on toes", to use her words, and filling in gaps that it was perhaps someone's else's job to have filled. Does that accord with your recollection of how it was back in April and May 2020?

A. It does, effectively, we were swimming in their custard and inadvertently showing up problems that they had with their data, and I don't think this was a conscious thing but I think it was an understandable human reaction to find that a bit difficult and, no doubt, I may have made it worse by the way that I operated but there were certainly some significant tensions at that stage.

Q. Did you ruffle feathers, Mr Donaldson, if I can put it colloquially?

A. I'm sure I did, yes.

Q. You say in your statement that there was a meeting on 10 May involving Sir Jeremy and Sir John Bell who reinforced to you how important Vivaldi was and that resources should not limit it so you should go on and

assemble the team.

I just want to ask you, we heard from Professor Shallcross and Professor Hopkins, in fact two days before they had spoken, and agreed to set up the study. Can you help with what happened in those two days between Professors Hopkins and Shallcross agreeing to set it up and then Sir Jeremy and Sir John speaking to you about assembling the team?

A. So -- not really, because I wasn't in all of the conversations. So I think -- and by the way, it's -- Susan Hopkins was busy on the SIREN study which was, sort of, as it were, the big sister study of the Vivaldi that was about hospitals, and so there were clearly conversations going on between those, between the senior scientists, including Professor Shallcross, Susan Hopkins and Jeremy Farrar, about the need for a study like this in care homes. And then separately, I'd been tasked to do a separate study within the Department of Health, and I was sort of trying to join the two together, if that makes sense.

Q. You mentioned there that Sir Jeremy and Sir John said resources shouldn't limit you. Can I ask you a little bit about the budget, because you say in your statement there was no significant accessible budget. Can you help us with what you mean and add any context to that,

Mr Donaldson?

A. Yes, so initially, and I'm talking here about May, and into June, we weren't able to access funding immediately for the different parts of the team. We had some very helpful people from Pillar 4 who came in and helped us to fix that over the summer, but the emergency funding that had been available in April, because there weren't systems in place for immediate funding, had been used up on other things. So there was a significant period where we were operating at risk.

Q. I think -- presumably there were various procurement steps that had to be gone through. Were you involved in those measures?

A. Yes.

Q. And in due course, was there an issue with funding going on with the Vivaldi project after the summer?

A. No, one of the reasons I was able to roll off is that we'd effectively won that battle and we had very significant funding which then, my understanding is, it's continued ever since.

Q. Did the funding issues at the beginning impact the way that the study was able to be set up? Did it have any practical effect or was it more of a bureaucratic issue if I may put it like that?

A. It was a bureaucratic issue. The only practical effect

was -- it wasn't just financial resource, it was people resource. Because I was the only person within the Civil Service who was working on Vivaldi, it meant that there was an enormous amount of time that was being wasted by having to sort out some of those procedural process issues.

Q. Right. You said there, I think in -- you mentioned there that there was a resource issue and you were the only person. You said you were making weekly requests to the department for reinforcements throughout the summer. Why did you need extra staff and indeed, were those requests met?

A. So those requests weren't met and I think that was just because, as I said, the HR systems had become overwhelmed.

Q. Right.

A. I desperately needed more staff to do things like set up the funding and things like that because we were all -- everyone on Vivaldi and, indeed, almost everyone we worked with -- we were all working hundred-hour weeks and there just wasn't enough time in the day to do everything that needed to be done.

Q. So one shouldn't read into that that there was not a desire to give you the staff, but more that the processes weren't in place to accommodate those requests

giving everything else that the department was doing?

A. That's right, and also -- but it wasn't that there weren't enough staff, because there were hundreds of these people who had been brought in, like I had; the problem was it was very difficult to persuade people that -- everyone thinks what they're working on is important but what we were working on, I thought at the time and I still think, was much more important where some of those resources were allocated, and it wasn't possible to just move people from one team into another.

Q. Dealing with other potential problems in the setting up of Vivaldi, you make a number of observations through your statement about problems obtaining the data.

A. Yes.

Q. I want to be clear about what data we're talking about and then what the problems were. Are you able to help us with that?

A. Yes. So there's a series of different points here. So, first of all, it was difficult for us to -- we wanted to ingest all the data we could get from everywhere about care homes, so that we could link it together and form an overall picture, and then present that to seniors.

But different parts of the system owned different data streams and were often reluctant to share them.

So, for example, it was difficult to get, from my

memory, the deaths data, and then the Pillar 1 outbreak testing data from PHE, and it was also difficult -- because of the extreme speed with which Pillar 2 had been set up, it was a very complicated set of data feeds that came through to us in the data lake, the data foundry -- NHS Foundry, so we had to -- in order to get the study to work, we had to sort of, as it were, go upstream to find all the blockages and unblock them. And as we did that, we realised that we were solving the problem that was bigger than just the -- Vivaldi's problem; it was a problem for everyone. And that work then led into what became the dashboard, which was the attempt to get all of the data in one place and analyse it.

Q. Fine. I'm going to come on to the dashboard a little bit later on but I just want to make sure I understand that answer. It's not that someone wasn't allowing you access, it's just that the systems didn't speak to each other, if I may put it like that, or -- can you help with what the blockage was?

A. I think it was probably both. I think the systems didn't speak to each other and there was a culture of information hoarding, I would suggest, which -- which often made it difficult to get the data.

And to be clear, this wasn't a legal data sharing

issue. We'd looked into that and COPI notices and so forth. We knew that wasn't the problem. It was a problem of getting different parts of the DHSC and PHE to share with each other and talk each other.

Q. All right. You did go on to say in your statement, though, that you had arranged for ministerial pressure to be brought to bear here to try to help the blockages with the data. The minister wasn't able to recall that when she gave evidence. Can you help it what the minister actually did to try to unblock the problems?

A. Yes, certainly. And to be fair to the minister, there's no reason that she would necessarily have known that that's what she was doing. So I think, to my -- in my mind, what happened was, there was -- there were meetings where we were saying: look -- effectively -- we've got this data, we don't have this data, the Pillar 1 data or deaths data, would it be possible to have that?

And the minister wouldn't have known that by asking that in front of the very people who we'd been arguing with -- it was a bit of a faux pas on my part, but I felt it was necessary to get that pressure from above to get the data unlocked.

Q. So she may have facilitated the unblocking without necessarily knowing that she was being asked to

unblock --
A. Yes, absolutely.
Q. All right. Can I just stick with the run-up to the findings of Vivaldi, which we know were published in July 2020, and can I ask you, please, about two specific paragraphs in your statement, at 55 and 56.
And you say at paragraph 55 that:
"The new Director [at] the ... [adult social care] team ... asked [you] 'who's telling you to do all this?'"
And you go to say that Vivaldi and you were then excluded from many of the relevant meetings. And I would just like some background and context to that comment. Do you know why the new director of the adult social care team was sort of asking you who's telling you to do all this?
A. Yes, so, first of all -- and before the moment in July when Vivaldi officially reported -- we had been reporting since May. As we got data, we reported it. And that created these tensions that I've described.
Q. Right.
A. So I'm slightly reluctant to sort of pick on one person or incident, but there was a series of moments, of which this was an example, where it seemed that PHE had spoken possible my bosses within the department and effectively

said: why are you cutting across us? This is coming out of your team, why are you trying to do the same thing that we're doing and creating these -- different reporting?
Q. Right. So was it intergovernmental department --
A. Exactly.
Q. -- issues there. Did you get the impression that the new director was telling you to stop doing Vivaldi or anything of that nature? I want to be clear.
A. So it is certainly the case that the new director and, indeed, others in the hierarchy above me did not want to use Vivaldi for the purposes of the policy making and the winter planning that was going on.
Q. We will come back to that. Put the interdepartmental issues to one side, you go on to say in your statement that in June 2020, you suspect after complaints from Public Health England, the then director general, Ros Roughton, rang you on your personal mobile.
Can you remember when this was, Mr Donaldson, apart from it being that month?
A. At this stage I'm afraid not.
Q. All right. And you say she phoned you on your personal mobile to ask why I was doing what I was doing in launching Vivaldi, and effectively to tell me to stop doing it.

Can we be clear now, when you say she "effectively" told you to stop doing the project, was that her actual words or the impression that she gave you?
A. It wasn't her actual words, but I was under no uncertain impression that I was being told off for what we were doing and the way we were doing it, and that after that call, I shouldn't be continuing in the way that we had been.
Q. Now, can I be clear. Did you get the impression that she wanted you to stop doing the project because she didn't think it had value, or she wanted you to stop the way you had, perhaps, been manoeuvring things to get the project done and ruffling feathers?
A. I think it was probably a bit of both, or that's how I interpreted it at the time.
Q. Right. But you did not stop what you were doing?
A. I'm afraid not.
Q. And I think you say in your statement you did not report that conversation with Ms Roughton to your line manager?
A. No.
Q. All right. Now, that was at some point in June, and as you rightly point out, although the study was published on 3 July, we know from Professor Shallcross that she was reporting preliminary findings in a number of different meetings. She's told us about a DHSC Data

Debrief meeting on a Thursday and a SAGE Social Care Working Group or PHE meeting on a Friday; have I got that right?
A. Yes.
Q. Data Debrief on a Thursday, SAGE on a Friday.
Professor Shallcross told us that she was reporting preliminary findings to the Data Debrief Group --
A. Yes.
Q. -- without any difficulty. She also said she shared the Vivaldi findings in the Friday meetings from 30 June. That was the date she was able to put on it. You look askance there, Mr Donaldson. Does that not accord with your recollection?
A. No, there is no disagreement between me and Laura and -- Professor Shallcross on that, but what I would say is that we had been making interventions into the Friday SAGE working group since May, in my -- to my memory.
Q. It perhaps matters not because it was going into both meetings.
A. Yes.
Q. But you do say in your statement in relation to the SAGE care home group working meetings, you had to gatecrash a June SAGE care home meeting. I suspect -- do you remember now which one?
A. Forgive me, I am now not even convinced it was June

rather than May. I honestly can't remember.
Q. Right, okay.
A. But what I can remember very clearly, and I think I may not have allowed Laura to know quite how difficult the battle was with the secretariat to get her in, I didn't want to professionally embarrass her, but initially it was very difficult to get into those meetings and present, but to be fair, the chair, Ian Hall, had an admirably open chairing sort of -- it was like a tutorial, almost. He was very happy to take interventions so once we were in and reporting, it became quite easy for us to start to be a formal part of that structure.
Q. Did you get the sense that Vivaldi was being deliberately excluded or it just takes time to invite a new person to a new meeting and have some familiarity with how those meetings are run?
A. I think there was perhaps initially a little bit of a sense of, you know, who are these new people and why are they, kind of -- (overspeaking) --
Q. Let me ask you this. Do you think there was a desire not to hear the findings of Vivaldi as they became -- as they emerged?
A. I think there may have been a purely subconscious reluctance from parts of PHE to hear that we were

inadvertently showing up problems with their data, because Vivaldi immediately found that they had been significantly underreporting -- (overspeaking) --
Q. Yes, so to be clear to people who are perhaps not as familiar with this as you are, Mr Donaldson, we know in due course that PHE found a relatively low number of infections, for various reasons, and, indeed, we are aware of the retrospective study they did in July 2021 --
A. Yes.
Q. -- which found seeding of 1.6% of hospital discharges led to infections in care homes.
A. Yes.
Q. Vivaldi was reporting slightly higher figures than that --
A. So --
Q. -- but I'll come on to hospital discharge as a discrete topic.
A. Yes, okay.
Q. But generally speaking, there was lower numbers being reported by PHE than the Vivaldi findings?
A. So significantly lower, and also, we weren't just finding that there were more cases; we were also finding that there had been more cases because we could see from the antibodies that many people had had the infection

without it having shown up.
Q. Right, well, that just helps contextualise it for those who are, perhaps, less familiar, watching. You say in your statement that when the results were delivered, there was a suggestion that the Vivaldi results needed to be packaged as SAGE advice. Can you help explain what you mean there?
A. Yes, and to be clear, I don't think that's quite right. I think that the thing that was extremely concerning was that when we finally published the results at the beginning of July, we'd already been reporting the extra cases and some of these risk factors around staff movement and sick pay and cohorting and so on. But there was a new and very important finding, which was that only about half of the care homes had had any cases, so there was a big danger with the second wave with no natural immunity, and also that -- and this cut against the modelling -- that people in small care homes, which was about two-thirds of the care homes, were per capita pretty much just as -- under just as much risk as people in the large care homes, and the initial drafts of the winter planning were going to focus what was limited testing resource just on the larger care homes, and what I had to do was get SAGE to reconsider that based on the Vivaldi findings that they

were all at risk, and then get the department to take that on board.
Q. Can I just ask you about the retrospective PHE study and the 1.6% findings.
A. Yes.
Q. In your statement, and it's at paragraph 39, Mr Donaldson, you have said that:
"Great caution is needed in interpreting 2020 PHE care home data."
And we're familiar with the lack of testing in January, February, March, at least up until about 15 April; all right?
A. Yes.
Q. And you were worried about the use of that data and indeed, you said, in terms, that you were worried that it:
"... did not tally with what Vivaldi had uncovered and it carries a substantial risk of the system 'marking its own homework'. It was not being checked by independent epidemiologists with no 'dog in the fight' or intellectual or professional interest at stake."
Can I ask you, please, to explain what it was you were worried about and whether you are suggesting there that perhaps they have either done something inappropriate with the data or they wanted to cover up

the data. I just want to be very clear about what it is you're saying.

A. Certainly. And this will take a minute to explain, if I may.

Q. Take your time.

A. So I think there are briefly three problems with this, because whether it's the Vivaldi Study in the summer or subsequent studies in the autumn and the following year, asking the question "What are the routes in for Covid to get into care homes?", is a different question from asking "What are the causes of excess deaths in care homes?"

And it is dangerous, and I've seen this throughout, that for perfectly understandable reasons, those two things have a tendency to be conflated. So whether it's Vivaldi looking at data from May, because we didn't have any testing data from the time when all the -- most of the excess deaths happen, or subsequently, by changing -- this is the first point -- by changing the -- expanding this time horizon, you're effectively expanding a denominator with things that aren't relevant to one of those two questions.

The second point is, the cases are defined by the testing. So both the numerator and the denominator, if you are saying, well, this case came from a hospital and

then we found it again in a care home, that would only be the case if you had tested for it in a hospital which in March you would have only done for symptomatic cases which were not as dangerous because people knew to isolate then.

And the third point and I haven't seen this anywhere else but I think it's really important, even if very small -- even if a very small proportion of entries of Covid into care homes came with, let us say, hospital discharge, untested hospital discharge, that doesn't mean that only a small proportion of the excess deaths would have been caused by that, by any means, because although all entry of Covid into care homes was dangerous, some was much more dangerous than others and asymptomatic ingress at the end of March, let us say, untested into care homes that weren't protected was very much more dangerous and likely to cause more cases than something that happened in May or down the line.

And so when I say marking -- to be clear, I'm not suggesting any impropriety, I just think that because of a limited number of people working in this field, I think there is a danger of us, as a system, marking our own homework.

Q. Thank you. I just wanted to be clear about what it was you were saying there. Thank you.

One of the other things that you speak of in your statement is references to the Inquiry in meetings that you attended. And I think you said at your paragraph 69 that there was comments made such as "come the Inquiry, we'll have to be able to say [X or Y]", or "the Inquiry will ask us [A, B or C]". Can you give us any context in which phrases like that were said and whether that was people covering themselves or it was saying from a defensive point, or it was said from a "We need to have a clear audit trail so we can remember this when we go to the Inquiry many years down the line"? Help us with the context, please.

A. Certainly. And to be clear, in terms of context and in terms of your last suggestion, this is definitely not the sort of thing that you would ever see paper-trailed. This would have been oral comments in meetings.

And I want to very clearly state I don't think this was -- I'm not suggesting that there was some kind of conspiracy or cover-up here, it was just very striking to me, as a then non-civil servant, that it was a cultural habit, if you like, or culturally acceptable to say, well, there's going to -- to focus on the fact that there was going to be an inquiry, and therefore that people, I think, were reluctant to take initiative or responsibility for things that weren't immediately

within their explicit remit. And what that meant was that there was a greater likelihood of sins of omission than sins of commission, if that makes any sense.

Q. Different topic, please, and the dashboard data.

In your witness statement, you say you were told not to share it with ministers, local authorities, Cabinet Office, Number 10, and you went on to say you granted access to everyone in local or central government who requested it.

We have in fact seen emails where there was -- various access granted to all those people, but can you help us with the reference to why you were told not to share it with ministers and other government departments.

A. Yes, so -- and to be fair, the context of this is I'd asked for this dashboard to be created sort of without anyone asking me to do it, because I knew that we had all this valuable data and we had -- I can't claim credit for it -- Gemma Hallatt from Palantir had created this excellent tool. I could see how powerful it was going to be for the second wave that we could already see from the data in this dashboard was coming.

But I was very, sort of, surprised that my seniors on the adult social care side were not using it to report upwards to ministers; they were still using the

flawed PHE data. And I didn't feel that they necessarily understood either the data itself or the potential power of this dashboard. So, I confess, I did use my control over the log-in access or my initial control over the log-in access to share it as widely as I could.

Q. Because you wanted to see what potentially it was able to show us, infections at national level, regional level -- as we understand it, it went down in due course to care home level?

A. Even at the start, in August, it went down to that level of granularity, individual care homes. And the thing that was terrific about Minister Whately is that she would -- she really wanted to interrogate the data and was then able to follow up and effectively, sort of, you know, ring up individual care homes or local authorities and say, "Look, we can see you've got a problem here. What is it? How can we help?"

So, because in August we could see that the second wave was taking off, we thought it was absolutely urgent to get this out to as many people as possible.

Q. Right. And just -- you mentioned there Minister Whately. You say you were told by your director not to share it with the minister and had to give briefings to the minister in secret without your

own managers knowing until the data became recognised as too valuable to stop.

A. Yes.

Q. Now, the minister didn't recall being briefed in secret. Maybe she wouldn't know about that. But are you able to provide any background or context as to why you had to brief the minister in secret, as you describe it?

A. Yes. And again, to be fair, there's no reason the minister -- so this was -- I effectively had a good relationship with Minister Whately's private office, and the fact we were all in lockdown here was our friend, because usually a junior official would find it difficult to get into the physical room with the minister but on Teams it was quite easy to say to the private office, "Oh, I think the minister will want to see this, can you add me to the invitation list?" So my bosses would, to their slight horror, I'm sure, would see me turning up in a meeting without anyone having asked me to be there. But they -- they were reluctant, I think, to take responsibility for this product which I had asked to be created and which did not have PHE, sort of, approval or badging on it.

Q. Once the dashboard was shared with a number of people different and bodies, did you get any sense then that people were not grateful or didn't appreciate the value

of the data that the dashboard could tell us?

A. I think in general people were extremely pleased with the dashboard because it was a very powerful tool for the second wave.

Q. Can I ask you one final question, please, and it's about your paragraph 111 and it may help if we have up on screen, please -- thank you very much -- page 35.

Now, some of the other witnesses that her Ladyship has heard from have been asked about this paragraph and I'd like your observations on it, but you say by way of summary:

"... we had to create Vivaldi because PHE and DHSC, [adult social care] Policy teams, had failed to do so. We had to use outsiders because they wouldn't and perhaps couldn't do it themselves. Parts of [Public Health England] and [the Department] effectively tried to stop Vivaldi happening, then tried to stop it reporting, then tried to avoid acting on the results, then tried to stop the creation and use of our ... dashboard. Having tried to stop our initial report, PHE first tried to ignore it, then tried to steal it and present it as their own, then tried to reinterpret it as justifying its own previous policy failings."

You go on to say:

"DHSC refused to share data, even when ordered to by

ministers, and regularly proposed not telling ministers important information. I believe that all this suggests a pattern of dysfunction that helps to explain why things were so bad with the care home policymaking at the start of the pandemic, and gives broader clues as to the systemic problems Covid revealed."

Now, the next line of paragraph 112 hasn't been shown before but you go on to say:

"In my view, none of this was because of bad faith or malicious or lazy individuals ... It was, rather, part of a wider problem of systemic bureaucratic inflexibility ..."

And you go on.

Now, wider systemic issues are perhaps not within the remit of this Inquiry but certainly Professor Hopkins was asked about this paragraph and she said she didn't recognise the matters that you set out there, and would like to see the evidence upon which it was based. Do you have any additional comment to make about what are, on any view, relatively strong criticisms there of both PHE and the department, and any other context you would like to add to that paragraph, Mr Donaldson?

A. Yes. So, first of all, I'd like to point out I say "parts of". I'm not trying to be too blanket in this.

And of course it was different parts doing different bits of this, so I think this paragraph only makes sense in the context of my wider statement, but I still think it's an accurate summary, and as I say, just make it clear, I don't -- everybody was working extremely hard, and I didn't see any evidence of anyone doing anything inappropriate individually, but it was an enormous struggle against a set of systemic problems.

MS CAREY: My Lady, they're all the questions I ask but I think there is one Core Participant who has been -- (overspeaking) -- some questions.

LADY HALLETT: There is.

Questions from MS STONE

MS STONE: Thank you, my Lady.

Good morning, Mr Donaldson. I ask questions on behalf of Covid Bereaved Families for Justice UK, and I have just got three questions for you, please, which relate to your evidence as to the impact of the hospital discharge policy.

So the first one is this: the Inquiry has heard evidence about the limitations of the PHE data linkage study given how constrained testing capacity was in March and April 2020. And you've touched on that this morning.

As Ms Carey King's Counsel noted at the outset, you

stress, fairly, at the beginning of your statement, that, you have no academic background in science or epidemiology.

A. Yes.

Q. But is such a background necessary to recognise those limitations?

A. So to be clear, I had a team of epidemiological and statistical experts who were helping me throughout that summer to interpret the raw data that we were looking at and it was my job as a policymaker to summarise their findings and interpret them for the purposes of policy.

Q. So is the answer no, that you were able to do that within the parameters of your role, relying on those experts?

A. So I think precisely because I had those experts in my team to help me, I think that I'm -- I make absolutely no claims for my own knowledge but I think I was in a good position, from where I was sitting, to understand the data, yes.

Q. Thank you. Second, please. You also say in your statement that given those data constraints, it's not possible to prove definitively whether the hospital discharge policy was the cause of significant numbers of unnecessary infections and deaths, but nevertheless, you say you believe it probably was. How were you able to

come to that conclusion?

A. My personal belief? So just because of Occam's Razor, I suppose. If you take lots of people who -- from hospitals full of Covid and put them into a vulnerable setting without testing them, given how many asymptomatic cases there were, it would be surprising if that did not cause, unfortunately, further cases and deaths, and the problem for all of us who were working on these issues at the time is that that policy was -- it was difficult to analyse for the same reason it's been controversial, there were no tests so it was impossible to know which of those people, unfortunately, were infected.

Q. Finally, Mr Donaldson, in your statement you describe a "generational slaughter" within care homes. And that's clearly not everyday language. Why or what prompted you to use such strong language in the context of this, of the hospital discharge policy?

A. Well, I think I use it in the context of the overall situation. I was asked to give this witness statement in my own words, and I can't think of a better form of words, given the horrible scale of the tragedy in the care homes, particularly in that first wave. We're talking about something like 27,000 excess deaths in the space of a few weeks, and of course, unfortunately,

concentrated, because of the nature of the virus, on one particular generation.

MS STONE: Thank you very much, my Lady.

LADY HALLETT: Thank you very much, Ms Stone.

That completes the questions we have for you, Mr Donaldson. Thank you very much for your help, for coming today to assist the Inquiry.

THE WITNESS: Thank you.

LADY HALLETT: Thank you.

MS CAREY: My Lady, the next witness is Jeane Freeman, and I'm going to hand over to Ms Jung.

Hello again, Ms Freeman.

MS JEANE FREEMAN (sworn)

Questions from COUNSEL TO THE INQUIRY

MS JUNG: Thank you, my Lady.

Ms Freeman, can you start by confirming your full name, please.

A. It's Jeane Tennent Freeman.

Q. Thank you. And thank you for coming today to assist the Inquiry for, I think, the fifth time; is that right?

A. Yes.

Q. The statement that you've produced for this module is at INQ000606530. And I understand that you have a copy of that?

A. I do.

Q. Thank you.

Dealing first with professional background. You served as the Cabinet Secretary for Health and Sport in Scotland between June 2018 and May 2021. After that, you did not stand for re-election and you did not have any further involvement in the Scottish Government's response to the Covid-19 pandemic; is that correct?

A. It is.

Q. Prior to being appointed as Cabinet Secretary for Health and Sport you served as Minister for Social Security. Previous to that you worked as a senior civil servant in education. You worked also as a special adviser, had a decorated career in social justice, and you originally trained and qualified as a nurse; is that all correct?

A. All correct, yes.

Q. Did you have any professional experience in adult social care before your appointment as Cabinet Secretary for Health and Sport?

A. No.

Q. Dealing, then, with your role as Cabinet Secretary for Health and Sport, you had primary responsibility for the Health and Social Care Directorate and also NHS Scotland; is that right?

A. That's correct.

Q. That included primary care, allied healthcare services,

vaccinations and therapeutics, healthcare and social integration, and carers and adult care; is that right?

A. That's correct.

Q. Did you also have lead responsibility for a number of public bodies, including NHS Scotland, the Care Inspectorate, the Scottish [Social] Services Council and Sports Scotland?

A. Yes.

Q. And dealing then with your role during the pandemic, is it right that you were primarily responsible for health and social care, and in terms of the areas that are relevant to this module, you had responsibility for adult social care policy, setting direction, and making decisions on resourcing and strategic decisions. However, you did not make day-to-day operational decisions on adult social care; is that correct?

A. That's correct, because, of course, the statutory responsibility for delivery of adult social care sits with our local authorities.

Q. Thank you. Can I ask you about levers, please.

A. Yes.

Q. At paragraph 6 of your statement you make the point that:

"Unlike health [care], the Scottish Government does not have direct statutory responsibility for the

delivery of adult social care."

The point that you've just made. To what extent did that constrain your ability to direct and coordinate the social care sector's response to the pandemic?

A. So it is a constraint, in as much as, in terms of the NHS, then, particularly using the legislation, it was possible for me to direct what we were doing in our health service. It's not the case that a health secretary has the power to direct what happens in adult social care, whether that is in a residential or an at-home setting. That sits with local authorities and with their umbrella body, COSLA. And so the way in which you work is to reach agreement with COSLA on those matters that you've just described, the strategic approach, the resourcing. But then you are dealing with individual stakeholders and, as you know, adult social care in Scotland is delivered by a range of agencies, both private and public.

Q. Thank you. Is it the case that local authorities and health boards delegate their social care duties to, in the majority of cases, what are called integrated joint boards? They then set the strategy and commission the work, and adult social care is delivered by what are called health and social care partnerships?

A. Broadly speaking, that is correct. Health and social

care partnerships will then commission the delivery of adult social care. So that might be to the private sector or, in some instances, local authorities deliver that directly by employing the staff themselves to do that.

Q. Thank you. And I think the only health board that's slightly different is Highland, where the NHS board is responsible for adult social care, I think, and the local authority is responsible for children's social care; is that right?

A. Yes.

Q. Can I ask you for clarification, please. At paragraph 6 you say:

"While Scottish Ministers can issue directions to local authorities, Health Boards and Integration Joint Boards/Health and Social Care Partnerships, [you] do not have statutory powers to issue directions to care providers."

Can you just be clear, please, what levers did you have during the pandemic, as far as the adult social care response was concerned?

A. In terms of the providers, or -- do you mean in terms of the providers --

Q. In terms of directing the response. So whether that -- we know that you didn't have any power to direct the

care home providers, but as far as the integrated joint boards of the health and social care partnerships were concerned, and also the local authorities and the health boards, can you tell us what levers you did have, please.

A. So there are some statutory levers, but at the same time, we have to remember that individual local authorities are themselves democratically elected bodies. So you have to respect the democratic basis of a local authority.

So the bulk of the work in practice involves discussion and agreement, which is why, as I think I say in my witness statement, and have said previously, the quality of the relationship with COSLA, and in particular their lead member for social care, was critical to being able to secure agreement on our overall approach, on resourcing, on additional support that might be needed, and so on.

Q. So is my understanding correct, then, that you did have some statutory levers but you chose not to use them for the reasons that you've just stated?

A. No, I wouldn't say I chose not to use them. It was -- there was limited difficulty in securing agreement between myself and COSLA on the direction of travel and what needed to be done, both in the overall strategic

approach and in some of the detail of delivery. Where there were issues, it arose in terms of individual providers.

Q. Thank you.

A. And on occasion, to be fair, with individual local authorities.

Q. Looking back, then, are there any particular levers that you wish you had had at your disposal or are there any, in hindsight, you wish you had used differently?

A. I think that's a difficult question. There were none with hindsight that I wish I had used differently, given what was available to me at the time. I think my answer to the second part of your question about what would I like to have had but didn't have, is really picked up in some of the recommendations of the Feeley report.

So the key one there is about securing consistency of standards across adult social care provision in Scotland, where, prior to the pandemic and indeed during the pandemic, there were differences in the consistency of delivery of some of the requirements we made, for example, visiting guidance in some instances, that would be best to not have that inconsistency.

And the comparison I'd make is where you have inconsistency in the delivery of healthcare between one health board and another, there are various steps that

Scottish Government can take to address that, both through our clinical teams but also directly as throughout NHS Scotland but also as government. Those steps are not as available in adult social care, so inconsistency of delivery is unfair on those receiving the care.

Q. And I think in fact, during the pandemic, you exercised your emergency powers to put the NHS on an emergency footing; is that right? And did that give you control, I think you refer to it in your statement as the NHS acting as one single unit?

A. Yeah.

Q. Is that the kind of lever that you would recommend should be in place in future to give ministers -- allow them to be better equipped to lead a response in the future?

A. So for accuracy, I used the legislation that allows a Health Secretary, I think it's the '78 legislation that allows the Health Secretary to put the NHS on to an emergency footing. That means that I could use powers if required. As it happened, I did not require to because our NHS all faced in the same direction, and so on.

I think it's worth consideration, in terms of adult social care, but I can see complications with that

because the provision of adult social care is split between private and public, whereas our NHS in Scotland is a publicly provided, entirely publicly funded, healthcare service. So the basis on which an elected government minister can direct that publicly funded agency is clear. I think it is less clear where you have that mix of provision.

So I'm not discounting that, I think it's worthy of some consideration, but I can see complexity in that.

Q. Thank you. Can I ask for your general reflections on a number of matters, please.

In your view, what aspects of the adult social care response in Scotland went well?

A. So I think, without exception, the response of staff working in adult social care, both in residential settings and at home, was exemplary. In many instances, staff sacrificed time with their own families in order to deliver as safe care as they could. In some instances, staff left their homes and lived in the residential setting, where they were providing care. So I think that the response of adult social care staff was absolutely exemplary.

I think, overall, the relationship with Scottish Care and with COSLA worked very well, and we benefited from a range of clinical expert advice on the

care and vulnerabilities of the population, particularly those cared for in residential settings.

Q. Were there any particular decisions where you feel, with hindsight, alternative actions may have led to a better outcome?

A. So I think, if I was currently dealing with a pandemic, then I think more consideration could have been given to the impact on those receiving adult social care of some of the measures introduced in order to safeguard them from the virus.

So I'm thinking particularly of those in residential care who suffer from dementia, for example, but also younger adults, perhaps with learning disabilities or other issues in residential care, who also suffered from the imposition of restrictions on their movement, on being outside. But at the time I did not believe there was a reasonable alternative to balance that concern against the overriding concern to try and prevent the transmission of the virus to a vulnerable population.

Q. Thank you.

Was the adult social care sector, in your view, the poor relation to the NHS in Scotland?

A. No, I don't believe it was, in terms of my actions with respect to how we would respond to the pandemic in that setting. I think, though, it is clear that the adult

social care sector is disadvantaged in terms of the terms and remuneration to the staff who work in that sector and the absence of clear career progression, all of which makes it difficult to attract the numbers of staff that you would need to that profession.

Now, that is complicated, as we've said before, by restrictions that arose from Brexit, but the fundamental problem is the terms and conditions. And that was one of the reasons, for example, why, during the pandemic, we intervened in order to provide sick pay to those whose terms and conditions of employment provided nothing more than Statutory Sick Pay and made it very difficult, then, for staff who wanted to comply with our requirements, for example, if they had Covid themselves or, more often, a member of their family did, with our requirements for them to stay at home, that was a financial loss that we stepped in to try and alleviate so they could comply. But that was because their terms and conditions of employment were poor.

Q. Thank you.

Do you think there was a fair balance and a broad enough range of adult social care voices that informed decision making during the pandemic?

A. Yes, I do. I think Scottish Care was a key and critical voice, critical both in its importance, and at times in

terms of what it said, and I had many meetings with Scottish Care, multiplied a number of times by the number of meetings my officials would have had. We also benefited from specific clinical advice in terms of geriatrician advice and I did myself meet care home providers and adult social care providers.

There were other organisations, too, that raised concerns and we had discussions with, particularly those who represented adults with disabilities or with learning difficulties.

Q. What changes do you think are needed to ensure that adult social care in Scotland is better understood, recognised, and equally prioritised alongside the NHS in future pandemic planning and response?

A. So I would not agree that it wasn't prioritised alongside the NHS in our pandemic response. And I think it's important for me to say that. But as we look ahead to what we need to do for the next pandemic that will appear, I think many, if not all of the recommendations from the Feeley report, should be implemented. I think, as I've said before, that our testing infrastructure needs to be, at a base level, better than it was at the start of the pandemic we're discussing.

I think we need to -- and in terms of the Feeley report, that is about agreed national standards,

consistently applied across the country in whatever setting adult social care is delivered, and inspected and regulated to ensure that that is happening and where it's not, that steps are taken to achieve those improvements.

That all also links into how, as any Scottish Government works with and seeks to offer people with disabilities the equity of opportunity that those of us without that enjoy or have before us.

Q. Looking back, do you consider that the care at home sector and unpaid carers received sufficient and timely attention and support from the Scottish Government during the pandemic, particularly in comparison with care homes?

A. So the care at home sector was included in the additional supply of PPE that we introduced. So the concern about the supply of PPE to residential social care first flagged up the problem that existed, to which our response was then to use our National Services Agency which supplies PPE to our NHS, to increase the volume of supply and the routes to include residential care but also care at home, and unpaid carers, personal assistants, and a range of others. And you'll know from the material that's already been provided to the Inquiry the various routes that we implemented in order to

ensure that that was the case.

I don't recall specific issues being raised with me in terms of care at home, with one exception, and that does relate to PPE, where, from the trade unions representing staff delivering care at home, they raised a concern that their members in some instances were not given an adequate supply of PPE to deal with the number of individuals in any given day that they would be visiting to provide care, and I made the determination that those staff in all circumstances should be given, if they were visiting, for example, five clients, they should be given five full sets of PPE and allowed to use their professional judgement on what PPE was appropriate for each individual.

Q. Thank you.

A. So that was one specific instance but there were -- I don't recall others being raised directly with me, in terms of adult social care.

Q. So the question was, do you think that they did receive sufficient support and attention and were they prioritised alongside care homes?

A. Yes. For me, yes, they were. And in terms of all the issues that came to me for me to then address in the practical delivery of our work, I don't recall any that were raised that I did not address.

Q. Do you think that anything more can be done to increase the recognition and visibility of unpaid carers and the care at home sector in Scotland?

A. So I think ... mm. I think that in terms of, if you like, the narrative around adult social care, too often we, collectively, confine our thinking to only those in residential settings and confine our thinking to the elderly, where, as I've said, adult social care is also a vital service to many much younger people which, provided properly to meet their individual needs, allow them to, for example, go to work, meet their friends, have the kind of opportunities in terms of education and otherwise that those of us who are fortunate take for granted.

So I think there is an attitudinal question that needs to be addressed with respect to adult social care as you would broadly define it, and properly define it.

Q. Thank you. Can I move on to a different topic, please, which is pre-pandemic preparedness and plans.

In your Module 1 evidence, Ms Freeman, you accepted that there were several key lessons from exercises Cygnus, Silver Swan and Iris that had not been implemented or fully implemented by the time the Covid-19 pandemic arrived. Can you tell us what risks were known to you as at January 2020 regarding the

pandemic preparedness, or lack thereof, of the adult social care sector in Scotland, please.

A. I do not recall specific risks being raised with me with respect to the adult social care sector in terms of lessons from those exercises that had not been implemented.

What was clear, and was discussed many, many times, was the overall vulnerability of that sector, and its disparate nature, and that was what factored into our thinking and our planning, and with the help of specialist advice, in terms of geriatric care, the issues that I've already touched on in terms of the particular vulnerabilities that were not clinical vulnerabilities but other vulnerabilities of that group.

Q. One of the recommendations that was not fully implemented was that local plans should integrate the health and social care partnerships.

Did you have oversight at the start of the pandemic as to how many of the health and social care explanations had been implemented, fully implemented or integrated into the local pandemic plans?

A. No, I didn't.

Q. Is that something you think a minister should have oversight of, at the start of a pandemic? Not only to assure themselves of the existence and the adequacy of

the plans, but also to inform the response of the sector?

A. Yes, I do. Yes, I do. And I think our colleagues in Scottish Care and otherwise have made the point about that sector being represented more consistently in non-pandemic times at that level of strategic decision making. And I think that is a very fair point.

Q. Can I ask you about the initial period of planning and response. So focusing for now on the months of January and February 2020, please.

A. Yes.

Q. And could I ask to be shown on screen INQ000238703, please, page 4. And if we could focus on paragraphs 15-17, please.

Can you see in paragraph 16 it says, three lines up from the bottom:

"Planning included work to assess the vulnerability of the social care sector."

Do you see that?

A. Yes.

Q. Can you tell us what specific work was done in relation to assessing the vulnerability of the social care sector and what the findings were, please?

A. So this was work undertaken by officials, and it would be undertaken in consultation with, for example,

Scottish Care, to look at -- and the Care Inspectorate -- to look at Care Inspectorate reports up to that point, identifying any particular residential settings where improvements were needed and how that had been progressed or not, and also looking at the mix of agencies and the delivery of social care. So for example, what proportion of adult social care delivery was direct from local authorities in that they employed the staff to do that? And then in the private sector, what was the mix between large-scale operations and small operations, a single care home run, but the operators only had one care home compared to others where maybe there was more than one.

Q. Do you think there are any steps that could have been taken in those early months to try to deal with some of the vulnerability issues going into the pandemic?

A. No, I'm not sure that there are any steps at that point that were not addressed that should have been addressed.

Q. Can I ask you about some early correspondence, please, between Professor Woolhouse and the then Chief Medical Officer. You were asked about correspondence in Module 2A. Was it fed back to you that in January, Professor Woolhouse had warned Ms Calderwood, who was the then CMO, that an integrated surveillance system that combined clinical surveillance, genomic

surveillance and serological surveillance and data sharing was needed and that should be set up in advance of the pandemic arriving in Scotland?

A. So that level of detail was not provided to me by Professor Calderwood, but I was aware that she was in touch with Professor Woolhouse, and I think met him along with other experts in the field of epidemiology or virology who were also in contact with her or her colleagues expressing views and offering advice.

Q. Did you take any steps in January and February in relation to building up the data infrastructure in relation to adult social care?

A. At that point, no.

LADY HALLETT: Can I, sorry to interrupt, but can I just ask, is it a level of detail that you wouldn't expect a minister to be alert to if we're talking about a surveillance system, or we're talking about data infrastructure? Isn't that the kind of detail that ought to come to the minister?

A. So I understood what our existing surveillance system was, and if Professor Calderwood had thought that there should -- that that should be improved in any respect, then she would have raised that with me and we would have discussed how that might have been done. I don't recall that being raised with me but I did understand

the existing surveillance system that we had which was primarily through GP practices.

MS JUNG: And could I just ask you, while we're on this topic, what the existing data system was in relation to adult social care, and in particular, whether there was any real-time data available in relation to care homes?

A. So there was real-time data available through the Care Inspectorate. It depends what kind of data you're meaning. So the existing -- or the pre-existing surveillance system, the Sentinel system, through our GP practices, would encompass care homes, and that is around infection, primarily. Other data around the provision of care, the quality of care, would come through -- the adequacy staffing and so on, would be data that would be available through the Care Inspectorate.

MS JUNG: Thank you.

My Lady, I see the time. I can either deal with a short topic now, or if it would be convenient --

LADY HALLETT: I'll return at 11.30.

MS JUNG: Thank you.

(11.14 am)

(A short break)

(11.30 am)

LADY HALLETT: Ms Jung.

MS JUNG: Thank you, my Lady.

Ms Freeman, in your Module 2A evidence you said that the Scottish Government's knowledge of and complete understanding of how the adult social care sector operated was not as adequate at the outset as it needed to be, and some other areas of understanding, particularly of the care at home sector, was not adequate at the outset.

First of all, was that a reference to your own personal understanding, or the government's understanding?

A. I think both.

Q. And in what ways was your understanding and the Scottish Government's understanding of how the sector operated inadequate?

A. So I think the most important way -- I think both I and the Scottish Government, ie officials, understood the structure of adult social care sector, the delivery of the adult social care sector, and importantly, the contractual arrangements around the delivery of adult social care. Where, importantly, I think there was less understanding was a presumption, certainly on my part, that the 2012 national manual for infection prevention and control, which is -- the obligation to deliver infection prevention and control, according to that

manual, is part of the contract that providers have.
My presumption was that that was understood, that staff were trained, consistently across the piece, to know what to do, and it was being delivered.
I think the -- from early in the pandemic response it became clear that that was not consistently the case.
Q. You said in your Module 2A evidence that there were some presumptions made, which, as you worked through the days, became clear could not stand. You've just referred to one of those presumptions there.
A. Yes.
Q. Were there any other presumptions made which turned out not to be true?
A. I don't believe so, but I think, for example -- this is not a presumption -- well, arguably it might be, but I don't see it as a presumption -- the difficulties that the sector faced in securing adequate PPE.
So that had never been a difficulty raised, I don't believe, with government in any respect prior to the pandemic, but of course, was raised during the pandemic, because it was a global pandemic, there was global demand for PPE, and individual care homes, and indeed individual local authorities, seeking relatively small volume of PPE were being pushed out of the market, if you like.

Q. Thank you.
A. And that's why we intervened. I'm not sure that's a presumption, but it is certainly an issue that arose early in the pandemic which had not been an issue pre-pandemic.
Q. We'll come to PPE a bit later.
A. Okay.
Q. But could I ask you this: in relation to the recommendations made pre-pandemic, one of them was that there wasn't enough awareness of the PPE stockpile and of the distribution. Is that something that you were aware of was an issue in relation to the adult social care sector pre-pandemic?
A. No, because the pre-pandemic stockpile was not necessarily something that the pre-pandemic would have access to.
Q. In a pandemic?
A. In a pandemic they would do, but --
Q. Yes, and so I think the recommendation was saying that the staff did not have enough knowledge that such a stockpile existed --
A. Right.
Q. -- to be accessed in the event of a pandemic.
A. Okay.
Q. So is that something you were aware of pre-pandemic?

A. No, but I was aware of very early in 2020, because I believe Mr Macaskill raised it with me.
Q. Thank you. On a podcast in April 2021 you said this:
"I think our failures were not understanding the social care sector well enough. So we didn't respond quickly enough to what was needed in our care homes but also in social care in the community."
Have you reflected, Ms Freeman, as to why, as the Cabinet Secretary for Health and Sport, primarily responsible for social care during the pandemic, your knowledge of the sector was not adequate?
A. Yes, I have, and believe I've just explained in what way it was.
Q. Sorry, it may be my fault for not asking the question clear enough. The question is: why wasn't your knowledge adequate?
A. Because I think the presumption that I made about infection prevention and control in the adult social care sector was a presumption made across government.
Q. Across the whole of government?
A. Well, health and social care.
Q. Do you think that, as a minister, you should have been asking questions where things were unclear in your mind?
A. I think I should have, and I did.
Q. In your Module 6 statement you say at paragraph 72:

"I do have a good understanding of the adult social care sector in Scotland and took this into consideration when making key decisions."
Can you please clarify, does that represent a change in your position or should we take that to read that you're referring there to decisions made later in the pandemic because you've just accepted that your knowledge at the beginning of the pandemic was not adequate?
A. No, I think what you should take it as is that from the outset, from being appointed the Cabinet Secretary in 2018, I understood the structure, contractual nature and multiplicity of agencies delivering adult social care. So in that sense I had a good understanding of how adult social care was delivered, and the requirement of government, in terms of funding, strategic decision making, and so on. I understood about integrated health and social care and the health and social care partnerships you've referred to earlier.
The practicality of delivery is something that early on in responding to the pandemic, became much clearer to me, and that is where I would say my understanding was not as full as I needed it to be at the outset, but I have to say I think it became pretty full, pretty early on.

Q. Thank you.

You say at paragraph 166 of your statement that:

"Any assumption that dealing more effectively with the issue of delayed discharge in March 2020 increased the risk of introduction, or transmission, of COVID-19 to care homes is, in my view, based on limited, if any, evidence."

Can you clarify, please, is that a view that you held at the time when you were making the discharge decision?

A. At the time when I was making the discharge decision, as I think I've explained previously, two points. First of all, it's really important, in all the decisions that were made during our response to the pandemic, to understand that these were not binary decisions. They were not decisions between a self-evidently risk-free approach and a risk approach. They were decisions between levels of risk. And so I understood, when I was making the decision, to ask that delayed discharge be paid attention to, which had been a position, prior to the pandemic, on my part and many previous Cabinet Secretaries', that in doing that, we needed to also ensure that mitigation measures were put in place in care homes, but we were looking to remove, where they were clinically ready to be discharged from hospital,

individuals from high-risk environment, ie, a hospital, where we expected largish numbers of Covid patients as well as other hospital infections, to an environment that was, relatively speaking, less risky, plus those additional mitigation measures.

Q. Can we move on, please, to the discharge --

LADY HALLETT: Sorry, just before you do, I'm sorry to interrupt.

MS JUNG: Of course.

LADY HALLETT: I'm just trying to get straight in my own head what you're saying, Ms Freeman. I haven't listened to the podcast, forgive me, but I understood from Ms Jung's questioning that you said the lack of understanding across Scottish Government, including your own, had led to a delayed response but you've just told Ms Jung that you became -- that you had understood the structure, contractual nature and multiplicity of agencies, and you pretty early on had a pretty full understanding of the practicalities of delivery.

I'm not quite squaring the two because if you pretty early on got a full understanding then there wouldn't have been any delayed response, would there?

A. I'm not sure there was a delayed response, my Lady.

LADY HALLETT: I thought that's what you said in the podcast.

A. I may have done, but, reflecting on it now, I don't believe there was a delayed response from us.

MS JUNG: It may be that you were referring to the April enhanced oversight package of measures.

A. It may have been, but that podcast was some time ago, and I have not listened to it. So I'm not entirely sure.

Q. Thank you.

Can we turn to the discharge policy in March, please.

There are number of area in which the Inquiry seeks clarification in relation to this policy. Dealing first with your role and accountability, you say at paragraph 122 of your statement that:

"The Scottish Government did not make individual discharge decisions. Scottish Ministers do not have powers, and did not, place named individuals in named care homes. Those types of discharge decisions are to be made on a case-by-case basis with clinical input. What the Scottish Government did do was to ask local authorities, through their adult social care staff, to prioritise and put additional effort into reducing delayed discharges in their hospitals."

So putting aside the individual decisions, do you accept that the Scottish Government did direct social

care staff to reduce delayed discharges and that in fact targets were set for them to do so?

A. Yes, but that was no different from the pre-pandemic position. If we look at the work that I was undertaking in 2019, that was to reduce delayed discharge because delaying someone's discharge from hospital because the social care support is not in place, is detrimental to that individual, particularly to an individual who's elderly, in terms of both their physical and their mental health.

Q. And as Cabinet Secretary for Health and Sport, do you accept ultimate accountability for that decision and the consequences of it?

A. Yes.

Q. Turning to the rationale for the discharge policy, the Inquiry understands that the first positive Covid case in Scotland was confirmed on 1 March and that it was around this time that it was realised, in SAGE, and throughout the UK, that community transmission was further along than initially thought. Did that change in understanding influence the pace and urgency of hospital discharges into care settings?

A. So, in terms of preparing our hospitals to be ready to receive the worst-case scenario of a number of people expected to contract Covid and to require

hospitalisation and of that number to require intensive care, a number of steps were taken, of which a focus on delayed discharge was but one, and arguably, the greatest impact was the pausing of elective care.

So delayed discharge had always been on the desk of a Health Secretary. It was on my desk, and --

Q. Ms Freeman, I'm sorry to interrupt, I don't dispute that. The question is, did that change in understanding influence the urgency and the pace of the need to discharge patients in a care settings?

A. No.

Q. No. Thank you.

Can I just deal with some of the chronology as background context, please.

You were asked in Module 2A about an email from the First Minister asking whether sector-specific guidance needed to be issued, because it had come to her attention that one particular care home was refusing admissions.

A. Mm.

Q. Is it right that on 11 March, so the next day, there was a submission in relation to care homes closing their doors, and it was in response to Scottish Care indicating that four large corporate care home providers had closed their doors to new admissions and had

restricted visitors to care homes and that there was a worry that smaller providers would follow suit? As I've mentioned, that issue had been raised previously by the First Minister the previous day.

The submission indicated that Health Protection Scotland had been urgently asked to draft some guidance to issue to the sector, and what was recommended was that you send a letter to providers highlighting that there was clinical advice, pointing to the fact that there was sector-specific guidance coming, and providing reassurance to the sector about supporting them for their role.

So the question is, was the letter that was then issued on 13 March, along with the Scottish Government's guidance, in response to you being told that care homes were closing their doors to admissions, as a way of reassuring them and encouraging them to continue to take discharges?

A. It was a means of reassuring them to take discharges if they felt that that was appropriate, because it was always their decision whether or not they took any admission to the care home, whether that was someone discharged from hospital or not.

Q. We're going to look at what the letter actually said, but could I first of all ask for a document to be

brought up, please.

It's INQ000362665. Page 5.

And Ms Freeman, if you want to turn it up, it's tab 19.

Can we see paragraph 15(d), sorry, it may be page 4. It says:

"The overall objective should be to do everything possible to keep the number of severe cases to a minimum: that is, to reduce hospital admissions and/or deaths among the ... vulnerable."

Can you help us as to why the "or" is in there? So it's "to reduce hospital admissions and/or deaths among the ... vulnerable". Was there any discussion about the need to choose or prioritise between those two?

A. No.

Q. That can come down now. Thank you.

Can I ask you about consultation on the policy, please.

You met with COSLA on 4 and 5 March 2020; is that right?

A. **(No audible response)**

Q. You refer in your statement to a meeting of the NHS board chief executives on 11 March, and what you say in relation to that is that:

"... no one identified as a particular risk the

movement of people being delayed in hospital to care homes; and no one asked for a comparative risk assessment of the respective hospital and care home environments.

"164. Rather, there was [a] consensus at that meeting that delayed discharge had to be effectively tackled ..."

This was a meeting of the NHS board chiefs, chief executives. Were there any voices representing the adult social care sector at that meeting?

A. No.

Q. So why were you expecting anyone or why do you say no one identified a particular risk? Is that surprising, considering there were no voices of the adult social care sector there?

A. No, it's not surprising, because NHS board chief executives have medical directors, and they will have consulted with them prior to the meeting itself on a number of issues with respect to the pandemic. And those medical directors will be in contact with our Chief Medical Officer, so they too will have a degree of clinical advice, as I had, on this and other issues.

So if any of their individual medical directors had raised a concern, then that chief executive would raise that concern with me.

Q. So following the submission on the 11th, the Inquiry understand that Health Protection Scotland issued their guidance on the 12th, and then on the 13th you issued the Scottish Government clinical guidance along with the letter to the sector?
A. Yeah.
Q. Did you consult with any other voices from the adult social care sector apart from COSLA prior to that 13 March letter being issued?
A. I believe Scottish Care were consulted.
Q. I think that first meeting was on 18 March?
A. That was their meeting with me. That is not the same as the range of discussions and consultations they would have with my officials.
Q. So what consultation had taken place prior to 13 March with the sector, please?
A. I can't give you specifics on that, because those would not be with me. But my officials were in relatively constant contact with Scottish Care.
Q. Did you yourself seek out the opinions of anyone in the sector on this particular policy?
A. I would ask my officials if any concerns had been raised with us, with the expectation that they would have been speaking to both local government, through COSLA, and Scottish Care.

Q. In your statement you say that admission was by agreement, and that the care facility were perfectly able to refuse to take admissions.
Can we have a look, please, first of all, at INQ000470123.
This is a letter that was sent out on 6 March from the then director general of Health and Social Care.
A. Mm-hm.
Q. And can we see in the second paragraph, it says:
"We now need to be able to create capacity and space within our hospitals ... I appreciate that this necessarily increases the pressures on ... social care systems at a point when there are challenges around how to provide care to vulnerable people in their homes ...
"Nevertheless, I would expect that appropriate steps are being taken in local systems ... that demonstrates this is being prioritised and driven forward ... The expectation being a material reduction in the delayed discharge figures across Scotland. In the immediate term, our requirement is to reduce the overall Scottish delayed discharge position from 1650 to 1250 by no later than 9 April -- efforts to achieve progressive reductions must continue thereafter."
Looking at the wording of that letter, do you have any reflections on whether that letter may have caused

some people to understand that they were being asked or required to prioritise accepting hospital discharges?
A. No, I don't believe so.
Q. Can we look next, please, to another document at INQ000147441, page 2, paragraph 2, please.
This is your letter that was sent out on the 13th. And it says:
"The long-term care and residential care sector is vital to the wider health and social care system. It is essential that it continues to function in an effective way so that people in communities are supported in the right way. It also in some cases provides a safe alternative to more acute settings, including hospital care. It is therefore imperative that care homes continue to take admissions if it is clinically safe to do so."
And at page 4, please, the section titled "Transitions from hospital", this is an extract from the Scottish Government guidance itself. It says:
"There are situations where long term care facilities have expressed concern about the risk of admissions from a hospital setting. In the early stages where the priority is maximising hospital capacity, steps should be taken to ensure that patients are screened clinically to ensure that people at risk are

not transferred inappropriately but also that flows out from acute hospital are not hindered and where appropriate are expedited."
Looking back, Ms Freeman, do you think that that letter should have more explicitly set out the right of care homes to refuse admissions?
A. No, because I think care homes were perfectly clear that they had that right, and in some instances appropriately exercised that right. The key word in all of the paragraphs you've highlighted is "clinical". So an assessment as to whether or not someone is ready for discharge is a clinical assessment. It's not an assessment made by me or any of my officials, or even by a care home. But the care home has the right to see that clinical assessment and take a decision for itself as to whether or not it can appropriately manage the care of that individual in their setting. And they've always had that right and they had it throughout the pandemic.
Q. Dr Donald Macaskill of Scottish Care gave evidence in Module 2A and he spoke of care providers, from media publicity and also the public messaging that was going out, feeling pressured to take hospital discharges. And also that they felt that they needed to to help society. Was that something that you were aware of at the time,

that care providers, even if they weren't being told that they had to take discharges, that they were feeling like they should or felt pressured to?

A. So I was aware that some may feel that, but you'll also recall, and I think the Inquiry has sight of it, Dr Macaskill's own letter to care home providers to his members following his meeting with me on 18 March where he urges them to continue to take hospital discharges, and urges them in the strongest terms, I think.

So he was understanding of the situation, both the need to free up hospital capacity, of which, as I've said before, delayed discharge was a small component cared to the other steps we took, affecting large numbers of people, but also aware, as he rightly should be, of the rights of his members to take a measured decision as to whether or not they could adequately care for someone coming to them from hospital.

Q. Dr Macaskill had in fact fed back on the draft guidance, and his concern was that what was deemed to be clinically safe, or the clinical screening process, was not clear enough, and at a meeting with you on the 18th it was agreed, wasn't it, that a mandatory isolation period would be introduced, and that, in fact, was not introduced until 26 March; is that right?

A. I believe so.

Q. Why was there that delay? Because there was no mandatory isolation requirement in the guidance that was issued on 13 March. Having had the meeting with him on the 18th, why did it then take until 26 March for that mandatory isolation requirement to come in?

A. So on 13 March, from recollection, there was advice to isolate, and to practice infection prevention and control. The subsequent position was to make that a requirement as opposed to advice. And also, from recollection, to say that that period could be completed either in the residential setting or in a mix of the hospital and residential setting. And so the delay, I presume -- I don't have it in front of me so I can't recollect exactly, but I would presume that that was around various toing and froing with Dr Macaskill but also our relevant clinical experts on what might be the right thing to do.

Q. Can we turn, then, to what protections were included and what thinking was done ahead of the policy, please.

So, as you've pointed out, the guidance on the 13th said that residents should be socially distanced and that visits should be reduced to essential visits. What, if any, consideration had been given at the time to the potential impact of the discharge policy on care homes? For example, did you ask for any modelling to be

done or did you ask for any data?

A. On what?

Q. To try to work out what the potential impact might be on care homes of the discharge policy?

A. I'm not sure I understand. The discharge policy was not new to the pandemic. I think I've made that clear. If there were any concerns from care homes about their ability to manage an individual discharge from hospital, in terms of the advice and the guidance, they would raise that and that would come to us from Dr Macaskill.

In terms of modelling and data, I'm still not quite sure what it is you're asking me.

Q. Did you ask for any impact assessments to be carried out?

A. No, we rested on Dr Macaskill's relationship with his members, and also with COSLA, and any concerns to be fed back to us in that way.

Q. Did you make any enquiries as to how many care homes had isolation facilities? Could you have asked, for example, for a list to have been drawn up of care homes with isolation facilities?

A. So isolation was in the resident's own room. So there wasn't a separate -- there wasn't a requirement for separate isolation facilities, other than the resident's own bedroom. So I didn't need such a list, if I'm

understanding your question correctly.

Q. Did you consider whether there are any alternatives to direct discharges into care homes, so, for example, step-down facilities where people being discharged from hospital could go before going into the care homes?

A. So there are two -- yes, that was considered. There are two difficulties with that. One, the availability of step-down facilities, and two, the concern expressed, particularly by our geriatrician expert advice, about the impact, particularly on an elderly person, of being moved more than once.

Q. Was that Mr Ellis? I think he was the Deputy Chief Medical Officer; is that right?

A. He was from 12 March, but he had been our adviser prior to that appointment.

Q. And did he also have a role in drafting guidance?

A. Yes, he did.

Q. Work was done on 6 March looking at hotel capacity. Was that something that you looked at in terms of step-down facilities?

A. Yes, it was. The difficulty with looking at something like hotel capacity is how you would staff that. If -- you can't take staff out of care homes in order to staff another facility, nor could we take staff from our NHS to staff another facility. So there were practical

difficulties in pursuing that, aside from whether or not hotel capacity was available.

Q. Did you ask for the issue of staff capacity to be looked into?

A. So our -- the part of our Health Directorate which is concerned with staffing and people issues did consider that, but at the same time, we were busy trying to ensure that we were adequately staffed in both our health and social care sector, in anticipation that our staffing numbers would be reduced because staff themselves would contract Covid or their family members would, and therefore they would not be in employment.

And that is why we launched the portal in terms of returners to adult social care and also to the NHS, but also sought agreement from the regulatory bodies about final-year medical and nursing students to be able to operate to the limit of their competence in our health settings.

Q. Forgive me, Ms Freeman, but can we focus, please, on this period of time. I think the portal, for example, came into -- it was established in April.

A. Yes, it was, but the work -- (overspeaking) --

Q. But just focusing on --

A. The work that led to the portal was happening at this time.

Q. So, focusing on this time, the PPE, because you have just been discussing that, the Inquiry understands that the submission dated 11 March, which first raised the issue for the need of -- the need for guidance, had also raised issues that providers were finding it increasingly difficult to source PPE, that there were issues about service and provider sustainability, about the costs of self-isolation, and about staffing issues?

So when you issued the guidance, then, on 13 March, did you make any provision for care homes to be given extra PPE?

A. No, I would -- not specifically at that point. The first triage helpline was 30 March. But we would have asked NSS at that point to liaise with Scottish Care to see exactly what was the extent of the problem. Was it individual care homes or was it a general issue across? At the same time asking COSLA to identify if they were facing similar issues in local authorities' provision of adult social care.

Q. And was it a widespread issue?

A. It emerged as one, yes, which is why we introduced the additional routes for the supply and delivery of PPE.

Q. We understand from Ms Lamb's evidence that no funding was provided on the guidance was issued on 13 March?

A. At that point, that's correct.

Q. Is there a reason why financial assistance wasn't given at that stage, knowing that there were concerns about the increased costs of self-isolation?

A. So there is a process to go through, even in a pandemic, about the use of public funds that requires you to adequately cost what might be needed, and where, and then secure that agreement in terms of the proper way in which government makes determination about the use of public funds and then issues it. So that would be the process that would be initiated at that point.

Q. The guidance did recognise that some people might find it difficult to socially distance, for example people with dementia --

A. Yes.

Q. -- and it was recommended that this may be best addressed using volunteers or charitable organisations to engage with those individuals. Did you think about the risk that those individuals would potentially give rise to, in terms of transmission?

A. Yes, and I think subsequent guidance removed that, as that understanding increased. I think we were aware of the difficulties in adhering to the guidance to the letter in a setting which is essentially people's home, and there was some flexibility available where it was going to be far too distressing for a resident to be

socially distanced, and therefore you would err against requiring that of them.

Q. So is it fair to say, then, that the main protection that was put into place on 13 March from the risk of hospital discharges was asking for residents to be socially distanced, and the visiting restrictions?

A. No, the other protection was isolation in their own room, and --

Q. That's what I meant.

A. -- and the application of infection prevention and control.

Q. And do you think that from the submission on 11 March and the guidance being issued on 13 March, was enough time to give adequate consideration as to what protections were necessary and what the potential impact might be, taking into consideration what was known about the vulnerability of care home residents?

A. So there's a balance to be struck. Care home providers through Dr Macaskill, primarily, were asking for guidance in order to help them maintain as safe an environment for their residents as possible, and remain open to admissions if they believed they could cope with that in terms of what was required. We were always clear that guidance that was issued would always be iterative, recognising that that in of itself created

additional demands on that sector.

So I think we struck the balance between responding to a need expressed, quite strongly, for guidance, and a recognition that if you produce guidance reasonably quickly, albeit with a degree of consultation, including with Dr Macaskill and his colleagues, that as your understanding of the virus evolves, that you will revisit that guidance.

Q. In the BBC podcast you said:

"We didn't take the right precautions to make sure that older people leaving hospital going into care homes were as safe as they could be, and that was a mistake."

Is that something that you stand by?

A. It was a mistake in the presumption that all our care homes understood infection prevention and control and were practising it.

Q. Sorry, forgive me. You said that you didn't take the right precautions?

A. That's right. Because I presumed that all our care homes were adhering to the national manual.

Q. So that wasn't referring to other things that you could have done, like PPE provision? That was just in relation to -- (overspeaking) --

A. At that stage --

Q. I see.

A. -- no, but we very quickly did introduce PPE provision but at that early stage we were not aware that there was a consistent problem across the sector on securing adequate PPE.

LADY HALLETT: If I may again, I'm sorry --

MS JUNG: Yes.

LADY HALLETT: When you told the podcast "We didn't take the right precautions", appreciate that you say that you didn't because it was based on a presumption, but what precautions could you have taken?

A. So I think we could have introduced earlier, if that -- if I had not made that presumption, we could have introduced earlier the wraparound support that we did from directors of public health and nurse directors in each individual board to provide greater clinical support to the care home sector.

LADY HALLETT: Thank you.

MS JUNG: And before we end this topic, can I just quote to you two accounts from Every Story Matters.

A. Mm-hm.

Q. The first is from a social worker in Scotland who says:

"At the beginning, people were discharged into care homes without any testing in place, and also at times without any real assessment to determine the views and wishes of the older people involved. I found this

a huge compromise of my ethical values. It was clear that hospitals were becoming overwhelmed."

And then another, by a loved one of a care home resident in Scotland:

"Two people that were discharged from hospital back into care homes, having tested negative. Two days later, turned out that they had Covid ... it was like my worst fears had been realised. I just kept waiting for the call to say she had Covid. I couldn't sleep. I couldn't eat -- it was torture."

Ms Freeman, looking back, do you have any reflections about the decisions that you made in relation to the discharge policy, and do you think that you could or should have taken a more cautious approach?

A. In the circumstances at the time, with the resources that I faced, and the understanding that we had of the virus and how it transmitted, I don't believe I could have taken a different decision from the one I took. I have always said that if I had the capacity at the time to test before discharge, I would have done so, and did so as soon as that capacity was available but we did not have it. And so -- and as I've also said, but I think it bears repeating, that we were not making binary decisions between a risk-free option and a risk option. We were making decisions between relative

degrees of risk.

Q. Can we move on, please, to visiting restrictions. The first restrictions, as we've covered, came into place on 13 March in that guidance. And it's right, isn't it, that they weren't fully lifted until 2021?

A. Yes, that's right.

Q. In a letter to CPAG, which was the -- is that the Covid professional advisory group? -- on 18 June Dr Macaskill put on record his growing concern about the lack of any communication to the care sector to families and the wider public about the restoration of visiting into care homes, and he said this:

"Today marks the start of the 15th week of lockdown for most of our care homes during which time there has been minimal visiting other than for essential purposes and end of life.

"Today is also when it looks as if the First Minister will move the rest of the community to the next stage of leaving lockdown. The complete lack of any public messaging on care homes is causing a real loss of confidence and distress in the sector."

One of the concerns raised by Dr Macaskill was that care homes were being treated as one homogenous group. Do you have a view, Ms Freeman, on whether it was right to keep the visiting restrictions in place regardless of

whether there was in outbreak in the home, for example, or whether the home provided residential or nursing care, or whether the home was located in a remote location such as an island community? Were those kind of factors taken in a consideration in your decision making when it came to visiting restrictions?

A. They were taken into consideration in the clinical advice that I received, in terms of whether or not we could lift visiting restrictions, and if so, in what way.

Q. But did you raise any questions outside of the clinical advice that you received?

A. With whom?

Q. Were those questions in your mind?

A. Yes, yes, they were in my mind. So I didn't get clinical advice and just apply it. Clinical advice comes -- came to me and discussions were held practically daily with clinical advisers, who themselves were reaching out to their own counterparts elsewhere. So it was the product of a number of discussions that then reached a decision.

Q. And the conclusion was to keep a restriction in place across the board?

A. Yes, I believe that -- without it in front of me, yes, that would have been the case.

Q. Dr Macaskill went on to say:

"All in all, we are in an extremely challenging position. There is a real danger that the trust and confidence families have had in care services over the last 14 weeks ... will be lost unless we do not take action to at least give an indication of when things might change. We urgently need the Cabinet Secretary and First Minister to give such an indication of hope."

Was that indication of hope given and how important do you think it is to maintain the trust and confidence of families and those receiving care during a pandemic response?

A. So, first of all, I think it is important to maintain the trust and confidence of the public, including families, during a pandemic, because without that, people will not comply with the reasonable -- or with the restrictions, the quite unprecedented restrictions that we were asking them to apply with across the board. So yes, I do think that is really important.

At the same time, we have to exercise caution in terms of those individuals who are the most vulnerable to a severe impact of the virus on them and their health. So I was very conscious of, if you like, the social impact of the restrictions that we were requiring people to meet, but that had to be balanced against the

risk of vulnerable adults acquiring the virus where their health was at a greater risk than perhaps others.

Q. Thank you. And the Inquiry has also received, through the Every Story Matters project, accounts in relation to visiting restrictions. One care home worker in Scotland talked about challenging behaviour as a result of the visiting restrictions. Another care home worker in Scotland said this:

"There were no visits or anything for a very long time, which was quite sad. Some of them didn't even recognise who their family were because by that point they'd totally forgotten, which was really upsetting for the family."

Do you consider that the restrictions struck the right balance between the benefits and the risks, and do you think that anything could have been done differently?

A. So I think at the time, with the knowledge that we had at the time, and the clinical and other advice I was receiving, the restrictions struck the best balance that we could at that time.

That's not to say that I was unaware or unconcerned about the harms that were also being caused by those restrictions. The entire experience of the pandemic was about the balance of harms. There was no situation, at

any point, where you could make a decision that carried no harm.

Q. Can we move on to guidance, please.

It's right, isn't it, that at the beginning of the pandemic, Health Protection Scotland were issuing their guidance? Scottish Government also issued guidance. And then I think in June, you put into effect what's called the PAC process. And was that effectively a process by which Public Health Scotland had to have guidance signed off by you personally before it was then issued to the public?

A. Yes.

Q. And the Inquiry has received evidence that that led to some delays in guidance being published. Is that something that you accept?

A. There were a few delays, yes.

I should be clear that approval by me was not approval of the clinical aspects of guidance.

Q. What was your rationale for?

A. I wanted the guidance to be clearer than it had been previously.

Q. Can I ask for on screen, please, INQ000334871, page 2, please.

And it's tab 37 if you want to turn it up, Ms Freeman.

This is a WhatsApp conversation between you and Mr Humza. And if we look at the last paragraph, you're giving him advice on him taking over the role, and you say, four lines up from the bottom:

"The other thing is [Public Health Scotland] -- do sometimes need [reminding] that they're an NHS board like any other and not a bunch of freelancers. They produced a list of forthcoming publications -- worth looking at to spot potential issues and worth querying some as to who commissioned the work!"

Do you have any personal reasons for implementing the PAC process? Was there any difficulties in the relationship between you and Public Health Scotland?

A. I don't believe there were difficulties in the relationship between me and Public Health Scotland, but I took the view that I would be accountable for guidance that was issued in any respect by any of our health bodies, and therefore it was responsible of me to ensure that I was content with the guidance that was issued.

Q. The Scottish Directors of Public Health have provided a health recommending that guidance should be specialist led and should be a streamlined process.

Do you think -- do you have any reflections on whether the PAC process was in fact necessary and whether it led to unnecessary delays?

A. I don't believe it led to unnecessary delays and I think where there were delays, there were very few.

I completely agree that guidance should be specialist led and I don't believe the PAC process compromised that in any way. However, guidance needs to be written in language that is easily understood by the layperson. And so any interventions that I might have made was about trying to get clearer English as opposed to changing the clinical foundation of the guidance. I had no locus in that, nor did I have any expertise in that, and I was well aware of that fact.

Q. Can we move on, please, to PPE. When did you first become aware of the global issues with PPE?

A. I'm not sure I can give you a specific point in time. I think early on it was clear there were global issues with PPE because it was a global pandemic.

Q. And I think you say in previous modules' evidence that you were aware that care homes would not have had the bargaining power, for example, to compete against the NHS in being able to get -- to secure supplies of PPE.

Do you have any reflections on whether, with that knowledge, you should have made arrangements earlier on in the pandemic to ensure that the care sector were able to get access to PPE supplies?

A. I don't believe I should have made any interventions

earlier than I did. The care sector is primarily a private sector. It is not part of our health service provision, and they guard that, perfectly reasonably, in quite a strong way. So it is for them to come to me and say, "We are struggling here", and as soon as that was clear, then we intervened, and took on the role of securing adequate PPE, both in volume and type, for not only the care sector, but also the care at home sector, and other areas, and introduced various improvements to the routes of both demand and supply.

Q. You've said a number of times today, and also throughout your statement, that issues were not brought to you, and when they were, you responded to them. To what extent do you think it's the responsibility of a minister, particularly dealing with a pandemic, to pre-empt issues that may arise, or think in advance, and provide support in advance of issues being raised?

A. I don't think any minister, and I include myself, is God like in that way. I think that the job of a Cabinet Secretary is to understand the sector as best as he or she can, to be open to improving that understanding as they go, to listen carefully to clinical and other advice, and to have a number of ways of hearing from individuals charged with the delivery of health and social care in pursuing those.

And I think my track record in all of that stands examination. I cannot be an expert in every field. What I can be is clear in seeking evidence and decisive in the decisions I make, and I do believe, overall, whilst not perfect, that I was both of those things.

Q. Thank you.

Just dealing briefly with the testing, is it right that a decision had been made to test GP surgeries for the purposes of surveillance? That would have covered up to 1.2 million people across all health boards, but it was set out in a briefing note that in fact that wasn't the most effective use of the testing because it would have required people to go into the GP surgeries to be tested.

With those 1.2 million tests, do you think that those could have been reallocated to the social care sector to allow testing of the sector to be carried out any earlier?

A. I'm afraid you've lost me a bit. I'm not quite understanding what you're saying. The testing capacity started out at 350 tests per day. And we scaled that up as rapidly as we could, both directly in terms of NHS Scotland, but also with our partners in the rest of the UK, through the Lighthouse initiative.

So I'm not quite understanding your question.

Q. I think it was -- later on, there came a time when you did make a direction that the GP surgeries should be tested for surveillance reasons. But if you don't remember, perhaps we can move on.
A. Yeah.
Q. Can I ask you about inspections, please.
Did you agree with the decision of the Care Inspectorate to pause regular inspections?
A. No, I didn't.
Q. What did you do in relation to that, then?
A. So I introduced a regular meeting with the Care Inspectorate and asked them to resume direct inspections focusing particularly on infection prevention and control, and also on the social aspects of residential care.
Q. Were you aware that one of the issues that they had was that they didn't have access to PPE?
A. I don't recall that but I am sure that if that had been an issue, they would have raised it with me and we would have acted to ensure that they did have access to PPE.
Q. We know that the enhanced oversight process came in in April, and you gave the Care Inspectorate some enhanced powers, is that right, in relation to reporting?
A. Yes.
Q. Did they have to report to you regularly on care homes

and how they were doing, and did you find that to be an adequate replacement for them carrying out the regular in-person inspections?
A. So I don't believe it was a replacement, it was what was possible in the circumstances of the pandemic, and they reported -- from memory, I believe they submitted a report to the Scottish Parliament on a fortnightly basis on their inspections and their findings.
LADY HALLETT: When you told them to resume inspections and to deal with the matters you've raised, did they do so?
A. Yes, they did.
MS JUNG: Can I ask you about the enhanced oversight process, please.
The Inquiry heard evidence from the Care Inspectorate that there were issues in relation to the carrying out of physical inspections because directors of public health were concerned about the risk that would be caused by inspectors going into care homes.
Public Health Scotland has also provided a statement to the Inquiry saying that it was:
"... becoming a very crowded pitch with an increasing number of players who were not all aware of what each [other] is doing and who is reported to whom."
And forgive me, I think that may be actually in an email rather than in their statement.

Do you think that the various roles of the public bodies that were involved in the process were clear throughout?
A. Well, I was clear on their roles so I presumed that they were too.
Q. What do you think were the benefits of the enhanced oversight arrangements? We know that they required, from May, multi-disciplinary teams going into care homes and assessing the care homes on issues such as IPC and staffing levels. What do you think were the benefits of that support?
A. So I think particularly in infection prevention and control, whilst it was part of a requirement of a care home provider that they would apply the national manual, it was clear that not all were able or had been doing that. So that enhancement was there to ensure that they were all doing that and they were given support to be able to practice the levels of infection prevention and control that we required them to practice, and in other areas, that they had direct access to local support where they required that.
Q. You say in your statement that you understood that the requirements might create additional burdens for the staff.
A. Mm-hm.

Q. And in fact a survey carried out later on by Scottish Care confirms that a number of care homes did in fact find it very burdensome.
A. Mm.
Q. What did you do to try to reduce that burden on staff?
A. Well, the support that they were offered and could receive from directors of public health in their local area and nurse directors in their local area was part of providing them with additional support.
That sector was not the only sector that was under a great deal of pressure, but, as in everything during the pandemic, it was a balance of what we believed was required in order to minimise the spread of Covid-19, to care for those who acquired the infection, particularly those most vulnerable to it, and to minimise deaths as far as we possibly could. So there was never, as I said before, any risk-free decisions.
Q. Is the enhanced multidisciplinary support process something that you would recommend should be put in place in future pandemics at the start of the pandemic?
A. Yes, I believe so.
Q. Can we move on, please, to DNACPRs.
You say in your paragraph 314 that there were concerns raised with the Scottish Government by third sector stakeholders, including Age Scotland, the public,

and reports in the media, about the use of DNACPR forms.
Can you give us an indication, please, of the scale of the issue as indicated by the anecdotal accounts you were receiving?
A. So from recollection, it was not widespread by any means, but it was sufficiently concerning for those impacted by it for us to ensure that everyone was clear about the way in which that conversation should take place, which was -- which preceded the pandemic, and the level of support that should be in place in order to conduct those conversations, and who should conduct them.
Q. Based on what you were hearing, did you order any investigations to be carried out?
A. So I -- from recollection, I asked for some work to be carried out to try to identify the extent of this, whether it was widespread or not, and then to take steps to ensure that everyone understood exactly what the policy and the practice of those conversations should be, and the appropriateness of having them at any particular point.
Q. Could I ask for a document to be brought up on screen, please.
It's INQ000147441.
This is your letter again on 13 March. And if we

look at page 3, at the bottom of the page, can we see where it says, "Anticipatory Care Plans", it says:
"[They] should be in place for as many residents as possible (and ideally all residents) in these settings. Clear documentation of "What matters to me' is helpful in the event of changing circumstances. In many cases the staff in the Residential or Nursing Home settings are able to start these conversations."
It goes on to say:
"Do Not Resuscitate paperwork should be in place where appropriate and communicated appropriately with patients or carers. It may be judicious to ensure that just-in-case medication is prescribed for high risk residents. Similarly verification of death paperwork for appropriate ill patients may help staff to anticipate and manage death and minimise [clinical] contacts."
Did you reflect at all on whether the wording of that may have caused some people to think that there was a suggestion that they should be issued on a more widespread basis?
A. So I think, with the benefit of hindsight, I can see how that may have been the interpretation by some. However, at the time, anticipatory care plans were not new. They had been a feature for some time pre-pandemic, and at

the time, the presumption here would be that this was not new to anyone reading -- anyone appropriately reading that.
I think, as I say, with the benefit of hindsight, understanding that they were not widely applied, then the wording could have been different.
Q. I'd like to just read to you some extracts from Dr Macaskill's statement of Scottish Care. He says that:
"In response to a number of outbreaks of Covid-19 in care homes, on 5 May ... the then Cabinet Secretary Jeane Freeman said that she was concerned the guidance was not being followed by care homes. She said that the guidance for care home providers was 'really clear' and that 'private care home providers have not, in some instances, appeared to follow the guidance that we require them to follow'. Whilst the Cabinet Secretary referred to 'some instances', the media agreements to interpret this statement as criticism of sector as a whole. This perpetuated the negative narrative that was developing in relation to care homes and let to increased scrutiny of the sector."
He goes on to say that:
"The pressure on care home managers to ensure that they were following the most recent guidance was

compounded by the announcement by the then Lord Advocate in May 2020 that the death of any care home resident due to COVID-19 or presumed COVID-19 was to be reported to the Procurator Fiscal. The investigations associated with these reports became known as 'Operation Koper'. This decision and the subsequent reporting and investigation of such deaths has caused considerable trauma within the care home sector. Scottish Care recognises that this decision arose from a legitimate desire to provide assurance to the general public, however, its impact has led to many skilled and experienced managers and staff leaving the sector, which undoubtedly contributed to a less resilient response to the pandemic."
Have you reflected, Ms Freeman, on whether the public messages and media narrative, that perhaps you may have contributed to, in relation to care homes not following IPC guidance rather than it being framed as perhaps support that could have been given to them earlier on, have you reflected on what impact that had on the care sector during the pandemic?
A. So, first of all, it's important to be clear that Operation Koper, as it was referred to, was a decision by the Lord Advocate, and it would be completely inappropriate for me as the Health Secretary to

intervene or comment on that decision by the Lord Advocate. So that was for him to make and, where it required the cooperation of government, for government to cooperate.

In terms of what Dr Macaskill is quoted as saying, I'm not entirely sure that I would agree with that quote. I think there is a wider context. I think a great deal of support was offered to the care home sector and, indeed, adult social care in its entirety, and on reflection, I think the approach that we took was the correct approach.

Q. And, finally, Ms Freeman, can I ask you about staff movement, please.

A. Yes.

Q. In your statement you say that there were issues in Scotland with staff moving between different places of work which resulted in the spread of infections between care homes. Can you give us an indication of the scale of that issue in Scotland, please?

A. Right at this moment I don't believe I can. I think you probably have material that would give you that. It was primarily where -- from recollection, it was primarily where a provider had more than one care home, and moved staff from one to the other in order to maintain staffing levels. And that clearly created a difficulty

in terms of the risk of infection spread.

Q. And I think you issued some guidance in relation to staff movement advising that staff should not work in more than one facility and that movement between care homes should be restricted.

Do you think that in the event of future pandemics, that the movement of staff is something that should be mandated? Do you think that's feasible?

A. So I'm not sure, with the current arrangements of how residential care is provided, ie, it is a mix of public and private sector provision, primarily private sector, that mandating that is feasible, but that's not to say that the overall nature of our provision of residential adult social care does not itself require some consideration as to whether or not the model that we currently have is the best model.

And again, that is something that the Feeley exercise and those recommendations considered.

MS JUNG: Thank you, Ms Freeman, those are all my questions.

LADY HALLETT: Thank you, Ms Jung.

Ms Mitchell, you may remember, that way.

Questions from DR MITCHELL KC

DR MITCHELL: And indeed, you may remember I appear as instructed by Aamer Anwar & Company on behalf of the Scottish Covid Bereaved.

The first question I want to ask you about, a few questions, in fact, is about a report from Public Health Scotland titled "Discharges from NHS Scotland hospitals to care homes -- Between 1 March and 31 May 2020".

In your statement at paragraph 202, I don't need that brought up, you say that the report found that care home size was much more strongly associated with the risk of an outbreak than all other care home characteristics, including hospital discharge.

Now, you've fairly noted earlier on that you can't be an expert in every field, and there's a lot of wording in that report, such as "confidence intervals", "hazard ratios". What assistance did you receive in understanding and interpreting the statistical analysis contained in this document?

A. So, first of all, we asked for that work to be undertaken, and it was undertaken by the universities of Edinburgh and Glasgow. So it was an independent report. In terms of its overall remit and then understanding its conclusions, both its initial conclusions and, I believe, a subsequent report was then produced later, then I would receive advice primarily from the offices of the Chief Medical Officer and the Chief Nursing Officer.

Q. And was that in relation to understanding and

interpreting the statistical analysis?

A. To a degree, yes.

Q. Did you have confidence in that regard that you understood what the report was saying to you?

A. Yes, I did.

Q. Moving on, then, there's a table -- again, I don't need it brought up, but there's a table in this report, comparing periods without a hospital discharge to periods otherwise without, in non-pandemic times, with discharge. And it talked about a risk and confidence interval. What it says is this:

[As read] "Compared to periods without hospital discharge, there was an increased risk of an outbreak observed in the period immediately after hospital discharge. The confidence interval includes 1.0 [that's a reference point, ie, the risk of an outbreak with no discharge] which means the risks in the period with a discharge is not statistically significant from periods without a discharge."

So that was saying, at that point, and this was the original report, that statistically they didn't see a difference. However, it went on to say:

[As read] "The confidence interval is relatively wide which means that there is uncertainty about the true risk, ranging from an 8% lower risk of care home

outbreak in the period soon after a hospital discharge to a 52% higher risk ..."

And the report goes on to say at that point:

[As read] "We therefore cannot rule out a small risk from hospital discharge."

What did you understand that to mean when you read it?

A. Precisely what it says: that they could not rule out a small risk from hospital discharge.

Q. And what about the 8% to 52% risk? Did you realise and understand that that was a wide uncertainty about the true risk?

A. Yes, I did.

Q. Now, the reporting of the statistical modelling in part 2, the part that we've been discussing, which analyses the risk of care from care home outbreaks associated with hospital discharge, was updated following feedback from the Office for Statistics Regulation, and in fact this Inquiry has a letter from Ed Humpherson, who is the director general for Regulation at the Office for Statistics, to Scott Heald, the Head of Professional Statistics for Public Health Scotland, regarding the findings from the discharges of NHS Scotland hospitals to care homes.

Were you aware of that letter?

A. Yes.

Q. That letter came on 14 January 2021, and when discussing the data contained in another table, table 11, Mr Humpherson stated:

[As read] "When looking at the different types of discharge, we see adjusted hazard ratios of 1 for tested negative, 1.7 for untested, and 1.45 for tested positive. Although the confidence intervals again suggest these findings are not significant, the observed and 'dose response pattern' in the adjusted hazard ratios is consistent with a causal relationship between positivity and outbreak."

What did you understand that to mean?

A. So my understanding of both the earlier report and that subsequent one, is that it was not possible to discount the risk of hospital discharge in terms of infection in care homes, but it was not the most significant risk. The most significant risk was, from memory, the size of the care home.

Q. So you accept that the data was consistent with a causal relationship between positivity and outbreak in care homes?

A. To the extent that I've said that, yes.

Q. Moving on, we have heard evidence this morning from Alasdair Donaldson, and the Inquiry also has the benefit

of his statement. He was a member of the DHSC's adult social care policy from April to October of 2020, and was officially responsible for creating the Vivaldi project. Were you aware of the project at the time?

A. I don't believe so, no.

Q. Were you aware of its findings later?

A. I can't recollect them.

Q. In his statement, and simply for the purposes of the Inquiry, that's at paragraphs 31 and 32 of his statement, he discusses how politicians in England used the Vivaldi data in relation to discharge in care homes, and he states the following:

"But, again, the study suggested how the disease was being spread within and between ... homes in May. Our data was not able to give definitive insight into how the virus got into many homes in the first place back in March, for the simple reason that there had been little or no testing back then."

And I pause to say: there was little or no testing in Scotland; is that correct?

A. That's correct.

Q. "Indeed, staff movement between homes would not have been so dangerous if the homes themselves had been genuinely protected in the first place, rather than full of the virus.

"32. I believe this is very important because -- perhaps in a psychologically understandable effort to absolve themselves of their responsibility for the original decision to discharge thousands of people from hospitals into homes without quarantine or tests, our study has been used to suggest that such a policy was not dangerous -- when in my view, as a matter of basic epidemiology and simple common sense, it probably was very dangerous indeed. Absence of evidence cannot be claimed to be evidence of absence, and there is no good data for the period when the main hospital discharge occurred for the same reason it was potentially so reckless: because there was no testing."

Reflecting on what he has said about the fact there was no testing, do you consider that the Scottish data contained in the Public Health Scotland report is not able to give a definitive insight into how Covid-19 got into many Scottish care homes in March 2020?

A. I think it gives as good an insight as it could at that time. I think there are other factors to be considered. For example, from my recollection, 843 individuals were discharged from hospital to care homes, and 348 were involved in -- care homes were involved in an outbreak. So, for example, a number of care homes who received a discharge from hospital did not have an outbreak of

Covid.

So I think this is a complex and complicated question, and an area we've not touched on is the risk to those individuals of remaining in hospital when they were clinically able to be discharged.

Q. I think the Chair has already heard evidence in that regard, so the Chair is already aware of that situation. But do you agree, as a matter of basic epidemiological and simple common sense that discharge of untested patients from hospitals to care and nursing homes in Scotland was probably, and I quote, "very dangerous" indeed?

A. No, I don't agree that it was very dangerous indeed. I believe that that decision, like many others, carried a degree of risk. As I've said earlier, there were no risk-free decisions in any of this at any point, and I believe that the mitigation measures that we put in place were there precisely because we did recognise the level of risk involved.

Q. But you've accepted in your evidence earlier that part of the mitigation process or procedures that were put in place you thought was happening when it wasn't?

A. That's true, and was subsequently addressed.

Q. So the decision taken to have the discharge was taking place on an understanding which wasn't correct, about

the risks?

A. It was taken on an understanding that proved itself to be incomplete, but that does not answer the question as to why some of our care homes that received discharge from hospital did not have an outbreak, and some did.

Q. Well, given the lack of testing, how could it be that a proper clinical analysis could be done before deciding to send someone to a care home?

A. So that is for clinicians to answer, not me, as a non-clinician, I believe. No one is discharged from hospital without a clinical assessment as to whether or not that is appropriate. That clinical assessment is then for the individual care home to determine whether or not they wish to accept that discharge.

Q. And I understand that, but I wonder if my Lady would allow me to ask a follow-up question?

LADY HALLETT: In fact, and if you want to -- the point of the question was the point about the testing. Clinical assessment is obviously not for you but I think the point -- so follow it up.

DR MITCHELL: I'm obliged, my Lady.

The question, as my Lady has identified, is about the testing. You knew, as minister, there was not the ability to test.

A. Yes.

Q. Therefore, how could it be that you considered that a proper clinical analysis could be carried out before deciding to send someone to a care home if you knew that there was no testing?

A. I'm genuinely not sure I understand your question. I certainly knew at that point, in the early stages of the pandemic, we did not have sufficient testing capacity to undertake those tests. Whether or not someone was clinically able to be discharged from hospital was a clinical assessment. Whether or not the care home accepted them was a care home decision. And what we put in place to mitigate against the absence of testing were the measures that you're aware of.

I'm not suggesting that they were fully adequate, but they were the only measures available to us at that point, and the alternative was to leave someone ready for discharge in hospital, which was a high-risk environment, given the level of Covid patients, and an environment that, prior to the pandemic, was widely understood as one that would carry a serious risk of physical and mental deterioration.

Q. I'll perhaps simply try the question a different way. What did you consider the purpose of requiring tests and getting tests into hospitals as soon as possible for people being discharged was? What was the point of

them?

A. It was an additional mitigation measure.

Q. An additional mitigation measure. Do you not think it, with respect, would be the primary mitigation measure?

A. No, I don't, because, as you'll know, there were, in the early stages of testing, concerns around the validity of test results. That improved over time, of course, but the test itself was not the silver bullet.

Q. We had people going from hospitals into care homes without being tested, which is one procedural mitigation, as you've described it, and then also going into care homes which did not or were not able or, for some reason, you say, weren't carrying out the tests that were required. So both of those procedural safeguards were not sufficient; is that correct?

A. So the care home procedural safeguard was a practice of infection prevention and control as required by their contract and set out in the manual. That, as experience demonstrated, was not universally practised in all care homes.

Q. Moving on, if some GPs were refusing to visit care homes, as this Inquiry has heard, and not going into care homes meant that residents were not being tested, what if any impact do you consider that had on the data contained in the Public Health Scotland report?

A. I'm not sure I'm equipped to answer that. There certainly were concerns around GPs being unwilling to go into care homes that we sought to address directly. Whether or not that had an impact on the data that -- the independent report from Edinburgh and Glasgow produced, I don't believe I am equipped to comment on that. I do believe, if those two universities had felt that they did not have adequate data to undertake the work, they would have raised that and made that clear.
Q. I think, in fairness, in that report they do make clear the relative limitations --
A. Mm-hm, they do.
Q. -- in that report; do you recall that?
A. Yes, I do.
Q. Mr Macaskill has also indicated that there were feelings of what he described as clinical abandonment in relation to care homes. Now, when taken alongside the lack of testing to care homes in March 2020, would that cause you to reconsider your views of the impact of discharge of untested patients into the care homes?
A. I think the only difference it would make is that I would have introduced the engagement of directors of public health and nurse directors sooner than we did.
Q. And you say earlier on, it's one of the questions I think has already been answered, that you were aware

of GPs being unwilling or refusing to attend care homes and there was an intervention. Can you explain to us when you took the steps to address it, when you became aware of it, and when you took the steps to address it.
A. I'm afraid I don't have those specific dates in mind. What I do recall is that, in circumstances like that -- and this is purely an assertion on my part, I believe the dates, if we check them, will back this up -- but as soon as I was aware of issues like that, then I acted as quickly as I could to address them.
Q. And we'll be able to look at the evidence of Mr Macaskill in that regard.
Again, moving back to Mr Donaldson, who gave evidence this morning, in his statement to this Inquiry, he said that the reason why so many thousands of excess deaths in care homes in England were not reported was the result of there not being enough tests to establish that these were Covid infections in the first place.
Do you consider there is the possibility that many deaths in care homes in Scotland were not reported as Covid deaths because there was a lack of testing?
A. I don't believe that I am qualified to answer that question. I think the body in Scotland that produced the data on deaths because of Covid or where Covid is mentioned in the death certificate is better placed

than I to say whether they believe the data they drew that from was adequate or not.
Q. And was that something you considered at the time? When you were looking at the number of Covid deaths, did you think: if there's not testing, how are we able to get this number?
A. No, I don't believe I did consider that at the time.
Q. Moving, then, on to my final question. It relates to evidence that we heard earlier this morning from yourself about the data system for adult social care, which I think you called Centennial; is that correct?
A. Sentinel.
Q. Sentinel, sorry?
A. It's the surveillance system.
Q. The surveillance system. And that is a surveillance system for adult social care?
A. No, it's a surveillance system for health in Scotland.
Q. Okay, which --
A. Not confined to adult social care.
Q. Okay, but includes adult social care?
A. Yes, it does.
Q. Yes. So you said, and I'm not quoting exactly here, but broadly, you said that it relied on GP practice to provide data on infection and other data around the provision of care, the quality of care, and the adequacy

of staffing via the Care Inspectorate, when you were talking about care homes; is that correct?
A. Not quite. The Sentinel exercise is simply around the prevalence of infection, and that comes -- that was -- pre- existed pre-Covid and comes through GP practices.
The other matters are around the Care Inspectorate, and their inspections, and the information that they provide from those inspections.
Q. I see. So the former only relates to the GP practice --
A. Yes.
Q. -- and infection --
A. Yeah.
Q. -- and the latter about care relates to the Care Inspectorate?
A. Yes.
Q. Given that the Inquiry has heard of the limited contact with some care homes of GPs, you've touched on it earlier yourself, and also the cessation of contact with the Care Inspectorate, this means, it would appear, that you weren't getting the provision of data on infection, and also the provision of care, the quality of care, the advocacy -- the adequacy of staffing, and the Care Inspectorate was also not there. Does this mean that the data system wasn't -- or does this mean that this system wasn't fit for purpose to give you the

information about adult social care?
A. So I think there's no question that the system, at that point, was not as useful as we would have wished it to be. However, the Sentinel system does not rest on every single GP practice. As I recall it, it is a system that statistically takes what the individual practices involved say and projects that to give you a Scottish-wide position. And during the pandemic, we increased the number of GP practices that were engaged in providing data for the Sentinel system. The inspections from the Care Inspectorate, as you rightly say, on 13 March, they paused their inspections, and you'll also know that as soon as possible thereafter, I required them to recommence their inspections.
Q. Does that mean that the system, for a time, wasn't fit for purpose?
A. So there would be a period when the information coming via the Care Inspectorate was not as adequate as I wished it to be.
Q. Or indeed at all, because there was a cessation in the --
A. Well, no, there was a cessation of their in-person inspections, and they moved to, I suppose, Teams or Zoom-type inspections which I did not consider adequate.
DR MITCHELL: My Lady, that's my time and those are my

questions.
LADY HALLETT: Thank you very much, Ms Mitchell, very grateful.
That completes the questions we have for you, and I gather from making enquiries that it's the last time that we'll be asking you to assist us, so I appreciate it's been quite a burden. Five times -- is this the sixth time?
THE WITNESS: Sixth.
LADY HALLETT: That's quite a lot to ask of you and I'm really grateful for the help you've provided to the Inquiry.
THE WITNESS: Not at all. Thank you, my Lady, I appreciate it.
LADY HALLETT: I shall return at 2.00.
(1.04 pm)
(The Short Adjournment)
(2.00 pm)
LADY HALLETT: Ms Jung.
MS JUNG: Thank you, my Lady. The next witness is Caroline Lamb.
MS CAROLINE LAMB (affirmed)
LADY HALLETT: Ms Lamb, Ms Freeman told me it was the sixth time she's given evidence. What is it for you?
THE WITNESS: Sixth as well.

LADY HALLETT: Sorry about that.
THE WITNESS: That's okay.
Questions from COUNSEL TO THE INQUIRY
MS JUNG: Can you confirm your full name, please.
A. Yes, Caroline Sarah Lamb.
Q. Thank you for coming again for your sixth time to assist the Inquiry. You've produced two witness statements for this module. The first is the corporate statement for the director general of Health and Social Care, which is at INQ000614179, and the second one is on behalf of the Chief Nursing Officer Directorate; is that correct?
A. That's correct, yes.
Q. And that's at INQ000614180?
A. Yes.
Q. You are currently the director general of Health and Social Care; is that right?
A. That's correct.
Q. And also the chief executive of the National Health Service in Scotland?
A. Yes.
Q. And you've been in that dual role since 21 January 2021?
A. Yes. I think it might have been 11 January, actually.
Q. 11 January, thank you. And is it right that the director general of Health and Social Care is responsible for the Health and Social Care Directorate

within the Scottish Government --
A. That's correct.
Q. -- also referred to as the "Director General Health and Social Care family"?
A. That's correct.
Q. And can I call it the DGHSC family for short?
A. Yes.
Q. Thank you. The Health and Social Care Directorates have responsibility for health policy, social care policy, public health, and the administration of the NHS, and this includes setting the standards for governance in NHS Scotland.
A. That's correct.
Q. Could you very briefly set out a summary of your relevant professional career prior to your appointment as the director general of Health and Social Care please --
A. Yes.
Q. -- in particular focusing on any experience that you have in adult social care, please.
A. Yes. So I qualified as a chartered accountant. I worked for a while in the profession. My first job out of the profession was director of finance in a housing association, which was also involved in the provision of adult social care to residents in its

accommodation.

From there, I moved to the University of Abertay, where I was director of finance and then university secretary.

I then moved to NHS Education for Scotland as -- initially as director of finance and then became chief executive there, before moving, on a secondment, to Scottish Government in December 2019, and I took up my current role, as you said, in January 2021.

Q. Thank you very much.

Do you have a view on whether there should be a permanent adult social care directorate?

A. So I think that's what's really important is that we recognise the connections across health and social care. It's a single system. No bit of that system functions really well without all bits of the system working well together. And so the director general (sic) that I head up is director general of Health and Social Care, and within that group of directorates we have a directorate that is focused on social care as well as directorates that are focused more on the performance of the NHS, for example.

Q. What about whether there should be a permanent minister for adult social care only?

A. So we do have a minister whose responsibility is for

adult social care.

Q. Sorry, I mean Cabinet Secretary.

A. So the Cabinet Secretary encompasses health and social care, and again I think that's because of the "whole system" nature, and the fact that in Scotland we have integrated joint boards and health and social care partnerships, so there is very much an attempt to see the system as one and to ensure that what we're doing works across the whole of the system.

Q. Could I ask you to slow down just a little bit, please.

A. Sorry.

Q. It's probably my fault for asking the questions very quickly at the beginning.

Can I ask you this, please, Ms Lamb: during the pandemic there were times when there were competing demands between the NHS in Scotland and the care sector, for example, in relation to discharge policy or access to PPE or access to testing.

Given the NHS-facing role of -- the other part of your role, which is as chief executive of the NHS, do you think it could be challenging in future, during a pandemic, for someone occupying that dual role to ensure that adult social care receives equal focus and priority, particularly when decisions involve competing demands?

A. I think any position where you're trying to balance competing demands is difficult but I think the advantage of having a director general responsible for health and social care is that you have within your purview officials who can advise you both on health and -- on matters relating to the NHS, but also on matters relating to the social care system, and that through the interactions that we have, not just with NHS chief executives but with the chief officers of our integrated joint boards, we're also linked in to the system.

So the systems are different but I think that we have good mechanisms for understanding what the issues are, and therefore trying, as well as we can, to balance out those priorities.

Q. So is the answer that you don't think there needs to be a separate ...?

A. I think that there are disadvantages in separating out. I think that could lead to a more siloed approach where you were really just looking, if you were just responsible for one element, then I think it would be easier to be siloed and blinkered to some of the issues in other parts of the system.

Q. Thank you.

The Inquiry understands that various working groups were set up during the pandemic, in particular the

Clinical and Professional Advisory Group from April 2020. However, in relation to the rest of the care sector, I think the CPAG originally only covered care homes, it was expanded later on to cover the wider sector in February 2021; is that right?

A. I'm not sure I can remember the exact dates, but the advisory groups were put in place so the -- the Clinical and Professional Advisory Group for social care I think did actually look at -- look across the whole of the sector. Initially there was quite a heavy focus on the care home sector but I think it was also looking at issues and concerns from the whole of the social care system.

Q. Do you think that unpaid carers or the care at home sector were overlooked in comparison to care homes?

A. I don't think that they were overlooked. I think that -- you're right that there was a focus on care homes, particularly in the early parts of the pandemic, but I do think that Scottish Government was also very aware of issues being raised by the care at home sector, and also by unpaid carers. So again, I think, as a result of the Carers Act 2016, we had well developed mechanisms for consulting with representatives of unpaid carers, and in fact we were pretty early -- as we expanded our provision of PPE, we expanded that not just

for the care home sector but the care at home sector and also to unpaid carers, as well.

Q. Thank you. Just very quickly on that point, how were you able to identify, I think you expanded the PPE provision to personal assistants and services that weren't registered. How were you able to identify them?

A. So that was one of the challenges in being able to identify, because personal assistants, you'll be aware, can be employed in many different ways. They might be self-employed, they might be employed by an individual. So one of the challenges was actually identifying those people, but one of the things I think we did was to try and make it clear in the guidance that we were putting out to -- not just to health boards and to our integrated joint boards, our health and social care partnerships, but also to GPs and others, that what were the mechanisms for people being able to come forward and to be able to sort of accredit themselves as being personal assistants.

Q. Thank you. We understand that adult social care in Scotland is delivered by a wide range of partners. Do you think that the government had sufficient oversight of all of that during the pandemic?

A. I think that from a Scottish Government perspective we had a good understanding of the structure of the adult

social care system, obviously through our integrated joint boards, health and social care partnerships, through our interactions with COSLA --

Q. Can I just ask you to slow down a little bit, please. Thank you.

A. Sorry -- through our interactions with COSLA and also through, you know, representative people like Scottish Care and also the Coalition of Care Providers in Scotland. I think probably in terms of oversight, our oversight in relation to the NHS is stronger because ministers are directly accountable for the NHS, whereas local authorities are -- have a statutory responsibility with regards to social care. And as you've said, there are multiple providers in the social care system. So I think that having oversight of those multiple partners was much more challenging, and having the data that would enable us to really understand that was more challenging we well.

Q. Thank you.

Can I ask you, please, about one particular aspect of -- the issue of levers. You say in your statement that the Health and Care (Staffing) (Scotland) Act 2019 received Royal Assent in June 2019 but it didn't come into force until April 2024. Can you just briefly explain what levers have been conferred by that

legislation coming into force insofar as relevant to the staffing of the adult social care sector is concerned, and whether those powers would have been helpful to have had during the pandemic, please?

A. So the staffing -- the legislation that you refer to covers both health and social care.

Q. So just focusing on the --

A. So focusing on social care, the legislation requires providers of social care to ensure that they have adequate staffing levels, having due mind to the nature of the service, the size of the service, the people who are receiving care from that service, and the nature of their needs, as well. And it also requires the providers to make sure that those staff members are adequately trained, as well. It provides powers for the Care Inspectorate to set out staffing methodologies, to assist providers in establishing staffing ratios as an example. And it requires reporting to Parliament around staffing levels on an annual basis.

So as you've said, that Act was legislated for in 2019 and implemented in 2024.

I think that had that Act been in place earlier, it might have improved our understanding of the levels of staffing and indeed the variance in relation to levels of staffing between different care providers as well.

Q. Can I just ask you, when you say there's a requirement also to ensure that staff are adequately trained, does that include in IPC measures?

A. I don't think the Act is that specific but I think we would certainly expect that, given that the National Infection Prevention and Control manual is mandated, that that would be one of the areas that is covered.

Q. Thank you.

The Inquiry has heard evidence from Ms Freeman that, in Module 2, she said that the Scottish Government's knowledge of and complete understanding of how the sector operated was not as adequate at the outset as they needed it to be. In your statement, you say that the Scottish Government had a deep understanding of the sector, both prior to and during the pandemic.

Can you help us as to what you meant by that, please?

A. Yes. I think that partly relates to what I said earlier, is that I think that in Scottish Government we had a number of mechanisms through dedicated policy officials whose role was to provide advice to ministers around social care, professional and clinical advisers, so our Chief Social Work Officer, as an example, and to our links into local government through COSLA, our links into the integrated joint board through chief officers,

so we had a lot of structures in place to enable us to gather intelligence and to understand the adult social care sector.

I think that what Ms Freeman referred to in her evidence is that within a sector that is as diverse as the adult social care sector, there is a lot of variability in relation to -- I think the example she quoted was around the use of the national manual on infection prevention and control. So there was a lot of variability, and I don't think that we had fully understood the extent of that variability.

Q. Thank you.

In your statement you refer to the four harms approach, harm one being direct health harms as a result of Covid, and harm two being broader health harms, primarily the impact on the effective operation of the NHS and social care associated with large numbers of patients with Covid-19 and it's knock-on effects on the treatment of illness.

Do you think that enough data was gathered on harm two, as opposed to harm one during the pandemic, so the indirect impact on social care, including people receiving it?

A. I think that probably our data gathering improved as the pandemic went on, and certainly as we sought to use that

four harms methodology to assess policy decisions, but I think at the outset of the pandemic, and again, down to the sort of diverse and diffuse nature of the social care sector, it was far easier for us to assess the indirect impact on health services through, for example, the stepping down of planned care than it was to assess that indirect impact on social care services.

Q. You've talked about, perhaps, knowledge of the variance not being adequate. Do you think that the information sources available to ministers and the government during the pandemic of matters on how the sector was operating on the ground was sufficient?

A. No, I don't. I think at the outset of the pandemic, there were a number of data gaps that we identified, and sought to address those by putting in place additional data collection measures, for example the Safety Huddle Tool and I think a clear example I could quote there was around staffing and staff absences.

So whereas for NHS services, there's a single payroll, a single time-recording system, we were able to get daily details on staff absences, there was nothing comparable to that in the social care system and one of the things the Safety Huddle Tool was used to collect was that data on staff absences. So staffing data was collected in the social care sector, but not on a, sort

of, daily or even weekly or monthly basis, and there was quite a time lag between the collection of that data and then being able to report on it, none of which was what we needed when it came to the pandemic.

Q. We know that you engaged with a range of stakeholders which included, for example, provider organisation representative groups. In terms of the breadth of information sources available, do you think that the voice of care home residents and their loved ones and also unpaid carers and personal assistants was loud enough within government?

A. I think that the ministers were always very keen to understand issues from the perspective of the people receiving services and their loved ones. But were those voices loud enough, particularly at a time when things were developing very quickly and we were having to make decisions very quickly? I think there's probably always improvements that you can make in terms of engaging with those groups, but that said, there were regular meetings. Scottish Care and others were represented around the table at many of the groups that were set up to provide that sort of input into decision making. And like I said, we had linked into -- links into unpaid carers and a network through that as well, but I'm sure there is always more that can be done in that respect.

Q. So the answer might be obvious, but do you think, on reflection, that had you had a broader cross-section of the sector in those meetings, that the government would have been assisted in its decision making?

A. I think -- so I think that we did have quite a broad cross sector in those meetings. I think it was also not the case that there was always a consensus in those meetings, and that -- and, you know, I'm sure a lot of the decisions that were made, as you will have heard already, were about balancing up different levels of risk and trying to reach the right decision.

So, certainly we were hearing a number of different voices, and those voices were not always in agreement, and so I think that the process of decision making was helped by understanding those range of agreements, but there was never a single sort of definitive source that you could use.

Q. Can I ask you about the discharge policy, please.

A. Yep.

Q. We know that guidance was issued on 13 March 2020, which accompanied the Cabinet Secretary for Health and Sport's letter to the sector. Do you know whose decision it was that care homes or the residents in the care homes should be socially distanced? And by that I mean that visits would be restricted to essential visits only and

that residents would be isolated in their rooms.
A. So I'm not sure -- so that guidance, the 13th -- the guidance that was issued on 13 March, I believe, was issued by -- that was -- is that the Scottish Government clinical guidance, you're talking about?
Q. So there was guidance commissioned by Health Protection Scotland on 12 March --
A. Yeah, and then the 13th.
Q. -- and then on 13 March the Scottish Government issued guidance, which is based on the Health Protection Scotland guidance but issued the next day, along with a letter from Jeane Freeman?
A. Yeah, so that's the clinical guidance. So HPS, Health Protection Scotland, issued guidance which was around, sort of, health protection aspects, and then it was recognised that there was additional clinical guidance needed.

In terms of what was in that guidance, that was based on the best evidence and the best advice from clinical advisers within Scottish Government, including the Chief Medical Officer, who was in discussion with other chief medical officers across the UK. So the advice came together based on, you know, all those clinical factors being taken into account.
Q. Do you know what was intended by the definition of

essential visits in that guidance?
A. So my understanding is that the definition of essential visits was in line with the definition that we'd adopted for hospitals, which was around end-of-life visits being deemed essential. But also, if residents were distressed, then that would be deemed an essential visit as well, if that could alleviate their distress.
Q. I think it was slightly broader than that on 13 March then it was narrowed down to those on 26 March. Can you help us any further with that?
A. I'm sorry, without having it in front of me, I can't.
Q. Thank you. Your statement explains that the guidance was issued urgently following a submission on 11 March about care homes closing their doors to hospital discharges. Do you know whether any thinking had been done by the government in advance of 11 March about social distancing measures or about visiting restrictions in care homes?
A. So I think that -- so there were a couple of things that happened in the run-up to that guidance being issued. In February, there was a resilience meeting that involved social care providers that had originally been set up to deal with resilience issues that we thought would come around as a result of Brexit, but then was sort of rapidly repurposed to be a meeting to share

information, share concerns, share intelligence around what was then the developing Covid pandemic.

And in early March as well, COSLA held the first of their national contingency group meetings. So I think, both of those, the thinking then was starting to emerge about the best way in which to protect people, and certainly I think, perhaps inevitably -- I'm not a clinician, but I think inevitably, when you have a new infectious disease, one of the measures that you can use to try to protect people from that is ensuring that they're not in -- that their close contact with people who may be infectious is limited.
Q. Did the government carry out any investigation to see if they could establish whether care homes could in fact isolate residents in their room or whether there was any suggestion of drawing up a list of care homes with isolation facilities?
A. So this wasn't about separate isolation facilities. This was about the advice being provided to isolate people, as you've said, in their own rooms.

We didn't carry out any research as to what -- which care homes had what sort of facilities. But -- and it was always a choice for care homes in relation to taking admissions.
Q. Do you know if any enquiries were made for assurance

purposes that the -- about Care Inspectorate ratings of care homes? So was any thought given to the risks of discharging patients into care homes that had had less adequate ratings, for example?
A. So my understanding is that standard practice at an individual health and social care partnership level would be to consider the ratings of care homes before making decisions about where to place residents who are needing to be placed in care homes.
Q. Are you able to help us, please, as to why the guidance advised that all care home residents should be isolated, regardless of whether the care home was accepting admissions from the hospital or the community, and where they were located or what types of care homes they were?
A. So my understanding, I think, would be that the advice to isolate residents would be to recognise that the risk -- there was a risk of infection coming in not just from new people being admitted but from staff coming in and out of the care home as well. And that's why infection prevention and control measures were so important.
Q. Do you know how long it was anticipated that those measures would be in place for?
A. No, I don't, because that would depend on how long it was before the pandemic eased, before we had

a vaccination, and I don't think any of us knew any of that at that point.

Q. Do you know if any impact assessments were ordered or carried out in relation to the measures?

A. So I would imagine that, at that point, there was simply not the time to carry out impact assessments.

Q. Do you know if any work was done prior to the guidance being issued on alternatives to those measures? So for example, step-down facilities? So, for hospital discharges, whether they could have spent some time isolating in step-down facilities before they went into care homes?

A. So I think that -- you know, standard practice would be, when people are being discharged from hospital, if those people are unable to be discharged back to their private individual home, that there would be consideration of whether a step-down facility is the most appropriate place for them to go to, and -- taking into account availability. I don't recall us having particular -- I think there was some discussion at some point of whether we could provide additional capacity, through hotels or anything else, but I think that was discounted, both in terms of the additional disruption to individuals, but also in relation to having to staff additional facilities and make sure that those

facilities complied with, you know, everything you would require to see when you're looking after older or vulnerable people.

Q. In your statement you say that no financial support was offered directly to care homes at the time that the guidance was published. Do you know why that was?

A. Well, at the time the guidance was published, as I say, that guidance was being published rapidly to respond to a rapidly developing pandemic. Any financial decisions have to go through a process of establishing what it is that we're offering assistance for, how we ensure that that represents best value for the public purse, how we make sure that the money is distributed appropriately. So there was financial assistance to care homes, but -- and that was backdated, but we had to work through all the mechanisms of setting that out and working with COSLA because that assistance was provided by local authorities.

So that process did -- was worked through, but it couldn't be done at exactly the same time as the guidance was issued.

Q. The Inquiry understands that supplies of PPE were low at this stage but bearing in mind that the submission of 11 March had indicated that some care providers were finding it difficult to source PPE, was any

consideration given to providing care homes with PPE supplies or asking the NHS to provide PPE alongside patients who were being discharged into care homes?

A. Yes, so early in -- so, as you heard in Module 5, I think it was, National Services Scotland procures PPE on behalf of the whole of the NHS in Scotland, and also managed the pandemic stockpile, and so from early March, possibly earlier than that, there were discussions with National Services Scotland about releasing stock from their pandemic stockpile, but also, a memorandum of understanding was signed with NSS so that they could take on the distribution of PPE stock to social care, as well. I think that was around about 15 March. And from then on, we set up -- NSS established a social care helpline so that social care organisations who were experiencing difficulty, particularly where they had suspected or confirmed Covid cases, were able to get rapid deliveries, and then we went on to establish the PPE hubs working with the local authorities so that not just social care organisations but unpaid carers, care at home organisations, everybody, could get access through those.

Q. Thank you, and if you could just focus on the time period we're looking at, which is when the guidance on 13 March was published.

A. Yes.

Q. You make the observation in your statement that whilst not complete isolation, the guidance advised that communal activities should be reduced by 75%. In Ms Freeman's statement she says that the mandatory isolation came in on 26 March, I think it may actually have been a bit later than that. Do you know when it came in, the hospital discharges for mandatory isolation?

A. My recollection is that it was in the 26 March guidance but I'm -- I'll stand corrected.

Q. Do you know why, in that case, on 13 March, there was no requirement for all hospital discharges to be isolated on arrival, or at hospital before they came to the care homes?

A. So I think that the 13 March guidance was focused around social distancing. I don't know why that wasn't -- why the mandatory isolation wasn't included at that point.

Q. Do you think it ought to have been, considering there was no testing of the hospital discharges and given what was known about the vulnerability of care home residents?

A. So I think that yes, I would accept that we probably should have been clearer about isolation as at -- in the guidance of 13 March, and I think it's important, as

well, because isolation continued to be really important even after we had testing, because of the possibility of false negatives.

Q. In the time between 13 March, when the guidance was first issued, and 26 March, when it was updated, did the Scottish Government receive any feedback about difficulties that care homes were having in implementing the isolation requirements or in accessing PPE?

A. So I think Donald Macaskill from Scottish Care met with Ms Freeman, I think on about 18 March, and she would have had, and officials would have had feedback from other areas, as well, but I think Mr Macaskill was in that meeting able to be clear and we would have had feedback from COSLA and others that -- both around the difficulties that social care organisations were having in accessing PPE, which I've explained what we did to try to address that, and also around challenges of isolation, as well.

Q. And what exact steps were taken by the government to ensure that it had oversight of the impact of hospital discharges on care homes, and that's focusing on this particular period in time, so between 13 March and 26 March?

A. So I think in that period between the 13th and 26th, we were very reliant on the guidance that had been issued,

and, you know, the activities of our local health and social care partnerships, but there wasn't anything else that we were able to do at that point in terms of oversight.

Q. In the event of a future pandemic, would the Scottish Government make any different decisions about the discharge of patients from hospitals to care settings?

A. So I think when we talk about discharges, I think we need to be really mindful of the fact that, first of all, it's really well established that being in hospital is not the best place for somebody who no longer has a clinical requirement to be in hospital. People decondition, they get confused, they deteriorate while they're in hospital. I think we also need to remember that -- and I think it's in the PHS report -- that quite a significant number of those people, about 46%, from memory, of the people who were discharged from hospitals to care homes were discharged back to the care home that had been their place of residence before they went into hospital, and so I think, you know, it remains really challenging, when you're facing a pandemic that is likely to require you to use all of your hospital capacity to the extent that you're having to stand down other areas of care that are very important for people, obviously it's important that we free up hospital beds

that are not required by the people who are in those beds, many of whom will be going home rather than into care settings.

I think if we were to think about what we would do differently, I think we need to maybe be even clearer than we were about the limitations of testing, the likelihood, the importance of maintaining a focus on infection prevention control and all the other mitigations you can put in place to try and ensure that people are kept safe in care settings.

Q. Can we look at the visiting restrictions that are set out in the guidance, please. On 25 March there was an email discussion involving the Chief Nursing Officer, and she was advised that most European countries had banned visits to care homes, and she was asked what she thought about the definition of essential visits only. I think in the 13 March guidance it had included named family contact, consideration in end-of-life situations, and suggested a risk assessment be carried out.

The Chief Nursing Officer at the time, I think that was Fiona McQueen --

A. Yeah.

Q. -- said it was her preference that essential visiting should be restricted to end of life and that was in accordance with what was being applied in hospitals. Do

you know if that was a unilateral decision by her to narrow the definition of essential visits, because you say in your statement that updated guidance was then issued on 26 March, so the next day.

A. I don't think there were any unilateral decisions. I think there was always a debate around some -- you know, weighing up different aspects of every decision, and I don't think either that we would have been unduly influenced by what other countries were doing, that we were always looking at what the situation was in Scotland, and what the assessment was based on a range of clinical and other professional advisers, including, as I said, the Chief Social Work Officer.

Q. Do you know whether anyone in the sector was consulted on that change of definition?

A. So I'm ... I'm sorry, no, I can't say for certain.

Q. Do you know if any impact assessments or equality assessments were carried out?

A. Again, I think at that point we were -- the pace at which we were issuing guidance made it very, very difficult to carry out those sort of impact assessments.

Q. And can you just help us, please, as to what Ms McQueen's professional experience was in the care sector as opposed to in the NHS?

A. Yeah, I'm sorry, I think I'd need to go back to that.

But she was a very experienced nurse.
Q. It's right, isn't it, that in June 2020, guidance was issued which outlined a staged approach to supporting indoor visiting, however a full return was not promoted until February 2021?
A. That's correct, yeah.
Q. Did you have any accounts at the time that care homes were not opening their doors in accordance with the staged approach?
A. Yes, we did. And one of the ways in which we tried to address that -- there were two ways, really. One is we used the Safety Huddle Tool to gather information about the extent to which individual care homes were or were not allowing visitors and what they were doing, and that was then -- the data from all of that fed into the health and social care partnership, so they could actually, sort of, contact the care homes and ask the questions.

There was also a survey that we carried out to try to understand what the barriers were to allowing visiting, so to try to understand what were the things that were making care homes anxious, what were the things that were preventing them from allowing more visiting.
Q. So some residents in care homes were effectively locked

down for a year or longer. We know that Anne's Law was consulted on in 2021. Is it right that that is still not in force? And could you give us an update on the progress of that, please.
A. Yes, so Anne's Law is part of the Care Reform (Scotland) Bill, which was passed unanimously in the Scottish Parliament in June just gone, June 2025, and is now waiting on Royal assent.
Q. The Inquiry has heard that it was a common complaint that guidance was often issued on a Friday, and there's a balance to be struck between issuing guidance as quickly as possible in a rapidly moving pandemic and also not causing an unnecessary burden on an already strained workforce. Were you aware of the concerns in the sector?
A. Yes, we were. We had a workforce leadership group that met really regularly, and through that we were advised that issuing guidance, probably particularly on a Friday -- I mean, obviously guidance was being issued rapidly and there was a lot of it, but that particularly on a Friday that that was difficult.

I think, for us, we had to balance the need to get guidance with changes out as quickly as possible, with, you know, the understanding that that was going to be challenging for those receiving it.

I think, you know, in some cases, guidance would -- the changes that were formalised in the guidance would have already been well trailed, so they might have been announced in Parliament by the Cabinet Secretary or the First Minister. Where there were more substantial changes we also tried to put out additional guidance to support those needing to implement the guidance. So there were, you know, videos, webinars, and more information, but I accept absolutely that there were times when guidance landed probably on a Friday afternoon and that that wasn't a particularly helpful time for people to be receiving it.
Q. The Inquiry has also received evidence that some of the staff are finding the guidance itself confusing. We've heard that there was guidance also issued by Health Protection Scotland or Public Health Scotland, as it became, on the one hand, and then Scottish Government guidance which was based on the Health Protection Scotland guidance.

Do you accept that that could have been confusing for the sector and do you think that the quality and timeliness of guidance improved with the increased input of the sector, through the working groups and wider engagement?
A. Yes, yeah, absolutely. I think that -- you quote an

example earlier where Health Protection Scotland issued guidance on 12 March and we issued clinical guidance on 13 March, and we moved quite quickly to having all that guidance issued by what was then Public Health Scotland, and the Scottish Government just then retained the responsibility for issuing guidance and things like face coverings that was more general.

So, yes, I do accept that -- I think that our processes by which we issued guidance, our processes for consulting with the sector and therefore being able to adapt that guidance and make sure that the language was understandable and was appropriate for the sector, I think we improved all of that.
Q. Can I ask about PPE, please.

In Scotland, is it right that social care providers received PPE support from the government in two ways? First, by recouping pandemic-related PPE costs from the local authority via funding from the Scottish Government. And was it right that when that came into force it allowed backdating of funding requests?

And the second way was, from March 2020, the national stock was provided free of charge for top-up and emergency provision where normal supply routes were unsuccessful.
A. Yes, that's correct, yeah. Both those methods of

support were used.
Q. The Inquiry has received evidence from multiple sources about some of the challenges that people had in obtaining PPE, also about the quality of the PPE that they were able to access, and also issues regarding the fit of PPE. Was the government aware of those issues?
A. So I think we were aware that there were issues with the -- with the social care sector being able to use the supply methods that they'd used pre-pandemic, and that's why we asked National Services Scotland to step in there and ensure that the PPE that the social care sector were getting was sufficient, of appropriate quality, and appropriately fitting as well.

So essentially we moved from pre-pandemic arrangements, whereby local authorities would source PPE for their social care sector through the Excel contract, and other independent private providers would have their own supply routes, we moved from that to a position where National Services Scotland was supplying the whole sector.
Q. And if there was a pandemic tomorrow, how would the sector be supplied with PPE?
A. We would take exactly the same approach.
Q. Thank you.

Can I ask you about the enhanced system of assurance

or oversight that came in in April 2020, please. Could you tell us, please, what you think went well with that process and what you think could have been differently or can be improved in future?
A. Yeah, so the enhanced system of assurance was set up, led by directors of public health in every NHS board area but with a really strong focus on bringing together multidisciplinary teams, so bringing together teams across nursing, across social care, across allied health professionals, GPs, and others, to provide -- start the -- the initial ask was for them to do a review of every care home within their geographical area, to bring together all the information and intelligence -- sorry, the Care Inspectorate was included on that, as well -- that they had, and then do a risk assessment and to then carry out a series of visits based on that risk assessment.

So in terms of what worked well, I think it was a really good way of bringing together a range of different professionals. Sometimes, again, with different views on things, but bringing them together to reach a consensus around the care homes that needed to be prioritised for visits. I think it gave Scottish Government ministers greater assurance that when the teams went to visit care homes they would look at things

like staffing levels, they'd look at training around infection prevention control measures, how infection prevention control measures were actually being applied in reality, the amount of PPE and other things and the general wellbeing of residents.

So I think it worked well in that it gave ministers greater assurance in the areas that they'd accepted that they were limited in their assurance because of that variability across different providers.

I think that we also recognised that there were some challenges in that approach, as well. So there were challenges around whether this was -- whether the visits were about improvement and supporting the care homes to be able to be as good as they possibly could be, or whether they were inspection visits, and therefore how that sat and rubbed up against the Care Inspectorate's role.

And I think there was also different professional groups coming together, it's really powerful, but also they have different roles, different responsibilities, and different views.

So there was further work done, and a guidance framework laid out for how to actually -- best practice in terms of that whole approach, and I think that, you know, if we were to be faced by that situation again,

then I think that guidance would stand us in good stead in terms of actually being able to understand what were the things that created the difficulties in the early phases of that last time and how we would approach that differently.
Q. There was a varied approach amongst the health boards as to whether they took an inspection-type approach --
A. Yes.
Q. -- or a more supportive role. Did you find that the ones that took a more supportive role were better received and had better outcomes?
A. I think that certainly some of the feedback and I think Scottish Care carried out a survey of their members, and I think they felt that where that system worked really well, it was actually incredibly helpful, and where more of an inspection-focused approach happened, then that became quite confusing for the care homes to be able to understand what the difference was between what the oversight team were saying and what the Care Inspectorate was saying to them.

So I think that, again, going forward, we need to be really clear about that role and that it is about support to improve, rather than an inspection.
Q. Another issue that was raised about that process is that care homes were providing a lot of information that went

into data analysis for public bodies and the government, but they weren't being shared that data themselves. So for example, if there was an outbreak in their area, they didn't have a forewarning about that. Is data sharing with care homes something that you would recommend should happen in future if there is a pandemic?

A. Yes, I think -- so I think that -- I appreciate that a number of -- many care homes probably felt that there was an additional data burden imposed on them, and I've explained why that was necessary because we didn't have -- there weren't other systems through which we could get that data. What we tried to do was to make it -- that data collection as quick and easy as possible. It was a web-based system so it didn't require lots of analysis, it would produce graphs and everything else straight away, and it was certainly used through the health and social care partnerships and I would agree yes, it should have been shared back with care homes, as well, so that they could see what was happening in their area and that is certainly, you know, our approach with regard to social care data now: is to try to make that as visible as possible.

Q. Thank you.

Can I ask you about staff movement, please. Did the

government ever consider legislating about staff movement, and what consideration did it give, if so, to funding for the workforce?

A. So I don't recall that there was ever consideration of legislation, and so there were lots of things that we put in guidance that would have taken a very long time to get through legislation and obviously there was a requirement to act very quickly. And I think legislation of that sort would be incredibly complex as well.

In terms of funding and support for the workforce, we did a number of things. So, one of the things I think was that we recognised that terms and conditions across the social care sector are variable, and are not always as good as we would want them to be. We recognised that some employers would only pay statutory -- if people were off sick, they would only be entitled to Statutory Sick Pay, so we put in place arrangements to ensure that they could receive an amount equivalent to their normal pay, so they weren't suffering financially if they were off sick or indeed if they had to isolate because a member of their family was off sick.

We also put in place a number of wellbeing supports. We had a national wellbeing hub to offer support,

advice, to people working across the sector, because it's an incredibly stressful time for people.

Scottish Government has also, consistently, since 2016, met the costs of ensuring that social care staff are paid the real living wage rather than just the minimum wage --

Q. Just focusing on staff movement and what funding was considered in relation to that issue, is there anything else you'd want to add?

A. I can't think of anything else that I'd add to that.

Q. Thank you. And just very quickly, do you think that legislating staff movement is feasible? I think you described it as being very complex.

A. I think that that would be very difficult, but I'm not a legal expert either.

Q. We understand that the Scottish Government or Scotland in fact had a central register of care workers. Do you think that benefited Scotland in terms of the adult social care sector's response? And if so, how?

A. Yeah. So, in Scotland, care workers are regulated by the Scottish Social Services Council, so we do have a register, and I think one of the ways in which that benefits the sector is that there are training requirements associated with being registered, and therefore I think that encourages people working in the

sector but also employers to support their staff in training as well.

Q. Thank you.

And before we end with what your top recommendation is, just one more short topic, please. Do you think that enough was done during the pandemic in relation to the issue of inequalities in Scotland?

A. No, I couldn't possibly say that. I think that Scotland has -- in common with other parts of the UK, has a persistent issue with inequalities. I think that all the evidence would show that the pandemic has worsened rather than ameliorated those inequalities and therefore I couldn't possibly say that there isn't more that we could have done.

Q. And your top recommendation, please, in the event of a future pandemic?

A. Just one?

Q. Well, how many top recommendations --

A. So, I think that -- first of all I'd say that I think there's a number of things that we have done. We've talked about Anne's Law. We've -- within that same legislation we've made additional provisions around data sharing and information standards, which I think will really help us going forwards. And we've also legislated for breaks for unpaid carers. So I think

there are a number of things that have already happened.

I think that probably, though, we need, as the UK, really, to look at the underlying resilience of the social care system. When you look at the demographics, this is a really important system for us, and I think it's hard to escape the fact that it's a sector that needs additional funding.

MS JUNG: Thank you very much, Ms Lamb.

My Lady, those are all my questions. I understand that there are some questions from the Core Participants.

LADY HALLETT: There are. Thank you very much, Ms Jung.

Ms Mitchell, who is that way, as you may remember.

Questions from DR MITCHELL KC

DR MITCHELL: I appear, as instructed by Aamer Anwar & Company, on behalf of the Scottish Covid Bereaved, which you may remember from I was asking you questions before.

Just touching on the last point that you were asked there by my learned friend about recommendations.

As we know, the chair can make recommendations and it's for politicians to implement them. Do you have any suggestions which would be low cost but high impact in relation to planning for the next pandemic?

A. Low cost but high impact.

I actually think that a lot of the -- and I've

explained that we've already done quite a lot around data but, actually, I do think that having a better understanding, a more up-to-date understanding of what's actually happening across the social care system and being able, therefore, to identify where there are variances and to understand whether those are warranted variances or whether there is additional support that could be provided to improve some services, is a relatively low cost, but I think it could be an incredibly high impact.

Q. And what would you be looking for there, when you're seeing the differentials? What sort of things would you be looking at?

A. So I think there's a number of things. If you look at our national -- the performance indicators for social care, which is a balance of, you know, what are the things that people can expect to receive. So I think it's looking at eligibility so ensuring that people are getting the care packages and the support that they need, ensuring that they're being treated with dignity and respect, looking to see that, you know, the care packages are the right sort of size for people, looking to see that staff are valued and well trained and well supported to do the best job that they possibly can. There's a whole range of indicators that I think we

could use usefully.

Q. So really using the data to either assure yourself that things are working properly or where they aren't, identify there you can implement change?

A. Absolutely.

Q. The next question I want to ask is probably just as broad, and it may be one that you've thought of before, certainly other witnesses have given an indication that this is something that they've thought of. If you were given the opportunity to go back and change one thing that was done that would make great impact, what would that be and why?

A. So I think that's a very broad question and it's also an incredibly difficult one to --

LADY HALLETT: Is it a bit like when did you stop beating your wife?

A. Yes.

DR MITCHELL: It was premised on the basis that a number of witnesses have said, "This is one thing that could have been done" or "We think this was the most important thing." I'm not suggesting that you discount all the rest but I'm just seeing if there is something that you think, "This could have been done differently and here's how it would have been better had it been done differently."

A. I think that, so I wish that we had had more testing capacity earlier and I think also that we could have been much clearer in our guidance earlier, as well.

Q. And why would that be?

A. Because I think that there was still -- I think there was still confusion and I think -- maybe I'm wrong, maybe that's the wrong way to describe it in being clearer. I think, I think we could have provided more support to ensure that guidance was fully implemented in the way that it was intended to be.

DR MITCHELL: My Lady, those are my questions.

LADY HALLETT: Thank you very much, Ms Mitchell.

Ms Jones, who's over there.

Questions from MS JONES

MS JONES: Thank you, my Lady.

Ms Lamb, my question follows quite well from the answer that you have just given. I'm asking questions on behalf of John's Campaign, Care Rights UK and The Patients Association, and our question is about the confusion that arose from the guidance that was published.

You were asked by Ms Jung earlier what you understood the term "exceptional circumstances" to mean in the visiting guidance, and you referred to end of life being an exceptional circumstance in which visits

should have been permitted under the guidance, but we know that there were real problems and inconsistencies with how different settings understood that term.

So, for example, the organisations I represent are aware of some care homes taking a more liberal approach to that, but others interpreting end of life to mean the last days, the last hours, even, in some cases, the last minutes of someone's life, so that very often family members were not able to make it in time to be with their loved one when they died and were not there to provide support in the period leading up to that. And we even know of some cases where, extremely upsettingly, family members were let in and then were kicked out again when their loved one did not die as quickly as had been expected.

So, given these real inconsistencies and unpredictabilities in how the guidance was interpreted, can you clarify for the Inquiry what you thought the definition of the end-of-life period was under the guidance, what was it intending to refer to and who should have been allowed in.

A. So, my understanding was that -- if you read the guidance alongside the, sort of, person-centered approach to care, that that should be -- the end of life -- essential visiting at end of life should be an

individual assessment based on the individual in front of you, that provides the time and the space for them to be able to -- for them and their loved ones to be able to spent time together as they approached the end of their life.

Q. But did you consider that any time period was being put on that by the guidance?

A. I don't think so, no.

Q. So, in circumstances, then, where it is a series of individual interpretations under the guidance applied to a particular person, what do you think would have been the way around the extremely unhelpful inconsistencies that arose in interpretation?

A. So I think if you -- if you sort of take a step back from that and -- what I explained about what we've done in Scotland around Anne's Law is to make sure that there is always, you know, a nominated essential visitor, which would avoid you having to get into the "Is it days, is it hours, is it" -- which is an incredibly difficult position to put not only those individuals in, but also care home staff trying to manage that.

MS JONES: Thank you, my Lady.

LADY HALLETT: Thank you, Ms Jones.

Ms Beattie, who is just behind, I think. Yeah.

Questions from MS BEATTIE

MS BEATTIE: Thank you. I ask questions on behalf of Disabled People's Organisations and my questions also concern the visiting restrictions.

You were asked some questions and answered them earlier about restricting those visits to essential visits and you said that you understood that that was in line with the definition for hospitals, which again, as just mentioned, was around end-of-life visits and also if residents were distressed.

How did the Scottish Government ensure that that restriction, those visiting restrictions, didn't prevent the continuation of vital health and clinical services to people in residential care settings, including, for example, visits by GPs?

A. Yes. So I think in -- there was a letter that was sent from the Chief Medical Officer to our GPs and it was a follow-up around some of the concerns that had been raised with us about the inappropriate use of DNACPRs, but there was a follow-up letter went out from the Chief Medical Officer which also, I think, stressed the importance of GPs in providing care and support to the care homes in their locality.

So there was that letter that went out, I think it was about the end of March, it might have been April, but also then when, once that system of enhanced

monitoring was put in place, that was -- under the oversight of directors of public health, that was also very much intended to ensure that care homes were well supported by general practitioners, by geriatricians in their local hospitals, and others as well.

Q. I think in your statement you say that initially the guidance said that essential visits might have to include visits by health and social care staff --

A. That's right, and that was then corrected -- sorry, that was then adjusted in the next version of the guidance. I think that was felt to be a bit tight.

Q. Right. And so obviously you weren't intending to prevent those kind of considerations?

A. No, absolutely not.

Q. Is it the case, though, that concerns and reports that GPs and others weren't getting into care homes continued really right up until and throughout 2020 such that a letter was still being sent, even in April 2021, stressing to care homes that GPs can and should visit?

A. Yes.

Q. So did that remain a concern, despite that early correction --

A. Yes.

Q. -- more than a year earlier?

A. Yes, so we had, I think, attempted to correct the

guidance. We had issued a letter, but yes, it did -- again, it's about the variability across -- across the country that it was felt necessary to issue that further letter.

Q. Are you aware of any checks or any auditing of whether that -- and those gaps perhaps in residents receiving that kind of ongoing routine care in circumstances where there had been stops on visiting, whether those kind of clinical care visits had caught up?

A. I'm not aware of that, no.

MS BEATTIE: Thank you, my Lady.

LADY HALLETT: Thank you, Ms Beattie.

That completes the questions we have for you, Ms Lamb, and -- I'm pretty confident in saying -- that completes the demands we're going to make upon you for this Inquiry, although I suspect there are other inquiries that there will be demands placed on you. But thank you for your help and I'm sure the help of members of your team, who helped provide the statement.

THE WITNESS: Thank you.

LADY HALLETT: So thank you, and safe journey back to Scotland.

THE WITNESS: Thank you very much.

LADY HALLETT: Very well. I think that completes the evidence for today, and so I shall return at 10.00 am tomorrow.

(3.06 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X