OPUS 2

Scottish Covid-19 Inquiry

Day 30

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(9.45 am)

(Proceedings delayed)

(9.52 am)

THE CHAIR: Good morning, everybody. Good morning to you all. Right, you're going to get asked some questions -- well, I should be careful here. I'm not entirely sure how Ms Bahrami is going to deal with this but I suspect there will be some questions asked to you, whether singularly or collectively, I am not so sure. Over to you, Ms Bahrami.

MS BAHRAMI: Thank you, my Lord.

MS MANDY RODGERS, MS CAROL ANN CURRIE, MS MADEANA LAING and MR PETER MCCORMICK (called)

Questions by MS BAHRAMI

MS BAHRAMI: Good morning. Thank you for joining us. Please could you start off by each just briefly telling us what your role is and a brief background of ICHS, starting with you, Ms Rodgers.

MS RODGERS: Yes, my name is Mandy Rodgers and I'm the manager of Blenham House Nursing Home in Edinburgh, which is a City Centre 60-bed facility for frail/elderly clients.

MS CURRIE: My name is Carol Ann Curry. I'm a principal carer in Randolph Hill, Dunblane.

MS LAING: My name is Madeana Laing and I'm a care home manager and a registered nurse at Beech Manor Care Home in Blairgowrie. We're a 45-bedded nursing home.

MR MCCORMICK: My name is Peter McCormick. I'm the managing director of Randolph Hill Nursing Homes. We've got seven care homes across East Central Scotland and ICHS is a group of care home providers who came together to give evidence to this Inquiry.

MS BAHRAMI: Thank you.

Now, I want to start off by looking at guidance. Guidance -- well, it's in the statement that guidance would be received from Government, from the NHS, local NHS branches and the local Health and Social Care Partnerships. Is that correct?

MS LAING: Yes.

MS BAHRAMI: Firstly, how simple did you find the guidance to interpret from those various sources?

MS LAING: It was very -- it wasn't something that was particularly -- from my perspective, something that was straightforward or simple, purely because of the amount and the volume of guidance that was issued. It would change numerous times in a day. Often you would just have, you know, read and shared with staff one set of guidance and then, by lunchtime, there would be something else or it would be late on a Friday evening

when you'd been working all week. So the content itself wasn't particularly complex in some ways, it was just the sheer volume of it, and implementing that into a care home environment, which is very different from a hospital environment as well, was quite challenging.

MS BAHRAMI: Thank you. Following on that, the timing of it, in the statement it said that often it was a Friday evening, which meant that matters were left unaddressed until Monday, but also there was an issue in that sometimes definitions came up to two weeks -- up to a week later. What impact did the timing of guidance being issued have on staff at different levels within the care homes?

MS RODGERS: For us particularly, it's the dissemination of the information. You're getting guidance at -- often when people were turning their computers off on a Friday to go home for the weekend and, because of the importance of following the guidance in our environment, we felt we had to implement it as quickly as possible because, if for any reason something appeared to go wrong and we hadn't adhered to the guidance as quickly as we possibly could, then it might fall on our shoulders.

MR MCCORMICK: I think as well, as Mandy says, the guidance would quite often come out on a Friday but it would

often be announced in advance on the Thursday or the Friday, so everyone would know it was coming, and that information had been passed out to the general public, you know, so all of the relatives would come with an expectation that guidance that was announced on the Friday night would be implemented immediately. And quite often the sheer volume of it just took a long time to go through, so it might be a couple of days even to implement some of the simplest things.

But some of the things involved people like Public Health and the local authority, who were just as -- who had only received the guidance in the same timescale as we did. So we often had to send proposals to them for their approval before we could implement pieces of the guidance and they'd only received the guidance on the Friday night as well so they weren't ready. None of these processes were set up and running. So on some occasions -- not every one, but on some occasions we'd have the guidance on Friday but actually implementing it might be almost as long as two weeks later.

MS BAHRAMI: Yes. I want to ask you about that. Well, firstly, it said in your statement that the guidance -- and we know this -- wasn't numbered and changes weren't highlighted. A suggestion that you've made is that

guidance could be better numbered and more discrete changes within guidance could be highlighted using track changes. What kind of difference would that have made to you if it was quite clear what had actually changed?
MR MCCORMICK: I think there were so many different bodies issuing quite often the same guidance, so we would see guidance apparently coming out from Scottish Government or the NHS nationally and then other parties, like the local council, like the local NHS trust, would issue their own version of the guidance, sometimes with little differences on it. And we were reading documents that were 100—plus pages long to try and work out little tiny differences between one council area and another or one NHS area and another, and it just struck us that, looking in retrospect at least, it would have been really helpful if they could have just called something like "Care home guidance 1.001", the same way that computer software is numbered, so it would be very clear which document was which, because sometimes we'd get a document from the NHS nationally and then we'd get a document from the local council and we were having to compare them both to see whether they were the same document or a different document. I think, as you said there, it would have been helpful if the documents were quite clear in terms of what had changed.

They were often very large documents and you were reading through with the old one and the new one, trying to work out what the difference was. Again, you see this in so many other cases where you get documents from people and they highlight in one colour all the things that have been added and they highlight with another colour or with cross—throughs all the things that have been taken out, and that would have been much easier to work with.
MS RODGERS: Also the terminology —— it was called "guidance". It wasn't guidance. It was these were sets of rules that we had to abide by but under the umbrella of "Well, the guidance says ...". But the guidance was —— it was like, "If you don't follow the guidance, what's going to happen? It's up to you what you do but the guidance says ...". So we had to follow it strictly so that we couldn't be accused of not —— even if some of it didn't make sense to us.
THE CHAIR: Can I press you on that, please, and I appreciate you're not a lawyer so this is a little unfair. Would I be fair to interpret your answer as saying that you regarded yourself as obliged to follow the guidance?
MS RODGERS: Yes.
MS CURRIE: Yes.

THE CHAIR: Even though a lawyer might take a different view of the obligation upon you, you felt as a matter of practicality it was a binding obligation upon you?
MS RODGERS: Yes.
MR MCCORMICK: I think there were a number of inspecting bodies, the Care Inspectorate most obviously in historic terms, but also at times the NHS, et cetera, they would come in and do inspections and they were inspecting against that guidance and therefore you had to have an absolutely compelling reason why you weren't following it. I suppose, if you weren't following that guidance and something negative happened, then you would undoubtedly face criticism then.
THE CHAIR: Yes, and I suppose, taking it perhaps to an absurd extreme but logically correct, you would have been entitled, had the Care Inspectorate made a finding against you —— an adverse finding against you based on guidance —— to challenge that, of course, but I don't imagine any commercial organisation like yours is enthusiastic about requiring to get into challenges to decisions made by bodies such as the Care Inspectorate.
MR MCCORMICK: Well, I think in a lot of cases a lot of the decisions are made —— this is not a very linear process. You're making decisions against a wide range of different moving pieces and therefore an awful lot of it

can be based on people's opinions, so challenging it in a very practical way is quite difficult.
THE CHAIR: It is, yes. I understand that. That's very clear. Thank you.
MS BAHRAMI: Thank you.
I want to ask you about the implementation of plans from Public Health as part of the guidance. You mentioned that it could take up to two weeks for Public Health to approve these plans and in your statement you say that's simply because the infrastructure wasn't there within Public Health to deal with these more quickly and you've also said that they didn't get the guidance themselves until you had it, which made things more difficult. What was the impact on the care of the residents and contact with their loved ones of this delay because you also say —— sorry —— that it seemed to you that certain guidance was required by the Government to be implemented quickly, immediately, but, in reality, despite your best efforts, it was taking a couple of weeks. So what impact did that have on patient care and contact?
MR MCCORMICK: I think very much —— it was the way that certain policies were announced in a sort of public arena, typically on the television, and then the guidance would come out some time after that. But the

way it was announced —— and I don't think anyone said this specifically —— but the impression given at the announcement was that these things would happen immediately whereas in the detail that wasn't really the way it worked. So I think for families particularly perhaps, more than residents, they had an expectation that —— what we're largely talking about is a lot of time when the visiting rules were relaxed, and so families would come with an expectation —— you know, almost immediately people would start to come to the home and say, "Well, the guidance has changed and said we can do this", and it was quite a difficult job, wasn't it, explaining to people that, "That's what you heard on the television, however ... and essentially that's true but it's a more —— it's more nuanced than that and it's going to take a little bit longer". So people who hadn't been able to visit face to face, for example, for an extended period were obviously just upset and disappointed, you know, that that wasn't able to happen immediately.

MS LAING: I think as well with the visiting —— because when the visiting was re—introduced —— and obviously it was broadcast all over the news, essential visitors and things like that —— but the definitions were never particularly clear. So the way that I would —— you

know, I've said, "This is classed as an essential visitor", and maybe what you would have said could have been totally different.

I certainly know from my experience because there were several care homes —— although my care home is quite rural, there are several within a five—mile radius —— so one was doing one thing and then that word might have spread to the other and so on, so if the guidance, the definitions, had been more clear, it would have been a lot more easy to implement in my opinion as well.

MS RODGERS: With the visiting, obviously we'd an extended period where people weren't allowed in at all and then we could re—introduce it slowly. We had to have a visiting co—ordinator, booked slots, we couldn't have too many people in the building at the same time, and the guidance clearly stated that they weren't allowed to have physical contact with their own relatives, so having not seen them for months and months and months, had to stay 2 metres distanced from them. And how can we —— we can't police that. How can you stop a loved one hugging their own mother, you know? But if we don't try and enforce it and somebody brings the infection in and gives it to their mother, then how did it get in? It's my responsibility how that got in.

MS BAHRAMI: Yes, and I will come back to the various visitation issues. Firstly, what sort of plans did you have to get approval from Public Health for?

MR MCCORMICK: I think we had to —— it varied at different times, but, as an example, once the visiting changed that we could have socially distanced visiting —— that was one of the sort of earlier ones within the home —— you had to write out a plan of how you would meet people at reception, how you would manoeuvre them —— move them through the home to the place where the visiting would take place, how you would assist the resident to go from, you know, their rooms or where they were down to that area.

MS RODGERS: One instance, which was if someone was ill, somebody's got a very high temperature and you need to put a fan on them to reduce their temperature, we had to put a risk assessment in place for every resident who needed that. Another sort of bizarre example would be we needed to have a risk assessment if we wanted to put a Christmas tree up. We weren't allowed Christmas trees for the residents, which might have been their last Christmas. We had ridiculous posters of Christmas trees on the walls to try and make it look festive, but we weren't allowed a Christmas tree in case it spread infection.

MS BAHRAMI: Thank you. You said ——

MR MCCORMICK: I was going to say, just to finish, as I say, we put all those documents together to show all of that, how you would move people round the building, how you would clean afterwards, clean before, all of that type of thing, and then that was sent off to —— and it was different people at different times —— but Public Health or the local Health and Care Partnership, and then they would review that. And if you think about, you know —— excuse me —— a council area, they would have 60 —— in some cases 20, in some cases 60 care homes, who would all be doing that at exactly the same time. So even their resources in order to approve that, you would be desperate to get the answer back but you would be hearing that they would be looking at your one next Wednesday.

MS BAHRAMI: Yes, and in the meantime you would have family members who were challenging you on the way you were implementing the guidance?

MR MCCORMICK: Yes.

MS BAHRAMI: We heard before —— we heard last year from family members who were quite upset about this and said that they found themselves having to challenge care homes and some people —— now, this may or not be the case in this situation —— but some people stated that

they found they were having to inform care homes of the correct position and, once they were doing that, they were then getting access. Do you think that just that process of having to have certain plans approved created the impression perhaps that care homes weren't aware of the guidance when in fact you were trying to implement it and would do so as soon as your plans were approved?

MS RODGERS: Absolutely. We really wanted the relatives to come in but we had to do it in such a structured way to prove that we were heeding guidance and that we weren't putting residents at risk.

MS LAING: I think as well, often, when the visiting was back in place, there was the guidance that went alongside that, which was fine, but also, if a resident became unwell and was suspected to have COVID, Public Health would very often, certainly for our care home, say, "No, well, just shut your visiting off again". So people were getting to come in and visit one day and then, because one person who was isolating in their room was potentially -- who had COVID, then no one else got a visitor. And that didn't come from us, that came from Public Health, but I think for families that was really difficult to understand because they just became so confused because one day they could come in, the next day they couldn't. They didn't understand what

was going on, which would be frustrating if you were one of them.

MS BAHRAMI: Yes, thank you.

Now, you state that the care sector wasn't consulted by those setting the policy and guidance. Presumably you think that the care sector should have been consulted. What do you think the impact of that consultation could have been? How could it have --

MS LAING: I think, if the care homes were consulted in that, probably the guidance would have been a lot more easier to follow, it would have been practical. Some of it just wasn't practical for a care home environment, and it was no disrespect to the people who were writing it; it's just, if you haven't been in that environment, how would you possibly know? It's not possible to isolate people with dementia sometimes -- all these different things that were just kind of overlooked and very much focused on infection control and, "You must do this and you must do that", but these are people's homes. It's not a hospital setting, it's not a clinical ward and things like that. So if care homes had been consulted in it, there would have been a better understanding of what it's actually like to live and work in a care home.

MR MCCORMICK: I was going to say, I think earlier -- this

probably changed across the time that the pandemic ran and I think there was more consultation later, but certainly in that first year it felt like the care sector wasn't listened to. So I work with Scottish Care, who I think you heard from last week, and I think we very much felt in the first nine months of the pandemic that the sector wasn't really listened to. It's obvious in a public health emergency like we had here that the Public Health Department would be leading, but I think there is a very big difference between -- all of us were faced with various restrictions in our lives, and my daughter was in Aberdeen and I didn't see her for a chunk of time, but we were always fairly safe in the knowledge that I would see her at the end of this pandemic.

I think for people in nursing homes, many of whom are right at the end of their lives, that's not the same. That's not the same dynamic for them. And I think that wasn't -- it felt like it wasn't taken into account and it felt like the sector wasn't being listened to. And I think the impact on people in care homes was -- and their relatives was -- underestimated by being faced with quite the same restrictions.

And I also think, in the summer, after Easter 2020, restrictions were lifted for many of us and it took

a long, long time for the restrictions to be lifted on care homes and I don't quite know why that is. I mean, I -- on the one hand, they're vulnerable people so it was a more risky thing to do, to lift the restrictions, so that's understandable, but I think by not lifting the restrictions as soon, there were other negative effects that weren't really accounted for.

MS CURRIE: I think as well for the staff, the pressure of the staff with the policies and procedures that were put in place, especially working in a dementia setting, was just -- it wasn't possible and the staff felt the pressure of trying to navigate the policies and procedures and into the dementia, but with dementia patients it's very, very difficult. So people should have came in and worked in these settings and realised what worked in one doesn't work in the other, and especially with dementia it was -- the staff felt the pressure. They crumbled sometimes because they felt it for the residents, they felt it from their family, but also management and above us as well, that if we didn't get it right, we would get in trouble or we would be endangering the residents, and it was impossible some days to go by these policies and procedures that were put in place.

MS RODGERS: You really can't underestimate how it is for

someone with really advanced dementia to be confronted with all these people wearing masks and they can't see your facial expressions, they don't know who you are. We had some residents who didn't know what we looked like. They couldn't remember our faces. And people who walk with purpose —— some people with dementia just walk all day long. You can't keep them in one room and you can't stop them from going out and touching things, which was a potential spread of infection. And it was really difficult on the staff to keep a handle on all of that, particularly as we were very scared.

You know, everyone else —— the vast majority of people were working from home or furloughed. We were working in the City. I was driving to work every day as if it was Christmas Day. There was no traffic on the roads whatsoever. And of course we have our own families to think about. So we were going into a care home that had active cases of COVID and then going home to our own families and worrying that they were going to get sick.

MS CURRIE: Yes.

MS RODGERS: So it was a very heavy burden for a lot of the staff, especially if they had compromised people at home.

MR MCCORMICK: I think as well —— Mandy was just saying

there —— some of the guidance was just unrealistic. Some of the earlier guidance said that residents should be isolated in their rooms. As Mandy said, people who were walking with purpose —— many of the residents simply can't understand that instruction. So there was a huge pressure on everybody in the care home that we were meant to be following this guidance; what would happen to us if we didn't follow this guidance. And, frankly, there was no way it was possible for it to be followed in some —— in many cases actually.

MS RODGERS: I had one lady in particular who was convinced that her whole family had died of COVID and she was extremely distressed, and we had to phone them to come and stand outside in the street so that she could see them through a window. But she could see them but she couldn't speak to them or touch them or hold them, and it was —— for us, as care—givers, that's a really tough situation to be in, very distressing.

THE CHAIR: Mr McCormick, I think you were envisaging there, a moment ago, a patient —— a person living in the care home —— who is ambulatory but very cognitively impaired because of dementia. Such a person, how on earth do you stop them moving? I mean, you would be actually breaking the law if you locked them in their room.

MS LAING: There was just so little understanding to that.

When you had visits from Public Health and you would have a resident, like Peter has described, walking around the home, you would be told, "Oh, you'll have to do something with that patient. You can't have them walking about". Well, it's their home. They're entitled to walk about in it. But also, in terms of the cleaning and the guidance to do with residents touching things, I was actually told at one point from Public Health, for a resident who was very poorly in their room, to pack up all their belongings so it didn't spread infection. Not that I'd done that, but that was the kind of things you would have been faced with on a daily basis really.

MR MCCORMICK: I think, as Mandy said as well, for the first Christmas there was things like —— no Christmas decorations were allowed, and we got these posters put up on the wall, which were really a very second— or third—best option, but we had to do all sorts of things, like we were instructed to take down photos and things like that in residents' rooms. Now, none of the rest of us were faced with that in our lives.

THE CHAIR: Ms Bahrami.

MS BAHRAMI: Thank you, my Lord.

When you contacted the relevant Government department or Public Health to seek clarity or to

challenge certain guidance requirements, how supported did you feel?

MS LAING: I think it varied, certainly from my perspective. Sometimes there were two or three individuals at Public Health that, when I spoke to, were very helpful over the telephone, but it depends because a lot of the contact that you had was over the phone. They were obviously overwhelmed with their workload too. There were times where you would get conflicting information if you weren't speaking to the same person or you were actually telling them, "Actually, no, this is the guidance so why would you be telling me that?". It was conflicting but it wasn't always negative from my own view.

MS RODGERS: No, I would agree with that. Some of them were very helpful, especially with getting like lab test results back quickly and things. When that was established at the beginning, it was taking up to —— you would do a PCR test on maybe a poorly resident and you weren't getting the result back for seven to ten days, by which time the whole home could have been infected, but once that was up and running, it was much better.

MR MCCORMICK: I think when you're speaking to the various different departments, I think people generally tried to be helpful. I don't think any of us would deny that.

But it was quite clear that —— you know, this happens in all sorts of walks of life but it definitely developed in the pandemic. You would know in Public Health who you might phone to get an answer that you wanted as opposed to who you might phone to get a very definite "No" to something you wanted to do. So they were producing —— you know, just the same as all of us were doing, they were looking at the same guidance and coming up with different answers. But sometimes that went against us in as much as, when people from the NHS came in, they would quite often give us quite definitive statements of what they expected and weren't that open to some of the suggestions we had, and yet, you know, in other parts of the public sector you've got two people in the same role who wouldn't give you the same piece of advice, so it didn't always feel like an even playing field. But I don't think anyone was trying to be unhelpful, but that is how it felt from our point of view.

MS BAHRAMI: One of the lessons that you think should be learned is that there should be a readily available mechanism for challenging guidance and another lesson that you believe should be learned is the enshrinement in law of Anne's Law, which you state your group supports. What do you think would be the impact of

those two measures being in place?

MR MCCORMICK: I think it's quite difficult with the challenging —— it was difficult through the pandemic that we had certain people stating things very much as if they're —— they made the decision and there wasn't anything else you could do about it. It was also busy —— particularly in the early stages of the pandemic, it was very much day to day and sort of mouth to mouth —— hand to mouth, rather —— but it did feel unfair at times that there were decisions made that we felt were wrong and there was no real mechanism to ——

MS RODGERS: Some of the decision—making was directly —— it was mandated directly to us and didn't apply to anybody else, so there was an unfairness in how this guidance was applied. My example would be we had to test ourselves. If our staff wanted to work, they had to take a lateral flow test. First it was daily and then, later on down the line, we had to do two lateral flow tests and one lab test a week. That didn't apply to anybody else and it certainly didn't apply to NHS staff.

MS BAHRAMI: Okay.

MS RODGERS: So I have colleagues who worked in the NHS who never had to test. So I had the NHS Care Home Support Team come to my door in the middle of this and wanted to come in. First of all, I didn't know who they were.

Secondly, I asked them, "Have you taken a test today?"; "No". I said, "Well, why not?"; "Well, we don't have to. We're not mandated to do that". I said, "But we are and anybody who comes in here has to, even contractors, repair men, whatever", and I said, "But you don't?"; "No". I said, "Where have you just come from?". And they were standing there in their uniforms —— bearing in mind that we had to get undressed at the door, they had just been in another care home and come straight to my door, untested and wanted me to let them in, but I didn't because that was against the guidance, but I got a bit of a bad rep for that.

MS BAHRAMI: But essentially you were having to enforce guidance which required you to take every possible measure to prevent infection spread ——

MS RODGERS: Absolutely.

MS BAHRAMI: —— and you had the people who were coming to make sure you were doing that ——

MS RODGERS: Who weren't doing it themselves.

MS BAHRAMI: —— and they were posing a risk to your care home?

MS RODGERS: Yes.

MS BAHRAMI: So you had to stand up against that as well?

MS RODGERS: Hmm—hmm.

MR MCCORMICK: I think as well we said in —— I think we said

in our evidence that there seemed to be —— again, this is probably just how it felt from our point of view. I don't think anyone ever said this —— but it felt as if the NHS were considered the experts in every circumstance and that all of the expertise that was within the care sector was essentially ignored in the early stages. And so some of the groups that you were talking about, Mandy —— we know that the NHS teams were sent out —— were people that they just reallocated, so they'd never been in a care home before, they weren't infection control nurses, they'd been doing an entirely different job, and in a relatively short period they were sent out to care homes to do infection control audits.

MS RODGERS: They were staffed that had been redeployed from departments that had been closed because of the pandemic, like outpatients' clinics. I think one of the ladies who came to me was a cardiology outpatient nurse who was coming in to check our infection control practices in a completely alien environment to herself.

MS BAHRAMI: I'd like to move on now to staff working and the impacts there. There's mention of people's hands starting to bleed from hand—washing so much and other things. Can you tell us a bit about how the guidance impacted your working practices?

MS CURRIE: I think for the care staff we had to wash our hands constantly. We had hand gel on us, we had to wash our hands constantly, all our hands were broke out up to our elbows. We then had to wear gloves that water got into or chemicals got into sometimes and some of the staff actually had to wear dressings on their arms. Our home was quite lucky, we did have a couple of different types of gloves, but still , with the constant hand—washing, it was very hard on the staff. We had rashes, cuts, things like that.
MS BAHRAMI: Were staff still able to gather in staff rooms to speak to and support each other?
MS CURRIE: Not really.
MS RODGERS: We had to socially distance.
MS LAING: Yeah.
MS RODGERS: So four people could take a break at the same time in our staff room if they all sat in the corner, they would be 2 metres apart, so it was very difficult . Our staff are cohorted anyway in teams —— we were on three floors so we work in teams, so very much it was quite easy for us to keep our teams together, but of course you do get overlaps. If you're testing your staff three times a week, you're going to have people going off with asymptomatic COVID, which I suppose might be one of the reasons —— one of the drivers why the NHS

staff didn't have to test because they could have ended up with maybe a quarter or half their workforce off at the same time, which at some points in time we did; 12/15 people at a time.
MS BAHRAMI: Were staff having to work more days or hours than usual?
MS RODGERS: They had to cover for all their COVID colleagues.
MS CURRIE: Yeah.
MS LAING: When you had an outbreak within the staff room testing , if you had a staff group of 60, you could have sent 30 home, which then leaves 30 staff, so you're working with half your staff load and there's not —— you know, the local authority and things would say, "We'll be able to send staff from the NHS to come and support or from agency", but through no fault of their own they just didn't have that to send. So your staff that you did then have left worked additional hours and worked —— really worked themselves to the ground until that next batch of staff then could come back.
MS CURRIE: I know personally I was working six to seven days a week. We'd done sleepovers as well. It was just for the benefit of the residents because, if we went home, then who would then look after them? It would be them that would suffer. So I think the staff really

stood up —— especially in our team, we really stood up. We worked six/seven days a week, and it wasn't because we necessarily wanted to, it was for the benefit of our residents and our other colleagues. But we were completely, completely worn out.
MS RODGERS: The one benefit that I felt that we got from this pandemic was that, because we only had the residents and they only had us —— we were going home, work, home, work —— the sense of community really, really increased because they —— we were the only other human beings they were seeing. They weren't seeing their own families. And to the staff's credit , that has remained. So that is —— it's one plus point in that the sense of community and sense of belonging —— did you find that in your homes?
MS LAING: Yeah.
MS CURRIE: Yeah.
MS BAHRAMI: I think in your statement you actually say we were like soldiers marching forward together.
MS RODGERS: Hmm—hmm.
MR MCCORMICK: I think one of the other things worth mentioning is —— you know, as has already been mentioned, when there have been COVID outbreaks, there were times when you lost a group of staff, you know, because they had to then isolate at home. There were

certain other rules that probably came in with the best of intentions but didn't necessarily help that much.
So earlier on we were told that we weren't allowed to move staff between one home and another home and so, in that sort of circumstance, we might have moved staff from one home to another to sort of fill that gap but we were told we weren't allowed to do that. We also used to have groups of staff called our "bank staff", who weren't contracted. They would come in and work individual shifts . And again the same thing, we were told we weren't allowed to move them around the group. But at the same time, you know, the place of last resort is then to go to agency to get agency workers, but we had no control over where those agency workers would come from. So that seemed a bit of an incongruous decision that didn't make sense from looking at it from that direction . You could see it made sense —— if you had a surplus of people, not allowing people to move around would make perfectly good sense, but there wasn't a surplus of people before the pandemic and it didn't get better during it .
MS BAHRAMI: Thank you. I think there's mention of NHS bank staff . Were you able to make use of those?
MS LAING: No. I think when you had —— when we had a COVID outbreak, you would have daily Teams calls with NHS

staff and the local —— the Health and Social Care Partnership staff and you would discuss how many of your staff team were absent and what you were trying to do to find staff to cover for them. But they would all say, "But you'll need to find someone, you'll need to find someone", but they weren't able to give us anyone. But there seemed to be a lack of understanding that, if they can't —— you know, as the supporting bodies to us, if they can't help and we don't have anyone because they're all at home, where do you then find that person.

So I know, myself, as a nurse, you then often ended up staying because all my nurses were off sick with COVID and I was the only one that didn't have it, so you were the only nurse for several days to cover that because there is literally no one else. But there seemed to be a lack of understanding of "There aren't just people", if you know what I mean.

MR MCCORMICK: I think these NHS banks were sort of mentioned quite a few times during the pandemic. They were set up and available to help. But I've got a role as the branch chair of Scottish Care in the Lothians and so I speak to a lot of care homes and I can only recollect one person that actually used the NHS bank and it wasn't particularly successful. They had a problem weekend coming up, they were lacking a number of staff

and they phoned up. In the end they got one person for one shift over that weekend. The reality was they were down a significant portion. One person —— not that one person didn't help, but it was nowhere near the resolution. And so I think most care homes took the decision —— or were of the opinion, particularly after this had been going for a while, that it was an absolute waste of time to call. If you had a need, they weren't going to be able to help.

MS BAHRAMI: How did all of that affect staff's home life and well-being at home?

MS LAING: It was really, really difficult. I know for myself there was just me and my daughter at home, so she was able to continue to go to like school hub whereas a lot of everyone else's parents were furloughed, so they were getting to stay home with their children and do all these things that everybody else was doing. But you felt so guilty —— you felt terrible because you were putting her away to the school hub, you were working all these long hours and then, when you were coming home, you were exhausted, you were worried about passing the virus on to then her or to other people and not just myself —— I think I can speak for all my staff team —— they were so scared to go home because they were petrified of giving that virus to other people that they

lived with just so they could go to their work. It was really, really difficult.

MS CURRIE: I'm the same. It's only me and my son at home and I was working six to seven days a week, 13-hour shifts. Sometimes I was doing sleepovers and sometimes I just came home, said "Hi" to him, went in the bath, sat and cried, and then came back out and was trying to be jolly and not let him see how upset and exhausted I was so he didn't worry, but try and keep my home life as normal as possible and not let him see the stress with what I was going through so it didn't affect him. But it did. He did see through it.

MS RODGERS: My husband and I didn't sleep in the same room for three months. He was very frightened of getting COVID, so, yeah, it affected our home life because he —— but he was very supportive. He could see the strain it was putting on myself as the leader of the team because everybody brings —— not that they're bringing their problems, but you have to try and support all your staff and to be seen to be doing the right thing, following the rules. One particular story is my long-term deputy manager died just at the beginning of the pandemic, just before the lockdown, but her funeral was on the day where the new rules came out on funeral attendance and I couldn't go because, as the leader of the team,

I couldn't be seen to not be doing what the Government had mandated, which was really, really, really quite upsetting.

MS BAHRAMI: Thank you. On the point of sleepovers and having children, if a member of the team had young children, did that mean they didn't take part in sleepovers or did they have to find someone to stay with their child overnight, if they were a single parent?

MS CURRIE: Sleepovers were voluntary, as a member of staff. Nobody was asked to do a sleepover. It was staff volunteering. If they had looked at the rota the next day and seen that there was X amount of staff off, they would just put their hand up and be like, "Listen, we'll sleep over tonight, we'll crash in one of the spare rooms". Nobody was ever asked. It was staff just stepping up, wanting to do their bit, again for their colleagues and for the residents. It wasn't mandatory or anything like that. It was just staff wanting to help and to do their bit.

MS LAING: I know for me I didn't often do sleepovers, but obviously the school hub was only open until 6 o'clock or 5 o'clock so you did then have to find someone else because you weren't going to be back in time because the nurse was off sick or somebody else was off sick. So it was really stressful trying to sort that out. Then, of

course, your children are wondering what's going on. They're not going to school like normal, they're not seeing their friends and you're not there for them because you're having to go to your work and deal with all that. So, yeah, it was difficult to try and deal with it too.

MS BAHRAMI: Thank you. I'd like to move on to anticipatory care plans and DNACPR. With regard to putting in place anticipatory care plans, I understand you had to contact patients -- contact families and also have discussions with residents. What was the reaction of families on being contacted about that matter?

MS LAING: I think we've always had anticipatory care plans, so getting in touch to update those, you know, on the back of the GPs asking to kind of just as lockdown came into play wasn't something that was out of the ordinary. The difficulty you then had was, if the family member had said, "Well, if my loved one becomes unwell, not specifically COVID related, just with anything, and hospital treatment is required, then yeah, I would still like them to go". That was then the challenge because you weren't able to put them anywhere because nobody would take them.

So trying to have that conversation was really difficult and it wasn't one that -- I personally would

then put the families back to the GPs because that's not on me. That wasn't my call not to escalate that. But people were still wanting their care escalated but were being told by medical professionals that they couldn't get it.

MR MCCORMICK: I was going to say, DNACPRs are a normal part of care home life, I guess. There's always a discussion with people about whether -- you know, which route they would like to go. But I guess there was an impression that there was -- I'm not sure this is the right phrase -- but a push-on by the NHS to get more of these things in place.

In one of our homes, we received DNACPRs for all of our residents that hadn't already got one in place, and we had a bit of a discussion back and forward and we actually sent them back to the NHS. But, again, it goes back to what I was saying before, which is that's one of our homes out of seven, so there's quite different processes going on throughout the country. It wasn't a sort of unified approach.

But I also think -- and again we mentioned this before. I mean, the pandemic was very busy, there were so many things going on -- but I think there was a restriction in terms of access to care for people in care homes. I think that was a decision that must have

been made by the NHS, but that wasn't a discussion that was held in the full public light, and I think, had it been -- well, there would have been people with all sorts of opinions, but, you know, it seemed to be a decision that was made very low key, not very well publicised but was a reality of the first couple of years of the pandemic anyway, yeah.

MS RODGERS: Yeah.

MS BAHRAMI: On page 5 of the statement -- I think it's a section that you've commented on, Ms Laing -- you state that you were advised GPs had discussions with families about DNACPR forms and then subsequently all residents who didn't previously have such forms were issued with them. But despite being told by the GPs that these discussions had taken place, your impression was that that wasn't actually the case?

MS LAING: Yeah. I think --

MS BAHRAMI: Why did you -- what created that impression for you?

MS LAING: I think it was because it was very much something that was just rushed, so it was, "Update your ACPs, your anticipatory care plans", which was fine, and then it was, "You need to look at who doesn't have DNRs because they will now then need to have one". So when that was the discussion that was had with myself, I had said at

the time, "I can't make that decision, you'll need to speak to the families about that, but I can let you know who doesn't have one", because standard practice would be for the GP to have that discussion with the family member if the resident wasn't able to have that discussion themselves. And then, within a couple of days, you then did then get these outstanding DNRs that we didn't have previously. So you would question whether that was something that was done in conjunction with families because the initial conversation was, "It's just they need to have them now because they won't be able to go to hospital", because they didn't want to take them.

MS BAHRAMI: So essentially there was no nuance? The conversation you had was based on there being no nuance, no individual consideration, just that everybody --

MS LAING: Yeah.

MS BAHRAMI: -- in your care home who is resident there must have one of these?

MS LAING: Yeah, because they wouldn't be going to hospital if they were unwell.

MS BAHRAMI: I take it on that basis then you weren't asked about your impression of a particular resident's health and frailty as part of the consideration of whether it was clinically appropriate to put a DNACPR notice?

MS LAING: No, we weren't, and even when residents who did have COVID or maybe didn't have COVID, just became unwell, as people still continued to do throughout the pandemic, it was very much a cut and dry —— you know, you got advice over the telephone but you still —— you would have to fight very, very hard and challenge a lot to get someone admitted to hospital when you could clearly see that, if they went to hospital, they had a really good chance of improving, of getting over what was making them unwell in the first place. But it was almost like —— you were not playing God, but it was just, "No, you can't go, so you just have to stay", when you could have gotten better if you'd been given the chance.
MS BAHRAMI: And your understanding is the lack of ability to access an ambulance, paramedics or hospital was the reason for these DNACPR decisions being put in place?
MS LAING: Yeah.
MS BAHRAMI: Thank you. Had you ever previously experienced a time where every resident ——
MS LAING: No.
MS BAHRAMI: —— in your care home had to have this?
MS LAING: No.
MS BAHRAMI: Did the others on the panel have similar experiences or were any of you in a care home that

didn't have to approach this issue at all?
MS RODGERS: We always have DNARs in —— that conversation anyway, and I have a number of residents who don't have one in place but that didn't alter.
MS BAHRAMI: Okay. So in your care home you didn't have GPs contacting you saying that all your residents ——
MS RODGERS: We were told that there would be no hospital admissions but they didn't put any extras —— it remained a choice.
MS CURRIE: I can't comment on that, but I know that 99% of our residents do have DNACPRs. Whether that was contacted through —— I can't —— I'm not involved in that side.
MS BAHRAMI: Sure. Thank you.
MR MCCORMICK: I think, as I said, it would be the normal process that everyone would be —— there would be a discussion about the appropriateness of it.
MS RODGERS: Yes, everyone has that conversation.
MR MCCORMICK: But, as I say, in one case we were issued with blanket DNACPRs for all of the residents and, just as you said, that couldn't have been a nuanced discussion. There would have been no discussion involved in that.
MS BAHRAMI: Was your impression also that the reason for that blanket imposition was the lack of access to

ambulances, paramedics and hospitals?
MR MCCORMICK: Yeah, I don't know about ambulances and paramedics particularly, but I think it was the pressures of the NHS and, you know, a decision or at least a direction of travel which was to limit the access to hospitals for nursing home residents.
MS RODGERS: I think at the very beginning, when we had it tough, when we did have very sick people who did have COVID, one conversation was that they couldn't be taken to hospital because it would take too long to clean the ambulance, to dis— —— you know, to disinfect it, so they wouldn't be going.
MS BAHRAMI: I'll come back to that again. In relation to the DNACPR forms, Ms Laing and Mr McCormick, did you ever have conversations with concerned family members about these? Did anyone approach you challenging this?
MS LAING: We had family members, when their resident became unwell, COVID or not COVID related, who were concerned about why a GP wasn't necessarily coming to see them in person. And don't get me wrong, they did come out in person at times, but again overwhelmed themselves. So it wasn't that they didn't want to come. I think sometimes just their workload meant that they couldn't. But the family members would become concerned about why that —— after they'd been seen by a GP, but why are they

not going to hospital, and that's where the challenges would become, and because the family members couldn't necessarily get in touch with the GP directly to have that discussion, we were the ones who kind of took the brunt of trying to explain. And how do you explain that because it's not —— it wasn't our decision and you didn't necessarily agree with it, but we took the forefront of dealing with that really.
MS BAHRAMI: So the challenge about hospitals and GP care in general but not specifically about DNACPR decisions in your experience?
MS LAING: Hmm.
MS BAHRAMI: Okay. Thank you.
Do you recall how long the blanket ambulance ban was in place? I think you mentioned and you say in your statement that for a while there was a ban on ambulances collecting patients —— residents from care homes.
MS LAING: I think, as the pandemic went on, so after sort of the first lockdown and into maybe towards near the end of the second, we did have a few residents who did —— probably just before the vaccine roll—out, we did have a few residents who did go to hospital, but that was quite a long time after it started really.
MS RODGERS: Yeah, months.
MS BAHRAMI: Months. And you mentioned that there were

times where a particular resident —— your impression was that a particular resident had a good chance of improving if they received hospital care but that wasn't allowed. Do you think that that led to otherwise preventable deaths?

MS LAING: I don't think you could really answer that in all honesty, but you know yourself from working in that environment, when people are poorly, COVID or not COVID related, if they've had courses of oral antibiotics or treatments for things and are improving a little bit but not quite improving the way you would want, if the family —— that was their wishes for escalation of care —— then in any other circumstance their care would then be escalated to hospital to try IV therapies or, you know, different kind of interventions that in a care home setting we just aren't able to do that. You couldn't really probably 100% say, but I would like to think that, yeah, you probably would have been —— some residents who would have gotten better if they had the opportunity to go to hospital.

MR MCCORMICK: Yeah, I mean, over any one person you can't really say but over a number of people it must have made a difference.

MS BAHRAMI: Thank you.

Ms Laing, I think it was you who said that you were

able to get GPs into your care home.

MS LAING: Yeah, they came in.

MS BAHRAMI: Did others have the same experience or ...

Ms Currie, in your experience the GPs didn't ——

MS CURRIE: No, we didn't get any GPs in. We consulted with GPs over the phone and nine times out of ten, regardless of what the resident's symptoms were, they were prescribed just—in—case medication. We really, really struggled. I think it was months and months before we got a GP into our home.

MS RODGERS: We were fine. We have a very good GP service and they supported —— without their support —— you know, they were really on it from the very beginning in terms of testing and trying to stop the spread.

MR MCCORMICK: I think again, as I said before, there's quite a mixture of reactions, so with seven homes there were seven different GP surgeries, some of whom didn't come, some of whom did. They were all available —— I think they were available on telephone, et cetera, so it wasn't a complete cessation of service, but it was delivered in quite different ways.

MS BAHRAMI: You mentioned that often all that would happen was that just—in—case medication would be prescribed. If it was something more mild, were you able to get things like antibiotics and mild treatments?

MS CURRIE: Yeah, we would be able to —— yeah, they prescribed antibiotics, but nine times out of ten, if a resident didn't get better from that, it was just—in—case that was prescribed.

MS BAHRAMI: Thank you.

We also know that allied health professionals weren't able to visit care homes and it's mentioned in your statement that other external activities also had to be diminished, and all of this would have impacted the quality of life for residents and their mental health. Were your respective care homes able to mitigate this in any way?

MS RODGERS: Yes, I became a very good YouTube hairdresser. I can do the YouTube bob, so all our old ladies had the same hair—do for a while. But apart from that, things like chiropodists and dieticians —— we could access other people outside and we just had to make do and mend really and do some —— most of it ourselves.

MS BAHRAMI: Yeah.

MS LAING: I think it was really difficult because, certainly in our care home, we have musical entertainers in every week, we have school children that —— primary children that come in every week for the whole day on a Friday. We have so many different things that there's just no way that you can mirror that, especially if your

own staff team is depleted because they're all ill. So your residents did become —— through no fault of your own and through want of trying, they did become isolated and they became lonely because there was not as much mental stimulation. If you're having to sit in your room, how can you —— it's just —— it's not practical, so it just became something that was a very fun and lively environment to be in with a lot going on to just nothing.

MS RODGERS: We were going round —— particularly when the residents were sort of stuck in their rooms, we were going round the home with a karaoke machine and standing outside their room and saying, "Right, what song would you like?", and that was the best that they got. And, to be honest, because they were in their rooms for so long, when they were allowed back out again, some of them didn't want to come out. They'd become accustomed to being by themselves and isolated and sort of we had to shoehorn them back out of their rooms to be social animals again.

MS LAING: Yeah, they'd forgotten how to socialise, I think.

MS BAHRAMI: And the lack of allied health professionals attending, did that cause your workloads to be increased as well?

MS RODGERS: Absolutely. Absolutely.

MS BAHRAMI: Okay. Do you have any thoughts on alternative measures that could be put in place in the event of another pandemic to try to mitigate the impact of some of this, the attendance of allied health professionals?
MS RODGERS: I think it was all very well intentioned. It was to protect these very vulnerable elderly people, but —— it was well intentioned but heavy—handed. Of course we saw what was happening in care homes in other European countries, you know, what happened in Italy and Spain, where they were really hit hard, you know, and all these —— and I think they were trying to prevent that happening here. So I know where that was coming from, but it was the lengths that we went to. It lasted too long and it was very unrealistic and I —— in some respects we felt a bit got at because there were rules applying to us that didn't apply to anybody else. And it really impacted on our residents because some of these residents, it's the final years of their lives to spend with their families and new babies had arrived that they'd never seen. So I think there will be a lot to learn from what we went through as a nation and hopefully not have to suffer it all again.
MS CURRIE: Yeah, I would just like to say that as well. I mean, especially they should go into a place and learn different policies and procedures don't work in every

different care home, and I think, for me, the one that struck me the most was at the end of life, families not being allowed to come in and see their loved ones at the end of life. You know, they were allowed in at the very, very end, but they missed out on precious moments. They missed out on telling their loved one that they loved them when they were conscious enough to understand it and to hear their loved one's voice back saying that.
So, to me, it would be revising —— especially if this was to ever happen again, it would be the end—of—life contact and things like that because, for me, that was the hardest part, refusing relatives that were banging on the door, wanting to come in and see their loved one at the end and refusing them entry. To me, that will stay with me forever.
MS BAHRAMI: I will come back to those issues, but in relation to allied health professionals, do you think, for example, certain professionals having virtual sessions could have made a difference if they were, you know, examining by video and perhaps attempting to guide you through processes such as —— you know, podiatry processes ——
MS RODGERS: You couldn't do that virtually.
MS BAHRAMI: No, but if they were to try to guide you through that, for example?

MS LAING: I think in theory that would work well, but if you were in a similar situation, again you would not have —— the likelihood of having the staff to take off to go and watch these videos would be very, very difficult, so it would have to be something that was all done in pre—planning of something like this happening again.
MS BAHRAMI: The situation I had in mind was more a video consultation between, say, a podiatrist and a resident, with a staff member there to facilitate the examination and then perhaps to take practical steps guided by a podiatrist or is this not something you would be comfortable ——
MS CURRIE: We are not allowed to undertake any podiatry work due to, like, nerve endings and things like that in people's feet, so we're not allowed to do that in our home anyway.
MR MCCORMICK: I suppose to some degree as well it seemed like a lot of these services stopped entirely from our point of view, and I think, as everyone is saying, the workload in care homes is already higher, so being able to do these things by video —— and some of those things did happen to a degree —— but it couldn't really replace it entirely.
So I'm not sure that —— it did seem to a degree that

some NHS services were switched off for an overly long time, almost like what were we saving them for if they weren't operating anyway, so perhaps with —— particularly once the initial problem with PPE had been overcome, perhaps they could have come out sooner rather than taking so long before things were reverting back to normal.
MS BAHRAMI: Yes, thank you.
Now, moving on to end—of—life situations, we've heard that some care homes didn't have sufficient supplies of oxygen and just—in—case medicine. Was that your experience or did your care homes always have sufficient supplies?
MS RODGERS: We didn't have oxygen.
MS BAHRAMI: Okay.
MS RODGERS: So that needs to be —— we can't even access oxygen therapy through the GP. That needs to come through a consultant in respiratory medicine. But we were getting our antibiotics and things no problem at all. But I would say that we did have COVID deaths in our nursing home but far more people got COVID and survived it than succumbed to it. And just like the rest of the general population, we had numerous asymptomatic COVID—positive, like myself. The only time I got COVID was through a mandatory PCR test and

I wasn't unwell at all. So you get two or three cases in the home and you had to test everybody and you wouldn't have known that half of them were positive.
MR MCCORMICK: I think there was a lot of difficulty during the pandemic, though, with established NHS procedures and how to deal with them in a different scenario. So things like —— you talk about oxygen. There was lots of consideration of, "We've got all these various rules in place. Can we throw them out or how do we go around that?". And I think it took a long time for a lot of those to work their way through the system as well, yeah.
MS BAHRAMI: Thank you. Now, in a section of the statement on page 13, it says that black bags were being used for gathering people's belongings after they died. We heard from relatives last year who were quite upset by this. They weren't a fan of those bags being used. What had been your practice before the pandemic and did the guidance require you to use a single—use bag for belongings?
MS LAING: So pre—pandemic families would normally come into the home and they would pack up belongings and take what they wanted to take and have time with their families to do that. Certainly during the pandemic they weren't allowed to come in to do that, so I think each home

would have used —— I don't know about the bag comment —— but certainly I know from our home, if we had boxes or things, we would just box it up —— or suitcases —— and put it into that. But the guidance, if I remember correctly, would have said that it had to be put in a bag of some description for infection, I should imagine.
MS RODGERS: Because it had to be single use so they could take these things home and isolate them for 72 hours before they did anything with them in case there was —— in case there was infection on them. There wasn't really very much that we could do. We weren't allowed to let the people in to come and clear the room.
MR MCCORMICK: I think that's the fundamental thing, isn't it? In the past people would come in and collect belongings, et cetera, and for a period of the pandemic that was just entirely stopped.
MS RODGERS: And it was awful actually, you know, just handing people's belongings over at the door. It's not a very nice feeling at all.
MS BAHRAMI: But it's not something you were choosing to do.
MS RODGERS: Absolutely not.
MS BAHRAMI: You were obliged to do that.
Moving on to visitation, your care homes locked down prior to the national lockdown. Were you ——

MR MCCORMICK: I think there was a difference between the different care homes.
MS BAHRAMI: Was there? Okay.
MR MCCORMICK: Yeah.
MS BAHRAMI: So which of your care homes locked down sooner and which didn't and why was there that difference?
MR MCCORMICK: In Randolph Hill we didn't choose to lock down sooner. I think Scottish Care had put a notice out a couple of weeks ago suggesting —— a couple of weeks before —— I don't think it was saying that you had to lock down but it was suggesting that it might be an idea. I think in our internal discussions we felt that visiting was so important, we were frankly hoping that it wouldn't actually come to this. So we locked down as a company when we were mandated to —— you know, when the UK Government and then the Scottish Government announced that we had to do that, yeah.
MS LAING: And we didn't fully lock down prior to the national lockdown but we did start to scale back some of our entertainers. And the visiting, as in family members and things, we didn't scale that down until it was the national lockdown and we were told we had to. But in terms of other people coming in, sort of your hairdresser or musicians, we did start to try to scale that back a little bit earlier along with the visiting

children, just to try and help really.
MS BAHRAMI: Thank you. Did your care homes lock down sooner?
MS RODGERS: We were part of Peter's group so we did it when we had to.
MS BAHRAMI: Okay. When things moved on and garden visits started, how did you find managing those actually?
MS RODGERS: We just had to be very adaptable. We had to redeploy staff to be guards, to make sure that the people who were coming in were tested and that they weren't getting too close because, if we got an outbreak, it would be because we didn't manage it properly, which was —— we were very fearful of that, that if we got an outbreak it might be construed that we weren't being vigilant enough whereas —— but the garden visits, they worked really well actually to start with because people were so happy to see each other.
MS CURRIE: I think as well, the garden visits, because they were outside, I think it felt to the relatives a little bit more relaxed rather than being stuck in a room face to face. It was outside and —— yeah, I agree, the garden visits worked well. The relatives were just so happy to see their loved ones.
MS BAHRAMI: Was then moving on to indoor visits more demanding of your time, resource?

MS RODGERS: Very much so. It was a bit like a hairdresser's booking sheet. We couldn't have too many visitors in at the same time, so people were ringing up to book a half—hour slot and they had to test before they came in and not —— and wear a mask, going to the room, around the building. But, to be honest, people were very, very kind to us and very compliant and they just went with the flow. As long as they were kept informed —— we did big group emails and —— like to tell everybody what was going on. But, yes, so we had visiting co—ordinators and people who —— and some of our visitors weren't able to test themselves, so elderly people, you know, coming to visit brothers and sisters, so they would take them into a little room and make sure that they weren't infectious before we let them in.
MR MCCORMICK: I suppose most people were happy to see visiting opening up so that would be the general idea, but, again, some of the things we talked about earlier were definitely issues. People were taking their own interpretation of what the rules were and not everyone was —— not every visitor was happy.
MS RODGERS: No.
MR MCCORMICK: There were various times when people were very unhappy and we had to in effect police the system, which is not a role we'd have wanted to do.

MS RODGERS: A few visitors who were very anti—vax or anti—mask and we were like, "This is what we've got to do. You can't come in unless you do".
MS BAHRAMI: How did you interpret or deal with essential visits and end—of—life visits and did you have a lot of push—back from relatives?
MS RODGERS: We interpreted essential visiting when it was allowed, something —— it's not always end of life because, if someone is in a very distressed state and very confused, very not well, I would interpret that as an essential visit —— if it's for the benefit of the resident who is distressed, not just dying.
MS LAING: Yeah, I would agree. The essential visiting, in some ways, because it wasn't particularly well defined, was an easy way around being able to let families come in because you would say, "It's an essential visit and people's mental health is just as important". So all residents' mental health was impacted during the pandemic, so when we were able to have essential visits, we would say, "It's an essential visit for their mental health because they're feeling down. They haven't seen their family". But, again, I think everyone's interpretation of it was different, but it did mean you could have people coming in.
MS BAHRAMI: Thank you. How did you find balancing the

requests or demands of those who wanted more restrictions put in place to safeguard their loved ones with the requests or demands of those who wanted more flexibility to spend time with their loved ones?
MS LAING: I don't really think we had anybody who wanted more restrictions ——
MS RODGERS: Yeah, we didn't either.
MS LAING: —— for their loved ones. They just wanted to come in to see them and for their lives to go back to the way they were before, I would say.
MS CURRIE: Yeah, we were the same. We never had anybody that wanted more restrictions. It was —— they were begging us to ease the restrictions.
MR MCCORMICK: I was going to say, I think there were a few people who we encountered who —— they weren't particularly asking for more restrictions but you could see in their actions that they were looking to be as —— take as little risk as possible. So there were some people throughout the group who continued to do window visits after visits in the home were allowed. They were probably a minority and they're generally quite a quiet minority, but I think we just need to be a little bit careful we don't forget about them entirely. But I think by and large most of us in the public as well as most people with relatives in care homes were looking,

you know, for restrictions to be lifted as soon as it was practical.
But, as I say, I do think we were a bit slow in lifting the restrictions within the care home sector. I think we all had more freedom to act in our own sort of personal lives, particularly in the summer of 2020, than nursing home residents and their families did. They were faced with restrictions that lasted longer, more burdensome restrictions, and things that most of the rest of us didn't encounter.
THE CHAIR: You've got ten minutes, Ms Bahrami.
MS BAHRAMI: Thank you, my Lord.
My Lord, I think we started ten minutes later than scheduled. May I be permitted to ——
THE CHAIR: You may be right. I don't know. Do you know by any chance? All right. I didn't pay any attention.
MS BAHRAMI: Thank you, my Lord.
I want to move on to testing. On page 8 it's stated that it took three or four months for a testing regime to be fully put into place. During that time, did the lack of testing lead to any issues? Did it add to anxiety and concerns for either residents, staff or families?
MS RODGERS: The staff team, they were very reticent. Nobody is used to testing themselves, even us as nurses,

so it became very onerous because we felt we were required to prove that all the staff were testing when they should be testing so it was -- and then recording because the powers that be can go on to Turas and have a look at -- well, not Turas. It was something else, wasn't it? -- to look and see that people are being regularly tested, so we did feel under scrutiny; "Have you tested? Have you tested?", every day.

MR MCCORMICK: I think it's difficult to look back -- we're looking back more than three years now, but I think in the early stage, I think everyone was quite worried about COVID and the risk of catching it. As you said earlier, we're all going into work every day and meeting far more people in that environment than most of the rest of the population were. So I think it was a worry in the early stage that there wasn't -- that there wasn't testing available.

I think it's difficult to be critical because this was a new -- it took time for all this to fall into place. I think, if you look back, the fact it took three-odd months was probably not -- was surprisingly good actually. But nevertheless in that period of time everyone I think felt very exposed.

I mean, we bought 50 tests as a company early on and we hardly used any of them because it was quite clear

that -- it cost £5,000, I'm not sure we could have got more, but we brought them in as a precaution. But we soon realised that actually the only effective way to use them -- we'd have used all of them overnight frankly and then it would have given us a momentary -- it was 600 employees, 50 tests -- it would have given a momentary snapshot of something and then nothing thereafter.

MS RODGERS: In our environment, if any of the staff were unwell, we had to phone up and book an appointment to go to an external -- the drive-through and get our nose poked and then wait for the result, and if we weren't positive then we could go to work and if we were, obviously we couldn't. So once the test kits came through, that made everything much more simple for us. We could just test ourselves.

MS BAHRAMI: Yeah. And on page 9 in relation to transfers from hospital, it stated that the NHS was not as rigorous in testing patients as they should have been. Could you expand on that?

MS RODGERS: People were being discharged without -- we had to ensure that they were -- to say, "We will not accept them unless they've had a negative COVID test". So it wasn't so much that they weren't being rigorous. You just had to remind them all the time.

MS BAHRAMI: Okay, because there was a possibility that they would discharge someone without a test?

MS RODGERS: Yes.

MR MCCORMICK: I think you have to remember that everyone else has their own pressures. We see that all the time. Even in the current environment hospitals are looking to discharge patients because they need the space for other people and the people in the social work departments are under pressure to move these people from hospital into care homes or into another environment, and I think that continued throughout the pandemic. I think there were multiple instances where a discharge was arranged and you would speak to the hospital and say, "Have you done the test?", and I think there were instances where you were told they had and, when you asked for evidence, they didn't have it and so we had to wait a couple of days until the test came through. There were other examples where they would say, "Oh, no, we haven't done it", and they went and did it.

It's quite difficult to pin that down from this point of view, what percentage that was, but it undoubtedly happened. I mean, does anyone -- yeah, so it undoubtedly happened, both from within our group and from other care home operators I spoke to. I doubt you could find many care homes that wouldn't have said they

didn't find individual examples of this happening.

I think, apart from the risk of passing the virus, we felt we were under a microscope with the various people coming in and inspecting us. They would have criticised us quite heavily if we'd knowingly brought somebody in without a test regime being followed through, and yet, just as we said there, it was not followed as rigorously as it should have been.

MS BAHRAMI: And that added pressure to your work --

MR MCCORMICK: It added pressure and it added a huge degree of risk for all the residents and all the people working in the care home.

THE CHAIR: You've actually got 11 minutes. I'm sorry to steal three minutes from you, but at 11.22 the stenographer's 90 minutes will run out. Sorry to hassle you.

MS BAHRAMI: No, thank you. On page 23 you state that you had to advise three organisations of a positive and subsequent negative test. Which organisations were these and why did you have to notify them separately? Could they not create a system?

MS RODGERS: No, it wasn't all joined up. So for each positive COVID test for each resident and each member of staff, we had to inform the Care Inspectorate, the Edinburgh Health and Social Care Partnership and

Health Protection. Then, when they had completed their isolation period and were no longer deemed positive, we had to notify again to close that notification, so the dates of a positive test and then the dates when the isolation ended. It was very onerous.
MS LAING: And that was the same in Perth and Kinross. Although we're two different areas, there was the same process.
MR MCCORMICK: I think this is very much par for the course for the sector. Prior to the pandemic, we already had situations like that around adult support and protection. From our point of view, you would have thought, if we were informing the Care Inspectorate and it needed to be notified to the local social work department, the local health department, they would have a system that allowed that to happen. But prior to the pandemic, that wasn't the case and then, during the pandemic, with COVID tests, equally that was the same thing. We weren't able to inform one part of the public sector that would share that information. It had to be done —— and often they would ask the same question but slightly differently as well. It wouldn't be —— it wouldn't be a matter of just filling out one form and sending it to three different people. You'd have to do it in three different ways.

MS RODGERS: We still have to do a daily notification now and declare any COVID cases, but that's just become routine. It was something we didn't have before the pandemic and it's been set up and we have to —— we do that routinely every day now.
MS BAHRAMI: I want to move on briefly to PPE. Three of you give accounts that you experienced no issues in obtaining sufficient PPE but one of you give an account that you struggled at the outset.
MS RODGERS: Yes.
MS BAHRAMI: Can you tell us what factors contributed in you being either able to source PPE readily or struggling with that?
MS LAING: I think we were quite lucky that we were able to source a lot of PPE. Our property manager for the group had went and sourced all this before the lockdown had actually come into force, so, yeah, we were really quite fortunate that they were able to get all that. And I guess maybe as well —— you guys are Edinburgh City Centre. We're quite rural so maybe there wasn't the same demand where I was potentially as what there would have been to here.
MS RODGERS: Yeah, we don't routinely —— before the pandemic we wouldn't have routinely kept lots of mask. Obviously other PPE, gloves and aprons, we wear all the time, but

masks were quite difficult to get at the very beginning, but once we got them, then there was a good supply.
MR MCCORMICK: I think like a lot of the things that we're talking about here, it was the first three months that were really very, very difficult. Prior to the pandemic, as Mandy said, we would use gloves and aprons and other bits of PPE. We generally didn't use masks ——
MS RODGERS: Not often.
MR MCCORMICK: —— very frequently. When the pandemic came in, suddenly there was changes in rules that we had to use all of these items far more frequently than we did before, and we all remember the television reports. You know, there was —— most of these things, for good or ill —— and it certainly caused a problem at this time —— most of these things are made in the Far East and they were being swamped by demand from not just us, the whole world frankly, and so it was very hand to mouth in the first three months. We never actually ran out of PPE, but we were often worried —— you know, we'd often be sitting here on a Monday thinking delivery was due on a Thursday and nobody was quite sure whether it was going to turn up, that type of thing.
You know, the production of all this stuff ramped up quite quickly, so after three months it really fell away as being a day—to—day problem, but at the beginning it

felt like it was just a constant worry. I think earlier on alcohol gel had never been used in such volumes either, and earlier on in the pandemic the people who made alcohol gel had all furloughed their staff and then they started bringing them back once they were told, "No, you need to be back", but actually the next thing that happened is that the people who made the bottles had also furloughed their staff and nobody got them to come back, et cetera. So there was —— so it just took —— it took a little bit of time to settle and in that first three months I think it was very much —— it wasn't so much that we ran out but it was a huge worry about where we would get things. And there were certain things that we frankly never used before, like visors, and we got them from —— I think it was Edinburgh University, one of their departments made them, until they became —— until they started ——
MS RODGERS: Yes, and there was a company in Northern Ireland that used to make blinds and they started making visors instead and we got some cases sent over from them. It was just getting them where you can find them. Eventually there was a rolling programme and actually the Health and Social Care Partnership had a hub where you could just phone up and you could get supplies really easily, but at the beginning it was sort

of quite difficult .
MR MCCORMICK: I suppose one of the things as well —— and I think this came from one of your comments in your statement earlier , Mandy —— is, you know, the PPE we used at the end of the pandemic was quite different to the PPE we used at the beginning. So, I mean, guidance changed across that period, but I think the level of protection that was offered later on with the things that people were using was more. So earlier on people were probably more exposed to the risk of catching it .
THE CHAIR: Five minutes.
MS BAHRAMI: Thank you, my Lord.
And what challenges did you face when you had to wear extensive PPE? At points I understand you had to wear shoe coverings and gowns and masks, visors and ——
MS CURRIE: I think for the care staff, during, for instance, personal care, where you're helping a resident , for instance, shower, it would be quite dangerous for staff because you had the shoe coverings, you had a wet floor, you were slipping , steam from the shower was in your visor so you couldn't really see that well , which posed a risk to you and your resident. Also putting on and off the PPE took a lot of time, and I think especially , for instance, if you went into somebody's room and they were maybe being sick and you

were having to then rush and get all this PPE on and things like that, it did take that little bit of time and was quite a stress for the staff as well .
MR MCCORMICK: I think, as Mandy said earlier, imagine that from the resident's point of view, particularly somebody with dementia, where it's quite difficult to explain why somebody is coming in almost looking like a spaceman at times.
MS RODGERS: Yeah. Care homes are warm places. They have to be nice and cosy for the residents . If you're working a 12—hour shift and you're expected to wear a mask the whole time —— so we were saying to staff, "Go and take five minutes. Go outside, get some fresh air , take your mask off", because it's unreasonable to expect people to work in those circumstances without some respite from it .
MS BAHRAMI: I'm very conscious of time and there are certain things that I would have liked to cover more if we had more time, so at this point really is there anything that we haven't covered that you would like to comment on?
MS RODGERS: There's one thing I would like to say and it's that we found, where our nursing home is, that the support of the local communities was invaluable to us. We were very, very well treated , and people leaving

presents on the doorstep for us, local bakery —— people who couldn't work —— the local wagon who does the bacon rolls in the morning were sending us round our breakfast, children sending letters to the residents and drawing pictures. And I don't think —— it was really surprising . They would watch us going into work and coming out and it was nice to know that they were thinking about us.
MS CURRIE: I guess I would just like to say, for all working through the pandemic was absolutely horrific and will never ever leave me, I think the support of the staff and the camaraderie and things like that, the teamwork, it really shone through. As well for the residents , what the staff done, outwith their working time, stayed behind, sat with residents and supported them, that was a highlight.
MS LAING: I think for me it would be that, if anything was going to be learned, that people's mental health and well—being is considered. I don't think initially that it was, and people's relatives weren't treated as carers and they are their carers . They should have been able to come in right from the offset and I think that would have helped a lot with the residents' mental health and well—being throughout the pandemic as well because they were just so lonely and so isolated , despite the staff's

best efforts , and regardless of whether they had COVID or became ill or not, they've never really regained the same people that they were before that because they just lost years of their life really .
MR MCCORMICK: I think, as everyone says, you know, there was a lot of pulling together, there was a lot of camaraderie and I think that was very positive in a very difficult situation . I do think though it felt within the sector it could be quite —— it flipped quite a lot . At times you were praised for various things and then at other times there was quite a lot of criticism , and I think an awful lot of that wasn't with the full facts .
MS BAHRAMI: Thank you very much.
THE CHAIR: Yes, thank you all very much indeed. I'm very grateful for your time and effort . Can I just say at this stage, I'm very sorry that you can't have as long as you might actually wish. I can only say that applies to everybody. You will probably appreciate that we have an enormous amount of material to listen to or hear and, frankly , if we gave everyone as much time as they think might be optimum, then we would never finish this Inquiry , so we have to ration your time, but all you have given to us in writing will all be considered as well .
Thank you all very much.

About 25 to 12.
MS BAHRAMI: Thank you.
(11.22 am)
(A short break)
(11.37 am)
MS LISSA DI GIACOMO and MR SCOTT FINNIGAN (called)
Questions by MR STEPHEN
MR STEPHEN: Can I start by asking you to confirm your full names, please?
MS DI GIACOMO: Lissa Di Giacomo. I'm a director with Oakminster Healthcare.
MR FINNIGAN: Scott Finnigan, group general manager with Thistle Healthcare.
MR STEPHEN: Thank you. Your age and contact details are both known to the Inquiry so I won't ask you those. Together you've helpfully provided a comprehensive written witness statement already, and for the reference the Inquiry reference number for that is SCI—WT0423—000001. Are you both happy for that written statement and the oral evidence you give today to constitute your evidence to the Inquiry?
MR FINNIGAN: Yes.
MS DI GIACOMO: Yes.
MR STEPHEN: And you're happy for that evidence to be recorded and published?

MR FINNIGAN: Yes.
MR STEPHEN: I should say also that everything you say in the statement and indeed today will be taken into account, and even if we don't touch on something in your oral evidence today, we will have it in writing, so don't worry, the Inquiry will have in regard to that. Finally, in terms of housekeeping, I would remind you about the restriction order that is in place. Please don't name other individuals when you are giving your evidence today. If it's a staff member, just refer to them as such, or a relative, without naming names. Is that clear? Thank you very much.
Lissa, I think you just said a moment ago your current position is managing director of Oakminster Healthcare Limited; is that right?
MS DI GIACOMO: Yes.
MR STEPHEN: How long have you held that position for?
MS DI GIACOMO: About eight years.
MR STEPHEN: And how many care homes does Oakminster operate in Scotland?
MS DI GIACOMO: Five.
MR STEPHEN: And how many residents roughly?
MS DI GIACOMO: About 330.
MR STEPHEN: And how many staff do you have operating?
MS DI GIACOMO: About 340.

MR STEPHEN: In what part of Scotland, the geographical area, roughly are these homes, the five homes you mentioned?
MS DI GIACOMO: Glasgow. They are within about a ten—mile radius of each other, of Glasgow City Centre.
MR STEPHEN: Similar questions for you, Scott. I understand you're group general manager, operations and quality improvement, for Thistle Healthcare Limited.
MR FINNIGAN: Yes.
MR STEPHEN: How long have you held that position for?
MR FINNIGAN: Seven years.
MR STEPHEN: How many care homes does Thistle operate?
MR FINNIGAN: Seven care homes under Thistle and three associated care homes.
MR STEPHEN: Again, in what part or parts of Scotland are those homes located?
MR FINNIGAN: The central belt, mostly Lanarkshire area, but one in Glasgow and one in Dundee.
MR STEPHEN: How many residents fall under the care of those homes?
MR FINNIGAN: 750 approximately.
MR STEPHEN: And how many staff?
MR FINNIGAN: Between 900 to 1,000.
MR STEPHEN: If I understand correctly, what would you say is the make—up of your resident population in terms of

age and their needs? How would you describe that, if you can?
MR FINNIGAN: Mostly elderly. We have three services which are alcohol—related brain damage services, so they're usually younger adults in their 40s/50s, but the majority of our population is elderly.
MR STEPHEN: Okay, and in your case?
MS DI GIACOMO: Mainly frail and elderly. We have a couple of YPD units for young physically disabled and we have two intermediate care units which are for discharges from hospital and it's sort of an assessment rehabilitation unit for 28 days while they go on their onward journey either to another care home or back home or to sheltered accommodation.
MR STEPHEN: Okay. Thank you. Now, if I understand correctly, those two distinct care home operating businesses, Oakminster and Thistle, plus another one, Keane Premier Group Limited, together they form Central Scotland Care Homes, the group that you represent today?
MR FINNIGAN: Yes.
MS DI GIACOMO: Yes.
MR STEPHEN: Thank you. I just want to ask you a question now about pre—pandemic. In the witness statement at paragraph 14, it talks about your members championing a person—centred approach to care. I just wanted to ask

you what that means, what that is.
MS DI GIACOMO: "Person—centred" is having the resident at the heart of all the decision—making process to enable them, empower them, include them to have their own voice and be in control. So really, if any of us were about to go into a care home, it's about what's important to us, what matters.
MR STEPHEN: Okay. And before the pandemic what was your members' policy on visiting those homes?
MS DI GIACOMO: We were open —— it was free access. The only stipulation we'd put, we tried to protect the mealtimes for residents, so we discouraged any visitation at a mealtime, but other than that they could come in freely.
MR STEPHEN: Okay. That takes us then to the initial lockdown. Can I ask you to cast your minds back? Lissa, I understand that Oakminster locked down its homes on 12 March 2020; is that right?
MS DI GIACOMO: Yes.
MR STEPHEN: And Scott, for Thistle, I think that followed one day later. Is it 13 March?
MR FINNIGAN: Yes.
MR STEPHEN: So that was around roughly ten days, I think, prior to national lockdown, as you say in the witness statement. Why was that decision taken to lock down

earlier?
MS DI GIACOMO: For me, I remember watching the news and seeing army trucks towing in Italy —— my family is Italian —— and I saw them carrying bodies, deceased bodies, from the villages, and I thought, "We are looking after and protecting the most vulnerable of our society". I didn't see it getting any better and thought we should close our doors until we understand more fully what we're dealing with and how we can best protect them.
MR FINNIGAN: Yeah, I think a similar situation for us. I think it was in the absence of any sort of guidance or advice on what we should be doing at that time. We were seeing numbers increasing of the virus and some outbreaks in some of the care homes. We were having relatives asking us, "What's the plans? What's youse doing?", or we were being asked by Health and Social Care Partnerships to provide contingency plans and how we were going to maintain people's well—being and safety. So I think, in the absence of any official guidance at that time, we took the decision that we thought it would be safer to lock down on the 13th.
MR STEPHEN: So those decisions were taken on 12 and 13 March. How quickly were those decisions implemented?
MR FINNIGAN: We tried to implement them as quickly as

possible. Certainly on that day that we made the decision, the 13th, we issued communications to relatives and councils and the Care Inspectorate and started phoning families to say that that's the decision that we had made at that time.
MS DI GIACOMO: And we were the same. We put notices on the door. We contacted families, our regulatory body and let them know that we were closing the doors.
MR STEPHEN: Scott, you mentioned attempting to contact the families.
MR FINNIGAN: Yes.
MR STEPHEN: By what means or methods was that done?
MR FINNIGAN: That was done by various methods, email communication, telephone. We tried to telephone everybody. That's not always possible for various reasons, but we made that attempt to contact everybody by telephone and we sent out written communication about that as well.
MR STEPHEN: Did all families receive those communications?
MR FINNIGAN: They did all receive them. I think inevitably there were some instances where some relatives didn't get that communication straightaway, and that's for various reasons. We have —— usually have one or two relatives that's the main contact and they perhaps didn't get through to passing the information on or that

was a relative that we just hadn't managed to get on the phone yet.
MR STEPHEN: What was the reaction of families that —— I appreciate it's a broad generalisation, you have a lot of residents to look after, but what was the general reaction of families to the decisions that you'd taken?
MR FINNIGAN: The general reaction at that time was okay. People felt uncomfortable, I think, but I think they felt that it was the safest option and it was the right thing to do at that time and, as I say, we were getting questions from lots of relatives about, "Is it safe? Is it still safe for us to come in? What should we be doing?". So I think there was —— at the beginning there was a lot of understanding from relatives about wanting to protect their relative in a care home.
MR STEPHEN: Was that the same for ——
MS DI GIACOMO: Yeah, by far it was. Most of them were understanding —— understanding the thinking process behind it and we just wanted to protect the residents.
MR STEPHEN: Thank you. I'd like to move on now to the effect that had on your residents. So during this initial lockdown period, how did the care arrangements for your residents change? We talked at the beginning about the person—centred approach. How did that change when lockdown kicked in?

MR FINNIGAN: I think the change at that time was just the visitation because normal care home life, apart from the visitation, was resuming. People were still spending time in communal areas and kind of going about daily care home life. So I think the biggest impact for that was about contact with families at the actual stages.
MS DI GIACOMO: Yeah, it was the same for us.
MR STEPHEN: Do I take from that, then —— where were residents located then when lockdown happened? Before I think you mentioned about them sort of moving around.
MR FINNIGAN: Yeah.
MR STEPHEN: Did that change as a result of lockdown?
MR FINNIGAN: That changed —— from our perspective that changed when the guidance changed, when we had the official guidance to say that people should —— you should try and keep people in their rooms 2 metres apart, that sort of thing. But up until that point we just took the decision to stop visiting. We didnae stop anything else.
MR STEPHEN: And in terms of the activities or social events that you would normally have run in your homes, one assumes, did that alter at all when lockdown kicked in?
MR FINNIGAN: In lockdown ...? Sorry.
MR STEPHEN: When lockdown started, how did that impact?
MR FINNIGAN: What was different was outside. So, like,

entertainment coming in, we obviously werenae going to allow outside entertainment to come in if we weren't allowing visitation, so —— but in terms of the daily things that the staff had already been doing, all of our services have got activity co—ordinator staff so that would have continued until the guidance to social distance came in.
MS DI GIACOMO: Yeah, and it would have been the same for us. We have well—being enablers and we brought actually our "living our values" enabler in especially in terms of supporting the staff through that period and helping keeping the activities in the home and supporting the staff —— the care staff on the floor to keep that sort of camaraderie there so it didn't impact them, because we have supportive links with the community and the entertainment and visitors that would normally come into the home couldn't.
MR STEPHEN: Yes. I think you give specific examples of this, for example, in daily care of the residents. Things like hairdressers, for example, I assume that no longer occurred?
MS DI GIACOMO: No.
MR FINNIGAN: No.
MS DI GIACOMO: The carers and managers at times ——
MR FINNIGAN: Yeah, stepped in.

MS DI GIACOMO: —— stepped in to help.
MR STEPHEN: What was the position as regards external medical visits from general practitioners, for example? How did that change?
MR FINNIGAN: From our perspective that changed dramatically —— varying degrees to be fair. There was some services where all visitation just stopped, so you didnae see a medical professional. It was all telephone assessments. There was some services where the GPs' surgery was very proactive and was still in visiting people. But I would say in the majority of cases it kind of moved to telephone assessment.
MS DI GIACOMO: And it was the same for us. One of our homes, the service continued. The GP was tremendously supportive and came in and they formulated a system between them so that the time the GP spent in the home was more specific and more organised, if you like, and then in other services they didn't come in at all. It was telephone consultations.
MR STEPHEN: And with those telephone consultations, did you find those to be an adequate or similar substitute for the physical version?
MR FINNIGAN: I don't think there's any substitute for physical assessment when we're phoning saying that there's somebody that's unwell. I think, especially if

we're using agency staff and it's agency staff who is phoning the GP about a resident who disnae seem to be well for various reasons, that can be quite difficult when they don't know that resident and they're trying to relay information to the GP. So I think that physical assessment being missing had a huge impact.
MR STEPHEN: Were there any alternatives that your care home explored? You mentioned mucking in, whether it was hairdressing, daily care, anything else you tried to do to engage the residents, socially or otherwise, within the limits of what you were allowed to do.
MR FINNIGAN: I think the teams and the services tried everything that they could. There was times where there was —— we had bingo going on, for example, but everybody was at their bedroom doors. That works to varying degrees and obviously that depends on the ability of residents to be able to participate in that kind of forum. Unfortunately a lot of the people we support are living with cognitive impairment so that in itself presents a lot of different challenges in terms of trying to facilitate anything that would have been normal life.
MR STEPHEN: Just to be clear, I think when testing became possible, what was the procedure in your homes if one of your residents was to be tested positive for COVID?

What would be the procedure that would then follow?
MS DI GIACOMO: To try and isolate them, to keep them in their room and barrier—nurse them in terms of looking after them, which is extremely difficult, especially if they're at the onset of the dementia journey or they have slight confusion. You could possibly relate it to if you have an elderly relative who comes to stay with you after a period in hospital, an operation or something, and they are slightly confused, they're on their own set journey, and trying to keep them in a bedroom within your house and asking them not to come out for 14 days is quite a challenge for one, never mind, when you have a care home or a unit full.
MR STEPHEN: Yes, you mentioned dementia. I was going to ask you about it so I'm glad you brought it up because you say in the organisational statement, I think, about the increase in attention I think that those with dementia required. Are you able to elaborate a bit more on what you mean by that? I think you have to an extent already, but if there's anything else that you would add?
MS DI GIACOMO: Well, not really. Just that they don't understand, and when you have what was a familiar face, even if they can't, you know, remember your name, when that person is going in with a mask on and gloves on and

an apron on, they can't really work out who they are, so it increases their anxiety, it increases their fear, if you like, of what's happening.
MR STEPHEN: Which leads me to ask this question, I suppose: do you think that those with dementia were taken into account or sufficiently taken into account when these restrictions, this guidance, was put in place?
MS DI GIACOMO: No.
MR FINNIGAN: No.
MR STEPHEN: Should they have been?
MR FINNIGAN: Absolutely.
MS DI GIACOMO: Absolutely, yes, because I think they were affected mostly by this.
MR STEPHEN: I want to ask you more generally just about the impact on your residents. We've talked about lockdown, self—isolation and of course visiting restrictions, not being allowed. What would you say were the primary impacts that you saw or your members saw upon your residents as a result of these restrictions being imposed?
MS DI GIACOMO: I think fear and anxiety because for reassurance you would automatically hold their hand or touch them to talk to them, to reassure, and we couldn't do that. And when visiting was —— when the restrictions were uplifted and families came in, it's natural that

they just want to embrace for that reassurance, for that comfort and peace of mind. And we created cuddle curtains which were really —— it was just polythene but allowed them to have that embrace. Both the resident and family, they just broke down through, you know, happiness and sadness that they were eventually able to embrace each other. But you can't —— you just can't put a price to that. It is invaluable. And I think not having that, not being with their family, was almost as detrimental as the virus itself to their well—being.
MR FINNIGAN: Yeah, I'd agree with everything Lissa just said. I think emotional and mental well—being is not to be underestimated and how it impacts people's physical well—being as well. So I think residents deteriorated as a result of the restrictions that were placed upon them. Visiting had an impact on that because they couldnae see their families, but I think also the restriction of —— limited movement had a massive impact on people's well—being.
MR STEPHEN: Thank you. Given that lack of physical visits at that time, I wanted to ask you about alternatives. Did you attempt alternatives and, if you did, what were they?
MS DI GIACOMO: There were video conference over —— we had tablets. We purchased more tablets and brought them in.

We set them up. We tried to arrange appointments, if you like, with families, where they could see their family, their children, their grandchildren, and although it brought a sense of joy at the time, it was followed by, you know, "Why can't I see them and why can't they come in and see me?", so in some cases it was more upsetting seeing them and not being able to be with them.
MR FINNIGAN: Yes, so we had video calls as well with families and towards the summer, when we had nicer weather, there was some window visits being carried out as well, which wasnae official guidance at that point but it was just something that naturally materialised, and I think that's —— we had a lot of care home providers doing that.
MR STEPHEN: I'll come on to visits in a second so I'm glad you mentioned it. How successful would you have said that those alternatives, the use of video calls and things, were in your view?
MR FINNIGAN: I think it was probably more beneficial for relatives than it was residents in most cases. I think some residents struggled to understand what they were looking at, what they were seeing, what was happening. We had an example that sticks out. There was a resident who was end of life due to COVID and the manager had

facilitated a call with the family, just —— and the family were on that video call as the resident passed, and that was for the family's benefit. The resident, as far as we're aware, couldn't —— didnae participate in that, in that call. So I think there's varying degrees of how successful that was across the resident group.

MR STEPHEN: Thank you. Turning then to visits, your statement talks about how, after the first national lockdown is relaxed —— I think you remarked that visiting in care homes still remained heavily restricted. There were subsequently window visits and then garden visits and then eventually indoor visits. I want to start by asking about window visits. Were window visits something that were available as an option in all of your care homes?

MS DI GIACOMO: Not in ours. They were homes or school conversions so the windows are quite high so we wouldn't be able to facilitate window visits or garden visits.

MR STEPHEN: I think, Lissa, you might have one example that's mentioned in the statement about perhaps the lengths that ——

MS DI GIACOMO: Yeah, I was driving into one of our care homes and I saw a family —— a lady and a gentleman —— up a ladder at one of our windows and they were both —— but they were both on the ladder at the same time, on either

side, but one was standing on the platform of the ladder and the other was on the steps. Initially I was in shock and then concerned for their safety because they were about, you know, five/six feet off the ground and I just —— my heart was in my mouth until I went round. And I understood why they were doing it. I couldn't say that under the same circumstances I wouldn't have done something like that myself, but it was their safety that I was concerned about.

MR STEPHEN: And, Scott, what was the experience ...

MR FINNIGAN: I think —— similar to Lissa saying there, I think most of —— all of our care homes are over two floors. We have one old school conversion as well. So I think for the majority of people who were living on the ground floor and that window was accessible, that that happened, but, unfortunately, if you werenae living on the ground floor, a window visit wasn't something that was possible due to the restrictions of moving people around the home.

MR STEPHEN: So overall, then, would you describe these window visits as beneficial or not?

MR FINNIGAN: I think the people who had the opportunity to have a window visit found them beneficial —— again varying degrees on whether residents found them beneficial or not. I think the relatives who had the

opportunity found them beneficial, but not every relative had that opportunity, so that presented a different set of challenges as well about, "Well, how can that relative get to see and I can't get to see my relative?". So I think that was —— it was one of the situations where it was making do with the situation that we had and the best option.

MR STEPHEN: Your point being there that perhaps some families would feel, what, hard done by if ——

MR FINNIGAN: Yes, absolutely. Absolutely.

MR STEPHEN: Understood.

MS DI GIACOMO: Yeah, I would agree that it was more beneficial for the families and more reassuring for them to see their loved one than it was particularly for the resident.

MR STEPHEN: I'll move then to garden visits. I think you say in the statement —— this is at paragraph 68. This was around winter 2020 —— and at the outset of your evidence today I think you said the make—up of a lot of your witness population are the elderly. Did you think garden visits were suitable for your resident population?

MS DI GIACOMO: It depends on the time of year. Certainly the families, yeah, it was —— if it was a nice day and they were out in the garden, it was fine. I think what

sort of tarnished it a little bit was they couldn't touch, and that was the hardest part and we had to sort of supervise that, monitor it. And that was just horrible for the staff and for the families, to be so close and not to have that —— especially for the resident because it's what they needed. They needed, you know, to see that gesture from their families to know that they are okay and that they are going to be okay. So I think it was sort of a double—edged sword in a way.

MR STEPHEN: Because in your statement —— I think it's paragraph 69 —— I think there's a description that's made that these visits were almost akin to sort of a prison visit, if you like, with no contact allowed and a guard supervising them, quite strident language I suppose. I was going to ask, because you've answered it to an extent, Scott, what was the experience of your staff in having to facilitate these visits?

MR FINNIGAN: I think staff on the whole felt uncomfortable. I think there was that expectation about, "Here's what the guidance is", and the guidance, although it was called "guidance", was, like you've already heard, a set of rules that was expected to be followed. So I think there was lots of apprehension around if we don't follow the rules what will be the consequence for us. So

I think people felt uncomfortable with that.
And completely I can understand why people would feel -- relatives would feel that way about being supervised visiting their relative. Personal circumstances, I had a relative in a care home who my dad was visiting and he made some comments about, "Well, you're sitting 2 metres apart and wearing a mask. I cannae hear what you're saying". But also you're being watched, so you feel that that conversation you're having can be uncomfortable.
MR STEPHEN: What would you say, then, to those relatives who perhaps didn't feel like they were being trusted with their loved ones? What would be your response to that?
MR FINNIGAN: I think it was all coming from a good place about trying to keep people safe. I think there was certainly no intention that I'm aware of of trying to be obstructive or difficult. In fact it actually made the job that the staff are carrying out extremely difficult. So actually it would have been easier for the staff not to have these things in place, but there was a real fear factor around doing something that's not in the guidance.
MR STEPHEN: Is there anything you would add to that?
MS DI GIACOMO: Yeah, and it is about following the

guidance. Even though we may not necessarily agree with it, then we would follow it to the letter. And even staff perhaps didn't agree with it when they were out, and with the pressures that were on us at the time, you know, to have staff sort of in that supervisory role was the last thing that we wanted to have, but found it necessary because, if a positive case was then detected after one of these visits, the consequences of that for us would be serious.
MR STEPHEN: Yes, because I think the words that are used in paragraph 69 are "professional duty", and I think that perhaps speaks to what you're saying there.
MS DI GIACOMO: Yeah.
MR STEPHEN: At paragraph 64 of your statement, when talking about following that guidance, I think you state that:
"Our members wonder with hindsight whether they should have made concessions ..."
I wanted to ask you about that. Looking back, do you consider that care homes could have handled these visits differently or not?
MS DI GIACOMO: In relation to the guidance, no. Unless we ignored the guidance and sort of did what we felt was the right thing to do, I don't feel that we had a choice to do it any differently.
MR FINNIGAN: Yeah, and that would be my view as well.

I think there was -- most have got views on how it could have been done better, but I think -- in terms of following the guidance, I think that's what you do because that's the guidance that's set for you.
MR STEPHEN: Since we're talking about guidance, I think you say in your statement that care home managers were struggling to keep track of the guidance on the visitation. Could you elaborate on why that was?
MR FINNIGAN: I think there was so many different views, I think it was quite -- a lot open to interpretation. And as things moved forward, there was local restrictions that had to be taken into account as well as the care home guidance visitation, so that presented some challenges. I think it was just the sheer volume and probably feeling the same as the care home managers did when you were speaking to Public Health, the Care Inspectorate and the care home assurance team. That was three different people and quite often you would get three different answers to the same question. And then the problem comes, "Well, whose advice do we follow?". The Care Inspectorate was the regulator but these other bodies are advising.
So that's, I think, the challenge. There was no sort of consistency in that and I think that's just pure -- down to the pure volume of guidance that was

being shared and how quickly and often it was changing and -- because it was quite often open to your own interpretation.
MR STEPHEN: Was that your experience or ...?
MS DI GIACOMO: Yeah, we had a similar experience in terms of the guidance was very much, we felt, open to interpretation.
MR STEPHEN: On essential visits, a similar theme. I think you say at paragraph 72 of your statement that there was no such concept before the pandemic and then this new concept is then introduced. Did you find the guidance on what constituted an essential visit to be clear when running these care homes?
MR FINNIGAN: No, I think it wasnae clear to begin with. I think there was lots of again varying views on what that should be. And I personally -- after having spoke with some relatives about what their view of essential visits would be and information they were getting after phoning Public Health themselves, Care Inspectorate themselves, I was taking that information, phoning the same bodies back, having the same discussion and I was getting different answers.
So initially the information I was provided, which was why we implemented it in our group, was that essential visits were for end of life. That changed as

the pandemic moved on and guidance did —— round about that became a bit more robust and a bit more clearer. But initially it wasn't clear and I think there was an inference, "Well, there is a facility for that but care homes aren't using it", but it wasnae clear that that's what it could be used for. So things like residents were distressed or even relatives were distressed about not seeing their relative, so that became a —— that became something that was used more openly towards the end of the lockdowns, but initially it was a brand new term that had just been brought in in this guidance without any sort of definitive explanation of what it was.

MS DI GIACOMO: Yeah, we had a similar experience and, when you often sought clarification of what it exactly meant, very often you would get different answers through so you were left —— bearing in mind that we had to —— sometimes, when information was released through the media, through the television, then families would arrive and say, well, you know, "I'm an essential visitor, I must see my relative", and how do you say, "Well, no, sorry, we can't let you in because your relative isn't at end—of—life care" or —— it was extremely challenging, especially for the staff because they were at the front line of this with families who

were visibly distressed, angry, frustrated. So it was a difficult time.

MR STEPHEN: So what would you say was the impact upon your staff of having to —— as you say, you're on the front line —— having to deal with that angst, distress from families? What would you say the impact was on the staff that you had?

MS DI GIACOMO: Oh, they were —— I think they were just burnt out. They were working long days. It's a 12—hour shift. Routinely they were working four and five days consecutively to cover and to prevent the use of agency staff because it was challenging enough for them going in with masks and gloves and aprons, but when you have agency staff, which were in effect strangers to the residents —— because the staff really became their family during that period. They were the familiar face, the familiar voice, the voice of reassurance, so they were —— yeah, I think they were burnt out and then they had to deal with facing their own fears, facing death, working tirelessly and then having to speak to and try and console and try and defuse a really upset relative. It was extremely hard on them.

MR STEPHEN: And you say the staff became their family, which leads me on, I suppose, to Anne's Law, which this Inquiry has heard about already. I just want to touch

on it briefly. I understand that Central Scotland Care Homes support that ——

MS DI GIACOMO: Absolutely, yeah.

MR STEPHEN: —— especially with that individual concerned having been a resident, I understand, in one of Thistle's care homes.

MR FINNIGAN: Yeah.

MR STEPHEN: I just wanted to ask, in your view, what is the impact then of removal of relatives from that care home setting, both for the residents themselves but also for your staff, because I think there's a football analogy you used in one of the paragraphs I think about family being the 12th player, if you like, so when you take them out of the equation, what is the effect of that in your view?

MR FINNIGAN: I think it's distressing for everybody. I think it's impacting in daily life. I think that's reality. We've got lots —— lots of our resident groups are already frail and, prior to the pandemic and now, a lot of these relatives visit daily, and that would have been a lot of people's daily routine, that they would see their relative every day. We've got some relatives that spend all day in the care home with their relative and go home, and then that daily life just changed.

I think the difficulty for the residents that have cognitive impairment was understanding, "What's happened? What's changed? Why can I not see ..." —— and I think the window visits, that could be distressing as well because they could see the person but couldn't understand why they couldnae hear or touch the person. So I think it's had a massive impact on everything, and just the wee bits of information that family hold about residents that staff might not always know, especially if a resident was fairly new to the care home.

MR STEPHEN: You mention staff being burnt out. Again, if relatives are removed —— and you've just highlighted the importance of them —— what effect does that have on staff?

MS DI GIACOMO: Absolutely because families would come in and they would spend time with their loved one and they would assist with different aspects for the resident or they would talk to them. They would take time with the resident that released the staff to then go and attend to other residents that maybe didn't have family coming in because many residents don't have family around.

MR STEPHEN: So that safety valve, if you like, was ——

MR FINNIGAN: —— removed.

MS DI GIACOMO: It was removed.

MR FINNIGAN: I think —— sorry, I would just like to add,

I think there was a view that it was easier for care homes not to have relatives visiting, and that's actually the complete opposite. It was more challenging in all the aspects we spoke about there for the staff workload, for the resident well-being, for the relative well-being. So actually we were -- it's not something that was easier for us to no have relatives visiting. Actually it's the opposite.
MR STEPHEN: I want to circle back to guidance just before we moved on. I think, Scott, you mentioned about the sheer volume of it.
MR FINNIGAN: Yes.
MR STEPHEN: I think they were the words that you used. I'm interested in the process for implementing that guidance in the home. For example, was it possible for every member of your staff to be familiar with that guidance, given the volume that you've spoken about?
MR FINNIGAN: No, I think what we'd done as a senior management team was digested that guidance, had conversations with the leaders and the services, who then disseminated that to their teams in a way that was meaningful to them and impacted all different job roles differently. So, for example, the housekeeping team, one of the products that we would be used to cleaning; on the care staff about how the direct care would be

delivered, so we were kind of breaking that down for each individual group of staff. It would have been completely overwhelming to share the huge documents with every member of staff and say, "Read that and get familiar with it". That's just not how it could be done.
MR STEPHEN: Was it a similar process for Oakminster?
MS DI GIACOMO: Yeah, we did the same. We took the guidance, digested it, discussed it and then decided how we would disseminate it out among the staff teams, get it on to the floors.
MR STEPHEN: I think you mentioned earlier, Scott, about the challenges of interpretation --
MR FINNIGAN: Yes.
MR STEPHEN: -- and perhaps getting various sources telling you different things --
MR FINNIGAN: Yes.
MR STEPHEN: -- I think was the way you put it. Did that cascade down then to the way it was to be implemented? Was it easy to decipher what to do in light of that?
MR FINNIGAN: No. I think getting the guidance initially was a challenge as well, so -- still to this day I'm not on the mailing list for guidance, so I was relying on the homes sending me the guidance when it was being released because it was getting sent directly to the

care home managers. So I think getting access to the guidance initially was a challenge and then trying to understand what changed and how quickly we should implement that and what that meant.
MR STEPHEN: Was it the same?
MS DI GIACOMO: Yeah, it was the same for us. It was about them understanding, and sometimes we would put guidance out and then we would get new guidance. So then, having embedded the first tranche of guidance, we were then saying, "No, actually, don't do that anymore. This is what we need to do". So that was quite challenging as well.
MR STEPHEN: You speak about that guidance being given to you which leads me to ask then about consultation. Did the Scottish Government consult with you about this guidance before it was --
MS DI GIACOMO: No.
MR FINNIGAN: No.
MR STEPHEN: And despite the pace of the pandemic, the way things were moving, do you consider that you should have been consulted about that?
MS DI GIACOMO: Yes.
MR FINNIGAN: Yes. Yes, I think the guidance is kind of perfect world scenario but daily life isn't perfect world. But there was really no consideration for the

practicality of applying this guidance in a care home setting. And I think the people writing the guidance were obviously using the best of intentions, but I think it was written very clinically for an NHS acute setting. I don't think there was any considerations for the practicalities that actually fundamentally it's people's homes, this is where people live, and then the understanding of people being able to actually apply that because of cognitive impairments.
MR STEPHEN: And do you think it would have been feasible for that consultation to have taken place with care homes given the way in which this was moving?
MR FINNIGAN: Absolutely.
MS DI GIACOMO: Yeah. Yeah, I think they could have spoken to the Health and Social Care Partnership and the local authorities, any of the care home membership organisations or the care homes directly in order to get just a better understanding of what happens in social care as opposed to an NHS setting.
MR STEPHEN: Thank you. Earlier on, Scott, I think you mentioned about guidance feeling like it was mandatory.
MR FINNIGAN: Yes.
MR STEPHEN: So I suppose -- you touch on this at paragraphs 117 and 118 of this statement. I wanted to ask what in general were the lessons learned on the use

of guidance during the pandemic but I suppose specifically do you think that guidance was the correct or appropriate label or do you think things should have been done differently?

MR FINNIGAN: I think things -- I think there's lots of things that should have been done differently. I think guidance -- well, the name "guidance" gives inference that it's a guide and "Here's kind of best practice", but that's not how it was being applied. We were being inspected on this guidance and robust action taken when we werenae -- where they felt that there was not that application of that guidance anywhere, so that created a real fear. So the guidance didn't become guidance. The guidance became a set of rules that we had to follow.

MS DI GIACOMO: Yeah, I would totally agree. It wasn't -- it may have been called "guidance" but we -- when we received that information, we would do our best to follow it to the letter.

MR FINNIGAN: And I think that presented challenges for residents because I know from speaking with some relatives personally that the message they were getting when they were speaking to Public Health was, "Well, it's guidance. The care home can apply that in how it's suitable for that individual facility". But there was

no support to sort of understand that application and, as I say, we were inspected on it, so it was "Well, that's what's written in the guidance. That's what you should be doing".

MR STEPHEN: So if you were drawing up a blueprint on what you would do next time -- hopefully there isn't a next time, but if there was, are you saying that it should be clear, the distinction between guidance on the one hand and something that's legally mandatory on the other?

MR FINNIGAN: Absolutely.

MR STEPHEN: Thank you.

I wanted to turn now to infection prevention and control or IPC for short. You describe the level of IPC expected during the pandemic as a completely new way of working for care home staff and as a steep learning curve. Can I ask you what these demands -- these new demands were that were placed upon those working in your homes?

MS DI GIACOMO: It was really about an increase. They were expecting us to be like a hospital setting, a clinical setting. So it's like somebody coming into your own home and, although you may have a high standard of cleanliness in your house, to compare that against a hospital can't -- there's obviously going to be significant differences. And care homes in general do

work to a high standard of IPC because we deal with norovirus outbreaks and things of that nature, but this was on a whole new level. And the care home staff are already under increased pressure because of staff shortages and because of staff falling ill under COVID and then the expectation was we had to up our game, if you like, and take it to a whole new level, where we didn't have the resources or the training in order to fully implement that.

MR FINNIGAN: Yeah, I think one thing that sticks out for me was one of my managers saying during a session they had done with their team was the team felt that they had to become infection control specialists overnight, and that's not what the role of a care home staff is. I think use of masks wasnae something that was routine in care homes. Actually I don't know that I've actually seen it prior to the pandemic as something that's routine. So all these changes were coming into effect: how things were cleaned; the chemicals we had to use to clean things all changed; cleaning schedules, the expectation of what that schedule would include. And these were all brand new things to care homes that we were kind of expected to implement straightaway without any sort of support or guidance or training for staff. That sort of stuff we had to facilitate ourselves

because any of the available teams, like the Care Home Assurance team, were always being used for scrutiny services. It was all about, "Go in and check that that's been done properly. Go and check that that's been done". So I think there was that lack of support round about staff's understanding of what that should be.

There's examples of the guidance just being very unspecific again. As I say, masks was a new thing for us to use in care homes and it talks about sessional use of the masks, so -- but there wasn't a definition for what that session was, so was that session after you left the resident's room, when you went on your break, after your shift? So they were all things that took a long time to get definitions for, which meant there was varying degrees of how that was applied in practice because it was very, very generic.

MR STEPHEN: What impact, if any, is that having then on your staff in terms of these additional things? You talked about -- cleaning I think was one example you gave. But what's happening to their working hours and their workload if they're having to implement these --

MR FINNIGAN: Oh, massively increased. So the workload increased for everybody tenfold. I think even just for our housekeeping teams, things like cleaning frequently

touched points, so light switches, door handles —— that was being done up to seven/eight times a day on top of having to keep clean the general areas of the home, and bear in mind there was lots of areas in the home not being used so we also had to keep the areas clean. Yeah, so it was —— the workload for everybody was just increased, including in the care staff about cleaning every piece of equipment more thoroughly, more generally; again all very acute based, so things that you would generally have seen in a hospital setting but not in a care home setting.

MS DI GIACOMO: And the products, they asked us —— they would come in and change the products we were using. We have quite a comprehensive suite of cleaning products for different parts of the care home, but they would change that overnight and we had to then source different cleaning products. And it was just about having the resources because another layer of paperwork came in because we had to evidence the additional cleaning that they were doing on a more frequent, more regular basis with new products and having the time to obtain the products, because they were going in to all care homes and saying this, so we were all trying to look for the same product that we don't normally use at the same time, which made availability a little

sparse —— supply and demand. The prices of things just escalated and it was —— in one case we were paying five times more what we would normally pay for a product. Then to bring that in and have the training and —— just the people, just the bodies in order to help, you know, manage all of that, on top of what we were dealing with. It's, "What do we prioritise? How do we do this? How do we manage it?".

MR STEPHEN: You mentioned earlier about that distinction between a clinical setting and a hospital and care homes, at least as traditionally understood. Do you think that a distinction should have been drawn in the guidance that was issued between those two settings?

MR FINNIGAN: Absolutely.

MS DI GIACOMO: Absolutely. If they had a better understanding, then they may have made a more informed decision about the social care aspect of it.

MR STEPHEN: I think in paragraph 119 of your statement you talk about the fundamental purpose of care homes being to maximise the quality of life and having to balance that with the requirements of infection prevention and control. In your view, do you think that balance was struck correctly? Lissa, you talked earlier about the effect that PPE might have on those who perhaps don't recognise or fear those who are caring for them. Do you

think that balance was struck correctly?

MS DI GIACOMO: Not really. I understood their intention but the challenge that we faced was the implementation of that because you're talking about —— when you were going into a resident's bedroom, for example, that is their bedroom, so I don't know how I would feel about somebody coming into my bedroom multiple times. And not only did we have that aspect of it but we were advised under the guidance about items that had a personal meaning. So you have residents who haven't seen their family, that would maybe have photographs or an ornament in their bedroom and, as these were being cleaned, some of them they were suggesting that we remove for —— to prevent infection. And that's just not right. It is not —— I understand it, I definitely don't agree with it and I think the impact on the mental welfare and well—being of the residents was hugely impacted not by one specific thing but a catalogue of things.

MR FINNIGAN: Yeah, I think similar situation. Care homes, although they support people who are unwell, usually when people were acutely unwell, that would have been when colleagues from Health would step in. I think there was an expectation that we just —— we just had to go on with caring for people and it was forgotten about that it was people's homes, and it was that —— that's

the homely environment for them and how they should be comfortable. A similar scenario to Lissa mentioned, I personally was in a home one day when we had an inspection from Care Home Assurance teams and there was a suggestion we lifted every carpet in the home and laid lino because carpets can't be cleaned effectively, and that was a bit of a debate with me to try and get that resolved, but that was a huge discussion actually that took quite a lot of time and involved quite a lot of people because people didnae understand the care home setting.

MR STEPHEN: It's timely you mentioned it because I was just going to ask you about inspections anyway so we'll go there now.

Prior to the pandemic, I think you say that these were generally —— inspections were conducted annually I think more or less for your care homes.

MR FINNIGAN: Yes.

MS DI GIACOMO: Yes.

MR STEPHEN: How and by what means were those inspections carried out once we get into the pandemic? How was that done?

MR FINNIGAN: I think inspection changed. Inspection before a pandemic was generally via the Care Inspectorate and that changed —— the Care Inspectorate introduced a new

key question which was round about the —— how people are supported during the pandemic. A lot of the inspections were supported by Health Improvement Scotland, which have never inspected care homes. That's about acute settings. And then latterly the Care Home Assurance teams, who ultimately are all made up from people who havnae worked in care homes either. So it presented lots of challenges and understanding various different pieces of guidance that were given at inspections or advice which often wouldnae marry with each other. So you could have a Care Inspectorate inspection and they could be saying, "Oh, we're quite happy with everything you're carrying out. Your report reflects that. Your grades reflect that", and then we would have a visit from the Care Home Assurance team that we would end up with a six—page action plan from because they didn't feel that our PPE storage was adequate —— where PPE was being stored was adequate. And there was no consideration about, actually if you have PPE all on your corridors where you have people who walk with purpose, who are living with dementia, that would actually present more of a risk because these things are being touched regularly, but there wasnae any understanding of that.

That's a view that I challenged regularly and

ultimately it was advised by the Care Inspectorate they had a regulator, so we should follow a regulator. But that presented challenges when dealing with colleagues at NHS because they've been sent in to scrutinise you on this guidance that's been issued, and again it's back to the practicality of how that guidance should be applied in a care home setting.

MS DI GIACOMO: Yeah, a similar experience for us. It became known as "the COVID inspection". There was three questions. Two were being covered by the Care Inspectorate and one by Health Improvement Scotland. And when they came in, they were inspecting us against the standards of a hospital, and I don't know how you can compare a care home to a hospital, but that's what we were inspected on. And from our own personal experience, we did not too badly, but it was scrutiny at a time where we probably felt more pressurised as a sector than we ever have and I thought a more supportive approach might have had a better outcome for us than constant scrutiny of, "This was the guidance, this is what we're inspecting you on and we expect you to meet that".

MR STEPHEN: So do you think those standards that you were being held to were realistic in the circumstances that you were facing?

MS DI GIACOMO: Not all of them. There were some we do as a matter of course, but they were inspecting us on something that they had introduced to us during the pandemic because this was a COVID inspection and we were flat out. I don't know how they expected us to meet those standards with a workforce that were —— that was virtually on its knees.

MR FINNIGAN: Yeah, I think just similar. It was just unrealistic. I don't think there was any appreciation for the challenges, and the health and social care sector never had staff before the pandemic, so during the pandemic it was even worse because you could have half your workforce off at the one time isolating. So there was all the challenges in line with that but there was still an expectation, "Well, this guidance has been issued. You should implement it".

MR STEPHEN: You mentioned the example I think of being asked to lift up all the carpets.

MR FINNIGAN: Yes.

MR STEPHEN: I was going to ask you if there were any others because I think it's at paragraph 110 of your statement you talk about these inspections being far more extensive —— and "forensic" is the word you use —— than it was before.

MR FINNIGAN: Yes.

MR STEPHEN: Are there any other examples you'd give? You've mentioned the lifting of carpets that you were being asked to do at this time.

MR FINNIGAN: I think same as some of the examples that Lissa has given. There was one home in particular which was younger adults that live in it, and there was advice given and it was written in an action plan that we should remove personal belongings from people's bedrooms because some rooms were —— "overly cluttered" is how it was put.

MR STEPHEN: I think, Lissa, you've answered this to an extent already, but I'll ask you the same question, Scott. How might you suggest these inspections could have been handled differently during this time?

MR FINNIGAN: I think there should have been input from people who understand care homes. I think that should —— fundamentally should have been what happened. I personally offered several times to —— if there was a way to get involved in that, to help that be carried out, because I think there was —— we were the only people in it, and with the best intentions there, they've come in with a set of guidance, thinking, "Right, this is what the care home has been told". But it'd be only people who were seconded from the continence service and from acute settings that had

been -- due to the pandemic had been stopped, so they've never been in a care home, they've never looked at a care plan. I mean, these are things that they didnae understand, but they were producing an action plan telling us how to do better, and often I was going back, saying, "These actions actually are nae appropriate".

MR STEPHEN: Thank you. I'll just move on to Operation Koper because it's something that you specifically mention in your statement. As you'll be aware and as is clear in the Inquiry's terms of reference, the Inquiry very much respects the independent role the Lord Advocate has here in relation to the prosecution of crime and investigation of deaths in Scotland, but in keeping with the purpose of these hearings, Impact Hearings, I would like to ask you about the impact that that had on your staff.

I'd like to take that in two stages if I can, first. So firstly I'd like to ask what was the effect of Operation Koper on the workload or administrative responsibilities that your staff had to carry out?

MR FINNIGAN: I think that was an inevitable increase in that you had -- when somebody had passed away from a COVID or suspected COVID death, you would be contacted by the police, you had to fill out this questionnaire with 37 questions on it, you had to provide numerous

pieces of evidence and documentation with that, including copies of all the guidance that had been issued from the Scottish Government, which was readily available on the Scottish Government's website, and six months' worth of off-duties for staffing, contact details. It was a huge piece of work that actually we had to have somebody solely working on that to facilitate it.

It was also distressing for people who have -- these staff have cared for a lot of these residents for a long, long time and care deeply about the people they support, and then it was almost being an inference that they felt they were being questioned about did they actually support somebody correctly. So it was a huge increase in workload.

MR STEPHEN: I was going to ask that. What's the impact upon the staff, on their morale, I suppose, or mental well-being in light of this investigation?

MS DI GIACOMO: It was devastating and I remember, apart from the tasks, a lot of this information was archived, and so you had this questionnaire and, as Scott said, all this information going, but for me it was one of our managers, and after our managers were on the floor during the pandemic in uniform, as were our ops team, supporting the staff, trying to keep morale up, lending

a helping hand. And she came and -- the manager sat at her desk and she opened an email regarding Operation Koper and the subject line was "Major crime" that came into her inbox and the signature on it was from the detective sergeant of Operation Koper, Major Crime Division, Major Crime Police Scotland -- or Serious Crime Division it was. And she just broke down. She just -- now, there was probably no intention behind that, they were given a job to do and they were doing it as they would normally, but for somebody who has seen a staff -- we had a staff member, a young lady, who contracted COVID, spent several months in hospital and is now at home with her young family and she hasn't been able to speak since then, and her managers are still doing sort of welfare meetings; care staff have lost their life, as have many. But to sit after your shift and -- ready to do your paperwork and to be greeted with that kind of email is just devastating and she broke down because there's an inference of, "We've done something wrong. We haven't got something right".

MR STEPHEN: How did you manage that with your staff to the extent that you could?

MS DI GIACOMO: Support them, reassure them, actually go in and take some of the burden away in terms of the paperwork side of it and the questionnaires, but there's

ultimately information that they will have that we need to get from them. But as it's still going on, it's still quite -- it's just devastating because we're the only sector to come under that kind of scrutiny and nobody really knows what it was like for us during that time. I think somebody had described it as a "war zone" and it was a bit like that, only they were trying to get statistics and information from us at the same time, so it was really hard.

MR STEPHEN: Thank you. You mentioned paperwork and you touch on this in your statement, the administrative burden that I think your staff were all facing. I think words like "staggering" and "immense" were used. I wonder if there are any specific examples you could give of that and I suppose also what you think might have eased that burden, looking back.

MR FINNIGAN: I think it's just answering these 37 questions, I think, and providing all the supporting documentation that went with that. And, as I mentioned there, I think there was some of this that actually could have been given from -- they're asking for guidance issued by Public Health. Well, we're then away coming up with all these different versions of guidance to provide that. That could have been something that could have been got from Public Health.

I think it's just the immense workload in terms of every resident having to go through that, and that presented an ongoing —— when we had more deaths after it had been —— Operation Koper had been announced, that dread, "Oh, my God, I've got another death", and actually the numbers of people who died of COVID are very skewed because there's —— lots of people who just took unwell were classed as suspected COVID without any test being carried out. So there was lots of workload that actually —— because it seemed that other kind of health conditions didnae exist during COVID, and if you took unwell when you were living in a care home, you were just automatically considered as being COVID—positive. And I think there was a lot of frustration round about that as well because the numbers don't actually reflect the amount of people that sadly passed away with COVID.

MS DI GIACOMO: Yeah, I would agree with everything that Scott had said. It was a —— really when the staff —— they used to —— they came in with newspaper articles and the care homes —— it was almost like a league table, with the highest number of COVID deaths against the name of that particular care home and then it was in descending order. And that was just —— it was devastating to see because they didn't see the other

side of it, of what they were facing. We had —— staff were sitting with residents at end of life when families couldn't come in, trying to reassure them, praying with them in some cases because, for the residents, the staff were the nearest thing they had to family, and then to see you in a sort of league table with the COVID deaths. And as Scott clearly said, it wasn't all about COVID—positive deaths. It was suspected COVID or COVID related, where it may have been another underlying health condition.

MR STEPHEN: You mentioned media coverage there. I was going to come on to it anyway. In your statement you say —— at paragraphs, I think, 104 to 106 you talk about being very unfair and one—sided and you've given an example of that there.

Scott, I was going to ask you, what was the impact upon your staff of —— did you experience something similar in terms of headlines or ...

MR FINNIGAN: Yes, I think there was several of our care homes that were featured in news articles. Inevitably they were all viewed quite negatively. I think that's very demoralising. We're asking —— people are giving up their lives, the protection of their family, to provide care to people. Everybody was working hard to do the best job possible in a very difficult set of

circumstances, with guidance that was forever changing, working in ways that they had never been asked to work before and hadn't been trained to work —— working at that level —— and then you were splashed across newspapers, and that was really demoralising. We lost lots of people, lots of staff, because of instances like that.

And I think there was also that fear of, "People know that I work here and do they think that that's what would happen in here?" —— because it was very generic information, but that also presented lots of anxieties for relatives because relatives cannae get in to visit, they're reading these headlines, and residents who have capacity were reading these headlines and saying, "How can they be saying this about the place that I live, my home?".

MR STEPHEN: I was going to ask you about local communities because, as you mentioned, your staff obviously have to go home and have their own families and things.

MR FINNIGAN: Yes.

MR STEPHEN: Was that press coverage mirrored in the experience of your members when they went back to the communities or not?

MR FINNIGAN: I'd say generally not. There were lots of examples of community rallying round and being

supportive. We've got similar stories to kind of what was heard this morning about children drawing pictures and them being handed in and bakeries handing in cakes and breakfasts and pizzas all that sort of stuff, so there certainly seemed to be that support from the immediate community anyway and, to my recollection, I don't recall any individual staff members raising that they felt that that was the view outside. The people who knew them, of course —— but it was certainly a difficult time and that fear round about that.

We're also talking about staff who are registered with a regulated body, a professional body, and they're then considering the implications of their practices being in the newspaper and, "How does that affect my registration and my ability to work?". Basically they're feeling that their professional conduct is coming under question.

MS DI GIACOMO: I think the community in a certain respect was a lifeline because the care sector was seen at the beginning as a sort of poor relation. When everybody was out clapping for the NHS and the focus was on the NHS and what a great job they were doing, it was sort of —— care homes just didn't factor in that. But certainly with our group and different care homes, we had a local restaurant that brought —— an Indian

restaurant brought curries up for all the staff, another local supermarket brought Easter eggs for all the staff as well, and there was bakeries. There was different -- there was neighbours handing in trays of doughnuts and things just to acknowledge, and that was a real boost for them, that somebody recognised what they were doing.

MR STEPHEN: I wanted, I suppose, to finish on the overall impact on your staff. I think you mentioned earlier, Lissa, but in your statement at paragraph 89, it talks about it was "like nursing in a war zone". That same paragraph also says:

"There was no hope of maintaining care standards compared with pre-pandemic, despite the best efforts of staff."

In view of the demands placed upon your staff and we've obviously touched on a few of those today, not necessarily all, what would you highlight to this Inquiry in particular about the physical and mental health impact that occurred on your staff?

MS DI GIACOMO: For those who have remained in the sector, I don't think it will ever be the same again. Some of them are still haunted by the images they saw at the time, bearing in mind we are a care home, we don't have access to oxygen or ventilators and our residents were not being admitted to hospital, which some may argue is

a basic human right. If you are not well and you need hospital admission, that you should be allowed to have that admission and not be discriminated against. So I think for those who are still with us, it will never leave them and it's something they have to carry.

I think for the sector, we've lost some good people who just couldn't carry on and couldn't take it anymore. Because -- in summary, we weren't consulted, they didn't have a conversation with us, which could have helped. It might not have but we'll never know. We were given guidance that we didn't fully understand and found it challenging to implement and now we're being investigated because we had COVID deaths. And we're the only body to have gone through that. But we've lost some good people that may not be there when my time comes.

MR STEPHEN: Thank you.

MR FINNIGAN: I think just what Lissa said there, I think that summarises it really well actually, and I would just be repeating what Lissa said. I think just difficult and actually lots of -- I've heard lots of people express it as "trauma", and through this process I've obviously met with some of my team to talk about some examples and you can see real hesitation about speaking about it. When you bring it up, it just brings

back all the memories. I've heard people saying that they cannae watch any TV shows that have got -- during the pandemic, if it's a care home or hospital setting, when people are all gowned and masked up, it really brings back that experience that they had. And although I personally never experienced lots of the challenges that they faced, I think it was horrific at the time and it's never going to leave them.

MR STEPHEN: Thank you. I don't have anymore questions for you. If there's anything else that either of you would like to add or you think that we've missed or you think it's important to say, now is the time.

MR FINNIGAN: I don't think so.

MS DI GIACOMO: No, I think we've covered it.

MR STEPHEN: Thank you very much.

THE CHAIR: And I have to thank you very much as well. Thank you both very much for your evidence. I'm very grateful.

Very good. That finishes us for today, Mr Stephen.

MR STEPHEN: I tried my best.

THE CHAIR: You did very well. 9.45 tomorrow morning. Thank you.

(12.50 pm)

(The hearing adjourned until Wednesday, 27 March 2024 at 9.45 am)

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