Scottish COVID-19 Inquiry

Closing Statement: Health and Social Care Impact Hearings

Independent Care Homes Scotland ("ICHS")

Introduction

1. Independent Care Homes Scotland ("ICHS") is a distinct group comprising 12 independent care home operators within Scotland. ICHS is a conglomerate group set up to form one distinct voice for the independent care home sector. It has been set up for the sole purpose of providing evidence and submissions to the Scottish Covid-19 Inquiry (the Inquiry").
2. ICHS Group members operate largely within the private sector and also accept local authority referrals of care home residents. Members of the Group cater for a wide range of residents from those who are essentially self-supporting through to those requiring varying degrees of assisted care to those with more acute nursing care need. Conditions affecting residents include those with varying degrees of vascular and other dementias.
3. On 25 October 2023, ICHS gave an opening statement to the Scottish Covid-19 Inquiry ("the Inquiry"). Thereafter, ICHS provided the Inquiry with a detailed Organisational Statement which included evidential extracts from a representative cross-section of ICHS employees and a Director, all of whom gave oral evidence to the Inquiry on 26 March 2024. ICHS' focus has been to highlight the common issues experienced in the

independent care home sector by residents, their relatives and loved ones and by care home staff and management during the currency of the pandemic as contrasted with pre-pandemic experience and with reference to post-pandemic developments. ICHS's written and oral evidence reflects this focus and the Inquiry is respectfully referred to that evidence for its terms.

4. The intention of this Closing Statement is to reflect the common issues referred to in evidence before the Inquiry and how thee might be mitigated going forward. There can be no doubt that the Inquiry has heard some very harrowing and concerning evidence from relatives and loved ones in connection with the often-inconsistent implementation of Governmental and other Public Authority Guidance within the Care Home sector and its variance when compared with Guidance outwith that sector. Relatives and loved ones often felt excluded, powerless and without locus. Many felt robbed of contact and at fundamental times towards end of life and even at death. Some of that criticism has fallen on the care home sector itself. In contrast, the Inquiry has also heard from relatives and loved ones to the effect that they understood that Care Homes were doing the best they could in extremely challenging and unprecedented circumstances; that Care Home staff truly cared for their residents and continued to strive to provide them with the very best quality of life they could, often at considerable personal expense through increased hours, administration and stress both to themselves and to their own families.
5. ICHS has paid particular attention to the evidence of relatives and loved ones with Care Home sector contact and, more widely, to the evidence of the expansive range of organisations and witnesses from whom the Inquiry has heard. ICHS very much values the role of relatives and of loved ones as equal partners in the care of relatives and as their best advocates.
6. Along with the acceptance of praise for the Care Home sector (often dubbed "The Forgotten Army") it is only right that the proper criticisms of the sector are also taken on board and acted upon. For its part, ICHS stands ready to provide for and mitigate against these to secure the very best outcome for its residents and the sector at large.

This Closing Statement addresses the following common issues in the Care Home sector:

Decision to lockdown;restrictions on visiting and measures taken to facilitate visiting

7. The Inquiry has heard from ICHS and others that, pre-pandemic, visitors to residents in care homes such as relatives and friends were (and, of course remain) critical both in maintaining residents' physical and mental well-being and to nourish and meet their emotional need. Reflecting that, ICHS Care Homes pre-pandemic operated an open-door policy on visitors coming and going as they pleased. Moreover, it was (and remains) fully recognised that relatives and others had a huge contribution to make in providing and supplementing the care given by the home a corollary of which was (and is) to assist care home staff in the provision of care.
8. Evidentially, what was foremost was that Care Homes are just that – that is, residents' homes in which they were fully entitled not only to care but to respect, dignity and privacy and in which they should feel happy, secure with their views heard and the ability to live their lives as they choose. These were and remain the goals of all ICHS members pre- and post- pandemic.
9. ICHS members took the decision either to lockdown earlier than that mandated by the Scottish Government or in line with that mandate and with visitation rights severely curtailed if not stopped altogether. With hindsight, the point has been made that the adverse effect on residents' physical and mental well-being outweighed the risk posed by COVID-19 but it should be appreciated that the intention was to protect residents from a deadly virus that was both novel and (at least initially) poorly understood.
10. As time passed and understanding increased, provision put in place to facilitate contact and/or visitation brought their own difficulties. As with the virus itself, the steps taken were often poorly understood and inconsistently applied. The Inquiry heard from ICHS, from Central Scotland Care Home ("CSCH") witnesses and others that while staff tried their best to maintain contact through technological means this was often difficult for many residents who were not at all *au fait* with technology and in any event, such contact proved a poor and sometimes distressing substitute. Equally, telephone calls and emails as a means of contact and update were not always satisfactory and with care home staff under increased workload pressure such contact was at times difficult to maintain. Telephone calls would come in at all times of the day. Staff did their best to answer these and respond as meaningfully as they could but often relatives and others enquiring would have to be told that someone would call them back as the staff member answering would not always know how a particular resident was doing.
11. Window and then garden visits followed. These brought their own frustrations and difficulties. The Inquiry heard that they proved largely unsatisfactory for all concerned – residents, relatives and staff. ICHS Staff

reported residents not being able to hear relatives properly during these types of visit due to physical barriers (window/masks) and/or distancing regulations; the distressing effect of residents and relatives not being able to hug or touch one another and with being uncomfortable in having to supervise these types of visit - of being placed in a policing role which was completely unnatural for them.

12. Indoor visits at Homes were later permitted but again these were burdened with social distance and PPE wearing regulation which greatly affected residents, relatives and staff and which gave rise to awkward, unnatural and at times distressing encounters for all concerned.
13. Further frustration for residents and relatives arose from the restrictions on the identity and number of residents allowed visits – with in effect only one nominated resident being permitted until this restriction was eventually relaxed at a later stage of the pandemic. ICHS staff recognised fully the distress, anger and frustration of certain relatives who wanted to visit but whom staff had the difficult job of refusing visitation, with relatives often finding themselves sitting in their car in the car park and (perhaps) connected to their loved ones by video call .
14. The Inquiry heard that there was much angst and confusion over what constituted "essential visits". ICHS witnesses recognised that there was, across the *whole* Care Home sector, confusion over the terminology used in official Governmental/Public health guidance issued which was often nowhere or insufficiently defined. In turn, this inevitably led to differences over interpretation of that Guidance and hence its application. What might be an "essential visit" or "meaningful contact" in one care home might not be the same in another. Where this was to the detriment of residents and their relatives that was productive of further distress and anxiety.
15. "End of life" visits were perhaps clearer in definition than "essential visits" but nevertheless, as the Inquiry heard, these too were not free of difficulty and distress for relatives and indeed staff. Restrictions were still in force for such visits. ICHS staff did their best to make these meaningful and dignified but report instances of residents dying without the presence of any family or friends due to restrictions. On these occasions ICHS staff would though be with their residents in their final moments, often lying beside them or just holding their hand.
16. Resident's activities and external stimuli were significantly diminished during the pandemic or taken away altogether. This included the loss of the inward support formerly coming from the wider local community such as visits by school children. This, in combination with the visiting restrictions and difficulties narrated above, only served to further shrink the quality of life enjoyed formerly by residents. Again, while ICHS staff did their best to maintain what stimuli they could, often this was simply not possible, and which caused ICHS

(and other care home) staff much concern.

Governmental and other Official Guidance/Consultation

17. The Inquiry heard that guidance as issued from Government/Public Health and other bodies was voluminous, frequent and constantly changing. ICHS and other care home staff simply could not keep up with it. It was often published at a time on a Friday evening which left it unaddressed until the Monday morning as appropriate administrative/managerial staff did not work weekends. It was ambiguous. It was not sufficiently definitive in its terms. It was then liable to differing interpretations or to misinterpretation. This resulted in a wide variance of application "on the ground". Key terms which were fundamental to the execution of the roles of staff and of vital importance to relatives and residents were overly elastic – for example, "essential visit" as already referred to. Guidance was often issued but without definition of its terms until up to a week later.
18. ICHS witnesses expressed a view that there was a lack of consultation by Government and other guidance issuing authorities with the care home sector. It felt like care homes were forgotten about or "last on the list". NHS guidance was not always appropriate for care homes. Care homes deliver a different type of care than the NHS and an overly clinical approach is inappropriate.
19. Guidance was very problematic. There was duplication, inconsistency and confusion. It all stemmed from the failure to have one clear person or organisation responsible for organising and issuing the guidance. There was no proper system in place. For example, guidance was not numbered and changes were not tracked.
20. Care homes received guidance from the Government and from the NHS. A local NHS branch might then replicate the document with its own branding. The local health and social care partnership might then do the same. One example before the Inquiry was that one particular ICHS member operated in two health boards and four local authorities which meant they could have six versions of essentially the same guidance.
21. ICHS members also spoke of their apprehension of "getting it wrong". They expressed constant worry about keeping on top of the guidance and not making mistakes which were made all the more possible given the volume and frequency with which guidance was issued, often with only minor amendments.

22. A further issue was with the ability and time taken for implementation when guidance changed. Care homes such as ICHS members often had to seek approval for any implementation plan from Public Health. It took time to create a plan, get approval, and then implement. Public Health often did not have the infrastructure to approve any plans care homes might make in attempting to follow the new and already issued Government guidance. The Inquiry heard that on occasion, it took almost two weeks to implement the guidance that the Government had announced as if it was in immediate effect. That issues was though very difficult to communicate to relatives and loved ones of residents.
23. In ICHS's view, many of these problems could have been avoided or at least mitigated by (i) a greater degree of consultation by Governmental and other official agencies which issued guidance with the care home sector which it is felt, would have led to a greater understanding of the nuances of application of guidance as it applied to the sector; rationalisation and/or centralisation of those issuing guidance to avoid variances in issued guidance and to ensure consistency and (iii) provision of conduits through which feedback could be cascaded up to guidance issuers to facilitate finessing of guidance and with a view to offering reassurance to those attempting to implement such that, in their particular circumstances (as could be explained through such a mechanism), no adverse consequences would follow where there was any failure to follow or variance in implementation.

PPE and Infection Control

24. The Inquiry has heard evidence of a variety of experience on this issue. Commonly, shortages of PPE were most keenly felt at the beginning of the pandemic when demand was at its highest and manufacturer gearing was not as high as was required to meet demand.
25. ICHS's experience was on the whole a reasonable one with adequate supplies being sourced and maintained but that was only through considerable effort on their part and with a hugely increased administrative burden. Supply worries were heightened on hearing that PPE deliveries were instead being diverted to the NHS as a priority
26. The Government turned to the NHS for advice on PPE and infection control which resulted in clinical responses but which were not always appropriate for care home settings. Patients are in hospital for treatment; residents generally live in care homes as their only home.. Care home staff found themselves having to remove personal items like photographs from bedrooms which was distressing to both residents and staff. The Inquiry heard for instance, how ICHS group members could not have Christmas decorations

in 2020.

27. During the pandemic care home staff would have to kit up daily in full PPE, There was constant handwashing and use of hand gel. While staff were no strangers to PPE, there were many items of additional PPE to be worn and which resulted in uncomfortable working conditions particularly during the Summer months.

GPs; Testing, and Transfers from Hospital

28. The Inquiry heard from ICHS witnesses and others that It was very difficult to get GP visits during the early stages of the pandemic and in some cases, throughout or indeed a hospital referral. Many GPs refused to visit care homes following the advent of the pandemic At the time, the NHS was operating on an emergency basis only. While it was understood why this was happening, it left care home residents struggling to access the services they needed and so took a toll on their health.

29. Testing in care homes did not happen at all initially and not until on or about June 2020. The Inquiry heard from ICHS group witnesses that, once in place, the testing regime worked relatively smoothly, but nevertheless care homes had to be diligent in checking that hospital patients had been tested before accepting them as residents.

30. The Inquiry heard that when care home residents were transferred out to hospital and then returned, they were returning without having been being tested and would then have to go into isolation. Clearly, where that that was happening, there would be a risk of residents returning to care home with COVID and spreading the virus to others.

DNACPR

31. The Inquiry heard evidence that families were simply told by residents' GPs that DNACPR forms (where not already in place) were being issued in respect of their loved one.
32. While ICHS Group members would accept DNACPR forms and arrangements are a normal part of care home practice, the import of the evidence before the Inquiry was that during the pandemic DNACPR forms were being issued either absent any discussion with families or that any such discussion was scant with the conclusion being forgone in favour of issuing forms. ICHS group members reported in evidence on such instances and fully accept just how distressing and frightening such an experience must have been for those relatives who encountered it.
33. ICHS Group members can see no validity in the practice as was complained of in evidence nor excuse for departure from the normal process of proper discussion, consultation and engagement of potentially affected relatives by those professionals engaged in issuing DNACPR forms.

NHS Involvement – Inspections and External Agency Visits

34. The Inquiry heard evidence from ICHS Group members that during the course of the pandemic, the Government introduced a care home support team. These were NHS nurses who had been re-deployed from other specialities. They were not experienced in infection control. They visited care homes putatively to offer support, but the reality was often that they were carrying out inspections of homes and were frequently critical of them.

35. ICHS and others in the care home sector often found this experience debilitating, if not galling. Government support team staff hailing from an NHS background, often did not have the requisite experience in infection control which care home staff themselves possessed.

36. The experience was all the more frustrating when frequently support team staff did not follow even their own policies. ICHS witnesses reported instances of support team staff not washing their hands when moving from one patient to another and of turning up to visit/inspect homes without a change in PPE.

37. ICHS would suggest that while any support or constructive criticism is welcome it should be carried out or offered by those who are suitably qualified and with experience of care home settings and who themselves "practice what they preach".

Effect on Care Home Staff/Administrative Burden

38. The Inquiry heard from ICHS witnesses and others that care home staff enjoy close and personal relationships with their residents. There is mutual friendship, care and support. It is by no means a mere transactional relationship. Likewise, the same is true of the relationships staff have with residents' relatives, visitors and friends.

39. There can be no doubt from the evidence before the Inquiry that those relationships suffered greatly during the pandemic. Staff found themselves having to fundamentally change their daily roles from those centred-on delivery of care and enhancement of well-being to having to fulfil that same function as enforcers of guidance/regulation which was completely unnatural to them. The Inquiry heard care home staff were likened to "jailors" .Inevitably, the relationships care home staff had with both residents and relatives suffered.

40. The Inquiry heard how care home staff workloads increased exponentially. While formerly infection control, PPE and isolation were no strangers to them this was on an altogether different scale. Routines had to change radically. For instance, attempting to maintain isolation of residents who suffered from dementia was practically impossible. Those residents could not understand that they had to stay in their rooms. Likewise, many residents did not understand why masks for instance were having to be worn or who suffered from poor hearing and/or who relied on lip reading to communicate. This often led to distress for residents. Delivery of care took much longer.

41. Care home staff were of course not immune to the virus. As the Inquiry has heard, some were already vulnerable and required to self-isolate. Others fell ill themselves and so had to take time off away from work. Recruitment of staff or additional staff was highly problematic. Agency staff were not always desirable depending on the home in question and type of care required. Some agencies refused to supply staff where the home had COVID. All this added to the work burden of those left to deliver residents' needs.

42. ICHS and other care home witnesses have spoken to being acutely conscious of the variance in application of guidance and regulations as between that which they were being asked to follow within the home and which was, in due course, more relaxed. Rightly, relatives questioned why restriction was more onerous as applying to homes and to the logic behind that. Staff were frequently on the receiving end of understandable frustration from relatives in this connection which placed them in a difficult position but with which they

had considerable sympathy.

43. Care home staff witnesses have expressed sharing with residents and relatives the feelings of frustration, helplessness and distress/anxiety at the loss of visitor rights at the initial stages and then with the various iterations of “window”; “garden”; “indoor”; “essential” and “end of life visits”. All these brought their own additional pressures and stresses upon staff who had to do their best to manage either their absence or the unsatisfactory nature of their execution. The Inquiry has heard how, in the absence of relatives, care home staff have attended to the end of life needs of residents and being with residents in their last moments

44. Further, the Inquiry has heard how the administrative tasks placed upon care home staff hugely increased during the pandemic with their having to record the allocation of staff to residents to ensure infection control, isolation and PPE were all being correctly deployed and safely managed. Contact with Public Health and other official bodies which had an executive role to play in the pandemic naturally increased and had to be dealt with including visits by Public Health, regular Zoom/Team meetings with them and the digestion, interpretation and cascading down to staff by the managerial/administrative staff of the copious Guidance issued.

45. All of the above had a significant and often lasting effect on the lives of ICHS group staff. They were and are invested in the care and well-being of their residents In evidence, ICHS group staff and other care home workers reported going home after their shifts physically and emotionally exhausted. They suffered in their personal lives and relationships as a result. Often, they would be in tears and felt they were not doing tier jobs properly or in the way they would like to think when, in reality, they were going above and beyond. Many shared (and share) the feeling that they were part of a forgotten sector/army and of little value or importance.

Operation Koper

46. The Inquiry has heard how the Crown Office’s Covid Deaths Investigation Team, named “Operation

Koper” has caused the care home sector stigma, distress and inconvenience. ICHS agrees with the concerns raised by Scottish Care on 22nd January 2021 and again in March 2022 (and reflected in evidence before the Inquiry) calling for a halt to that investigation. ICHS therefore welcomed the announcement by the Lord Advocate on 22nd December that Covid-19 related care home and worker deaths no longer required to be reported to the Procurator Fiscal.

47. As the Inquiry has heard though, there are still some ongoing cases being dealt with by the Police and Procurator Fiscal which a number of ICHS group members have been subject to. Looked at in the round, significant numbers of care home staff have been subject to formal investigation for a prolonged period now, some for over two years and without closure.
48. Given what is now understood and accepted scientifically about the pandemic, there appears to ICHS group to be no justification for Operation Koper to continue. It is particularly frustrating that the care home sector was specifically selected for investigation, especially in light of what the sector had to deliver throughout the pandemic.
49. It is submitted that care home staff subject to such investigation have already suffered enough both professionally and in their personal lives as a result of the pandemic. For those who have been involved in Operation Koper, this has added to the stress, worry and concern caused by such formal investigation. The fact that Operation Koper remains open is an ongoing source of anxiety to the sector. Particularly so without resolution by this time. The distress and anxiety caused to all in the care home sector is added to by the fact that hospital deaths are not being investigated in a similar way, which suggests that the care home sector has been singled out.
50. The Inquiry has heard how Operation Koper makes some staff feel like suspects in a criminal investigation. This surely cannot have been its intention and, although individual staff are often not placed under caution, they do not understand the distinction and they are not people who are accustomed to providing statements to the police..
51. Frontline staff and managers have had to spend significant amounts of time ingathering documents and responding to investigations while, initially, also responding to a pandemic and, subsequently, trying to deal with the day to day needs of residents who often have complex medical and social needs.
52. ICHS group is clear that they have no issue with the professionalism of either the Crown Office or the police officers involved in the investigations. Their concerns are as follows: -
    a. They question the necessity of Operation Koper;
    b. They question its scale;
    c. They are concerned about the impact it had not only on staff for the reasons set out above; and
    d. They ask the Inquiry to question its proportionality.

53. In conclusion, it is respectfully submitted that for Operation Koper to continue "as is" is both disproportionate and unreasonable.

Conclusion

54. The ICHS group continues to stand ready to assist the Inquiry further in whatever ways it can. It is hopeful that from the representative cross-section of ICHS group witnesses that it has provided useful insight into the salient issues facing the care home sector during the pandemic and in its aftermath. It also trusts that it has demonstrated and offered assurance that throughout it has, and continues to, strive for the very best in care for its residents and support for their relatives and friends. Its residents are at the core of its operation and their health, safety and well -being at all times is paramount.
55. The Inquiry has so far heard a great deal of evidence from core participants and their witnesses from all perspectives and experiences. More is to follow. ICHS are grateful to the Inquiry and its core participants for both the opportunity to contribute and to share and to learn from the experiences lived and the suggestions made for the future. It has been hugely instructive and that no doubt will continue.
56. It goes without saying that the ICHS group will continue to follow the Inquiry closely through its future stages, to continue to contribute and respond where required and to look forward to its findings.
57. There are clearly lessons to be learned, perhaps on all sides. ICHS group earnestly hopes and is confident that that the Inquiry can and will identify those lessons.
58. From ICHS's perspective, it would respectfully suggest that central among those lessons would be recommendations from the Inquiry on the issuing of Governmental and other official Agency Guidance to address the issues mentioned above in that direction and, hand in hand with that, consideration on the latitude of its application, which should (in its view) evolve from a collaborative and consultative base and with continued input from the care home and other sectors to which guidance is directed such as would lead to greater understanding and enhanced efficacious application, free from fear or favour. All that to the benefit of care home residents among others. Equally, the group is and would be supportive of recommendations centred around "Anne's Law".

Personal Data

David McKie

Solicitor

On behalf of Independent Care Homes Scotland