Witness Name: Jeane Freeman
Statement No.: 7
Exhibits: JF7
Dated: 4 April 2025

UK COVID-19 INQUIRY
MODULE 7

WITNESS STATEMENT OF JEANE FREEMAN

Background

1. In relation to the issues raised by the Rule 9 request dated 3 December 2024 in connection with Module 7, I, Jeane Freeman, will say as follows: -

A. Introduction

Role and responsibilities

2. I am Jeane Freeman of the University of Glasgow, University Avenue, Glasgow, G12 8QQ.

3. I have provided many previous witness statements to the UK Covid-19 Inquiry ('UKI'), as has the Scottish Government as an organisation. In the Rule 9 request dated 3 December 2024, the UKI has explained to me that helpful content can be replicated in this statement from my own previous witness statements to the UKI. The UKI has also told me that I can utilise relevant content from the Scottish Government's own organisational statements to the UKI – quotation marks make it clear where I am endorsing previous organisational content within this statement.

4. In May 2016 I was appointed as the Minister for Social Security within the Scottish Government, and I held this role until June 2018. As part of this role, I led the establishment of Social Security Scotland, including the underpinning legislation under the newly devolved social security powers. In June 2018 I became the Cabinet

Secretary for Health and Sport. I held this role until May 2021. I had no involvement with the Scottish Government's response to the pandemic after that point.

5. My responsibilities as Cabinet Secretary for Health and Sport included the NHS and its performance, staff and pay, health and social care integration, patient services and patient safety, national clinical strategy, quality strategy and national service planning, allied Healthcare services, carers, adult care and support, child and maternal health and sport and physical activity. I was supported by the Ministers for Public Health, Sport and Wellbeing and for Mental Health.

6. My involvement in the testing and tracing strategy was to receive clinical and expert advice on the approach that should be taken in relation to this strategy, to understand how to operationalise the strategy, authorise any resourcing that was required and monitor its operationalisation taking any decisions necessary to resolve resource or other challenges.

7. I ultimately had political responsibility for ensuring that there were sufficient supplies of ventilators, lateral flow tests, PCR equipment and oxygen in Scotland. However, the practicalities of ensuring that those supplies were delivered to the right places on time lay with officials.

Decision making structures

8. As Cabinet Secretary for Health and Sport, I was a member of the Scottish Cabinet which met at least weekly as the key decision making forum of the Scottish Government. I attended meetings of the Scottish Government Resilience Room as relevant to my portfolio – which was consistently the case for the Covid Pandemic. I attended early meetings of COBR in January and February 2020 at the invitation of the UK Government on 24 and 29 January [JF7/001 - INQ000056163], [JF7/072-**INQ000587269]** and 5 and 26 February [JF7/002 - INQ000425550], [JF7/003 - INQ000056215], [JF7/004 - INQ000056201], [JF7/005 - INQ000056216]. I also attended subsequent meetings on 2, 4, 9, 12, 16, 18 and 23 March, 9 and 16 April and 10 May [JF7/006 INQ000056157], [JF7/007 - INQ000056217], [JF7/008 - INQ000056218], [JF7/009 - INQ000056206], [JF7/010 - INQ000056219], [JF7/011 - INQ000056221], [JF7/012 - INQ000056210], [JF7/013 - INQ000056211], [JF7/073 - **INQ000587268], [JF7/074 - INQ000589746]** [JF7/075 - INQ000233498] [JF7/076 - **INQ000589751], [JF7/077 - INQ000589755], [JF7/078 - INQ000589757].**

9. I attended three meetings of the Healthcare Ministerial Implementation Group, chaired by the UK Secretary of State for Health, 24 March, 2 April and 9 April 2020. I took part in Four Nations calls (with UK, Northern Irish and Welsh Health Ministers), which took place weekly on a Thursday from the end of April 2020. I occasionally deputised for the First Minister on Four Nations calls with the Chancellor of the Duchy of Lancaster. I convened the Mobilisation Recovery Group from 28 August 2020, which focussed on the actions needed to allow recovery of NHS care that been paused in the first phase of our pandemic response. It factored in TTI in as much as that, together with other measures, placed an additional demand on staff resources both in the NHS and in Scottish Government. I convened Covid-19 Strategic Issues meetings, which were chaired by FM under SGoRR conditions and attended FM chaired deep dive meetings (involving members of the Covid-19 Advisory Group) with Sir Jeremy Farrar (16 December 2020) and on scenario planning (04 February 2021). I also attended, when requested, relevant Committee meetings of the Scottish Parliament.

10. During the Covid-19 pandemic between January 2020 and May 2021, I was primarily responsible for health and social care. Other bodies which were important points of contact in my role included Public Health Scotland (PHS), Health and Social Care Trade Unions, Convention of Scottish Local Authorities (COSLA), Scottish Care, Health Boards and their chief executives, Astra Zeneca, Pfizer, the First Minister's Advisory Group on Covid, the Lord Advocate and the Care Home Relatives Group. My officials and I would liaise with each of these bodies in relation to the actions necessary for the effective implementation of TTI, to address concerns and problems that may arise, and provide or commission necessary guidance and information. I attended or convened many “deep dive” meetings which covered subjects such as testing, vaccines, the redesign of unscheduled care, and Scotland’s Proximity app. That app, also known as “Protect Scotland”, launched in September 2020 and provided a digital tracing tool that individuals could download to their device and that would notify them if they had been in contact with a person who also had the app active on their device and later entered a positive test code into the app.. It is extremely likely that decisions would have been taken and actions instructed after such meetings.

11. The primary individuals involved in reaching key political and administrative decisions within the Scottish Government were the First Minister, the Deputy First Minister and myself. The First Minister was responsible for the overall response to the Covid-19

pandemic. The Deputy First Minister was responsible for the resilience structure. My responsibilities in the Covid-19 pandemic were specifically within the health and social care response. Our overarching objective as a government was as far as possible, to protect the Scottish population from the harms of Covid-19 and minimise the loss of life. The overarching principles guiding core political and administrative decision making within the Scottish Government in this period were as set out in the Framework for Decision-Making published in April 2020 [JF7/079 - INQ000346286]. There the Scottish Government set out these principles as follows:

- Safe - We will ensure that transmission of the virus remains suppressed and that our NHS and care services are not overwhelmed.
- Lawful – We will respect the rule of law which will include ensuring that any restrictions are justified, necessary and proportionate.
- Evidence - based - We will use the best available evidence and analysis.
- Fair and ethical – We will uphold the principles of human dignity, autonomy, respect and equality
- Clear - We will provide clarity to the public to enable compliance, engagement and accountability.
- Realistic - We will consider the viability and effectiveness of options
- Collective - We will work with our partners and stakeholders, including the UK Government and other Devolved Nations, ensuring that we meet the specific needs of Scotland.

12. Other Cabinet Secretaries had respective roles within their portfolios which involved key decision making at times. For example, the Finance Secretary would liaise with the UK government on issues of funding. The key civil servants involved were the Chief Medical Officer (CMO), the Chief Nursing Officer (CNO), the Chief Pharmacist, the Director General of Health/Chief Executive NHS Scotland, the National Clinical Director (NCD), Special Adviser for the Health portfolio, my private office, and the private office for the First Minister. There was no specific role for the Secretary of State for Scotland in the response of the Scottish Government during the Covid-19 pandemic and there was no liaison between his office and my office.

13. Between January 2020 and May 2021, I worked very closely with the First Minister in reaching key political and administrative decisions in relation to the management of the pandemic in Scotland. I met with the First Minister during this time period every day at least twice a day. These meetings were in person. We would also on occasion

make phone calls to each other to follow up on previously agreed actions and discuss any developments or new information which had occurred or been presented. There would be additional in person meetings dependent on what was needed.

14. I communicated with the First Minister primarily in person and via phone calls. My preferred method of communication was in person. The only other form of communication with the First Minister was through text messages and telephone calls. The content of these text messages was limited to following up on decisions already taken through other means of communication.

15. In my role as Cabinet Secretary for Health and Sport, my main working relationship with the Deputy First Minister was through cabinet meetings. I did not have regular 1 to 1 meetings with him. We would both attend the Scottish Cabinet and Scottish Government Resilience Room (SGoRR) meetings, and we were both part of the First Minister's Advisory Group on Covid-19. I would speak with the Deputy First Minister over the phone on occasion.

16. Beyond my statement above, I did not discuss the management of the pandemic with the First Minister or the Deputy First Minister on informal or private communication channels or other messaging platforms.

17. In my role as Cabinet Secretary for Health and Sports, I worked closely with the Ministers of Health, Sport and Well-being, Joe FitzPatrick, until 18 December 2020, and subsequently Mhairi Gougeon, in operationalizing key political and administrative decisions about the management of the pandemic in Scotland. In addition, I also worked closed with Clare Haughey in her role as Minister of Health with responsibility for mental health. Between January 2020 and autumn 2020, the frequency of meetings with them depended on the work required in any specific circumstance or area. Towards the autumn of 2020 and leading into 2021 I had regular meetings with them in order to provide an update on the overall health portfolio. I communicated with both ministers through Microsoft Teams or Zoom. I did not discuss the management of the Covid-19 pandemic with either minister using informal or private communication channels or other messaging platforms.

18. I had regular portfolio meetings which involved my Ministers and key officials. Prior to January 2020, these meetings were held fortnightly and in person. From the end of

March 2020 (when the first lockdown began), until April 2021 they were held weekly and via Zoom/ Microsoft Teams. Joe FitzPatrick and I (or Mhairi Gougeon) and Clare Haughey would have all attended these meetings unless apologies were given. Another series of regular meetings with my Ministers were the weekly comms meetings. Until lockdown in March 2020 these were held weekly. From April 2020, these meetings became woven into the portfolio meetings. Again, I and the health ministers would have attended these meetings unless apologies were given. I also had meetings with my ministers on a frequent basis in regard to matters of individual portfolio responsibility. These included discussions around vaccines / testing / drug policy / dentistry and sport-related / cluster outbreak Covid incidents. We also attended the Mobilisation Recovery Group, which met from August 2020 and initiated or attended meetings with Opposition health spokespeople [JF7/063 - INQ000324328] **[JF7/064 - INQ000589779], [JF7/065 - INQ000587300]** [JF7/066 - INQ000324298] [JF7/067 - INQ000324611] [JF7/068 - INQ000324615]. Finally, I attended meetings of the Scottish Parliament as required, both in Chamber and with relevant Committees.

19. Below is a summary of some of the TTI-related discussions I had with the MRG whilst I convened the group:

a. **30 October 2020** – The group discussed the need for there to be effective links between occupational health services and Test & Protect. The group also discussed an offer for private testing from Boots, at a cost of £120 per test, with rapid results. I noted that these tests still needed to be validated and that at that point, the most accurate and sensitive test remained the PCR variants already in use. The group also spoke about a clinical and scientific review of the Government's approach to testing has been undertaken by the Chief Medical Officer, Chief Nursing Officer, National Clinical Director and Chief Scientists and was published on the same day as the Strategic Framework. This review endorsed the five priorities of the testing strategy: whole population testing of anyone with symptoms (Test & Protect); proactive case finding by testing contacts and testing in outbreaks; protecting the vulnerable in high-risk settings by routine testing; testing for direct patient care; and surveillance to track prevalence. It was the unanimous view of the clinical and scientific advisers that these overriding priorities for testing capacity in Scotland remain appropriate and must focus on symptomatic demand and the clinical care of patients. The clinical and scientific review found that prioritisation of testing capacity, over and above that required to meet symptomatic demand and clinical care, should be focused on protecting those most vulnerable to severe harm; e.g. care workers;

healthcare workers; or testing for surveillance – at a population level and in key population groups including healthcare workers. A copy of the minutes of this meeting are provided [JF7/063 – INQ000324328]

b. **20 November 2020** – The group discussed how best to optimise a reduction in the isolation period, as well as how best to use new testing technology. The group also discussed whether the MRNA vaccine interfered with the proposed Innova Lateral Flow Test that was rolling out to NHS staff. A copy of the minutes of this meeting are provided **[JF7/064 - INQ000589779].**

c. **11 December 2020** – I noted a number of developments since the last meeting of the group, including: a new testing approach with all emergency, planned medical and surgical admissions tested for COVID-19; testing introduced for all patient-facing healthcare staff working in hospitals, COVID-19 Assessment Centres and the Scottish Ambulance Service; and the pathfinder testing of designated visitors trialled in 14 early adopter care homes, leading to the full roll out from Monday 14 December 2020. A member of the group queried whether false positives from the lateral flow testing of staff could further undermine staff resilience; and whether this had been factored into planning for staff absence rates and modelling. I responded by stating it was my understanding that these aspects were considered in the modelling and reminded the Group that any staff who receive a positive lateral flow test will then receive a PCR test; helping to minimise false positives and any associated impact on workforce resilience. A copy of the minutes of this meeting are provided [JF7/065 - **INQ000587300].**

d. **22 January 2021** – The group noted that testing capacity was continuing to grow and had almost doubled since November 2020; with turnaround times largely stabilising; and growth in local test sites and mobile provision. A copy of the minutes of this meeting are provided [JF7/066 – INQ000324298].

e. **12 February 2021** – The group received a short update on testing, noting that testing capacity was relatively stable at around 77,000 PCR tests available per day, with an average utilisation of 25-30%. Work to increase access through a range of new pathways had been announced by the First Minister in the previous week. Guidance was due to be published on 15 February 2021 for extended healthcare workers in primary care settings; inviting staff to take part in the testing programme from 22 February. Overall, steady progress was being made across the range of pathways, including Scottish Ambulance Service control room staff, hospices, international travellers, the food processing and distribution sectors, close contacts, schools, and asymptomatic mobile testing in communities. A copy of the minutes of this meeting are provided [JF7/067 - INQ000326411].

f. **26 March 2021** – The group heard that the Test & Protect programme was on track. Some of the key testing expansions include schools, primary care, and the extension of testing in non-patient-facing NHS workforce, to help maintain the delivery of essential services. A copy of the minutes of this meeting are provided [JF7/068 – INQ000324615]

20. In my role as Cabinet Secretary for Health and Sport I also worked closely with Kate Forbes, who was the Cabinet Secretary for Finance at the time. We spoke regularly about funding in relation to the Scottish Government's response to Covid-19 as far as that affected areas in my portfolio. I had a number of informal discussions with Ms Forbes, and, along with other Cabinet Secretaries, received updates from her both during the course of Cabinet meetings and otherwise as she determined. With the passage of time I am not able to recall the detail of these discussions and updates, but would expect that where there were issues of funding for TTI or other matters to discuss we would have done so. I also worked closely with Ivan McKee who was the Minister for Trade at the time, specifically in relation both to the international procurement of personal protective equipment (PPE) and the creation of a domestic PPE supply chain.

21. The group of key decision makers within the Scottish Government and their advisers had a close, trusting and effective working relationship. I believe this affected the manner in which the Scottish Government managed the pandemic. It ensured as far as possible the Scottish Government responded timeously to new information, made decisions based on available evidence and implemented these decisions as speedily as possible.

22. It is my view that the information and advice provided to me between January 2020 and May 2021 were timely and regular in the circumstances of the Covid-19 pandemic. The information and advice provided to me was regularly updated. In this context, it was readily available, sought and shared well within the key group of decision makers.

<u>Informal Decision Making and Communication</u>

23. Key decisions about the Scottish government's response to the Covid-19 pandemic were not made outside formal government process. All key decisions were made in formal settings and minuted or noted.

24. The only information which I received in an informal manner was factual and medical information about the nature of the virus. I would receive this information through text messages, email or by telephone depending on the urgency with which I should be made aware. These updates could be frequent given the developing nature of the virus and our understanding of it and would come primarily from the NCD or the CMO. On occasion the information would relate to a specific debate or discussion within the scientific community and may include reference to a journal article or social media post. Some text messages are retained on my mobile phone, alongside a WhatsApp exchange with the CMO and are being supplied to the Inquiry. Where factual information or advice was contributing to subsequent decisions, these would be recorded in a minute or note.

25. I do not recall and am not aware of meetings between core decision makers including the First Minister and counterparts in the UK government which I would have expected to attend in my role as Cabinet Secretary for Health and Sport but which I was not party to.

26. There was a very clear process by which significant meetings were conducted within the Scottish Government. Cabinet Secretaries would be made aware of the agenda prior to each meeting and their private offices would source the briefing. If a Cabinet Secretary placed an item on the agenda, they would ensure that other attendees had the relevant briefing. There would be a minute of a previous cabinet meeting available in advance of each meeting. All decisions made at Cabinet and other significant meetings would be recorded. For example, in relation to the First Minister's Advisory Group on Covid-19, when either the First Minister, the Deputy First Minister, or myself would have specific questions that we wished to raise, this would be communicated in advance to the Group. The meeting would be subsequently held, and any formal actions noted.

27. The Cabinet is the highest Ministerial decision-making body of the Scottish Government. As set out in the Scottish Ministerial Code, [JF7/014 - INQ000102901] the Scottish Government operates on the basis of collective responsibility. This means that all decisions reached by the Scottish Ministers, individually or collectively, are binding on all members of the Government. The First Minister approves the content and timetabling of the agenda for any Cabinet meeting. Generally, these are matters likely to engage the collective interests of a number of Cabinet members.

28. Most substantive Cabinet papers are circulated to the First Minister, Deputy First Minister and other Cabinet Secretaries in correspondence for a period prior to the scheduled meeting. The draft Cabinet paper is then cleared by the lead Cabinet member and tabled for discussion. SCANCE (Scottish Government Analysis of News and Current Events) is a paper comprising short written items from each Ministerial portfolio. SCANCE aims to be a rapid and flexible way to brief Cabinet about rapidly developing or otherwise important issues which do not require a standalone Cabinet agenda item. SCANCE cannot be used to seek formal decisions from Cabinet.

29. From my perspective as the Cabinet Secretary for Health and Sport, there were no side meetings or informal meetings in and around Cabinet in which significant decisions were discussed.

30. There was a regular meeting on Thursday evenings over Zoom which involved the health secretaries from the Four Nations and on occasion, their respective ministers. I would always have an official present. These meetings were recorded, and notes were taken. The purpose of these weekly meetings was primarily to discuss any operational issues being experienced. For example, we discussed the performance of the Lighthouse Laboratory network, which utilised academic and private sector partnerships to increase lab processing capacity in Scotland, including direct contracting arrangements. One of the first three Lighthouse Laboratories was established in the University of Glasgow and together with PHS testing facilities routinely processed a significant portion of Scotland's population-wide PCR testing. We discussed where there were backlogs in the processing of tests in a particular laboratory and how that impacted on process times elsewhere across the 4 nations.

31. We also discussed aligning the timetable across the 4 nations for the delivery of the vaccines.

32. A WhatsApp group existed for the Cabinet Secretaries for Health of the Four Nations. All four health ministers agreed to the formation of this group. The WhatsApp group was used to facilitate the running of the weekly meetings over Zoom. I am providing the messages I still hold with these individuals to the Inquiry. Formal communication existed between the private offices of the four health secretaries. Formal communication existed primarily with between my office and Matt Hancock's.

33. I was not a member of any other WhatsApp groups, or other forms of group chats on platforms involving key decision makers, politicians or senior officials discussing the response to Covid-19 in Scotland or the UK.

34. I am aware of guidance which governed internal communications, messaging and data retention. This was set out in the Scottish Government Records Management policy and associated guidance and latterly in specific guidance on mobile messaging applications [JF7/015 - INQ000222963]. To the best of my knowledge this guidance was adhered to in relation to discussions or decisions made about the Scottish Government's response to Covid-19. I am not aware of any gaps in the use of the Scottish Government's Electronic Document and Records Management System or of any key communications that have not been retained on this system.

35. To the best of my knowledge, the use of informal communications did not affect the efficacy of decision making or the proper recording of decisions.

Co working

36. Within the Scottish Government there are a set of devolved responsibilities. Each individual and office within the Scottish Government worked within their devolved roles as they related to the management of the pandemic. These areas of work benefitted in their cohesion from the Four Harms Framework and were subject to Cabinet discussion and agreement where required.

37. It is my view that the communication between the Four Nations health secretaries was generally reasonably good, albeit that it could be slow at times. My recollection is that delays could occur when the Secretary of State was uncertain as to whether the action he wished to take or we wished to agree with him would be sanctioned by Number 10. An example of this would be the desire by the 4four nations Health Secretaries to deliver the first vaccine to a patient on the same day. This could not be met by delivery on the earliest possible day for Wales and England due to the geographical challenges for Scotland and Northern Ireland. Whilst all four Health Secretaries were keen to ensure the date was not the earliest but the one all could meet, there was still some uncertainty until Number 10 confirmed agreement. There were occasions when discussions and decisions had been agreed upon by the four health secretaries, but the UK government's response would be different. I found it

frustrating and difficult at times to understand the rationale for the basis on which decisions changed after they had been agreed at four nations meetings.

38. Inter-governmental fora that provided clinical and scientific advice during the pandemic, such as those that my clinical and policy officials engaged in, including the Scientific Advisory Group for Emergencies (SAGE) and those that involved PHS, including the Scottish Government Covid-19 Advisory Group, worked effectively for the purposes of my role as Cabinet Secretary for Health and Sport. I do not believe that COBR worked as well as it could or arguably was needed during the pandemic: it was too large, meetings were not by any definition discursive, and it appeared for the most part to operate on basis of an agenda set by the UK government alone. COBR meetings were used for the UK Government to pass on whatever information they considered relevant, and in effect to confirm or 'rubber stamp' agreed approaches that had been reached between the four nations.

39. As there were multiple inter-governmental fora operating in parallel, I would receive all key information and advice from key clinical and scientific advisors. Whilst there may have been a risk of information overload given the volume of information and the necessary frequent updates to it, I remain firmly of the view that it was necessary for me to have all the relevant information to allow me to make necessary decisions. Being able to deal with large volumes of at times complicated information, analyse the information and form the judgements necessary for decision making is part of the job of a Cabinet Secretary in normal times and even more so during a global public health emergency.

40. I do not have a view on whether the four Ministerial Implementation Groups should have remained in place after May 2020 in light of them being replaced by the Covid-S and Covid-O committees.

41. In broad terms, my experience was that the engagement between the Scottish Government and the UK government, such as in relation to the coordination of policy and communication responses, sharing of data analysis, and pooling of resources worked reasonably well. The Scottish Government had taken a very clear view that any pre-existing tensions and disagreements had to be set to one side in the face of the pandemic with the priority being to work as collaboratively and respectfully as possible to protect the populations we served.

42. The main challenge in relation to intergovernmental working between the Scottish Government and the UK government was that we were dealing with two different systems for health and, to an extent, social care between England and Scotland, which the UK Government did not fully understand. This was a challenge when considering the operationalisation of decisions. There were challenges for example in respect of understanding the differences in geography across the Four Nations and how that impacted on both aspects of policy and on delivery. Scotland's geography was a factor in this, in relation to not only the substantial land mass north and south of the population concentration of the central belt, but also our many islands. There were also challenges in instances where the UK Government held reserved powers and resources that could impact on the Scottish Government's intent to take specific actions in managing the spread of the virus. It is my understanding that the First Minister at the time raised these issues with the Prime Minister and I believe they were also raised at COBR and with the Chancellor of the Duchy of Lancaster. Although these issues were raised at various fora, it is my view that the Scottish Government and the UK Government were not always able to overcome these challenges.

43. It is the case that the pace of the pandemic response, the unprecedented rhythm of ministerial meetings and the short turnaround time on commissions for papers meant that the Scottish Government may not have always received invites, agendas or papers in time. I do not find the Secretary of State for Scotland's reasoning for the late receipt of agendas entirely credible. I do not believe the Scottish Government was late in supplying information to the UK Government during the pandemic. It was my experience that within the UK government there was a view that the Scottish Government was not an equal partner in the management of the pandemic response. My observation was that this view also applied to the other devolved governments.

44. It is the case and has been so despite the 20 plus years since devolution, that the knowledge, understanding and experience of devolution varies considerably within Whitehall Departments. It is regrettable that successive Secretaries of State appear to have been unwilling or unable to improve that situation. From my experience of working with the UK government both before and during the pandemic and in previous roles, there is a significant need to improve on that situation at both official and political levels of Whitehall. At points during the pandemic, colleagues from Wales and Northern Ireland also raised issues around this understanding. That had

an impact, in some respects, on every aspect of our pandemic response, including TTI.

45. The First Minister made announcements to the public at the timing agreed by the Scottish Government, as a result of a collective decisions made by Scottish ministers. The timeliness of announcing these decisions was important to the people of Scotland and the announcements were made with the best interests of the Scottish people in mind. There were times during the pandemic when announcements were specifically coordinated between the four nations, for example, in relation to the delivery of the vaccine programme.

46. At the outset, the Scottish Government was clear that wherever possible it would follow a four nations approach, but retained the right to depart from that if, based on the data, evidence or advice provided, it judged it to be in the best interests of people in Scotland to do so. This important caveat applied to the approach of all the four nations of the UK. Consequently, where the approach changed it did so because of the judgements the Scottish Government made based on the factors outlined.

47. There was no advice received that we should not plan on this basis, and no 'plan' to depart from the four nations approach inasmuch as the existence of a plan can be implied as representing a long-standing intent. In this, as in other decisions and judgements, the Scottish Government acted on the basis of the information available to it at the time.

48. Where the risk of confusion on the part of the public could exist, the Scottish Government's view was that retaining the clarity of its message, the clear explanation of the decisions being taken and the rationale for those decisions and the regular communication of these through all communication channels at its disposal was the most effective way to guard against and mitigate any potential confusion. The Scottish Government also ensured that its ministerial colleagues in the other nations understood what it was doing and why.

49. The address by the First Minister on 11 May 2020, in which she clarified that UK government guidance to return to work did not apply in Scotland and the reasons for that is an example of this. In her media briefing she provided the data, as was done at every daily briefing, on confirmed case numbers, hospitalisations and deaths where covid was present. That data and the trends seen over a number of data

periods together with the clinical advice the Scottish Government received was the basis for its retention of the 'Stay at Home' advice at that time.

50. I do not consider that the First Minister's comments with respect to the UK Government's shift away from the 'Stay at Home' message should have in any respect adversely affected relationships between the Scottish Government and the UK Government, given all four nations clearly understood and had stated that they respected the right of each nation to act in a way it judged to be in the best interests of those it represented in what was a public health emergency. I am not aware that this situation in particular affected the working relationship and was not aware that it altered the pre-existing relationship between the First Minister and the Prime Minister. It was the case in some instances that the UK Government made decisions citing England data with which we did not agree.

51. During the pandemic, there were a number of instances where decisions taken by the UK Government – based primarily on data from England – had an impact on Test and Protect. For example, in March 2020, the UK-wide move from the "contain" to "delay" phase led to the suspension of routine contact tracing across the UK, including in Scotland, despite differences in case numbers at that time. In September 2020, significant pressure on the UK Lighthouse Lab network in England resulted in proposals to limit access to testing booking slots in Scotland, which were strongly opposed by Scottish and Welsh Ministers and were ultimately prevented through direct engagement with the UK Government. This highlighted the extent to which operational decisions based on England-specific data could have disrupted the delivery of Test and Protect. Scotland and Wales then started to bolster NHS lab capacity to avoid relying on the UK Lighthouse Lab system. Another example is that in summer 2021, changes to the NHS COVID app in England driven by high case rates and to reduce the volume of self-isolation notifications, created confusion in Scotland, despite no changes being made to the Protect Scotland app.

52. In each of these cases, the Scottish Government did not dispute the validity of the data used by the UK Government but reached different conclusions about the appropriate policy response in Scotland. While England-only data may have provided a sound basis for decisions in England, it was not always appropriate to apply those decisions uniformly across the UK. The Scottish Government's position was that decisions relating to public health should be informed by relevant data and expert

advice, and its priority was that Test and Protect was tailored to the specific needs of Scotland's population.

53. Between January 2020 and May 2021, I had direct contact with the respective Cabinet Secretaries for Health across the four nations in relation to the management of the pandemic in Scotland. My interactions with the health secretaries were largely operational in nature. We discussed where policy positions differed across the four nations in relation to health and explained the reasons for these differences. I believe these interactions were effective.

54. My personal and working relationships with key decision makers and advisers in the Scottish Government, the UK government and other Devolved Governments during the pandemic were warm and productive. I do not believe there were any personal relationships between the Scottish Government and the UK Government that made it more challenging to work together. I am not aware of any personal relationships that may have had an overall effect on the manner in which the Scottish Government worked together with the UK Government and other Devolved Governments or the efficacy of its response to the pandemic in Scotland.

55. I am not aware of the role that Alister Jack MP, the Secretary of State for Scotland, and his office played in UK Government's core decision making insofar as it related to the management of the pandemic in Scotland. I am not aware and have no experience of the formal and informal role and responsibilities the Secretary of State for Scotland and his office may have had in facilitating intergovernmental workings between the Scottish Government and the UK Government. When Matt Hancock met with me and the CMO on 12 March 2020 to discuss Scotland and the UK's preparedness for the pandemic, Mr Jack was present but that was the only direct contact I had with him.

56. I believe the Secretary of State for Scotland attended COBR meetings which I was also present at and that he was also regularly present at meetings chaired by the Chancellor of the Duchy of Lancaster, at some of which I attended for the First Minister. I had no other direct or indirect contact with the Secretary of State for Scotland.

<u>The Other Devolved Governments</u>

57. Between January 2020 and May 2021 there were regular meetings and calls between the health secretaries of the four nations. Where appropriate, there were also meetings and calls between the officials of the three devolved nations. There were regular meetings and calls between the Chief Medical Officers of the 4 nations. There was a mutual aid agreement between the Four Nations with respect to PPE and that was enacted with Scotland at one point providing PPE to Wales and Northern Ireland. Once approved by me, communication in this regard would be handled between officials.

58. I had a very good understanding of when and why the governments in Wales and Northern Ireland were taking steps in their management of the pandemic and, aside from my comments earlier, understood as best I could the decisions of the UK government as they were communicating and explained by Mr Hancock. I believe the health secretaries of the four nations made an effort to explain to each other how and why management of the pandemic, including in relation to TTI, differed in each of the devolved nations.

59. In the Scottish Government's Module 3 DG Health and Social Care Corporate Statement [INQ000485979], paragraph 188, it was explained that:

"The UK has a seat as a member state on international organisations, such as the World Health Organisation *(WHO) and the World Health Assembly (WHA). Whilst Scotland is not a member state, information provided by these relevant international organisations was provided to the Health Protection Network and the CMO. The CMO received verbal updates from Professor Chris Whitty, CMO for England."*

60. My senior clinical advisors, including those members on the advisory committee chaired by Andrew Morris had a wide range of formal and informal global contacts. All information gained through these contacts contributed to overall advice I received.

Tracing Apps and other Devolved Governments

61. At the start of the Pandemic we already had a system in Scotland that could test, trace and provide advice to people with transmissible diseases. We used that primarily pre-pandemic in instances of Sexually Transmitted Infections. As we already had a public health system in place for doing this, we could use it in a modified form in the early days of the pandemic and that's how we traced, for example, people at

the NIKE conference. We quickly scaled that test and trace system up considerably to have a Scotland wide TTI system. Caroline Lamb primarily led this work. There was not a significant difference between Scotland and England. All UK Four Nations would have had a test and trace capacity, but just on varying scales. I do not recall the detail of the level of variation that existed.

62. Each nation also had its own App to notify people who has been exposed to the virus. The Protect Scotland App was launched on 10 September 2020 and by 28 September 2020 had been downloaded 1.3 million times, with 833,000 active users.

63. Scale of access and interoperability were key considerations when designing the App. Modelling indicated that the App would have maximum utility and impact if a large enough proportion of the population used it, hence its use was promoted repeatedly in the daily television briefings. It was made very clear that the App was anonymous and optional. This modelling was largely either commissioned by NHS England in support of the NHS Covid-19 App, and carried out by the Alan Turing Institute or was publicly available research. This was in recognition that because the underlying technology was the same worldwide then modelling from one app or country was directly applicable to all apps/countries.

64. Initially the intention had been for the App to be based on England's NHS Covid-19 app. However, this was not possible as the app for England had been developed in England to integrate with England's (and Wales) contact tracing system. Instead, Scotland joined the Republic of Ireland's 'federated server' which allowed Protect Scotland to work with the Republic of Ireland's 'Covid Tracker Ireland' app and Northern Ireland's 'StopCOVID NI' app. This initial decision was taken because Protect Scotland was built on the open source code from the Republic of Ireland's app by the same company. The English/Welsh 'NHS Covid-19' apps later joined the Irish federate server, resulting in all UK and Irish apps being compatible with each other. Scotland then took the lead on establishing interoperability within the UK and NHS Education for Scotland (NES) started developing its own federated server at the start of October 2020. On the 28 October, Scotland, England, Northern Ireland, Wales, Jersey and Gibraltar signed an Interoperability Agreement [JF7/080 - **INQ000589741].** Scotland took the lead on this because we considered it the right thing to do, we had the expertise and the capacity, and that there was limited time to wait for others to take the lead.

65. There was also a second App, Check in Scotland, which launched on 18 December 2020 and provided a free, national, voluntary service that supported hospitality businesses (restaurants, cafes, bars, public houses and hotels) in complying with the legislative requirements to tackle and reduce the spread of Covid-19. I do not recall the detail of how that app operated.

B. System readiness and capacity

Initial understanding of the nature and extent of the threat

66. Towards the end of 2019, I became aware through media reports of a situation that appeared to be developing in the Wuhan province. I asked my clinical advisers for any information they could get around that, just so we could be conscious of it. We did not realise at that point the threat we were dealing with, but I wanted to be sufficiently aware of what was happening, as far as that was possible. In the early part of 2020, very quickly clinical advisers were able to provide more detailed information. The CMO for Scotland was connected with her counterparts in the rest of the UK. She and our National Clinical Director at the time were also part of an international network of clinicians and were able to speak with colleagues elsewhere in Europe and understand their knowledge and information.

67. We could also see the situation emerging in Italy and began to receive more information about the Covid-19 virus, how it transmits and who it impacts more severely. I was aware, even at that point, that there were groups of people that are more vulnerable to viruses and exposed to severe illness and death. I had awareness of the implications of Covid-19 for Scotland from the CMO and her network of experts. Knowledge was being updated very quickly and there would be discussions before the Scottish Government Covid-19 Advisory group (SGCAG) was set up. These included various experts such as Mark Woolhouse, Stephen Reicher on behavioural science and others, which helped to explain some of the UK Scientific Advisory Group for Emergencies (SAGE) advice, or offer a counter to SAGE's advice.

68. Between January 2020 and March 2020, the Scottish Government's clinical advisers were liaising with the WHO and other relevant international organisations during this period. Contact between the CMO for Scotland and the WHO was primarily co-ordinated through the CMO for England. I was also liaising with other health

secretaries in the four nations and normal coordination mechanisms were in place between Scottish Government Officials and their UK counterparts.

69. An information briefing to the Minister for Public Health, Sport and Wellbeing, was copied to me on 17 January 2020, noting one potential case in the UK. A further briefing was circulated to the FM, DFM and key officials on 24 January 2020 setting out information on case numbers in China and beyond from the WHO and outlining planned actions in the event of a confirmed case in the UK/Scotland [JF7/081 - INQ000249287] and **[JF7/082 - INQ000589741].**

70. The core group of decision makers involved in attempting to understand the implication of the Covid-19 virus, receiving advice from clinical advisers at this time were myself and the First Minister. When communicating medical advice to me and the First Minister, the CMO would reference scientific articles and reports published in January 2020. These would be brought to our attention and referenced in her advice.

71. The information and advice at this stage was relatively sparse and was updated on a daily basis. As we progressed through this early stage of the pandemic, our understanding of impact grew as more information became available. Initially, the assumption was that like influenza, the Covid-19 virus would not transmit between those who did not have symptoms. It became apparent very soon that with this virus, asymptomatic transmission was possible.

72. Between January 2020 and March 2020, in terms of health, I put NHS Scotland on emergency footing using the relevant legislation. This meant that the direction the health service took was determined by me. We undertook a number of steps to ensure the health service in Scotland was ready to deal with the modelled high numbers of people requiring hospital treatment, including intensive care. This involved the cancelling of elective and non-urgent healthcare. This also involved redeployment of staff to areas to respond to patients with Covid-19 and arrangements to bring back retired qualified health staff. This also involved bringing into the health service final year medical students and nursing students to supplement the workforce, bearing in mind the virus would impact healthcare staff.

73. There was significant work done, based on clinical advice, on the type of PPE needed, ensuring a flow of supply to increased distribution routes to cover social care

and community-based care, to establish a Covid-19 pathway for patients in the community to protect GP services for patients did not have Covid-19. There was a large amount of guidance around supporting healthcare staff and in particular, specific guidance for people deemed clinically vulnerable and at-risk based on their existing health conditions.

74. Work was also undertaken to significantly increase Scotland's capacity to process Covid-19 tests, while retaining a capacity to process other diagnostic tests needed for emergency care or cancer. I believe the foundation on which Scotland could increase preparedness was very sound and the health service in Scotland responded very quickly to prepare for the pandemic. In that sense, Scotland was reasonably well prepared and had the advantage of good supply lines through a single procurement system.

75. My understanding of the essential features of the virus was informed by the understanding of my clinical advisers. I believe this was a situation replicated globally. As senior clinicians, epidemiologists and virologists understood this virus was behaving in a way that was different from what had been previously modelled, my understanding of what that meant increased.

76. In January 2020, I believe I reacted as appropriately as I reasonably could in the circumstances, given that our response and understanding increased as we understood the virus was spreading through Europe. I believe the First Minister also understood the imminence and the importance of the threat of the virus as it spread throughout Europe. I and the First Minister properly appreciated the seriousness of the spreading virus.

77. As our understanding grew about the virus, Cabinet and other parts of government became more directly aware of the threat as we began to try and take steps to contain spread of the virus, minimise the numbers of people that would be harmed by Covid-19 and increasingly recognised the consequential risk of harm in other areas, including other health impacts. The steps taken are described in the preceding paragraphs.

78. I do not think there was a view within the Scottish Government that Covid-19 was similar to influenza. Swine flu was the most recent experience that clinical advisers and decision makers had of a likely emerging pandemic. My recollection is that

decision makers and advisers became aware very quickly about how different Covid-19 was from either swine flu or influenza.

79. I understood why a declaration of a Public Health Emergency of International Concern would be made by the WHO. As the UK is treated as a single body by the WHO, the UK Government would make any formal representations or expression of views to the WHO in relation to a declaration of a Public Health Emergency of International Concern. I would consider that WHO advice is always relevant to Scotland. I would look to my clinical advisers; the CMO (both Catherine Calderwood and Gregor Smith), Jason Leitch (National Clinical Director) and the CNO (Fiona McQueen); for their view on the degree of relevance and the degree to which the Scottish Government was able to implement WHO guidance. If the Scottish Government was not able to implement WHO guidance, I would look to my advisers for their views on how the Scottish Government could reach a position to be able to implement the WHO guidance and what mitigation measures could be implemented, if any, in the interim.

80. By the end of January 2020, the First Minister and I were aware that we were undoubtedly dealing with a potentially fatal virus and were already making decisions about preparing for the virus. We had by this point done a significant amount of work to think through what needed to be done to realign Scotland's health service to cope with the virus, which included using our TTI expertise (and increasing its capacity) and the other measures set out at that early stage in the four nations plan. My priorities at the end of January 2020 were to ensure that we were maximising our knowledge of the spread of the virus and its likely effect, working through and taking steps to ensure that we could cope with the health threat of Covid-19.

81. The first case of Covid-19 in Scotland was recorded at the beginning of March. I was also aware of cases at this time in the rest of the UK. Briefing on the Reasonable Worst-Case Scenario (RWCS) was provided to a meeting of SGORR(M) on 17 February, the outcome of which was discussed in Cabinet the following day. There was further discussion of the implications of a RWCS following the first cases in Scotland in Cabinet on 3 March [JF7/083 - INQ000238763], **[JF7/084 - INQ000589762],** and [JF7/085 - INQ000233538].

C. Development of policies for test, trace and isolate

82. Prior to the pandemic, the Scottish Government has had in place law, policy and practice to prepare for, respond to, and mitigate the impact of emergencies including the management of pandemics/epidemics. However, the national preparedness for a large-scale and rapidly deployable system to test, trace and isolate was limited, as the concept of comprehensive whole population community testing and contact tracing was not yet central to pandemic planning. As was the case with the other UK nations, Scotland's preparedness plans for an influenza pandemic did not anticipate the scale or speed of testing required for Covid-19.

83. As noted in my earlier comments, my involvement in the testing and tracing strategy was to receive clinical and expert advice on the approach that should be taken in relation to this strategy, to understand how to operationalise the strategy, authorise any resourcing that was required and monitor its operationalisation taking any decisions necessary to resolve resource or other challenges.

84. At the outset of the Covid-19 pandemic, it was widely believed that transmission was not possible between individuals who were not experiencing symptoms. Therefore, at that point this directed our approach to testing.

85. Roughly around the middle of March 2020, the CMO notified the Scottish Government about asymptomatic transmission. I was also aware of WHO advice on testing from my advisors and the extent to which this advice would apply to the UK. As we increasingly understood the nature of the virus and how it operated, and therefore that asymptomatic transmission was occurring, this carried implications for the importance of testing and of contact tracing in the management of the pandemic.

86. As it became clear that asymptomatic transmission was occurring, we sought to increase our testing capacity as part of the overall UK response in order to meet additional testing demand.

87. Between January and February 2020, testing capacity of NHS Scotland was at a size designed to meet normal everyday diagnostic testing requirements for NHS Scotland. It was not designed to meet the testing requirements of the pandemic. This is why significant effort was made in Scotland and as part of the UK to increase the testing capacity of the National Health Service to deliver and process tests. As highlighted in the First Minister's statement of 1 May 2020 [JF7/086 - INQ000571263], she

described the starting position at the beginning of the pandemic of Covid-19 testing being available through the NHS Lothian and NHS Greater Glasgow and Clyde laboratories at a capacity of 350 tests per day. By the end of April 2020, Covid-19 testing capacity was established in the 14 health board laboratories and total capacity was 4350 test per day through NHS Scotland routes.

88. It was not possible to implement a mass testing programme before February 2020 given the level of testing capacity of NHS Scotland and the advice at that point which suggested that asymptomatic transmission was not possible. It was only as we understood the nature of the virus and asymptomatic transmission that we understood the dedicated level of resource required to be able to deliver a mass testing programme as part of the UK's response to the Covid-19 pandemic.

89. While we expanded testing capacity, we were quite reliant on members of the public in Scotland downloading and utilising the Protect Scotland App to record positive test results. The expansion of testing and the recording of data produced through that testing (through the App) therefore went hand-in-hand with one another.

90. Scotland has for a long time had a surveillance programme, which is in part delivered through General Practice and overseen by what is now PHS. This surveillance operation was increased during the Covid-19 pandemic, although I do not now recall the detail of how it was scaled up, and contact tracing formed an early part of our response in the contain phase of the Four Nation plan. On 10 February 2020, two labs opened in Scotland to ensure more rapid turnaround of testing in Edinburgh (100 tests a day) and Glasgow (250 tests a day). This strategy was about identifying where cases were appearing, tracing the contact that these individuals had, and then to test whether these contacts had Covid-19. Surveillance was also undertaken to understand where cases of the Covid-19 virus was appearing across the geography of Scotland. This developed significantly through the use of genomic sequencing.

91. The surveillance programme referred to above includes Scotland's established Sentinel General Practice (GP) surveillance system, which has traditionally been used to monitor seasonal influenza trends within primary care settings. In addition, the Severe Acute Respiratory Infection (SARI) surveillance programme has been used to monitor individuals presenting with serious acute respiratory illness requiring hospital admission. During the COVID-19 pandemic, these existing systems were significantly scaled up and adapted to respond to the emerging public health

challenge. From April 2020, Health Protection Scotland collaborated with NHS COVID-19 Community Assessment Centres (CACs) to implement enhanced surveillance for COVID-19. This involved the sampling of individuals with mild to moderate symptoms, with a target of up to 1,000 samples per week across all NHS Health Boards. Patients were recruited into the surveillance programme through three main routes: COVID-19 Hubs and Assessment Centres; UK Government testing facilities, including drive-through sites and home testing kits; and community testing teams, which facilitated staff-led or self-administered swabs in individuals' homes. In October 2020, community surveillance was further expanded to include testing for additional respiratory pathogens such as influenza and respiratory syncytial virus (RSV), and the programme was extended to operate throughout the year rather than solely during the winter season. In November 2021, the Community Acute Respiratory Infection (CARI) programme was launched. This relied on samples gathered through CACs and GP practices enrolled in the programme, with a central laboratory conducting multiplex PCR testing to detect a broad range of viral respiratory pathogens. Following the closure of the remaining CACs in March 2022, the CARI programme continued using only samples collected through participating GP practices.

92. In addition to these programmes, surveillance was further strengthened during the pandemic through a range of additional measures. These included asymptomatic testing in dental practices, serological and antibody testing, participation in UK-wide initiatives such as the Office for National Statistics (ONS) COVID-19 Infection Survey and SIREN, and advanced data linkage enabled by the EAVE II study.

93. Pathogen Genomics (also known as whole genome sequencing) is a specialist laboratory technique which provides the highest resolution data for identifying new or concerning variants and mutations (VAMs) of SARS-COV-2 and other pathogens and it is key to understanding regional and global spread. Data from pathogen genomics has been used throughout the pandemic in Scotland to detect changes in the SARS-CoV-2 genome which may affect the efficacy of vaccines, therapeutics, or the epidemiology of the virus. In July 2020, funding was agreed for a Scottish SARS-CoV-2 Sequencing Service to sequence up to 200 samples a week from tests carried out in NHS Scotland. Demand for the service within the NHS increased, to a large part driven by the emergence of variants and mutations of concern, and demand to sequence these for enhanced surveillance. In March 2021, Ministers agreed to increase the capacity within the SARS-CoV-2 sequencing service to 5000 per week

with surge capacity of up to 7000 per week. The Service was a partnership between the specialist virology laboratories in NHS Lothian and NHS Greater Glasgow and Clyde and PHS who provide bioinformatic analysis of the data.

94. This initiative was part of the broader Covid-19 Genomics UK (COG-UK) Consortium, established in April 2020 to collect, sequence, and analyse SARS-CoV-2 genomes across the UK. COG-UK was initially supported by £20 million in funding from the UK Government's Department of Health and Social Care, UK Research and Innovation (UKRI), and the Wellcome Sanger Institute. COG-UK partners were funded to sequence 300 SARS-CoV-2 samples per week, with funding secured until the end of June 2020. To maintain and enhance sequencing capacity beyond this period, additional funding was sought from the Scottish Government to support sequencing efforts through the end of the year. In March 2021, to build genomics capacity, Scottish Ministers approved £13 million of funding to increase the capacity within the SARS-CoV-2 sequencing service from 200 sequences/week to 5000/week with surge capacity of up to 7000/week, and development of centralised computing and bioinformatics capacity within PHS to support analysis and dissemination of genomic data to inform public health decision making and intervention.

95. I met with Richard Crossman Chief Scientist (Health) (CSH) and Professor Jim McMenamin (Director of PHS) during the pandemic to discuss the need to expand genomic sequencing in Scotland, and I agreed to allocate public funding to that expansion. By testing wastewater, we were not entirely reliant upon people testing themselves and submitting test results. As I recall, I agreed to the use of wastewater testing and received advice about that from PHS and the Covid-19 Advisory Group. I do not recall how much financial resource was allocated to wastewater testing. Testing wastewater was the belts and braces approach, which indicated if people had Covid even where test results were not being submitted. This allowed us to be aware of patterns and strains of Covid infection across Scotland. Of course, collating accurate data is important, especially where decision making is partly reliant upon that data.

96. From a fairly early stage in the pandemic I was made aware by Professor McMenamin and Richard Crossman of the importance of genomic sequencing and how it could help detect early variants of the virus, offer an additional surveillance method beyond clinical case data and guide public health interventions such as targeted testing.

97. For example, genomic sequencing was used to examine the Covid-19 outbreak that was initially suspected to be linked to the NIKE Conference in February 2020. It demonstrated that the conference did not result in community transmission of the virus. There was a Scientific Briefing for Cabinet with the Covid-19 Advisory Group on 29 May 2020 which included an outline of this genomic investigation [JF7/087 - **INQ000589767].**

98. On 14 July 2020 I received a submission setting out proposals for establishing a whole genome sequencing service for Covid-19 and other viruses of public health importance in Scotland, provided: [JF7/016 - INQ000245032]. It recommended that the Scottish Government provided £154,844 to meet PHS's costs as part of establishing an end to end WGS service in Scotland. I was content with this recommendation and agreed that funding be provided.

99. The purpose of lockdown restrictions was to severely restrict opportunities for the virus to transmit and mutate new streams. As the virus transmitted, it had the opportunity to alter itself in order to be more infectious. The purpose then of lockdown was to limit the opportunity for virus transmission in a severe way in order to limit the opportunity for mutation and be able to cope with the numbers of people becoming seriously ill and requiring intensive care in hospital treatment as modelling had originally suggested.

100. As we moved to a position in the pandemic when case numbers indicated it was possible to begin to ease some of these restrictions, that is when the Test and Protect scheme was needed in order to identify, pinpoint and contain the virus and its spread as best as we could.

101. The four nations of the UK were at official and ministerial level discussing the implementation of this strategy. In Scotland this scheme was called Test and Protect and in England it was called Test and Trace. Essentially, these schemes were introduced in order to continue to control the virus as restrictions on people's movement were removed. However, the most sensible way to implement this was to develop each scheme to suit the particular geography and requirements of each of the four nations. This accounts for the differences across the four nations. For example, the scheme in Northern Ireland needed to take account of movement to and from the Republic of Ireland; in Scotland, the scheme had to take into account

our rural and island communities (including movement within and between those), and movement across the border between Scotland and England.

102. It is my understanding that the Test and Protect system and contact tracing as part of this, was fully operational nationwide by the end of May 2020. Details of the chronology of the development of the system are included in the corporate statement supplied by DG Health and Social Care in June 2023, including the agreed interaction with the UK-wide laboratory testing programme as well as the development of Scotland's Test and Protect infrastructure.

103. I think Scotland's contact tracing operation worked very well during the Covid-19 pandemic, thanks in large part to PHS officials. I also think there was good cooperation with Local Authorities and Local Authority officials within Scotland. Our capacity to process tests through the Lighthouse Lab in Glasgow, which was part of the UK's Lighthouse network, worked well overall and the Glasgow Lab was the most efficient of the Lighthouse laboratories. It worked exceptionally well to set up and deliver the testing operation at scale within a very short period of time.

104. Initially the Scottish Government's target was to test 3,500 samples a day across NHS labs by the end of April. However, on 30 April 2020, this target had been exceeded and laboratory capacity to process tests in Scotland had increased to 8,350 samples per day. Subsequently, Scotland's Testing Strategy had a target of building laboratory processing capacity to approximately 65,000 tests per day between NHS Scotland laboratories and Lighthouse Lab in Glasgow, ahead of winter 2020. These targets were published on the Scottish Government website [JF7/016a-**INQ000571251].** I am not aware of any interference in broader processes as a result of resources being diverted for this purpose.

105. The importance of testing and contact tracing was understood early in the course of the pandemic. The Directorate for Test and Protect was established on 6 April 2020 to lead on testing capacity across Scotland to support a Test, Track, Isolate approach to managing Covid-19. In terms of resourcing, Test and Protect utilised parts of the UK's four nations testing programme, in which devolved nations received a share of services.

106. One of the issues to consider as we look towards future pandemics, is to what degree we retain an increased baseline capacity for testing in Scotland, beyond that

which might be required for everyday NHS diagnostic testing in Scotland. Another issue to consider is to what extent Scotland has backup plans to increase its testing capacity with pace.

107. On 14 September 2020 when the First Minister said there were "very serious concerns" about Covid testing backlogs, I believe she was referring to the time during the pandemic when the Glasgow Lighthouse Lab was processing tests primarily from the rest of the UK. The Glasgow Lighthouse Lab was part of the UK Lighthouse network, and it operated to process tests taken in Scotland alongside our increased NHS capacity. However, when one of the Network labs in England encountered problems, all tests taken there were transferred to Glasgow. This resulted in our drive-through test centres being unable to administer tests, and tests taken in Scotland being processed at a much slower rate with results provided back to individuals at a slower rate. All of this occurred without any prior notice or consultation with the Scottish Government. This was producing very serious concerns in Scotland in relation to tests submitted for processing from care homes and because individuals were waiting for a long period of time to receive their test results, that had an impact on them, their families and their employment. It also posed a risk to the continuing high levels of compliance. At this time, the Scottish Government was asking individuals who tested positive for Covid-19 to isolate at home, not go to work and not have any contact with their families. Therefore, significant waiting times for individuals produced significant difficulties for them and risked that they would not be able to follow Scottish Government advice that was being given to them. These were issues of concern. My recollection is that these issues were resolved with the UK government by the UK Secretary of State and I speaking on the telephone, which allowed our test centres to operate fully. We also agreed a proportional approach to processing tests at the Glasgow Lighthouse Lab that would avoid any reoccurrence of these issues impacting on the processing of tests that came from citizens in Scotland.

108. As mentioned previously, I attended or convened many “deep dive” meetings which covered subjects such as testing, vaccines, Scotland’s Proximity app and the redesign of unscheduled care. It is extremely likely that decisions would have been taken and actions instructed after such meetings. The deep dive meetings I attended which specifically concerned Test, Trace and Isolate matters took place on the following dates:

Date	Topic	
03/04/2020	Testing	[JF7/088 - INQ000233564] **[JF7/89 - INQ000233398]**
15/04/2020	Testing (pre-meet)	N/A
16/04/2020	Testing	**[JF7/90 - INQ000202129]** [JF7/091 - INQ000233519]
27/04/2020	Testing	[JF7/092 - INQ000202367] **[JF7/93 - INQ000233581]** [JF7/094 - INQ000233577]
08/05/2020	Test, Trace and Isolate	[JF7/095 -INQ000233417] **[JF7/96 - INQ000218310]**
25/05/2020	Test and Protect (FM briefing)	**[JF7/97 - INQ000233585]**
03/09/2020	Scotland's Proximity App	[JF7/098 - INQ000233509]
12/10/2020	Testing	[JF7/099 - INQ00217920]

Sources of advice

Advisory bodies

109. During the course of the Covid-19 pandemic, the Scottish Government had regular access to papers produced by SAGE and the output of SAGE meetings. SAGE was created primarily to provide scientific advice to UK Ministers during emergencies, but Scottish Ministers were also allowed access to that advice and during the pandemic we received feedback from officials who attended on behalf of the Scottish government and from Professor Andrew Morris, Chair of SGCAG. However, the Scottish Government had limited insight and influence over SAGE's development and the reasons behind any changes made. Whilst the evidence and advice produced by SAGE was an important source to us, it was also the case that the commissioning of advice from SAGE was undertaken by UK government departments who were of course, focussed primarily on conditions in England and there was no capacity for Scottish Ministers to engage directly with SAGE. This

situation led the First Minister of Scotland, rightly in my view, to commission our CMO to set up the Scottish Covid Advisory Group which, working in complement to SAGE, could address these deficits. Scotland also had access to information from the New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG), the Joint Biosecurity Centre (JBC) and the Joint Committee on Vaccination and Immunisation (JCVI).

SGCAG and SAGE

110. The SGCAG was set up from March 2020 to provide advice specifically for Scotland. Scottish Government clinical and science advisers and officials who attended SAGE meetings met with key Scottish ministers to answer specific questions. The Group also engaged in advice on epidemiology and virology, benefitted from input from very senior members of PHS and included expertise on behavioural science, which the Scottish Government considered critical to its response in management of the pandemic. I attended regular meetings between Ministers and SCAG, whose core members were:

a. Professor Andrew Morris (Chair)
b. Chief Scientist (Health), Scottish Government
c. Chief Scientific Adviser for Scotland, Scottish Government
d. Chief Medical Officer, Scottish Government
e. Deputy Chief Medical Officers, Scottish Government
f. Professor Chris Robertson, University of Strathclyde
g. Professor Mark Woolhouse , University of Edinburgh
h. Professor Jill Pell, University of Glasgow
i. Dr Jim McMenamin, Public Health Scotland
j. Professor Tom Evans, University of Glasgow
k. Professor Steven Reicher, University of St Andrews
l. Professor Aziz Sheikh, University of Edinburgh and Scottish Science Advisory Council
m. Professor Devi Sridhar, University of Edinburgh
n. Professor Jacqui Reilly, Glasgow Caledonian University and NHS National Services Scotland
o. Professor Linda Bauld, Chief Social Policy Adviser, Scottish Government
p. Professor Sir Harry Burns, University of Strathclyde
q. Professor Nick Hopkins, University of Dundee
r. Dr Audrey MacDougall, Chief Social Researcher Scottish Government

s. Professor Nick Phin, Public Health Scotland

111. The SCAG had the remit to "consider the scientific and technical concepts and processes that are key to understanding the evolving Covid-19 situation and potential impacts in Scotland" [JF7/100 - INQ000326312]. The SGCAG evolved over time depending on demand and the requirement for advice on different topics depending on the phase of the pandemic. The SGCAG had a number of sub-groups, on Public Health Threat Assessment; Education and Children's Issues; Universities and Colleges; on Testing; and the Covid-19 Nosocomial Review Group.

112. The first meeting of the group was held on 26 March 2020, early in the response to Covid-19, to apply the advice coming to the four nations from the SAGE and other appropriate sources of evidence and information and use it to inform decisions in Scotland during the pandemic. Members were chosen and appointed, via a letter from the CMO, based on their scientific or technical expertise and their understanding of the situation in Scotland.

113. The SGCAG was designed to share information with SAGE on a reciprocal basis. The SGCAG had access to papers from SAGE and its subgroups, while the SAGE secretariat was provided with copies of SGCAG papers. Consequently, the SGCAG did not duplicate the work of SAGE but interpreted it in the Scottish context. Precisely how SGCAG interpreted SAGE's work is a question for them.

114. In so far as I am able to comment, I consider that the SAGE/SGCAG system, under which SAGE and the SGCAG and their sub-groups, advised on scientific matters, was appropriate for dealing with a pandemic of this nature and for ensuring that where necessary, available scientific and clinical advice was offered which was appropriate to Scotland.

115. The system by which scientific advice was provided to the Scottish Government in the period before the formation of the SGCAG was of value. However while Scottish Government officials were observers at SAGE and would receive advice in that manner, Scottish Ministers had no direct engagement as noted earlier and we identified a clear need to have direct access to an eminent group of scientific and clinical advisers who also understood the situation in Scotland and with whom we could engage directly in order to improve our own understanding as was necessary for the decisions we needed to take. The National Clinical Director and the Chief

Scientific Adviser for Scotland would provide and receive advice through contacts in the rest of the UK and Europe. I do not know the details of those contacts.

116. I did not regularly attend SGCAG or SAGE meetings. These would have been attended by Scottish Government clinical leads who would then have reported back to and updated me on the current position. My diary reflects that I attended one meeting of the SGCAG on 1 May 2020. I also attended a briefing from the members of the SGCAG to the First Minister on 29 June 2020 as well as regularly attending specific deep dive sessions mentioned above.

CSA, CMO, DCMO, CNO and NCD

117. The role of the Chief Scientific Adviser (CSA) to the Scottish Government is set out in the corporate statement supplied by DG Economy in March 2023 in paragraphs 2 to 14. The CSA was a member of the SGCAG and contributed advice in that context. She did not have any direct reporting role to my role as Cabinet Secretary for Health and Sport. However, I did have contact with Professor David Crossman, CSH to the Scottish Government. This role is part of the Chief Medical Officer Directorate (CMOD) in the Scottish Government, and works to identify, promote and encourage research which addresses the health and healthcare needs of the people of Scotland. The role of the CSH is set out in the corporate statement supplied by DG Health and Social Care (Health Entities) provided March 2023 in paragraphs 11 to 17. The CSH was the Deputy Chair of the SGCAG and contributed advice in that context.

118. The role of the CMO and DCMOs is as independent clinical advisers to government. An important part of the role of CMO is to be able to use judgement and professional clinical experience to be able to communicate effectively and fully, so that their commitment to professional and ethical requirements as defined by the GMC is not breached. During the pandemic, the CMO or a DCMO would be in attendance to provide clinical advice in SGoRR and Cabinet as required. The CMO or DCMO attended media briefings to support public scrutiny of their advice.

119. I believe that the advice I received from the Chief Scientist (Health), CMO for Scotland and DCMOs for Scotland, the CNO for Scotland, Chief Pharmacist and the NCD during the course of the pandemic was clear and transparent. I felt able to and did challenge the advice provided to me by these officers, the SGCAG and SAGE in

order to improve my understanding of the advice as did the First Minister and the Deputy First Minister, which I observed from my interactions with them. I do not have knowledge of whether other core decision makers in the Scottish Government properly challenged scientific advice provide to them, but I questioned advice, its rationale, and its operationalisation.

Four harms assessment

120. The four harms assessment was the structure through which the Scottish Government was provided with expertise related to the economy, communities, including vulnerable or at risk citizens, and education. The four harms assessment was formally articulated as part of Covid-19 – A Framework for Decision Making which was published on 23 April 2020 [JF7/079 - INQ000346286] and was intended to support decision makers to balance the harm to health from Covid directly, with the harm resulting to health indirectly and wider economic, education and social harm. The SGCAG also considered the issues of at-risk and vulnerable groups and ethics.

121. In April 2020, the Scottish Government published clinical advice and an ethical and support framework [JF7/017 - INQ000233594] that aimed to support front line staff with clinical and ethical decision making throughout the pandemic. The ministerial code pertains to the actions of ministers. As far as I am aware, there were no concerns raised under the code related to the management of the pandemic.

122. It was recognised that whilst the primary harm facing the population was from the Covid-19 virus, other consequential harms needed to be understood and considered. The development and application of the 4 Harms Assessment sought to take account of the consequential harms and risks to the economy, other areas of health and social harms which may or were likely to arise from the range of measures being considered at any one time to mitigate against the risk of Covid harm to health.

123. The CMO and senior clinicians provided advice on direct and indirect health harms as a consequence of viral spread and Covid-19. However, I and all other Cabinet Ministers also considered wider impacts of the pandemic and the measures to control it in taking decisions. This approach was formalised in the Four Harms assessment incorporating consideration of societal and economic harms. Under this process, combined cross-government advice, evidence and modelling was presented to ministers to inform our decisions.

124. To the best of my knowledge, decision makers used the four harms assessment after it was introduced in April 2020 to weigh medical and scientific advice with other considerations when making key decision-making in response to the pandemic.

125. The Scottish Government's response to Covid-19 was based on the best available advice at any given time, scientific or otherwise. As the understanding of the nature of the virus and its impact on individuals increased, the sufficiency and adequacy of the scientific and other expert advice improved. There was a process of continuous refinement and improvement of data and analysis. I believe I was able to understand and interrogate any advice provided to me through one-to-one discussions with clinical and scientific advisors and the Covid-19 advisory groups.

126. In cases which involved conflicting medical and scientific information and advice, these were always pointed out to me by my advisors. I was provided with alternative analysis and alternative recommendations by my advisers. There was a significant amount of information available from reputable advisers in Europe and the United States. I would review the alternative advice and ask questions of our advisors in order to ensure the Scottish Government was taking account of as many views as possible. I would have discussions with my advisors and make judgments based on those discussions.

127. I am not aware of any decisions in relation to which medical and scientific information or advice or data modelling was not sought but which ought to have been sought.

128. In relation to the patient experience within the healthcare system during the pandemic, I had access to information and advice from regular discussions with trade unions working in health and social care, Care Home Relatives Group, Scottish Care, British Medical Association (BMA), Royal Colleges and COSLA. In addition to this, the Director General for Health and Social Care and Chief Executive of NHS Scotland and the former Minister for Public Health, Joe FitzPatrick, were in regular contact with the NHS Scotland health boards. Information from these conversations was fed back to me where relevant. I do not at this stage recall the specific detail of the information I received in relation to patient experience.

D. Testing

Overview

129. A general overview of how the testing programme, including how the Scottish government worked with the UK Government and the other Devolved Administrations has been provided earlier in the statement.

130. Scottish Government worked with Local Authorities through the Scottish Resilience Network. The Scottish Resilience Network comprises Scottish Government and Local Authorities together with public authorities whose responsibilities are relevant to the issue which had prompted the network being activated. Regardless of the issue, Scotland's Local Authorities are always key members, collectively represented by COSLA but on occasion – as was the case during the pandemic – Local Authorities would also be at the table.

Capacity

131. I understand that the UK Covid-19 Inquiry has already been provided with the following timeline in the Scottish Government's Module 5 DG Health and Social Care Corporate Statement:

"In Scotland, polymerase chain reaction (PCR), lateral flow device (LFD) and loop-mediated isothermal amplification (LAMP) tests were rolled out across a number of pathways. Testing eligibility expanded in line with testing capacity and clinical advice. Additionally, antiviral tests were used for antibody surveillance. While Test and Protect was formally established on 28 May 2020, there was testing and eligibility prior to that date. Key events include:

- *24 February 2020 – the first two people were tested for Covid in Scotland. Both individuals tested negative*
- *15 March 2020 – surveillance testing was expanded to GP practices to monitor the spread of Covid in the community, covering up to 1.2 million people in Scotland*
- *15 March 2020 – SG updated health boards on the pause to the locally-led test, trace, isolate strategy for the general public. All symptomatic people are advised to stay at home for seven days regardless of travel or contact. Testing of the general public stops but is maintained in hospitals for admissions with*

suspected Covid, and all ICU admissions with upper respiratory-related conditions, for the purposes of clinical care and diagnostics

- *15 March 2020 – the First Minister announces all symptomatic patients in care homes will be tested, not just initial cases to establish the cause of an outbreak*
- *24 March 2020 – SG publishes guidance for NHS health boards in Scotland to prioritise testing to enable health and social care staff to get back to work*
- *25 March 2020 – SG announces the creation of its C19-AG to supplement UK-wide Scientific Advisory Group on Emergencies (SAGE)*
- *5 April 2020 – the first UK PCR site (Glasgow drive-through regional test site) opened for testing on 5 April 2020. Online ordering also opened for those eligible*
- *23 April 2020 – SG publishes the Framework for Decision Making which includes setting out the role of testing, contact tracing and supporting self-isolation as part of transitioning out of lockdown*
- *1 May 2020 – testing eligibility was expanded in line with additional capacity*
- *4 May 2020 – the test, trace, isolate, support strategy was published*
- *18 May 2020 – testing eligibility was extended to those over five with symptoms.*
- *28 May 2020 – Test and Protect was established and those with Covid symptoms were encouraged to book a test and self-isolate if positive*
- *23 June 2020 – health and social care staff were offered weekly PCR testing*
- *21 July 2020 – testing was expanded to under 5s*
- *17 August 2020 – Scotland's Covid-19 Testing Strategy was published*
- *25 August 2020 – increasing capacity and accessibility of testing was announced, with 11 walk-through test sites to be set up*
- *26 August 2020 – NHS Scotland procures 300 point of care testing machines and 500,000 tests*
- *2 October 2020 – SG announces an antibody survey for education staff*
- *23 October 2020 – SG publishes its Strategic Framework*
- *11 November 2020 – SG announces a Covid-19 student testing scheme to support the safe return of students ahead of the winter break*
- *25 November 2020 – SG announces an expansion in testing for hospital patients, health and social care staff, and communities in Level 4 areas*
- *2 December 2020 – SG announces the opening of Scotland's first Community Asymptomatic Test (CAT) site in Johnstone, Renfrewshire. The trial lasted to 9 December 2020*

- *6 December 2020 – SG announces lateral flow testing of designated visitors will be trialled in 14 care homes in North Ayrshire, Fife, Argyll and Bute, Inverclyde, and Aberdeenshire*
- *23 December 2020 – SG announces community testing in areas with high coronavirus prevalence from January 2021*
- *5 January 2021 – SG announces a new way of testing, small-scale test sites, coronavirus testing will be available from two fire stations in Thurso and Lochgilphead between 6 and 29 January, as part of a trial to increase testing access in remote and rural areas*
- *2 February 2021 – SG announces expansion of testing in order to try to drive down rates of Covid-19 in Scotland. The expansion includes routine testing for patient-facing primary care workers, regular testing offered to support the return of schools and nurseries, an expansion of targeted community testing, routine testing for certain workplaces and tests offered to all close contacts of people who have tested positive for Covid-19*
- *17 February 2021 – SG announces an expansion of testing to include anyone who is identified as a close contact of somebody who has tested positive for Covid-19, from 18 February 2021*
- *18 January 2021 – targeted community testing formally commences, following pilots in Johnstone, Renfrewshire*
- *23 February 2021 – SG publishes its Strategic Framework update*
- *26 February 2021 – SG announces access to testing is now available from 21 fire stations across Highland and Argyll & Bute, completing the rollout of small-scale test sites in rural and remote areas of NHS Highland*
- *17 March 2021 – SG published an updated testing strategy, including a £13 million investment in 2021/22 to establish Scotland's own genomic sequencing service to track new Covid-19 variants and manage future outbreaks*
- *25 April 2021 – SG announces free lateral flow test kits to be available for anyone without symptoms from Monday 26 April"*
- *9 June 2021 – SG announces rapid test kits to be rolled out to community pharmacies from 9 June*
- *17 June 2021 – SG publishes its Strategic Framework update.*
- *22 August 2021 – UKG launches UK-wide antibody surveillance programme for the general public for the first time. Home antibody tests available for up to 8,000 people a day across the UK who opt in to the service through NHS Test and Trace*

- *22 September 2021 – SG announces more than 10 million Covid-19 PCR tests have now been carried out in Scotland over the past 19 months since testing got underway*
- *16 November 2021 – SG publishes its Strategic Framework update*
- *23 November 2021 – SG announces that from 6 December, people attending venues covered by Scotland's COVID certification scheme are to be given the option of providing a recent negative lateral flow test for the virus, as an alternative to proof of vaccination*
- *27 November 2021 – SG imposes new travel restrictions as a result of the omicron variant – fully vaccinated arrivals will need to take a PCR test within two days of arrival and to self-isolate until a negative result is received*
- *6 December 2021 – SG announces that from Monday 6 December, the domestic Covid certification scheme will include provision for a negative test for Covid-19, as an alternative to proof of vaccination*
- *29 November 2021 – SG announces that priority for PCR test site slots will be given to essential workers, those at highest risk and anyone eligible for new Covid treatments. A self-isolation exemption scheme is also available for essential workers*
- *3 January 2022 – SG advises all secondary pupils to take at-home Covid-19 tests before they return to school to limit the spread of Omicron*
- *5 January 2022 – SG announces changes to self-isolation and testing. From 6 January, new cases can end self-isolation if they don't have a fever and test negative on a LFD on Day 6 and again at least 24 hours later. Anyone who tests positive on a LFD will no longer be asked to take a PCR test to confirm the result*
- *24 January 2022 – fully vaccinated arrivals into Scotland will no longer be required to possess a negative test result from 4am on 11 February. Non-vaccinated arrivals will still be required to take pre-departure tests and a PCR test on or before day two – but the requirement for isolation will end – and they will no longer have to take a day eight test*
- *22 February 2022 – Scotland's updated Strategic Framework is published*
- *15 March 2022 – SG's Test & Protect transition plan is published. People without Covid-19 symptoms will no longer be asked to take regular lateral flow tests from 18 April. From this date, free lateral flow devices (LFDs) will no longer be available except for any purpose for which testing continues to be advised.*

People with symptoms should continue to isolate and get a PCR test until the end of April

- *30 March 2022 – SG announces that from 18 April most people without symptoms will not be required to take tests. Lateral flow devices for twice weekly testing will no longer be available. PCR tests for people with Covid-19 symptoms will be available until 30 April, when test sites will close*
- *28 April 2022 – SG announces public health advice will change to a 'stay at home' message from 1 May All contact tracing will end. Testing for the general population will end on 30 April, with test sites closing. Testing will remain available to certain groups. NHS Scotland will be taken out of emergency footing at the end of 30 April*
- *25 September 2022 – SG announces that health and social care workers will no longer be required to test for Covid-19 every week as asymptomatic testing is paused by 28 September."*

132. As stated earlier, Scotland has for a long time had a surveillance programme, which is in part delivered through General Practice and overseen by what is now PHS. This surveillance operation was increased during the Covid-19 pandemic and contact tracing formed an early part of our response in the contain phase of the Four Nation plan. On 10 February 2020, two labs opened in Scotland to ensure more rapid turnaround of testing in Edinburgh (100 tests a day) and Glasgow (250 tests a day). This strategy was about identifying where cases were appearing, tracing the contact that these individuals had, and then to test whether these contacts had Covid-19. Surveillance was also undertaken to understand where cases of the Covid-19 virus was appearing across the geography of Scotland. This developed significantly through the use of genomic sequencing. It was clear in the early days of the Pandemic that the existing surveillance programme was not sufficiently resourced or widespread for the anticipated Covid demand, so work was undertaken to scale this up.

133. I therefore quote helpful paragraphs from the Scottish Government's Module 2A DG Health and Social Care Corporate Statement [INQ000215488] (although it is important to note that I stood down as Cabinet Secretary for Health and Social Care in Scotland in May 2021):

"Because health is devolved, responsibility for much of the management of the pandemic in Scotland fell to Scottish Ministers. However for Test and Protect - and in particular the development and application of testing capacity and technologies - Scotland was part of the UK 4 Nations National Testing Programme, along with Wales and Northern Ireland, which significantly impacted the approach to testing taken at all times in the pandemic.

Regarding the procurement of Covid-19 tests to support the testing programme, SG did not procure PCRs or LFTs directly. Prior to the testing programme MoU being implemented, the devolved administrations and the UKG worked collaboratively on the testing programme. Devolved administrations established high-level principles for the 4 Nations UK Testing Programme in September 2020 and shared them with DHSC officials.

The MoU covers the key principles of consultation, discussion and joint decision-making between the four nations, and provides a clear framework for the UK and devolved governments to work from. It was imperative that open engagement and close, productive relationships were fostered at an official level in order to support the application of the MoU.

The MoU sets out the services the UKG were responsible for procuring and delivering, these are also set out above. As outlined in the MoU, devolved administrations were entitled to a "Barnett share of National Testing Programme capacity in lieu of the consequential funding they would otherwise receive from health spending in England". This translated to approximately an 8% share of all UK testing programme capacity. In line with the MoU, SG could opt in or out of services received. The MoU states:

"At the point of Significant Procurements, Scottish Ministers can request to opt-out of a particular technology and receive equivalent funding calculated according to the Barnett Formula. Such requests can be exercised at the Investment Board, in accordance with the following key principles: The opt-out provision only applies to Significant Procurements of technologies; Scottish Ministers should seek to exercise formal opt-out in writing in advance of the Investment Board where possible (during formulation of business case), but can also do so verbally at the Investment Board, or in writing within one business day of the Investment Board. Once Scottish Ministers have exercised their right to opt out, it is not possible to opt

back into the same business case. If Scottish Ministers choose to opt out of a Significant Procurement of technology, they can choose to:

- *receive Barnett funding calculated using the Barnett Formula. Officials will agree the detailed mechanics of how the Barnett funding calculation will be made; or*
- *choose an alternative technology to deliver equivalent testing capacity, where logistically feasible, up to the value of the original Significant Procurement they are opting out of."*

The MoU relating to testing and laboratories, provided as paragraph 365, allowed devolved nations access to four nation/UKG procurement frameworks and contracts which are likely to have been less cost effective and more time-consuming to establish separately. The validation and assessment of new technology was conducted on a four nations basis, where the validation was carried out by PHE Porton Down and the results and analysis shared with devolved governments. Colleagues in NSS's National Laboratories Programme also undertook comparator validation on LFDs for reassurance. Devolved governments and their Ministers could also request to opt out of a significant procurement in a particular technology and receive equivalent funding calculation according to the Barnett Formula, or an alternative technology.

From January 2021, there were some considerable governance changes for the Testing Programme due to the transition of part of DHSC and PHE into UKHSA. During this period of evolving governance arrangements, top level decisions were considered at UKHSA's Executive Committee ("ExCo") including for the testing programme. Devolved governments were not represented at this forum, despite requests for representation. As a result of these requests, the UK-DA Board was established to sit alongside ExCo, which Professor Jenny Harries chaired. This board became the key route for senior officials from all four nations to engage, discuss, raise issues and make decisions to be carried forward to ExCo and beyond.

The governance which existed within UKG departments was not designed to facilitate decision making on an equal basis for the four nations, particularly in areas such as health, where decision making is devolved. Particularly in the early set up of services, but also through the peak of the pandemic response, decisions were routinely made within UKG governance structures, with Scotland being informed of

the decisions taken and therefore largely becoming 'recipients' of the decisions made by UKG. This way of operating was of lower impact in areas where policy in each nation was fully aligned, but became problematic where policies differed or where timescales for implementation differed. An example of this would relate to the timing of school terms, which differ particularly in the start of summer holidays and therefore meant a differing timescale for return to school testing because Scottish schools return earlier in late summer than schools in England. This required a different, and earlier timescale for return to school testing. Similarly on decisions on the level of funding available for Covid services such as testing, these have remained decisions taken by the UKG, rather than being decisions taken on a four nations basis.

The UKG and DAs worked together to support joint aims of securing additional testing capacity, stocks of tests, scientific expert advice and rapid decision-making.

Decisions made by the UKG for England on continued funding for testing had an impact on the funding available for population testing in Scotland. That in turn influenced decision making in Scotland as to the timescale for transitioning to the 'steady state' Test and Protect model from May 2022, in terms of both the timing and the length of that transition."

134. In relation to the development of testing capacity in Scotland between January 2020 and February 2022, as I have explained earlier in this statement, at the outbreak of the Pandemic, Scotland did not have a pandemic scale testing capability, but practical steps were taken to ramp up capacity and create an effective test processing system through the Lighthouse Network, by May 2020.

135. Testing throughout the pandemic was monitored on a daily basis and that information made available to me. From time to time there were backlogs and where it was possible we undertook steps to clear these, including:

- Prioritisation - Pressures on testing capacity during the first wave of Covid-19 meant there was a need to prioritise those who were tested. In the UK and Scotland this prioritisation focused on:
  - clinical care
  - key workers

- vulnerable settings such as hospitals, outbreaks in care homes, prisons and immigration and detention centres

- The creation of The Adult Social Care Testing Board - this was a Short Life Working Group established in January 2021 to support efforts to roll out PCR testing to care home staff and raise/resolve any issues raised through the group.

- The establishment of Regional Laboratories - as briefly mentioned earlier in the statement, to reduce waits at peak demand times for processing PCR tests at UKG labs, NHS National Services Scotland led on setting up three regional labs that would primarily be used for care home staff PCR testing. The first of these opened in December 2020 in Glasgow with sites in Aberdeen and Edinburgh opening in early 2021. They opened when they did because we had already scaled up our NHS labs to maximum capacity and established the Glasgow Lighthouse Lab in the previous months. This was additional capacity to the existing regional capacity.

136. It is worth noting that Local NHS Boards also had pre-existing flexibility to direct testing to address the most critical local needs, including needs in social care.

137. The then First Minister, Nicola Sturgeon, did say on 14 September 2020 that she had "very serious concerns" about Covid testing backlogs. However, the specific issue in the question was a single event in terms of its scale and to my knowledge was not repeated at that level, in part due to the agreement I reached with Mr Hancock. As explained earlier in the statement, the big problem with the Lighthouse project at that time was testing centres in Scotland were unable to carry out more tests. There was some issue at a Lighthouse laboratory in England which meant all of the tests came to the Glasgow Lighthouse, reducing (or even eliminating) the capacity of the Glasgow Lighthouse to process test samples that had been taken in Scotland. A couple of phone calls between myself and Matt Hancock resolved this issue - we reached an agreement around the proportion of tests from Scottish test centres that would be processed through the Glasgow Lighthouse, regardless of what was going on elsewhere in the UK.

<u>UK Lighthouse Labs Network</u>

138. I have described above what the Lighthouse Network was earlier in the statement. It is fair to say that any problems we experienced in Scotland were logistical teething

problems that one would expect when setting up processing capacity on a dramatic scale in a short timeframe. I have also mentioned that in my view the Glasgow Lighthouse did perform consistently well during my time as Cabinet Secretary for Health and Social Care in the Covid 19 pandemic. I have explained how the Glasgow Lighthouse was able to process tests taken from elsewhere in the UK, but that this assistance had to be measured to also retain capacity for the Glasgow Lighthouse to process Covid tests undertaken in Scotland.

Testing technologies

139. Decisions around what technologies should be used in testing were made by those with clinical expertise in epidemiology and virology. My role was to understand as best I could those experts' rationale and thinking and, when required, provide the additional resources those experts told me were required.

140. With regards to the advice was given about the efficacy and/or accuracy of PCR and Lateral Flow tests between January 2020 and June 2022, I can actually only comment on advice I received up to May 2021 (after which I was no longer the Cabinet Secretary for Health and Social Care).

141. I did receive advice from Sir Gregor Smith (the CMO to the Scottish Government) and from Professor Jim McMenamin (Director of PHS) about the failure percentage rates for PCR and Lateral Flow tests. They made it perfectly clear that neither form of testing was 100 percent reliable, but that PCR was initially the only method of large scale testing available and was sufficiently robust that (in the absence of a better alternative) the data generated from PCR tests could be relied upon for the purposes of decision-making.

Supply of tests

142. I ultimately had political responsibility for ensuring that there were sufficient supplies of ventilators, lateral flow tests, PCR equipment and oxygen in Scotland. However, the practicalities of ensuring that those supplies were delivered to the right places on time lay with officials.

143. The details of the provision of PCR and LF tests in Scotland are described in the following paragraphs from the Scottish Government's Module 2 DG Health and

Social Care Corporate Statement (please note that the exhibit references have been updated):

"24 February 2020 – the first two people were tested for Covid in Scotland. Both individuals tested negative

Scale and timeline of mass testing

Targeted community testing was intended to undertake asymptomatic testing of people who were otherwise not eligible under other testing pathways in areas of highest transmission to improve identification of cases that were being missed, and to better use mobile testing units to enhance symptomatic testing. This programme was led by SG with input from territorial health boards, NSS, PHS and local authorities.

Targeted community testing was piloted in eight communities with high prevalence from 26 November 2020 to 9 December 2020. Over the course of the community testing pilots in Scotland, 22,133 tests were completed and 850 positive cases identified (3.8% positivity). Additionally, the interim evaluation report, provided: [JF7/018 - INQ000488599*], from community testing in Liverpool found that "large-scale, intelligence-led, targeted, and locally driven community testing for SARS-Cov-2, in concert with other control measures and vaccination, can support Covid-19 resilience and recovery." This also informed the development of the targeted community testing approach and was a key basis for its rationale. The growing evidence base underpinned decisions around deployment.*

The targeted community testing programme commenced on 18 January 2021. In line with the Test and Protect Transition Plan, symptomatic test sites and LFD collection points closed on 18 April 2022, from when the SG no longer asked the general public to test themselves regularly if they were well and not experiencing Covid symptoms. On 1 May, population testing for those with symptoms ended, this included for targeted community testing sites with symptomatic testing provision.

The focus of targeted community testing changed in line with pandemic response priorities and the emergence of variants of concern. However, in programme board terms of reference documentation from January 2021, provided: [JF7/019 -

INQ000496431] *and June 2021, provided*: [JF7/020 - INQ000496432], *it was defined as:*

- *The strategic application of testing and other public health measures to reduce COVID-19 community transmission by identifying and isolating positive cases that would otherwise be missed, and encouraging local compliance with non-pharmaceutical interventions (NPIs), achieved through:*
- *Use of Public Health Scotland community level test positivity data, waste water testing data and local intelligence from directors of public health to identify areas with concerning levels of community transmission*
- *The rapid deployment of local and national resources to that community to enhance symptomatic testing provision, offer asymptomatic testing options, promote isolation support and encourage compliance with NPIs.*

As the Omicron variant emerged, SG further expanded the availability of lateral flow tests and encouraged people to test regularly to reduce asymptomatic transmission. This was done via the targeted community testing programme at pop-up collection points located in high traffic areas, such as shopping centres, train stations and garden centres.

An evaluation was undertaken by the SG that summarises evidence and insights at a national level from the evaluation of targeted community testing. The report covers the period 18 January 2021 to 26 September 2021 and was published on 14 December 2021, provided: [JF7/021 -INQ000243924].

Targeted community testing ended in line with the dates and timelines set out in the Test and Protect Transition Plan, provided: [JF7/022 - INQ000235186].

From "CIIG – Note on explanation of role of Test Protect in overall strategic approach in management of pandemic"

As new technologies such as LFD testing became available at sufficient volumes to enable novel population wide approaches, this document set out how testing would continue to provide a protective function for those at highest risk, and to ensure symptomatic people were tested and encouraged to isolate. However, in addition to this it set out the ambition for the potential of new testing technologies to allow different approaches such as asymptomatic testing. This included the potential use

of new testing technologies to minimise the harm caused by public health interventions by potentially enabling alternative approaches to be taken with public health advice in the future, subject to agreement on the evidence supporting this to be safe.

From 25 April 2021, lateral flow tests were made available for whole population access to people without symptoms to participate in twice weekly testing. Access to tests was made available through home ordering or from a wide range of places such as walk-in or drive-through test sites. From 9 June 2021, the offer was rolled out to pharmacies and dispensing GPs, increasing access to over 99% of the population within a 30 minute drive and over 99% within a 30 minute walk in major urban areas such as Glasgow, Edinburgh and Dundee.

The Scottish Government planned the locations of walk-through local test sites in areas of high deprivation, low car ownership and high population density, and initially high student population, to increase testing uptake and access for the communities that most needed better access. By April 2021, over a third of mainland Scotland's population was within a 30 minute walk of a walk-through local test site.

In achieving the strategic intent of reducing transmission to the lowest possible levels, the Scottish Government took steps to maximise ease of access to testing. In recognition of the high levels of rurality in Scotland work was undertaken in December 2020 with UK Government to extend home test kit coverage to previously excluded postcodes in NHS Highland and NHS Forth Valley."

144. The following paragraph from the Scottish Government's Module 5 DG Health and Social Care Corporate Statement may also be of assistance to the UKI in answering that question (please note that the exhibit references have been updated):

"The MoU [JF7/023 -INQ000203654] *sets out the services the UKG were responsible for procuring and delivering, these are also set out above. As outlined in the MoU, devolved administrations were entitled to a "Barnett share of National Testing Programme capacity in lieu of the consequential funding they would otherwise receive from health spending in England". This translated to*

approximately an 8% share of all UK testing programme capacity. In line with the MoU, SG could opt in or out of services received."

145. From my perspective as the Cabinet Secretary for Health I believe that the relations with the Convention of Local Authorities (COSLA) worked well and effectively, that we were able to identify problems where they arose and addressed those wherever possible through shared decisions. We were also able to respond where issues around regional testing availability, the speed of tests being processed and local test and protect operations needed to be addressed.

146. The Scottish Government had a longstanding relationship with COSLA and direct engagement with Local Authorities in regard to health, the economy and the national resilience framework. That was the foundation on which we built on our response in the Covid-19 Pandemic. As the Cabinet Secretary for Health and Social Care I had been working for 2 years or more with the spokesperson for Health and Social Care within COSLA, Stuart Currie. I continued this positive working relationship in formal and informal meetings. Issues could be raised with me directly and I would work to resolve them.

147. The national resilience framework was how Local Authorities were involved in local and national policy decisions in regard to testing and local restrictions, as we moved through the Pandemic. Interrelation between the Scottish Government and local authorities are described in my personal statement M2AJF01 dated 16th November 2023 in paragraphs 339 to 344.

Equalities

148. In my view, we were conscious throughout the pandemic in ensuring, as far as possible, that there was equity of access to testing, (as well as equality in all of our other responses to the threats of the pandemic). That is evidenced in our approach to shielding and the support provided. In respect of testing, we engaged directly with community, third sector organisations and Local Authorities to ensure we could, as far as possible, reach vulnerable groups. This included 'inclusive communications' to ensure accessibility for vulnerable communities, including people with visual and hearing impairments and those with learning disabilities. The Scottish Government also worked closely with stakeholders to amplify key campaign messages and delivered messaging in an inclusive way to reach all geographies and seldom heard

communities which include Minority Ethnic (ME) Groups. For example, the Scottish Government worked with Scottish Public Health Network (ScotPHN) to create a bespoke, printed Easy Read Version of the Test and Protect Door Drop created specifically for the Gypsy/Traveller community, which was distributed by COSLA to Gypsy/Traveller sites. As the pandemic developed, we looked to provide mobile testing which could be made available in remote communities across the country. [JF7/101 - INQ000369706]

149. I have already referred to content above in a pervious corporate statement that explains how walk through testing sites were set up in certain locations to increase access to testing.

150. I do not believe there were significant testing specific issues in respect of mistrust with any community in Scotland. It was possible for people to request test kits be delivered to their homes.

151. The following paragraphs from the Scottish Government's Module 5 DG Health and Social Care Corporate Statement may assist the UKI in terms of understanding how the Scottish Government communicated with communities across Scotland (please note that the exhibit references have been updated):

"The Enhanced Testing Outbreak Marketing and Communications toolkit was shared with local authorities after the emergence of the Delta variant (v1 [JF7/024 - INQ000496404]*, v2* [JF7/025 - INQ000496405]*).*

The Scottish Government works closely with stakeholders to amplify campaign messages and communicate effectively to the whole of Scotland, encompassing all geographies and minority communities. The team worked closely with NHS 24, Public Health Scotland and third sector partners to ensure key public health information on Covid-19 was available in multiple languages (17 languages) and accessible formats via the NHS Inform website. The Strategy and Insight and Partnerships teams co-created materials specific to Minority Ethnic communities. For example, the Communications team worked with the Scottish Public Health Network (ScotPHN) to create a bespoke, printed Easy Read Version of the Test and Protect information specifically for the Gypsy/Traveller community, provided: [JF7/026 - INQ000348705]. *This was distributed by the Convention of Scottish Local Authorities (COSLA) to Gypsy/Traveller sites.*

Communication campaigns were delivered by the Scottish Government throughout the pandemic to share public information and inform people of the required protective behaviours identified by Policy at each phase. Campaigns were delivered across a range of topics including: reducing virus transmission; informing people about the restrictions (including the Levels approach); testing and isolation; Protect Scotland proximity alert app; Covid Status app; vaccination; protective behaviours; mental health; building resilience and community support. Examples of TV advertising are published on the Scottish Government YouTube account."

Review

152. As mentioned previously, I was only performing my Cabinet Secretary role until May 2021. We had turn around time targets (from test being taken to test result) but not a target specifying that a particular percentage of the population needed to be tested.

153. I did receive genomic data that showed certain geographical areas appeared to have a high prevalence of Covid-19, but a low number of people being tested. Public Health Scotland's targeted community testing dashboard brought this information together and the areas targeted were typically areas with high transmission rates but limited access to fixed test sites, including parts of the Central Belt, remote and rural communities, and areas with higher levels of deprivation. Mobile testing units were deployed to these locations at the request of local partners to improve accessibility and increase testing uptake.

154. As mentioned previously, Scotland's Testing Strategy had a target of building laboratory processing capacity to approximately 65,000 tests per day between NHS Scotland laboratories and Lighthouse Lab in Glasgow, ahead of winter 2020, and this was achieved by winter 2020.

D. Test and Protect

155. The UKI has asked me to provide relevant evidence on the effectiveness of cooperation between Test and Protect and its counterparts across the Four Nations. However, there is a little to say on that point – governments in each of the Four Nations had their own respective testing programme and had an awareness of the testing systems in other parts of the UK.

156. The UKI has also asked me to comment on why the testing system in Scotland was branded as “Test and Protect” (as opposed to the branding used in other parts of the UK).

157. There was no specific decision made in Scotland to depart from the branding used in any of the other UK nations, as I imagine there was no specific decision taken in England, Wales, and Northern Ireland to depart from the branding used in Scotland. Our understanding in terms of response from our population was that ‘Test and Protect’ would be a more effective brand. The development, roll out, and implementation of Test and Protect was not significantly different from the testing systems used in other parts of the UK. The important element for the Scottish Government was that the Scottish population understood what they had to do, and the Four UK Health Secretaries understood each others’ testing systems (which I believe they did).

158. I have been referred to evidence to the UKI from a former Cabinet Colleague that suggested that it may have been possible to implement Test and Protect earlier in Scotland than when it was actually introduced, and that the Scottish Cabinet had a discussion about this in early 2020. I have no knowledge of the instance to which my colleague refers. As the Cabinet Secretary for Health and Social Care until May 2021, I know that the Scottish Government wanted to make available a mass testing programme as quickly as possible and as I have outlined earlier, that speed was determined by the rate at which we could scale up our testing capacity.

159. There was data at a Scotland wide level from the test and protect system covering the number of tests, the number of positive tests, and the overall location of the virus. This information was summarised and provided to Ministers on a weekly basis. PHS also provided testing figures to the DG Heath and Social Care twice daily, and briefings were provided to me regularly to provide the latest updates. This was all part of the information that informed the advice to me on the prevalence of the virus and nature of individual strains. This in turn formed the basis on which decision were made to respond to the virus. For example, the setting of restriction levels at the point where we moved out of lockdown.

160. The UKI has asked me how I was apprised of information and/or data from Test and Protect. Earlier in this statement, I have described how I received advice from clinical groups and the CMO.

161. During the pandemic I was receiving data from different sources (Test and Protect, the SCAG, PHS, the CMO, Local Authorities etc). I had to take all of this information into account when making decisions, such as the scheduled and regular reviews of restriction levels (which were intended to reduce transmission of the Covid-19 Virus).

Capacity and effectiveness

162. The Scottish Government did not set targets for the number of people to be tested each day, but did set targets for the processing of tests. In August 2020 'Scotland's Testing Strategy— Adapting to the Pandemic' was published, [JF7/027 - INQ000147448]. It set out the role testing continued to play in tackling Covid-19 and noted that the Scottish Government's intention was to build laboratory processing capacity to approximately 65,000 tests per day between NHS Scotland laboratories and the Lighthouse Lab in Glasgow.

163. A clinical and scientific review of Scotland's Testing Strategy was published in October 2020, [JF7/028- INQ000496425]. It reviewed the principles and priorities of the Testing Strategy and presented the consensus clinical and scientific view of prioritisation for the additional testing capacity being built. It noted that the planned expansion of overall testing capacity to 65,000 tests per day by Winter 2020 was on track and the expansion of NHS Scotland capacity was expected to rebalance the processing ratio towards a more equal split between UKG and NHS Scotland laboratories.

Scaling back of testing

164. The UKI has asked me to explain the impact the UK Government's decision to end testing for Covid- 19 (in most circumstances) from April 2022 had on the funding for the Test and Protect Scheme in Scotland. However, I resigned as Cabinet Secretary for Health and Social Care in May 2021, so I am not best placed to comment on this.

Tracing

165. A key factor in Scotland's test and trace strategy was the quick evolution of tracing infrastructure. Prior to the pandemic, territorial boards had delivered a range of contact tracing functions as part of their health protection activities. This was delivered locally, and generally on a small scale; the health boards themselves may be able to speak to their capacity in that regard. In April 2020 I agreed plans to scale up this function via a 'hub and spoke' delivery model, with NHS National Services Scotland operating a central call centre function (National Contact Centre) and each territorial board scaling up local capacity to deliver the service in their area under one central approach. This was established 04 May 2020. From memory, I would have received from my officials a submission with clinical input setting out plans to scale up this activity and seeking my agreement, which I gave. The submission would have been prepared with input from NHS territorial health boards and NSS.

166. My understanding is that the model was a recognised one, and was designed in line with WHO guidance at the time on effective contact tracing delivery. This included performance metrics around case processing times, undertaking tracing within the proposed 72 hour window and aiming to trace and to isolate as many cases as possible. All Health Boards were asked to ensure they had a sufficient workforce to support operation of the system. Flexibility to respond to changing demands was built into the service model through the hub and spoke approach and through access to built in surge capacity, such as call-off contracts.

167. As set out earlier in the statement, initially the intention had been for the App to based on England's NHS Covid-19 app. However, this was not possible as this app had been developed in England to integrate with England's (and Wales) contact tracing system. Instead, Scotland joined the Republic of Ireland's 'federated server' which allowed Protect Scotland to work with the Republic of Ireland's 'Covid Tracker Ireland' app and Northern Ireland's 'StopCOVID NI' app. This initial decision was taken because Protect Scotland was built on the open source code from the Republic of Ireland's app by the same company. The English/Welsh 'NHS Covid-19' apps later joined the Irish federate server, resulting in all UK and Irish apps being compatible with each other. Scotland then took the lead on establishing interoperability within the UK and Director General Health and Social Care commissioned NES to start developing its own federated server at the start of October 2020. On 28 October, Scotland, England, Northern Ireland, Wales, Jersey and Gibraltar signed an Interoperability Agreement **[JF7/080 - INQ000589741].**

Apps

168. As the Protect Scotland App was anonymous and there was a deliberate decision to minimise the amount of personal data collected by the Check In Scotland App, there was no information available around the people who used / did not use either App. That decision was made to address concerns that members of the public would be less likely to use the App if it required their personal data.

169. While the Scottish Government encouraged as many people to use the Protect Scotland App as possible, it was recognised that some people may not be able to, or want to, for various reasons. However, people could still benefit from the App, even if they didn't use it. For example, it reduced the chance of a non-App user coming into contact with a covid-positive contact who did have the App, as they would be alerted to their positive status faster and advised to self isolate. For both Apps, extensive marketing and communications was undertaken to raise awareness and to encourage uptake, whilst making it clear both were voluntary, and it was entirely possible to fully participate in society without using either App [JF7/102 - **INQ000589768], [JF7/103 - INQ000589769], [JF7/104 - INQ000589770].**

170. For those who did not, or could not, use the Check In App, legislative requirements, derived from the Public Health (Scotland) Act 2008, UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018, mandated hospitality venues to obtain, record and retain visitor information for a period of at least 21 days from the date on which the visit occurred. The legislation also required mandated settings to provide the contact details of visitors to the setting to Test and Protect when requested, to assist with contact tracing and outbreak management. Hospitality settings therefore had to provide an alternative check-in method to collect the contact details of those who do not wish to use a digital service, for example providing a handwritten register.

171. Privacy concerns were a key consideration throughout the development of the Protect Scotland App and Check in App. While the Protect Scotland App was anonymous, the Check In App required the collection of various personal data. I was kept informed of this work through my usual Ministerial advice channels. For example, on 7 July 2020, provided: [JF7/029- INQ000241138], I received a submission providing advice on the approach to customer data collection by sectors beyond the hospitality sector and agreeing to the development and publication of

further guidance to support improved customer detail collection, in a lawful and proportionate manner. A further submission I received on 24 July 2020, provided: [JF7/030- INQ000242714], set out a further update on the development of the Check In App and stressed that privacy and security were central to the design, with planning for a Data Protection Impact Assessment and clear Privacy Notice in motion.

172. Media managers within the Scottish Government worked closely with news organisations and other public sector communication partners (including PHS and NHS Boards) to promote guidance, advice and support in relation to Test and Protect. Messaging was generally aimed at the general public, though some messaging was targeted at specific audiences where required. As I have previously stated, Scottish Government made use of the expertise of Professor Reicher of St Andrews University given his recognised expertise in behavioural science; our use of his input extended to communications and messaging.

173. This work included arranging TV/radio broadcast interviews with Ministers and clinicians, and preparing news releases to communicate to news media and directly to the public through Scottish Government social media channels.

174. Communication campaigns were informed by regular online polling carried out by YouGov on the Scottish Government's behalf: c.1000 interviews per wave with a representative sample of adults 18+ across Scotland - weekly from end of March 2020 to June 2021. This opinion polling was also used to monitor attitudes and reported behaviour from April 2020 onwards.

175. In April 2020 a Covid-19 campaign tracker to evaluate performance of marketing campaigns. This ran at cost-effective intervals to obtain post-campaign metrics for recent campaigns. Each wave consisted of a sample of c.500 adults (age 16 and above) across Scotland, with fieldwork carried out via an online omnibus. The campaign tracker was designed and set up by the Strategy & Insight Team within Scottish Government Communications. It was executed (questionnaire design, fieldwork and reporting) by the independent research agency appointed to carry out campaign evaluation research for health-related marketing campaigns.

176. The evaluation research ran at appropriate intervals, and each wave consisted of a sample of c.500 adults (aged 16 and above) across Scotland, with fieldwork carried

out via an online omnibus. Two or three campaigns were usually evaluated on one wave (dependent on how many campaigns had been running) to maximise cost efficiency. Each wave cost approximately £10,500-£13,000 excluding VAT, to cover two or three campaigns that had run recently. The questionnaire measured campaign recognition, message take-out, opinions of the advertising and action taken in response. Where appropriate this was supplemented with other data such as longer term knowledge, behavioural and attitudinal data from the organisational polling and relevant website or social media analytics.

177. I was kept in informed of the public communications around Test and Protect through my regular Ministerial advice channels. As an example, on 3 July 2020 I received a submission seeking approval of a proposed overarching communications strategy the Test & Protect campaign, provided: [JF7/031- INQ000243838]. This included an evaluation of the previous phase of campaign, which then informed the later phase.

178. I was not aware of the cost of building Scottish Government Apps or of maintaining them.

179. When Apps were launched, I was made aware of how many people had downloaded them through a text message system. We wanted to encourage people to report positive tests, so we made a conscious decision not to collect much demographic data (out of a fear that asking for too much personal information would dissuade people from downloading and using the App).

180. I was advised on a number of occasions (often via media enquiries) on the core metrics related to the two apps. For the Protect Scotland App, NES could provide information such as the number of downloads, number of active users, and how many close contacts have received an alert. For the Check in Scotland App aggregated and anonymous statistics were collated and provided to me and other Ministers as required.

181. I am not aware of there being any specific incidents, time periods or demographics in which the Apps were ineffective.

182. I understand that during my time as Cabinet Secretary for Health and Social Care there was no review, debrief, or evaluation of the Apps conducted or brought to my attention.

G. Isolation

183. A timeline detailing the key events and guidance in relation to isolation is provided below:

Table of key events and guidance for isolation policy in Scotland			
Category	**Date**	**Guidance/event**	**Summary**
Key guidance	15/03/2020	Pause of locally led TTI strategy for the general public	Scottish Government updated health boards on the pause to the locally-led test, trace, isolate strategy for the general public. All symptomatic people were advised to stay at home for seven days regardless of travel or contact. Testing of the general public stopped but was maintained in hospitals for admissions with suspected Covid, and all ICU admissions with upper respiratory-related conditions, for the purposes of clinical care and diagnostics.
Key guidance	14/04/2020	National Assistance Helpline (NAH)	A single point of contact for requests for support relating to self-isolation commences.
Key event	23/04/2020	Framework for Decision Making published	Included setting out the role of testing, contact tracing and supporting self-isolation as part of transitioning out of lockdown.
Key event	01/05/2020	Testing eligibility was expanded	Scottish Government announced that the normal daily capacity for analysing tests reached 8,350. Testing was expanded to enhanced outbreak investigation in all care homes where there were cases of Covid-19, sample testing in care homes without cases of the virus, symptomatic individuals aged 65 and over. Symptomatic individuals who needed to leave their homes to work. Household members of the above groups, if they were symptomatic.
Key guidance	04/05/2020	Coronavirus (Covid-19): test, trace, isolate, support strategy	Sets out our plans to help disrupt community transmission of the virus.

Key guidance	26/05/2020	Coronavirus (Covid-19): Test and Protect - summary	Guidance on what you should do if you have to stay at home to self-isolate because of Covid-19.
Key guidance	26/05/2020	Coronavirus (Covid-19): Test and Protect - advice for employers	Advice for employers on helping staff who need to self-isolate at home.
Key guidance	26/05/2020	Coronavirus (Covid-19): Test and Protect	Information and support for people who are asked to self-isolate because of Covid-19, including the Self-Isolation Support Grant (£500).
Key event	28/05/2020	Test and Protect established	Test and Protect - a system of test, trace, and isolate was established and those with Covid symptoms were encouraged to book a test and self-isolate if positive.
Key guidance	15/07/2020	Coronavirus (Covid-19): guidance on food and other essentials for Local Authorities	Guidance for Local Authorities to support people to access food and other essentials, including those isolating under test and protect.
Key guidance	30/07/2020	Coronavirus (Covid-19): self-isolation advice	Advice on self-isolation changes from 7 to 10 days. Statement from the UK Chief Medical Officers on extension of self-isolation period (for Scotland, Dr Gregor Smith).
Key event	20/09/2020	Decision not to replicate UKG self-isolation legal requirements	Recommendation not to replicate UK Government decision to make self-isolation in Test and Trace a legal requirement enforced by fines of up to £10,000.
Key event	10/12/2020	Self-Isolation Support Grant (SISG) commenced	Self-Isolation Support Grant commenced.

Key event	19/10/2020	NAH and LSIAS extension	Continuation of the National Assistance helpline and Funding for the Local Self-Isolation Assistance Service to mid-January 2021.
Key guidance	12/11/2020	Coronavirus (Covid-19): self-isolation factsheet	Information on when and how to self-isolate if you or someone in your household have coronavirus symptoms.
Key guidance	14/12/2020	Coronavirus (Covid-19): discretionary Self-Isolation Support Grant guidance	Guidance for Local Authorities on the administration of the discretionary Self-Isolation Support Grant (SISG) in relation to No Recourse to Public Funds (NRPF) using statutory provisions in the Public Health (Scotland) Act 2008.
Key event	14/12/2020	Isolation period changes	Isolation for contacts of positive cases and people returning from international travel reduced from 14 days to 10 days; self-isolation support grant payment stayed at £500.
Key event	19/01/2021	NAH and LSIAS extension	Extension of the Local Self-Isolation Assistance Service (LSIAS) and the National Assistance Helpline (NAH) services beyond 11 January 2021 to 31 March 2021.
Key event	11/03/2021	Decision not to create an offence relating to employers and self-isolation rules	Scottish Government decided not to create an offence relating to employers and premises owners knowingly allowing or encouraging workers to attend their place of work whilst self-isolating.
Key event	17/03/2021	NAH and LSIAS extension	Extension of funding for the National Assistance Helpline and the Local Self-Isolation Assistance Service to 30 June 2021

Key event	23/07/2021	Self-isolation changes	Changes were made to self-isolation rules for close contacts of Covid-19 cases to allow essential staff in critical roles to return to work to maintain lifeline services and critical national infrastructure. It made it possible to apply to exempt those who worked in critical roles where staff shortages were in danger of putting essential services, at risk.
Key event	09/08/2021	Reduced isolation changes	Reduced isolation for vaccinated close contacts.
Key event	05/01/2022	Changes to self-isolation and testing	Scottish Government announced changes to self-isolation and testing. From 6 January, new cases could end self-isolation if they didn't have a fever and test negative on an LFD on Day 6 and again at least 24 hours later. Anyone who tested positive on an LFD would no longer be asked to take a PCR test to confirm the result.
Key guidance	17/02/2021	Coronavirus (Covid-19): Scottish Welfare Fund statutory guidance	Guidance covering the Scottish Welfare Fund and Self-Isolation Support Grant (SISG) .
Key guidance	17/02/2021	Coronavirus (Covid-19): Self-isolation support discretionary payment - regulations	Explains the regulations allowing Local Authorities to award the Self-Isolation Support Grant (SISG) using section 4 of the Public Health (Scotland) Act 2008.
Key event	28/04/2022	Ending of contact tracing, some testing	Scottish Government announced public health advice will change to a ‘stay at home’ message from 1 May All contact tracing would end. Testing for the general population would end on 30 April, with test sites closing. Testing would remain available to certain groups. NHS Scotland will be taken out of emergency footing at the end of 30 April.

Key event	01/05/2022	Ending of contact tracing, some testing	Ceasing of routine contact tracing in health and social care settings from 1 May and cessation of population wide contact tracing.

184. At the outset, the people most disproportionately affected by isolation policies included those in low paid employment with terms and conditions that did not cover their isolation period, single households, older people, and people with a range of vulnerabilities. Steps were taken to respond to these situations. For example, in adult health and social care there was the introduction of a financial payment where employer terms and conditions did not include financial payment for isolation. There was also the galvanising of existing community support networks to provide practical support e.g. shopping and social contact for the vulnerable, those experiencing loneliness, or those with mental health issues. I took the decisions in this regard that related specifically to health and social care, and my Ministerial colleagues took such decisions that were relevant to their respective portfolios.

185. The community response was led by colleagues working with Local Authorities – the Cabinet Secretary for Communities and Local Government (Aileen Campbell) worked in partnership with Local Authorities, community groups, and third sector organisations.

186. The Cabinet Secretary for Economy (Fiona Hislop) liaised with supermarkets in respect of prioritising home deliveries.

187. My understanding is that the relevant equality impact assessments were completed and have been provided to the Inquiry. As Cabinet Secretary for Health and Sport I was only directly aware of those relating to my portfolio. For example, the Equality and Fairer Scotland Duty Impact Assessment, covers the three pillars that comprise Test and Protect: testing; contact tracing; and support for isolation was undertaken and published which set out the Scottish Government's assessment of the potential differential impact of aspects of Test and Protect across groups with protected characteristics [JF7/032 - INQ000147449]. Due to the emergency introduction of Shielding, an Equality Impact Assessment (EQIA) could not be carried out in advance. However, an interim EQIA of the support required by people who were at clinically highest risk of severe illness was carried out at the beginning of April 2020. A retrospective EQIA was carried out as a follow up to the interim report from April 2020 [JF7/033 - INQ000147447].

188. The following information from the DG Health and Social Care – Module 2A – Corporate Statement [INQ000215488] may be helpful to the UKI (please note that the exhibit references have been updated):

"On 17 March 2021. an Equality and Fairer Scotland Duty Impact Assessment, covering the three pillars that comprise Test and Protect: testing; contact tracing; and support for isolation was undertaken and published which set out the Scottish Government's assessment of the potential differential impact of aspects of Test and

Protect across groups with protected characteristics. This included an assessment of the differential impacts and potential harm caused by isolation guidance as an NPI on the range of groups with a protected characteristic. This is produced, Equality and Fairer Scotland Duty Impact Assessment [JF7/032 - INQ000147449].

Having considered the potential differential impacts of isolation guidance, the Scottish Government implemented a range of services to attempt to mitigate the potential harm of isolation as an NPI including:

- *The Self-Isolation Support Grant*
- *The National Assistance Helpline*
- *The Local Self-Isolation Assistance Service.*

On 17 June 2021, the First Minister, Deputy First Minister and Cabinet Secretary for Education and Skills were provided with advice on the potential impact of isolation on children and young people including on educational continuity. The advice contained a wider discussion on the potential harms caused to this cohort by isolation, and is produced, [JF7/034 - INQ000147450].

On 9 July 2021, Ministers were provided with advice and a draft contribution for a Cabinet paper which set out the equalities considerations of implementing the range of policy options provided. This is produced, [JF7/035 - INQ000147451].

On 13 July 2021, a paper with policy options, produced, [JF7/036 - INQ000147452] *was provided to the Covid Education Recovery Group (CERG), an advisory group with membership including a wide range of child, young person and educational stakeholders as well as public health and clinical advisers, to seek an assessment*

and advice on the potential differential impacts on children and young people that would support an assessment for Ministers following.

Test and Protect was anticipated to have a positive impact across all groups in society by reducing transmission of Covid-19 reducing deaths and serious illness caused by the virus. It was a fundamental part of the Scottish Government's strategy to mitigate the severe impacts of Covid-19 on public health and adapted as the pandemic progressed, scientific evidence on the nature of transmission of the virus emerged, and new technologies became available."

189. The UKI has asked me what steps the Scottish Government took to provide guidance and support for at-risk and vulnerable groups and/or those with protected characteristics who were required to isolate.

190. The answer to that question is found in the Director General – Module 2A – Corporate statement [INQ000215488]:

"Communication campaigns were delivered by the Scottish Government throughout the pandemic to share public information and inform people of the required protective behaviours identified by Policy at each phase. Campaigns were delivered across a range of topics including: reducing virus transmission; informing people about the restrictions (including the Levels approach); testing and isolation; Protect Scotland proximity alert app; Covid Status app; vaccination; protective behaviours; mental health; building resilience and community support. Examples of TV advertising are published on the Scottish Government YouTube account.

From late January 2020, media managers in the News (press office) team in DG Corporate used a range of channels, working closely with news organisations as well as public sector communications partners (including Public Health Scotland, NHS Boards and Police Scotland) to promote online guidance on reducing the transmission risk and to provide advice and support (health-related and economic). Messaging was largely aimed at the general public though some messaging targeted specific audiences such as key workers, people at higher risk of Covid-19, business owners, people from specific Minority Ethnic groups, and others.

The Scottish Government works closely with stakeholders to amplify campaign messages and communicate effectively to the whole of Scotland, encompassing all

geographies and minority communities. The team worked closely with NHS 24, Public Health Scotland and third sector partners to ensure key public health information on Covid-19 was available in multiple languages (17 languages) and accessible formats via the NHS Inform website. The Strategy and Insight and Partnerships teams co-created materials specific to Minority Ethnic communities. For example, the Communications team worked with the Scottish Public Health Network (ScotPHN) to create a bespoke, printed Easy Read Version of the Test and Protect information specifically for the Gypsy/Traveller community, provided: [JF7/026 - INQ000348705]. *This was distributed by the Convention of Scottish Local Authorities (COSLA) to Gypsy/Traveller sites."*

Other decisions in relation to TTI

Sector testing

191. From 17 March 2020 the NHS was under emergency measures, meaning decisions relating to the operation of the NHS in Scotland were my responsibility. Taking this step was based on the modelling of worst-case scenario received and the requirement that presented to ensure that all of the NHS in Scotland was focussed on responding to the threat of Covid-19. The decision to discharge anyone from hospital is first and foremost a clinical decision based on a clinician's view that hospital treatment is no longer required. At the point where people were discharged from hospital to care homes, it would be based on that clinical decision that hospital treatment was no longer required and they would be discharged to a care home or their own home depending on where they lived permanently. The decision to discharge people in terms of freeing up the NHS capacity to deal with Covid-19 and attempting to ensure that all patients no longer requiring hospital treatment were not exposed to the virus in hospital, was of course made in the early days in the context of the modelling of anticipated numbers of the population affected by Covid-19 and the percentage of that number which would require acute hospital care, which along with other decisions was designed to ensure the NHS could cope with the demands of the pandemic.

192. Testing of both health and social care workers started on 16 March and was ramped up significantly from then. On 1 April 2020, the FM publicly confirmed the work underway to significantly increase our capacity to process tests with a capacity on that date of around 1900 tests per day with an increase planned to 3,500 per day

and all within the NHS Scotland laboratory network. Commercial partnerships were being developed at the UK level to increase capacity beyond that and as part of one of those partnerships, a new laboratory had been established in Glasgow, which we expected to be operational by the end of April 2020. As testing capacity expanded, we progressively increased the number of health and care service workers who are tested. We had already published guidance to support that [JF7/0105 - INQ000496422].

193. My understanding and expectation of all care homes was that basic infection prevention and infection control measures were understood, staff were trained to operate those, and that they would be regularly practiced. (It is a contractual requirement for registered care and nursing homes to comply with the National Manual for Infection Prevention and Control. That self-evidently includes ensuring staff are aware of their responsibilities and are trained to perform these. Details of such training would be held by individual care homes, who are not accountable to Scottish Government and are in the majority of instances private businesses. It is for the Care Inspectorate to satisfy themselves that a care home is meeting these registration obligations.) Therefore, early into the pandemic, where there was not the capacity to test people being discharged from hospital to a care setting, my expectation was that the basic infection prevention and control standards which I expected the care home sector to be practicing, together with the specific additional guidance provided, would provide mitigation against risk of transmission.

194. My understanding of the domestic care sector was comparable to that of the residential care home sector. I knew that our Local Authorities took seriously the importance of ensuring staff and those who received care were protected. Of course, there were additional demands on residential and domestic care sectors for PPE because of the nature of the virus and the upsurge in global demand for PPE and, as covered elsewhere we took steps to seek to ensure supply and distribution of PPE for all staff involved.

195. We understood there was a risk of Covid-19 spread in any setting where numbers of people were together, and that was part of the rationale for the NPIs we introduced including lockdown, to limit social mixing and thereby the spread of the virus. Residential care homes were issued specific guidance surrounding the isolation of individuals on their admittance for a period determined by clinical advisors [JF7/106 - INQ000147440]. In order to ensure that, if a newly admitted individual did have the

virus, then the risk of spread was reduced. We also took steps to ensure that staff had the right guidance about the PPE that was required. Guidance on this and other areas was regularly updated as new information appeared. We had taken steps to supply that additional PPE to care homes. In normal times, they were responsible for that equipment themselves. In addition, public health directors in each NHS board and their colleagues undertook contact with residential care settings, where that was required, to provide them with advice and guidance. Additional nursing and other support were also made available from our health boards, and was paid for by the Scottish Government.

196. The rationale behind the announcement I made in Parliament on 21 April 2020 was as set out in that announcement [JF7/037 - INQ000280688]. We sought to provide assurance to care home residents, staff and the families of those with loved ones in care homes as well as those being discharged about the measures in place to reduce the risk of infection in care homes. In that announcement, as well as the expansion of testing, I also made clear the efforts being made to enhance the workforce in the care sector, increased engagement by Directors of Public Health and the establishment of the Rapid Action Group to address any emerging concerns, as well as outlining further measures to increase the availability of PPE. The purpose of the Rapid Action Group was to bring together representatives from across the system to monitor data on developments in the care home sector, reacting swiftly to developing issues and scenarios. Membership is designed to ensure all core partners have input in the analysis of the current situation and identification of evolving risks and of actions to be taken [JF7/107 - INQ000437452].

197. Clinical advice at the time, based on advice from the Chief Medical Officer and PHS, was a 14 day period of isolation for those entering care homes from the community or hospital to mitigate the risk of transmission, including from those who were asymptomatic at the point of entry. However, as set out above, the addition of testing was intended to strengthen assurance for all stakeholders.

198. The Scottish Government knew that the WHO was advising the use of widespread testing albeit that it was not specific to care homes or older people. We knew that to be the case but could not at the outset implement that because we did not have the capacity to do so. Once we did have the capacity to do so then we could implement

testing, not only for admission to care homes but also widespread testing for the public.

199. Advice was given to the First Minister and I in an urgent submission of 20 April 2020 [JF7/108 – INQ000249330] from the Director of Community Health and Social Care summarising the position of the CMO on the question of testing all admissions to care homes. The advice provided set out the latest clinical advice, the position in England and feedback from the HSC sector. In England, the guidance on hospital discharges was changed on 15 April 2020 to require NHS trusts to test all patients prior to discharge and admission into a care home.

200. At this stage, all testing within Scotland was in the form of PCR tests. The advice given in this submission was that although these tests were effective at identifying those with Covid-19 when symptomatic, they could not reliably detect infection prior to the onset of symptoms and could not confirm whether a person had had the infection once symptoms had resolved. It was also possible that someone would test negative while still within the incubation period of the virus.

201. Negative tests would therefore, it was posited, provide a level of false reassurance. The recently published guidance in England (within the Coronavirus: adult social care action plan) at that time had committed to testing all residents prior to admission to a care home, but it acknowledged that care homes may still wish to isolate new residents for a 14-day period following admission. Indeed, the advice stated that patients could be discharged to care homes whilst their results were pending, and would be isolated in the same way as a Covid-19 positive patient until the results were available. The English approach also stated that for individuals entering care settings from the community, individuals would be tested prior to admission but that the care home may still wish to isolate the new resident for a 14-day period.

202. The CMO advice therefore also included the observation that a positive test may not have an impact on how care home residents were treated in practice. The advice itself, contained in full within an annex, was to continue with robust IPC policies (including a 14-day isolation period for all new admissions to residential care settings) along with appropriate numbers of staff to support this. The contributors to the full set of advice were listed as CMO, CNO and PHS.

203. Our overall aim was, as far as possible, to limit the transmission of the virus. Particular social and domestic settings required additional steps and that included care homes and those receiving social care in the community. In some instances, and with regret, we required the closure of adult day centres for example. We knew these offered vital social support to many receiving adult social care but it was part of our intention to limit the number of people coming together in order to limit the transmission of the virus.

204. The Scottish Government's key advisors were making use of their contacts and networks within the UK and elsewhere. Any advice from those relations that they believed to be appropriate would be given to the Scottish Ministers.

205. On 21 April 2020, I had made a statement surrounding the testing of staff in care homes and our progress in working on a four nations basis to increase the testing capacity in Scotland as part of the UK offer [JF7/37 - INQ000280688]. We had the capacity by then to introduce the testing which we had not had the capacity for beforehand. Therefore, at the very outset of the pandemic there was a significant discharge of people from hospital back to their care homes or returning to receiving care at home, whose treatment in hospital had finished and whom we wished to protect from hospital- acquired Covid infection. At this time, we did not have the physical capacity to test, I believe capacity was around 350 per day. We simply had no capacity to do that, so other steps were taken to mitigate against transmission aside from expecting care homes to understand and practice basic infection prevention and control was the guidance around isolating someone who was admitted for 14 days, the wearing of PPE, the supply of PPE and then as our testing capacity improved we then introduced the requirement that someone should have two Covid tests before being admitted to a care home whether they were coming from hospital or not.

206. I was in regular contact with Scottish Care and throughout this period met both with Scottish Care but also with individual care home providers, COSLA and with the Trade Unions representing staff in the care home and home care sectors. That contact and those meetings were all around discussions about how we would manage the threat of Covid in residential and domestic care sectors.

207. My ministerial diary records that I met with Scottish Care on the following dates during the pandemic period:

- 18 March 2020
- 3 April 2020
- 7 April 2020
- 16 April 2020
- 22 May 2020
- 5 June 2020
- 19 June 2020
- 1 July 2020
- 16 July 2020
- 7 August 2020
- 24 August 2020
- 7 September 2020
- 23 September 2020
- 7 October 2020
- 20 November 2020
- 9 December 2020
- 14 January 2021
- 17 February 2021
- 25 March 2021

208. These frequent meetings were important to discuss the ongoing management of the virus in the care sector specifically around infection prevention and control, as well as the provision of PPE. One of the initiatives that I took in response to issues raised at those meetings was to introduce a direct distribution route of PPE to residential care homes and in consultation with COSLA and the Trade Unions to agree that adult social care staff working in domestic settings should have a supply of PPE available to them for each of their clients and that they would take the professional decision on what PPE to use dependent on their own individual assessment of the risk presented. Another issue that was raised was the difficulty of care home staff in staying off work if they believed they might have covid or had covid because they were not in receipt of sick pay and the financial restriction was considerable given that they are low paid individuals. Therefore, we took a decision to make sure that financial support would be available to all staff in adult social care knowing that in the future we would need to raise terms and conditions with the care sector but in the immediacy of the pandemic, we took the decision to spend the Government money supporting staff so they could follow the guidance we were giving them to stay at home if they were unwell. The additional support was sick pay relevant to their salary

grade, even in circumstances where the employer was a private business, and was resourced by the Scottish Government.

209. I was aware of Scottish Care's position of advocating for robust clinical assessment and testing of residents entering care homes from both the community and an NHS setting. Had we had the capacity to have testing of residents entering care homes from the outset then we would have done so but we did not have the testing capacity and we did introduce testing as soon as that capacity was available. However, we did offer guidance to care homes in Scotland requesting that all new (or returning) residents be isolated for 14 days immediately upon arrival into the care home, just in case they were positive for Covid 19. The rationale behind this decision for all new or returning residents to be isolated on admission was based on additional protection offered by the identification and exclusion of those who were potentially infective without symptoms and the isolation of any new admissions to minimise the risk of false negatives and emerging infection. These incoming (or returning) residents were barrier nursed and supported on a one-to-one basis. Additionally, we ensured that PPE was available where a care home told us that they required that additional support.

210. These measures on testing all people admitted to a care home were to support care homes to continue to admit patients in a manner which is clinically safe. These policies were reflected in both SG and HPS guidance for care homes. Two specific sets of HPS guidance were updated: (i) Version 1.1 of 'Guidance for stepdown of infection control precautions and discharging COVID-19 patients from hospital to residential settings', provided [JF7/109– INQ000189405] on 22 April 2020; and (ii) Version 1.1 of 'COVID-19: Information and Guidance for Care Home Settings', provided [JF7/110 – INQ000189332] on 28 April 2020. The requirement for testing and isolation was included in subsequent clinical guidance in addition to the isolation of new admissions as additional protection offered by the identification and exclusion of those who were infective without symptoms and the isolation of any new admissions to minimise the risk of false negatives and emerging infection. The announcement and updated guidance was shared with the care home sector representatives.

211. The requirement of the importance of testing was raised in the Scottish Parliament and we were of course aware of the WHO advice on that issue and as previously stated, we were unable to introduce testing in the early part of the pandemic because

we did not have the capacity to process the tests. As soon as we did as part of the four-nation initiative to increase testing capacity then we introduced it for individuals being admitted to care homes.

212. I was not influenced by political considerations in the decisions I took regarding the discharge of patients from hospitals to care homes. Nor do I believe that the decisions of other Cabinet Secretaries or Cabinet collectively were influenced by any such consideration. A glance at the record of the Scottish Parliament's proceedings will show cross party support for the steps that the Scottish Government was taking including the discharge of patients from hospital including to care homes, when they no longer required hospital treatment. As previously stated, the first decision and the decision maker of whether a patient is discharged from hospital is the relevant clinician. Only s/he can determine that someone no longer requires hospital treatment. No politician could or should do such a thing. That includes discharge to any setting whether it is to a person's own home or to a residential care home. The decision to support the discharge of patients no longer requiring hospital treatment to care homes once that clinical decision was made was the responsibility of the Scottish Government in supporting that to happen.

213. As I have previously noted, we were aware that any situation where individuals were together, particularly in any kind of closed setting, was one where the risk of transmission was increased. We were also aware of the WHO guidance on testing but at the outset, lacked the laboratory capacity to deliver that. Our understanding of the importance of testing informed the rapid upscaling of capacity within NHS laboratories noted earlier and our active engagement in the UK wide development of laboratory capacity. Alongside this, as previously noted was our understanding that asymptomatic transmission was a significant feature of the Covid-19 virus and so the decision to test both symptomatic and asymptomatic individuals entering into a care home was made as soon as we were able to deliver on it. This was in addition to the guidance and support described previously.

214. In regard to the concerns noted from Scottish Care, from January 2020 throughout the early part of the pandemic we were engaged in a process of significant upscaling of our testing capacity both in Scotland and across the UK. As our testing capacity increased, we had to make judgements about how we would introduce the opportunity for testing across various sections of the population. NHS and social care staff were a priority because they were treating individuals who were seriously ill from

COVID, and we required our staff to be as sure as they could be that they did not have the virus. As we could phase further introduction of testing, we did so.

215. Care homes were responsible for securing their own supplies of PPE, however, in recognition of the issues being raised by the sector, by 21 April 2020, NHS Scotland were providing a top up service in recognition of current, exceptional, demand in all settings. A triage centre was established through NHS National Services Scotland for supplying urgent PPE to registered social care providers. Once the system was in operation, improvements were also introduced such local cluster points for distribution of PPE and increasing staff numbers to prepare and deliver PPE.

216. My letter of 13 March 2020 addressed to IJB Chief Officers, Local Authority Chief Executives, IJB Chief Social Work Officers, Scottish Care, Coalition of Care and Support Providers in Scotland, Care Inspectorate and the Scottish Social Services Council included advice from the CMO that appropriate PPE should be used for positive cases and also that long term facilities should ensure that they had access to adequate stock and knew where to access additional supplies if needed. The advice on what PPE to use, how to obtain equipment and dispose of it had been made available through HPS. The CMO underlined that all staff must be made aware of the guidance [JF7/038 - INQ000280689]. How PPE was distributed in a care home setting was a matter for those operating the facility.

217. From very early March, discussions were underway with NHS Boards and with COSLA as to how to reduce the number of so-called delayed discharges, where those judged clinically fit to be discharged from hospital were unable to access appropriate facilities or support outside a hospital setting, leaving a reduced number of hospital beds available for new admissions. On 6 March 2020, the DG for Health and Social Care wrote to Chief Officers, Territorial Health Boards and Local Authorities to note the importance of reducing the number of delayed discharges **[JF7/111 - INQ000470123].** The advice underlying this would have been connected to concerns about NHS capacity to manage a significant number of covid infections. As ever, individual discharges remained a matter of clinical judgement within the hospital setting.

218. My statement to Parliament on 21 April 2020 set out a number of measures put in place to support the care homes sector, including requiring NHS Directors of Public Health to take enhanced clinical leadership for care homes. Directors were asked to

report on their initial assessment of how each home was faring in terms of infection control, staffing, training, social distancing and testing and the actions they were taking to rectify any deficits they identified.

219. The national Care Home Rapid Action Group (CHRAG) was also established in April 2020 comprising the key partners with operational oversight and delivery responsibility for care homes. The group received daily updates and was tasked with initiating any local action needed, as well as informing and coordinating a wider package of support to the sector. The CHRAG initially focused on care homes but in September 2020 its coverage widened to adult social care under a new group Pandemic Response Adult Social Care Group (PRASCG). I commissioned the establishment of these groups. From memory, their function in relation to TTI was to ensure all information disseminated was received and understood, and to alert officials and, if necessary, me to any difficulties being encountered in terms of compliance.

220. From March 2020, the Care Inspectorate had significantly increasing levels of contact with care homes across Scotland. In a statement to the Scottish Parliament on 21 April, I advised that we were equipping the Care Inspectorate for an enhanced assurance role including greater powers to require reporting. Following this the Coronavirus (Scotland) (No.2) Act 2020, which contained provisions around duties of the Care Inspectorate in relation to care homes including on inspections, was introduced on 10 May 2020. This Act came into effect on 26 May 2020 and the following provisions were included:
    - That the Care Inspectorate must lay a report before Parliament every two weeks during the emergency period setting out which care home services it has inspected in the two-week period as well as the findings of those inspections.
    - New duties for the Care Inspectorate around reporting of deaths in care homes services from or attributable to coronavirus.
    - That care home service providers must provide certain information to the Care Inspectorate each day in relation to the numbers of deaths which have occurred in a care home service, whether caused by or attributable to coronavirus or not.
    - That the Care Inspectorate must prepare a report of the information provided by care home service providers and share with Scottish Ministers.

- That Scottish Ministers to subsequently lay reports prepared by the Care Inspectorate before Parliament.
- The Care Inspectorate reported on infection prevention and control, PPE and staffing and amended its quality framework for care homes to support this process.

221. 'Coronavirus (Covid-19): enhanced professional clinical and care oversight of care homes guidance' was issued by the Scottish Government on 17 May 2020. I met regularly with the Care Inspectorate to consider the situation and receive their updates on actions taken and their advice on the situation in residential care facilities and used the daily SitReps I received on residential outbreaks to communicate between meetings and inform discussions with my officials and the Inspectorate.

222. An early warning system of enhanced notifications was established, requiring services to tell the Care Inspectorate about both suspected and confirmed cases of Covid-19, and staffing levels affected by Covid-19. The Care Inspectorate operated these oversight arrangements seven days a week to carry out scrutiny checks and enhanced their communication with daily Updates, a dedicated area on their website, and information on social media. Where risk was indicated as high, the Care Inspectorate commenced onsite inspections.

223. I have already discussed the decision making process around testing for both patients and staff and the advice, timing and constraints on the approach taken above.

224. I was very aware that the restrictions that we were imposing were difficult for the population as a whole and were additionally so for residents in care homes and their close families. However, the judgements we were making were aimed at protecting individuals as best we could from the harm of Covid-19 and as the pandemic progressed, I had a number of discussions with the Care Home Relatives Group, and we were able to ease those restrictions and encourage care homes to follow our guidance on the easing of restrictions. Care homes of course are private enterprises and cannot be directed by me or any government minister in the way for example I could direct the NHS. While some care home employers offered employment contracts closer to the Scottish Government's fair work principles, it was clear that others did not. In recognition of the exceptional circumstances and in order to ensure

that social care workers were given the urgent support they deserved, we developed a Scottish Government funded scheme for care workers in respect of sick pay and death in service benefits. The Social Care Staff Support Fund became operational on 24 June 2020 to provide financial assistance to staff facing financial hardship when off work self-isolating and whose employment terms only provided for Statutory Sick Pay (SSP). As described earlier in this statement, this support comprised sick pay relevant to their salary grade, even in circumstances where the employer was a private business, and was resourced by the Scottish Government.

225. The rationale for increasing regulatory requirements and the inspections was to ensure that all care homes were following the guidance, receiving support where possible and applying the clinical and infection control practice that had been made available to them. However, we were aware that not all were managing to do so, therefore, the intention behind the additional regulatory requirements and the significant support offered to these private enterprises was to ensure that they were given the best opportunity to provide the level of care and protection to residents. Undoubtedly, in circumstances where individuals are working at pace and under pressure, mistakes and misunderstandings will arise, for example in terms of the guidance issued or the role of the Directors of Public Health, but where we were aware of those, we took steps to try to redress those and I am confident that our directors of public health behaved in the same way.

226. As described above, from early on in the pandemic the Scottish Government required local professional leads – Directors of Public Health, Executive Nurse Directors, Chief Social Work Officers, Chief Officers, Medical Directors from NHS boards and Local Authorities to provide oversight and support to adult care homes. The Scottish Government had no direct role in local outbreaks in addition to these requirements. However, with regard to the specific outbreaks raised in Redmill, I did meet the Care Inspectorate on 29 October 2020 to discuss the outbreak and their findings and intended follow up action. In general, outbreak monitoring and intervention was the responsibility of the local incident management teams, with follow up action coordinated by the local Health and Social Care Partnership. The daily SitReps I received as noted earlier, allowed me to monitor the situation and pursue any further action or require additional pace in response that I considered necessary.

227. I think I was clear from the outset that there were a number of risks in all of the decisions that I and collectively as a government we were making, and we were making those decisions based on the evidence we had available to us at the time we made the decisions, our capacity to deliver as noted in relation to testing, and trying to mitigate the risks as best we could. Throughout the pandemic we were making decisions between difficult options, none were risk free and none were optimal. As mentioned, if we could have tested patients discharged from hospital into care homes or a domestic care setting at the outset then we would have done that, but we did not have the capacity to do so. As soon as we did have the capacity then we introduced that testing regime. What was not as clear to me at the outset, but quickly became clear was the degree of variation in the level of understanding of infection prevention and control across the entirety of the care home sector and the requirement for some care homes to be additionally supported to achieve that standard. This was absolutely not because the staff in those homes did not want to provide the best possible care, but because they had not necessarily had the level of training or the support of proper equipment that they should have had. That disparity particularly in the residential care sector is what led to my commissioning of the Feeley Inquiry into adult social care which reported to the Scottish Government in the spring of 2021. None of Professor Feeley's outcomes related directly to TTI.

228. I do not accept that the Scottish Government did not respond quickly to what was needed in care homes and social care in the community. In the context of everything that we were dealing with, as soon as we were made aware of the need for additional support or of problems, we acted very quickly to respond to that. The residential social care sector is essentially composed of private enterprises, some of which are UK wide in their operations and are part of a larger enterprise with other interest and shareholder expectations. In that circumstance, government has limited locus on what they can direct and require. Some of the steps that I took, including with the Care Inspectorate and additional regulation, were, in the context of the pandemic, to try and increase the locus of government in the residential care sector. To my recollection, that did not extend to matters concerning the TTI system in Scotland. The domestic care sector is a purview of Local Authorities so whilst the Scottish Government provides financial support much of the delivery is at the hands of the Local Authority but even, so we have a more direct relationship with Local Authorities. That is why it is so important that the Scottish Government worked well with the Convention of Scottish Local Authorities, but it is also why in both instances commissioning the Feeley Inquiry and supporting its recommendations were so

important as we look ahead to how we can improve the standard of care across the adult social care sector and the dignity and respect with which those requiring social care are treated.

229. It was not the case that the absence of testing in homes with no known Covid-19 positive individuals at the beginning of the pandemic resulted in a failure to adopt a preventative approach in a setting with a high risk of community transmission. That view is supported by an independent report from Edinburgh University that concluded that there was no evidence that the absence of testing of residents or admissions in the initial period led to outbreaks in care homes. From the earliest stages of the pandemic, specific advice on enhanced infection control was produced and promoted to the care home sector, provided [JF7/112 – INQ000147514]. In addition, the guidance from an early stage that individuals entering a care home setting, whether from hospital or the community, self-isolate for 14 days, and access to testing for health and social care staff, was intended to ensure a preventative approach was adopted.

230. I do not agree that there was reluctance from decision makers at the onset of the pandemic to take into account the expertise or experience of those operating in the social sector. As previously noted, pre pandemic I had regular contact with Scottish Care and that increased considerably with me and my officials as the pandemic progressed. My officials were also engaged with stakeholders with respect the relevant considerations to be taken into account when supporting a population with significant behavioural needs and challenges and it is the specific discussions with Care Home Relatives Group that focussed attention on the specific issues with respect to family/loved one contact that we then tried to address.

231. I regret if at any point Scottish Care felt that their engagement with anybody of the Scottish Government was tokenistic. I certainly valued their input and advice and the frequent contact that I had with them both before and during the pandemic. Of course, they will understand as I do, that in situations where people are rapidly coming to terms with a circumstance that they have had no previous experience of and are required to respond at pace and in detail, it can be the case that the best practice you would like to follow is not always possible.

232. PHS played a vital and valuable role throughout the pandemic, and I am confident that if there were areas where it had limited experience, it sought to address those as best it could.

233. In the circumstances of the pandemic, I believe that the Health and Social Care Directorate, other Scottish Government directorates, the NHS, NHS National Services Scotland, PHS and the care sector worked reasonably effectively. Where there were problems drawn to my attention, I aimed to take steps to address those as soon as possible and where practical.

234. The following content from the Director General for Health and Social Care– Module 5 – Corporate statement may be of assistance to the UKI (please note that the exhibit references have been updated):

"Standard operating procedures were developed to distribute tests in different locations and scenarios and to ensure testing programmes were operated safely and effectively. The key SOPs in place for different aspects of the testing programme are set out below.

Additionally, the following table summarises additional testing SOPs held by the SG in relation to Covid-19 testing:

SOP	***Exhibit***
Schools & ELC Testing - LFD Collect	[JF7/039-INQ000496368]
Public & 3rd Sector Workplace Testing - LFD Collect	[JF7/040 - INQ000496370]
Private Sector Workplace Testing - LFD Collect	[JF7/040 - INQ000496370]
Colleges Testing - LFD Collect	[JF7/041 - INQ000496372]
Higher Education Institutions Testing - LFD Collect	[JF7/042 - INQ000496374]
Individuals in Prison Custody Testing - LFD Collect	[JF7/043 - INQ000496375]

Prison employees Testing - PCR Regional Hub	[JF7/044 - INQ000496378]
Test Site Staff Testing - LFD ATS	[JF7/045 - INQ000496379]
Community Testing-Small Scale Test Site-Rural Access - Symptomatic PCR	[JF7/046 - INQ000496339]
Mental Health and Children & Young People's community Services Testing - LFD Collect	[JF7/047 - INQ000496381]
Workplace Testing (general) LFD ATS model - LFD ATS	[JF7/048 - INQ000496383]
Universities LFD ATS	[JF7/049 - INQ000496384]
Schools Supervised Self-Test - LFD Supervised Self-Test	[JF7/050 - INQ000496385]
Social Care Testing Workstream 2 – LFD Collect	[JF7/051 - INQ000496387]
Visiting Professionals	[JF7/052 - INQ000496391]
Care Home Visitors	[JF7/053 - INQ000496393]
Universal offer – test site/pharmacy collect	[JF7/054 - INQ000496335]
University Collect LFD	[JF7/055 - INQ000496394]
LFD Clinical SOP Framework	[JF7/056 - INQ000496397]
University Staff and Student Testing – LFD ATS	[JF7/057 - INQ000496399]
Employees – Control Room Staff – LFD Collect	[JF7/058 - INQ000496400]
Care at home staff – LFD	[JF7/059 - INQ000496401]
Healthcare workers – LFD	[JF7/060 - INQ000496403]"

235. As Cabinet Secretary for Health and Social Care, my role was to respond to requests made to me by other Cabinet Secretaries covering their respective departments. On the basis of advice I then received from clinical experts, the appropriate levels of testing were made available to those Cabinet Secretaries.

Internal UK borders

236. Wales did impose a public closure on their border with England for a period in order as one of the measures to prevent the inward transmission of the virus from areas of England which bordered on Wales. So, in that sense the closure of borders internal to the UK partially or for particular purposes is technically feasible. However, the border between Scotland and England was not considered feasible for closure not least because of cross-border NHS employee traffic, both between the hospitals in Carlisle and Dumfries and the ambulance service. Recognising that, we sought to be as clear as possible about travel restrictions where those restrictions differed between Scotland and England. Policy officials and Ministers engaged with the aviation and airline sector regularly throughout the pandemic with the Aviation Working Group, chaired by Gordon Dewar Chief Executive of Edinburgh Airport. All travel restrictions and requirements were updated on gov.scot before regulations came into force to allow travellers to prepare for their journey. The Scottish Government was committed to 4 nations alignment with travel restrictions where possible, which helped to minimise confusion if restrictions varied across the UK. Ministerial statements were released as soon as restrictions were agreed to update the public as early as possible. Transport officials within Scottish Government may be able to expand on the practical efforts that were undertaken in this regard. I am not aware that formal consideration was given by the Scottish Government to closing borders between Scotland and the other nations of the UK.

237. Guidance set out by the Scottish Government during 2020 related to travel beyond the Local Authority of residence. By implication this also affected travel between Scotland and the other nations of the UK. The rationale for these measures included the risk of importation of the virus into areas of lower prevalence and in particular the need to address the potential for greater travel between areas of different prevalence under the tiering system when different parts of Scotland were experiencing different levels of restrictions. Examples of this guidance follow:

- Scottish Government announced restrictions on indoor gatherings and limits to hospital and care home visiting in East Renfrewshire, Glasgow and West

Dunbartonshire, from midnight on Tuesday 1 September. A copy of the guidance is provided **[JF7/113 - INQ000589771].**

- On 7 September 2020, the Scottish Government announced restrictions on meetings in indoor household settings in West Scotland were extended to people living in Renfrewshire and East Dunbartonshire. A copy of the guidance is provided **[JF7/070 - INQ000369747].**
- On 11 September 2020, the Scottish Government announced the extension of local restrictions to North and South Lanarkshire, limiting household gatherings from midnight on Friday 11 September. A copy of the guidance is provided **[JF7/115 - INQ000589773].**

238. In late 2020, as the responsible administrations varied restrictions addressing the different circumstances in the four nations of the UK, the four governments co-operated to publish a web page with signposts to the guidance applicable in different areas [JF7/069 - INQ000369731] [JF7/070 - INQ000369747] [JF7/071 - INQ000224267]. Guidance was published to explain the restrictions, and made it clear, for example, that Covid-19 rules and guidance did not prevent anyone from leaving their home to escape domestic abuse or taking other measures to keep themselves safe from domestic abuse. Polling helped monitor if people were clear on what was required of them as a result of both non-legal guidance and legal restrictions.

1. The differences between England and Scotland placing different controls for quarantine for returning travellers was understood and taken account of by the Scottish Government. With regard to the concerns raised by PHS in terms of differential quarantine arrangements between Scotland and other nations, from September 2020 additional communication measures were put in place to ensure travellers were aware of the quarantine requirements. The additional communications measures put in place were as follows:

    - Information relating to FACTS (with S representing self-isolate and book a test) and the importance of completing the Passenger Locator Form were distributed to points of entry.
    - Information was shared via Scottish Government social media channels.

- All relevant Scottish Government digital communication assets were shared with ports of entry to run on their digital signage where possible.
- The Scottish Government campaign in October 2020 that ran across TV and radio included messaging relating to travellers as part of broader guidance on the importance of self-isolation. This film was also translated into 7 other languages for use by relevant stakeholder groups.

International borders

239. I am unaware of any role the Office of Secretary of State for Scotland played in decision-making around the closure of the UK border. As I have advised, I raised a concern about widening the control of inbound traffic to the UK with UK Government, particularly in the context of why we were just stopping flights from Wuhan and not recognising people travel through Europe to get into the UK. I understand that the First Minister may also have raised issues around the closure of the UK border, but I am not aware of those details.

240. Any discussion or decisions in relation to borders were discussed at Cabinet. Michael Matheson was primarily involved in this and would be better placed to address the approach taken in relation to Border control.

241. Regarding my involvement in the decision-making with regard to quarantine and / or self-isolation on arrival into the UK, my representations were made between January and February 2020 surrounding my concerns of ongoing transmission as there were no direct flights from China to Scotland. My concerns were straightforward: a person entering the UK from China but with onward travel to Scotland would be unlikely to leave the entry airport and therefore not be required to self-isolate. On arrival in Scotland, we would have no data on their country of origin. My concerns were not addressed. Thereafter, it was the First Minister and Prime Minister who began attending COBR meetings.

242. Our testing capacity, as already stated, was very low at the start of the pandemic and significant work was undertaken in Scotland and across the UK to increase capacity. Until that capacity was increased it was not possible to test passengers. Pre-departure testing was implemented in January 2021.

243. I am asked to comment on why, on 12 March 2020, the advice to travellers arriving in the UK from category 1 countries to self-isolate even if they were asymptomatic and the advice to travellers arriving in the UK from category 2 countries to self-isolate only if symptomatic was withdrawn. The decision to withdraw, or even introduce such guidance, was a decision made by the UK Government and it was entirely their decision to make. Therefore, it was also their decision as to whether or not there was a legal requirement for travellers to self-isolate, as this is within their reserved powers. The Scottish Government role is very limited and there would be little consultation on such matters. There is self-evidently an interplay between border control decisions which are reserved to the UK government but which impact on Scotland, and the Scottish Government's judgement as to the necessary measures to control transmission of the virus. This is exacerbated when there is limited if any consultation by the UK government. However, that is the reality of the situation faced and it was the Scottish government's job in those circumstances to take what mitigating steps it could and continue to communicate as clear as possible to all those it represented. In this context, i.e. where UK Government was exercising reserved powers without consulting Scottish Government, the mitigating steps we could take were very limited and comprised largely of reinforcing public safety and prevention measures to all passengers arriving in Scotland. Scotland as a devolved nation cannot issue advice against all but essential travel with the same authority as the UK Government Foreign and Commonwealth Office. Those powers are not devolved.

244. In the early part of 2020, studies were not available to inform the Scottish Government where precisely outbreaks of coronavirus were coming from. However, it was clear that there was a significant outbreak in Italy, which we were informed of through the international contacts that our clinical advisors had, as well as what we were seeing generally in the media. As more international engagement took place, which was often informal between our clinical advisors and their senior contacts in Europe, further information became available as to the spread of the virus appearing as noted in Spain and France at that time.

245. On 5 July 2020, having received briefing from my officials with input from PHS. I outlined that quarantine checks had not been carried out on passengers arriving in Scotland from overseas (following the measures being imposed regarding two-week isolation requirement from 8 June 2020) because PHS officials had not been granted

security clearance to access the passenger details required to carry out these checks. The Scottish Government and its officials were ready to implement the isolation checks from the point that the rule was instigated. However, there was delay in this due to the Home Office process of providing clearance to access the information we self-evidently needed on the passengers who would be involved in the quarantine requirement. The Scottish Government was aware that security or access to home office systems would be required by suitably cleared PHS officials. Some PHS officials in certain roles have a level of security clearance given the nature of their role, so we understood that requirement and had every expectation that the UK Government, would ease that access, given their stated commitment to collaborative working. Unfortunately, this proved not to be as easy or straightforward as anticipated and significant exchange was undertaken with the Home Office (HO) to resolve the obstacles they considered to be in place and to do so at pace. My direct involvement in relation to this was discussions with Matt Hancock to attempt to expedite that clearance and my immediate contact with my own officials to remain up-to-date with the situation. It took around four weeks to obtain the necessary clearance from Home Office. It was not possible for the Scottish Government to resolve the issue any quicker than that, given authorisation rested solely with the Home Office. Clearly insufficient efforts were made by the UK Government since, as stated above, it took around four weeks for them to act and give my officials the necessary clearance. This was a situation easily foreseen by them at the outset, but not addressed for some time.

246. Informal discussion, in which Michael Matheson participated as the relevant Cabinet Secretary, took place during Summer 2020 in relation to whether stricter travel restrictions may be imposed, however, as I mentioned earlier in my statement, such restrictions would involve border control from outside of the UK into Scotland, which was a matter in the hands of the UK Government, and therefore we were limited in terms of any steps that could be taken.

247. Michael Matheson as the Cabinet Secretary was responsible for leading on this area and would be best placed to address matters relating to UK Border Control. I will outline below matters which I can speak to.

248. All restrictions to travel imposed by the Scottish Government were considered with care and were as effective as it was possible for them to be. The decisions taken by the Scottish Government in this regard were made in the manner that all decisions

were made throughout the pandemic, which was on the basis of scientific and clinical advice. This advice, which was for Mr Matheson and came from SG clinical advisers with input from our independent COVID Advisory Group chaired by Professor Morris, outlined that these measures were required. Where these decisions differed from other governments within the four nations, they were taken because it was judged to be in the best interest of controlling the virus in Scotland. I do not now have information to hand regarding the detail of the other four nations' decisions about borders.

249. My view is that decision-making with respect to borders, in particular borders in the sense of individuals coming into the UK from outside of the UK, did not work as well as it could have. These decisions were entirely in the hands of the UK Government and were undertaken with limited genuine consultation with Scotland. That decision-making would have worked better if it had involved proper and timeous consultation by the UK Government with the devolved nations, on the basis of the four nations being a partnership of equals.

Data and modelling

250. I believe I had adequate access to reliable data and modelling information, including from the private sector. I believe I understood the data and modelling information advice, including its limitations, which was made available to me. Data was disseminated to me daily, often twice daily and on occasion, more frequently. Information was provided to me about the number of people in hospitals, the number of deaths and whether these happened in care homes or hospitals. Additionally, I received daily SitReps related to PPE volumes in hand and on order and held and related to infection incidents and levels in adult residential care. All of this allowed me to monitor the situation across a range of areas and instruct action where necessary.

251. Advice was provided by SGCAG, CMO/DCMO, Chief Pharmacist, CNO, Chief Scientist (Health) and others as detailed above. In addition, officials provided a suite of statistics on a regular basis including modelling data, and wastewater data. These would cover issues such as transmission, infection, mutation, re-infection, geographical spread and death rates based on the best available data at the time. At a later stage in the pandemic, daily data on vaccine delivery was provided by officials focused on operational support and programme delivery modelling.

252. The systems for the collection and dissemination of data amongst the Health and Social Care Directorate, other Scottish Government directorates, NHS National Services Scotland and PHS were adequate at the start of the pandemic for a 'normal' situation. These systems also provided the foundation on which the Scottish Government and agencies could make the necessary updates to data collection, validation and delivery at pace in a pandemic situation. The systems were responsive to the understanding of the virus and were subject to constant improvement.

253. For my purposes as the Cabinet Secretary for Health and Sport, the mathematical modelling of epidemiological outcomes available to me was sufficiently reliable.

254. In relation to other factors, such as economic, societal, educational, non-Covid health related and mental health impacts, it is my view that the modelling was significantly improved with the introduction of the Four Harms assessment.

255. In relation to whether the impacts on vulnerable and at-risk groups were sufficiently modelled, these were considered in clinical modelling, especially in the way new and emerging strains of the Covid-19 virus impacted clinically vulnerable and at-risk groups. Other impacts on vulnerable and at-risk groups were picked up under the four harms framework. Impacts that were directly relevant to TTI were picked up by the Four Harms framework in the same manner as all other impacts, i.e. via direct feedback from third sector organisations, local government, COSLA and our polling work.

256. I believe it was an accurate representation of the reality of government decision making to refer to using 'following the science.' The Scottish Government relied on clinical and scientific advice to inform decisions made and I used this phrase on occasion.

Collection and sharing of data

257. My recollection and my understanding is that coordination, dissemination and analysis of data among PHS, NHS National Services Scotland, Scottish Health Boards, Local Authorities, the UK Government, and other devolved administrations worked well on the basis of their already established relationships. No specific areas of difficulty that were impacting on our response were brought to my attention.

258. The UKI has asked me to what extent did the collection and modelling of data relating to testing and tracing consider the impact of Covid-19 on at-risk and vulnerable groups and/or those with protected characteristics. The data from testing and tracing along with other information and factual data from PHS, our Local Authorities and those third sector and other bodies working with vulnerable and at risk groups all informed our decision making as far as possible.

J. Public communication

259. The following table details the campaigns delivered by Scottish Government Communications which were specific to behaviours linked to Test & Protect. It does not include more general campaigns which included Test and Protect behaviours alongside others such as face coverings, avoiding crowds, handy hygiene and physical distancing.

Table of Scottish Government communication campaigns linked to Test and Protect					
Start Date	**End Date**	**Campaign**	**Notes**	**Target Audience**	**Media Channels**
11/05/20	22/05/20	Health Information: Covid-19 Health Contact Tracer Recruitment	Recruiting individuals to work as contact tracers	General Public	Social: Facebook, Instagram, Twitter and local press platform
22/05/20	31/05/20	Test and Protect Eligibility for Testing	Public information on which individuals are eligible to be tested for Covid-19	General Public	Radio, digital and press
29/05/20	12/07/20	Test and Protect: Phase 1	Launch of Test & Protect service	General Public	TV, Video On Demand, Radio, Digital, Print and Press Partnership, Out of Home, PR.
22/06/20	27/06/20	Test and Protect: Phase 1 Door Drop	Mailer to all households on Test & Protect service	General Public	Direct mail to 2.5 million households
16/07/20	26/08/20	Test and Protect: Phase 2	Promoting the Test & Protect service	General Public	TV, Radio, Digital (Display and Social), Press Partnerships, PR
11/09/20	08/10/20	Test and Protect: Protect Scotland App Launch	Launch of mobile phone app to support contact tracing by identifying	General Public	TV, radio, press, digital (social and digital display)

			individuals who have been in close proximity to someone with the virus		
02/10/20	29/10/20	Test and Protect: Self-isolation	Campaign on importance of self-isolation if you have the virus or have been in contact with someone who has	General Public	TV, radio, press, digital (social and digital display)
02/11/20	15/11/20	Test and Protect: Protect Scotland App Phase 2	Campaign promoting contact tracing app, Protect Scotland	General Public	Digital only
14/12/20	10/01/21	Protect Scotland app 12+ capability launch	Protect Scotland app now available for those aged 12-15 (previously on for use by those 16+)	12-15s, parents/guardians	TV, digital, Young Scot partnership
16/12/20	24/12/20	Protect Scotland app	Promoting downloads of Protect Scotland app	All adults who did not have the Protect Scotland app on their phone	Digital only

27/12/20	10/01/21	Self-isolation	Public information campaign on why and how of self-isolation	General public	TV, Digital, Radio, Press
25/01/21	28/02/21	Protect Scotland app older phone capability	Promotion of Protect Scotland app	Those with older smartphone models, adults 50+	Digital only
12/02/21	31/03/21	Test and Protect: Self-isolation	Campaign promoting importance of self-isolation	General public	TV, digital, radio, press
05/03/21	31/03/21	Self-isolation	Campaign promoting the importance of self-isolation	All adults, upweight to 18-44 men	TV, radio, digital
15/03/21	14/04/21	Community Testing	Campaign promoting availability of testing services within the community	All adults, upweight to 18-44 men	Social media
26/04/21	31/05/21	Test and Protect: Asymptomatic Testing	Campaign promoting regular self-testing to identify those who have Covid-9 but no symptoms	General public	Radio/ social media

11/06/21	30/06/21	Universal Testing	Urgent activity to promotes testing following increase in Covid-19 cases	All adults, men 18-44	TV, radio, digital
01/07/21	02/08/21	Test and Protect: Asymptomatic Testing	Campaign promoting asymptomatic testing	General public	TV, radio/ social media
01/07/21	05/09/21	Test and Protect: Symptomatic Testing and Self-isolation –	Campaign promoting importance of self-isolation	General public	TV, radio, digital, out of home
01/08/21	08/09/21	Test and Protect: Back to school	Campaign promoting school pupils testing on a regular basis	Secondary school pupils in Scotland	Secondary school pupils in Scotland
13/09/21	29/10/21	Universal Testing - Reminder	Public information campaign on the importance of regular testing for Covid-19	All adults, young adults	TV, outdoor, radio, digital

260. The following paragraph was in the Module 2 DG Health and Social Care corporate statement, and may be helpful to the UKI (please note that the exhibit references have been updated):

"Public health communications in Scotland during the Covid-19 pandemic

The Scottish Government corporate communications team leads on all internal and external communication, working closely with communication leads in the other governments, executive agencies, statutory responders and key resilience partners. Further information on the role of corporate communications during the pandemic is provided within the Module 2/2A DG Corporate statement provided to the Inquiry on 23 June 2023.

A full timeline of material published by SG, including press releases, throughout the relevant time period, has been made available to the Inquiry as part of the Module 2/2A DG Corporate statement provided to the Inquiry on 23 June 2023 [JF7/061 - INQ000131057]. *The Module 2/2A DG Strategy and External Affairs statement provided to the Inquiry on 23 June 2023 describes the comprehensive guidance that was published for the general public and for businesses and other organisations.*

When officials are notified by PHS or by other public bodies of an incident or outbreak, the Health Protection Division take immediate responsibility for ensuring relevant policy areas, clinicians and communications leads within the Scottish Government, and where relevant Scottish Ministers, are aware of all the issues and are prepared to act as necessary.

During the specified time period the Scottish Government and HPS liaised closely during incidents. However, it was HPS, as public health experts, which led on communication with the public about high-consequence infectious diseases. Advice was also provided on NHS Inform. In addition, the Scottish Government, represented by the CMO, DCMO, Senior Medical Officers or the NCD often provided further communications to media requests. This was in the form of reassurance and explanations where necessary.

In all scenarios, the Health Protection Team worked to ensure both the Scottish Government and PHS communications were connected and that all messaging aligned in the public interest. Where the Scottish Government's communication lines were put forward, the Health Protection team sought clinical input from the CMO's team and other policy areas as required.

The Scottish Government's precise role in public facing communications varied, depending on the circumstances of the nature of the incident. Some communications were best dealt with as a purely clinical matter for HPS, in which case the Scottish Government's voice could have caused unnecessary confusion or undermine messaging. In other situations, proactive or reactive communication lines were required with the management of logistics including the availability of HPS and Scottish Government experts. HPS Management of Public Health Incident guidance on roles and responsibilities sets out the relationships, [JF7/062 - INQ000130954]*."*

261. The following paragraph was in the Module 2 DG Health and Social Care corporate statement, and may be helpful to the UKI (please note that the exhibit references have been updated):

"Monitoring the effectiveness of communications

A number of different tools were used to monitor the effectiveness of communications. A Covid-19 campaign tracker was set up in April 2020 to evaluate performance of marketing campaigns. This ran at cost-effective intervals to obtain post-campaign metrics for recent campaigns. Each wave consisted of a sample of c.500 adults (age 16 and above) across Scotland, with fieldwork carried out via an online omnibus.

Where appropriate this was supplemented with other data such as relevant website or social media analytics (e.g. parentclub.scot, gov.scot), calls to helplines, vaccine uptake and / or app downloads. Claimed use of First Minister's briefings as a source of information was monitored via regular opinion polling. Public access of key public health information on Covid-19 was continuously tracked using an online dashboard tracker for the NHS Inform Coronavirus Hub pages in English and in all translated languages and accessible formats.

Assessing the success of public health messaging

The regular opinion polling via YouGov described above was used to monitor attitudes and reported behaviour from April 2020 onwards. It monitored key metrics over time, including:

• Trust in the Scottish Government to work in Scotland's best interests in relation to the coronavirus pandemic

• Agreement/disagreement that 'I believe that the best thing to do in the current situation is to follow the Government's advice'

• Agreement / disagreement that I trust the advice and guidance from the Scottish Government to…. Stay at home, protect the NHS and save lives / Stay safe, protect others and save lives

• Agreement / disagreement that I think the advice from the Scottish Government is clear and helpful

• Agreement /disagreement that I feel clear about what is required of people who live in Scotland as the restrictions change

• Importance of protective behaviours / how well doing protective behaviours"

262. The following paragraph was in the Module 2 DG Corporate statement, and may be helpful to the UKI:

"Public health messaging *for different religious or faith groups*

The Scottish Government works closely with stakeholders to amplify campaign messages and communicate effectively to the whole of Scotland, encompassing all geographies and minority communities. The team worked closely with NHS 24, Public Health Scotland and third sector partners to ensure key public health information on Covid-19 was available in multiple languages (17 languages) and accessible formats via the NHS Inform website. The Strategy and Insight and Partnerships teams co-created materials specific to Minority Ethnic communities. For example, the Communications team worked with the Scottish Public Health Network (ScotPHN) to create a bespoke, printed Easy Read Version of the Test and Protect information specifically for the Gypsy/Traveller community, provided: [JF7/026 - INQ000348705]. *This was distributed by the Convention of Scottish Local Authorities (COSLA) to Gypsy/Traveller"*

263. The success of communications, outreach programmes and policies in increasing engagement and compliance overall across the population will have been monitored in the form of polling data relating to particular Scottish Government campaigns. However, as mentioned earlier we made a decision not to ask people if they were a member of a vulnerable group when they were being tested because there were concerns expressed to us that asking for this data would deter people from taking the action we needed them to. This meant that we did not generate data which showed which specific groups were being tested (or not being tested).

K. Lessons learned

264. It was clear at the outset of the pandemic that our NHS in-house testing capacity was inadequate. Notwithstanding the considerable and swift effort that was applied to significantly increase capacity in Scotland and as part of the UK wide effort, I believe that increased NHS Scotland core testing capacity and genomic capability should be secured in preparation for any future emergency that may arise. It may be that current work to introduce additional diagnostic testing as part of NHS recovery will provide this.

265. The UKI has asked me to provide details of any internal or external reviews or lessons learned exercises that you or the Scottish Government more broadly were involved with relating to any of the issues in Module 7.

266. The following paragraphs from the Module 3 DG Health and Social Care corporate statement appear to be the most relevant:

"In June 2022, the UK and Devolved Administrations Board (UKDA), a four nations board attended by officials from the UKHSA, the SG, the Welsh Government and the Northern Ireland Executive, commissioned the SG to lead on four nations 'test, trace and isolate lessons learned' activity. The Directorate for Population Health has overseen and led the work on behalf of the four nations.

This report was not intended to be a clinical review, or to provide evidence of the absolute impact on transmission of delivery models across Test Trace and Isolate (TTI). Rather, it was intended to provide a review of lessons learned to date. The framing of this activity was to consider a potential response in relation to high case numbers of Covid-19 in future where the clinical view was that the risk of population

wide health harm remained broadly similar to the assessment of the risks at that time.

The scope of this 'lessons learned' activity is to provide a collective view across the four nations on:

- *the efficacy TTI delivery models and their suitability, considering constrained budgets currently and reduced population-wide health risks;*
- *an overview of the various aspects of TTI and a literature review of the evidence base;*
- *an assessment of aspects of TTI as part of winter preparedness/contingency and how its deployment might support resilience of key workforce groups.*

To deliver this report, officials from Scotland, Northern Ireland, Wales, and England attended a weekly work group session between June 2022 and September 2022. Analytical input including the literature review activity and modelling was delivered by the Health and Social Care Analysis (HSCA) team within the SG, which led Covid- 19 Test and Protect analysis throughout the pandemic.

The draft report remains in progress with officials continuing engagement and work to finalise it. In September 2022, UKHSA officials notified officials from Wales, Northern Ireland, and Scotland that their view was that the paper would not be put forward to the UK and Devolved Administrations Board, following the reconstitution of that board and revised governance from November 2022."

267. However, as previously mentioned I stood down in May 2021 so my understanding of reviews after then (including the June 2022 review) is from outside Government.

268. Given that I stepped down as Cabinet Secretary for Health and Social Care in May 2021, I cannot comment on the legacy of the Test and Protect system in Scotland. However, as I have noted previously, it was built on a pre-existing testing and tracing system used by PHS before the Covid-19 pandemic and I would hope that that system, and the infrastructure of that system, has been consolidated and has the capacity for rapid scale up if required.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed:

Personal Data

Dated: 04 April 2025