SCOTTISH COVID-19 INQUIRY

FIRST ORGANISATIONAL IMPACT STATEMENT OF SCOTTISH CARE

I, Dr Donald Macaskill, c/o Scottish Care Ltd Bld [Irrelevant] [Irrelevant], will say as follows on behalf of Scottish Care:

I wish to begin by expressing my sincere condolences to all those who were bereaved during the COVID-19 pandemic and by acknowledging the suffering of those who were separated from family and friends who resided in care homes.

I would also like to thank staff in the social care sector who worked tirelessly to care for others, whether that was in care homes, by providing homecare or in housing support services – I recognise the strain that doing so put on them and their families and that for many the impacts of the pandemic are still being felt.

Introduction

1 I am currently the Chief Executive of Scottish Care. Scottish Care is a membership organisation representing the independent social care sector in Scotland. My professional background has focused on issues relating to human rights, bereavement, palliative care and workforce wellbeing. I have a doctorate in theology, sociology and occupational psychology and my thesis focused on staff burnout in teaching, clergy and social work. On completing my doctorate, I worked for the Church of Scotland in adult education, and thereafter in an associate college of Napier University and became its Vice Principal in 1992. I left that role to become the Head of Training and Learning at the Scottish Human Services Trust in 1999. The Trust focused on improving the experience of people who use services across health, social care, education and justice. In 2003 I established an equality, diversity and human rights consultancy which I ran for 13 years. During this time, I was an external adviser on specific projects including to the Scottish Human Rights Commission and helped to write and develop the *Care About Rights* programme which introduced human rights training to social care. As a consultant I gained extensive experience, in the United Kingdom and internationally, of embedding human rights, equality and diversity training into organisations such as public authorities including hospital trusts and organisations within the criminal justice system.

2 I first worked with Scottish Care to develop the *Tell Someone* programme which introduced the Adult Support and Protection (Scotland) Act 2007 to the care sector, thereafter as part of the *Care About Rights* project and worked with it again when I was writing guidance in relation to the Social Care (Self-directed Support) (Scotland) Act 2013. I carried out some further work for Scottish Care as a consultant before becoming its Chief Executive in April 2016. When taking up this role, I made it clear my priority would be to help build a human rights-based approach for the delivery of social care.

3 In 2018 I co-formed and chaired a working group to produce Scotland's National Bereavement Charter for Children and Adults. The charter was published during the pandemic in May 2020 with support from the Cabinet Secretary for Health and Social Care. I was one of 16 commissioners on the UK

Commission on Bereavement which was chaired by Dame Sarah Mullally and I currently sit on a number of advisory groups related to bereavement, palliative care and end-of-life care.

4 At the start of the pandemic, I was chairing the Scottish Government's Care Home and Dementia Group as well as sitting on the Scottish Government's Dementia Advisory Board and I did so until the end of the pandemic.

5 I have recently been elected as a Fellow of the Royal College of Physicians Edinburgh, however I am not medically qualified.

6 In this statement I will predominantly focus on the key issues faced by care homes during the pandemic and the related impacts. I will touch upon issues relating to care at home, however, I am aware that Scottish Care's Deputy Chief Executive Officer, Karen Hedge, is providing a separate statement on behalf of Scottish Care in which she will speak to the impact the pandemic has had on those providing and those receiving care at home services.

Scottish Care

7 Scottish Care is a company limited by guarantee, registered in Scotland, SC243076, and is a registered charity, SCO51350, and membership organisation with a registered office at Irrelevant Irrelevant.

8 Scottish Care's charitable purpose is "*the relief of those in need by reason of age, ill-health, disability, financial hardship or other disadvantage*". To achieve this purpose Scottish Care's objectives are to:

a) promote, maintain, improve and advance, for the benefit of those referred to in its charitable purpose, organisations which offer care and support services in Scotland;

b) promote the common interests of organisations which offer care to those referred to in its charitable purpose and advance their position to the advantage of their members; and

c) assist the sector in this field to develop their services and standards.

9 Scottish Care's membership includes those who are care home providers as well as those who provide at home care. Scottish Care has 350 members which cover approximately 900 services. Scottish Care's members are independent social care providers in Scotland which deliver residential care, nursing care, day care, care at home and/or housing support services. Its members include private, not for profit, employee-owned and charitable organisations. Scottish Care represents more of such providers than any other representative body in Scotland.

10 Scottish Care's membership includes organisations of varying types and sizes including providers of single facilities, small and medium sized groups, national providers, and family run services. Its members deliver a wide range of registered services for older people as well as those with long term conditions, learning disabilities, physical disabilities, dementia, and mental health problems.

11 During the pandemic Scottish Care's members were at the forefront of the frontline response to the pandemic, caring for older people and people with disabilities in residential settings and/or in those individuals' homes. The pandemic impacted all of Scottish Care's members.

12 Scottish Care engages with key stakeholders, including the Scottish Government, local authorities, the Care Inspectorate, the Scottish Social Services Council, the Convention of Scottish Local Authorities ("COSLA"), Healthcare Improvement Scotland and NHS Education Scotland. In doing so, Scottish Care advocates for its members on issues that impact them at a national and local level. It also undertakes robust quantitative and qualitative research, often in partnership with public bodies and/or universities, in order to highlight the key issues facing the independent care sector and those to whom the sector provides care.

13 During the pandemic Scottish Care was directly and deeply involved in supporting its members in the delivery of those services and in communicating to Scottish Government and other decision-makers the experiences, concerns and fears of those delivering social care services. The response of the Scottish Government and others to Scottish Care and the social care sector during the pandemic is a matter which Scottish Care anticipates being examined by the Inquiry at a later stage. However, I refer to this response in this statement to the extent that it provides context to, and relates to, impact.

14 When it became clear that COVID-19 was going to be a significant issue in the UK, Scottish Care recognised that it needed to support its members and we did that through four avenues:

14.1 our usual contact with members, which was typically direct communication with myself or Ms Hedge. Initially members were predominantly raising practical questions they had with the guidance. We quickly realised we could not individually respond to the number of queries which our members were raising;

14.2 the creation of a members' section of our website titled "Information on Coronavirus (COVID-19) Members Area" ("the COVID-19 Members Area") on 13 March 2020, which was regularly updated throughout the pandemic – often several times a day in the initial weeks. Scottish Care used this to alert its care home and care at home members to new and frequently changing information and guidance. It also contained discussion groups which allowed members to share information and seek support from each other;

14.3 I began writing weekly updates to members which were called "CEO Review of the Week", which were shared on the Scottish Care website alongside any documents and media statements which we felt it was necessary or helpful for our members to know about alongside a weekly blog I produced that was publicly available; and

14.4 the hosting of online interactive meetings with members, as described below.

15 Throughout the pandemic Scottish Care represented members and the wider independent social care sector in Scotland by attending meetings and working groups convened by the Scottish Government.

It also maintained regular and direct communication with Scottish Government officials on key issues and impacts including the financial sustainability of care providers, testing, regulatory and other oversight, personal protective equipment ("PPE") and workforce related matters.

16 Scottish Care also liaised with other organisations such as the Royal College of General Practitioners Scotland (RCGP Scotland), the Royal College of Nursing Scotland (RCN Scotland), Marie Curie and the Five Nations Care Forum and published joint statements with these organisations in order to represent the position of social care providers and to advocate on behalf of those to whom social care was being provided. As part of the Five Nations Care Forum, Scottish Care attended meetings with leaders of care associations across England, Wales, Northern Ireland and the Republic of Ireland to share information on the pandemic response, understand any differences between the responses in each nation, identify and share best practice and provide mutual support. I was also a Director of the Global Ageing Network and was involved in World Health Organisation groups in the lead up to and throughout the pandemic.

17 During the pandemic, Scottish Care's National team dealt with an unprecedented level of activity. The pandemic also had a significant impact on Scottish Care's local staff who were supporting members in their local area. Such members were traumatised by what they experienced and local staff were deeply affected by what they heard.

18 Scottish Care's staff really stepped up to the challenges they were faced with. They were quick to adapt their roles to help find solutions for members. For example a staff member who is usually responsible for events management took on the responsibility of updating Scottish Care's COVID-19 Members' Area with information about PPE; one liaised with a local distillery to arrange the production of alcohol gel and then delivered this to members; and another took the lead on initiatives relating to mindfulness and wellbeing for the social care sector.

Online meetings with members

19 In order to actively support its members, Scottish Care began running online meetings on COVID-19 twice a week (every Tuesday and Thursday) from 17 March 2020. These sessions were predominantly for Scottish Care members, however some were opened to non-members including some which external speakers also attended. The purpose of these meetings was to provide a forum in which members could ask questions and share information with each other.

20 The majority of these early meetings/webinars covered a range of issues relating to COVID-19. The session on 14 April 2020 was dedicated to PPE and on 24 April, 5 May and 14 May 2020 Scottish Care hosted the Care Inspectorate, PHS and Professor Graham Ellis (who was at that time the National Clinical Adviser for Ageing and Health) respectively as guest speakers. A number of meetings provided support to interpret and follow guidance issued by the Scottish Government and PHS which was being updated frequently.

21 The frequency of meetings changed depending on the support our members required. From 9 June 2020 the meetings took place once a week and from 11 May 2021 the meetings changed from being directed to all members to alternating weekly between sessions for care home members and members delivering care at home. They continued on this basis throughout 2021 and into summer 2022, apart from a brief period in February 2022 when the frequency of the meetings reduced. This schedule reverted to weekly sessions for all members on 25 October 2022 due to the challenges that the care sector faced as winter approached.

22 These meetings provided Scottish Care with the opportunity to obtain feedback from its members in relation to what was happening in the social care sector in each part of the country. This supplemented the daily information Scottish Care was receiving from its regional staff based throughout Scotland. This enabled Scottish Care to ensure it could advocate on behalf of its members facing challenges specific to particular regions in addition to the national challenges being faced by the sector.

23 Some of these meetings focused on specific topics such as bereavement, testing and wellbeing and Scottish Care continued to host guest speakers at some of these surgeries, including representatives from the Scottish Government.

24 The meetings frequently had over 100 people in attendance, for some early meetings there were over 250 people in attendance. The meetings were recorded and made available for members on the COVID-19 Members Area.

25 By meeting with its members in this way, Scottish Care heard firsthand the impact the pandemic was having on them. In one of the earliest meetings, the overwhelming sense I got from our members was that COVID-19 was being perceived as different from other infectious diseases, which the care sector was (and is) used to managing. This was because of the fear members had as a result of what they were seeing on the news. Around 24 March 2020, it was being reported that care home staff in Spain were so terrified of the virus that they had abandoned care homes. It is difficult given the period of time that has passed since the beginning of the pandemic to remember the sense of terror people felt at that time. Care home members were terrified for their residents and those that might die as a result of COVID-19. They were also concerned about the safety of their staff. Staff members working in care homes were scared by the thought of taking the virus home to their families or bringing it into the care home.

26 Scottish Care's members would come to the weekly meetings with questions about the guidance that was being published by the Scottish Government. For example, in the lead up to Mother's Day on 22 March 2020 there was conflicting guidance as to whether cards, flowers and/or presents could be delivered to care homes. This was the first main celebration for which people were separated. At that stage the UK and Scottish Governments were communicating that COVID-19 was not airborne and there was a huge focus on cleaning surfaces and therefore the concern was that items carrying the virus could enter care homes. The advice from local Health and Social Care Partnerships and local infection prevention and control ("IPC") specialists ranged from recommending that family members

of residents be prohibited from sending anything into care homes (and that care homes should not receive such items) to recommending that gifts be quarantined for a period, or wiped down, after they were delivered to a care home. Scottish Care supported members by providing advice which took into account the PHS guidance that existed at that time.

27 By April 2020, Scottish Care was starting to hear from in its members that the three main diagnostic symptoms of COVID-19 (continuous cough, high temperature and a fever) were not illustrative of how COVID-19 was presenting in older people. Members said that they suspected that other symptoms such as delirium may be evidence that an older person had COVID-19. Scottish Care's members were also expressing concerns that there was an airborne element to transmission of Covid-19 because of the way it was spreading within care homes. These concerns were raised by attendees at one of Scottish Care's online meetings on 2 April 2020 which included a guest from the Chief Medical Office of the Scottish Government. This meeting was open to Scottish Care members and external colleagues. At this meeting care home staff asked if they should be wearing masks at all times. At this point in the pandemic it was understood that Covid-19 was transmitted through droplets and guidance stated that care home staff need only wear masks if they were within two meters of someone who had or was suspected to have Covid-19. This guidance was reiterated by the guest from the Chief Medical Office who attended that meeting. There was a sense from Scottish Care members that this advice was not reflective of what they were experiencing in terms of transmission of Covid-19 within their care homes. There was a continual sense that some medical professionals and the Scottish Government had a lack of regard for the experience and expertise of those at the front line of social care during the pandemic.

The key issues and impacts in care homes

Visiting restrictions

28 On 11 March 2020, Scottish Care issued an urgent letter to all of its care home members asking them to give serious consideration to restricting access to their care homes, if they had not already done so. This letter noted the importance of family and close friends being with an individual at the end of life and noted that care homes should adopt appropriate screening mechanisms and undertake risk assessments to enable this to take place. This was in line with good practice for managing outbreaks of other viruses such as flu or norovirus and I consider that it was entirely proportionate and reasonable guidance aimed at protecting care home residents from a virus we did not know anything about.

29 However, as early as April 2020 Scottish Care made representations to the Scottish Government that the complete restriction of visiting to care homes (save for limited exceptions in relation to end-of-life) was increasingly disproportionate and failing to meet the pastoral and care needs of individuals. Scottish Care also highlighted the traumatic effect this was having upon families. Throughout the pandemic Scottish Care's national staff sought to work with local providers to ease restrictions when these were allowed, and Scottish Care made detailed representations at each time the various strands of visitor guidance published by the Scottish Government changed.

30 Scottish Care continually called for a human rights impact assessment to be carried out in relation to the restriction of visitors to care homes. These calls were made by Scottish Care at meetings of the Clinical and Professional Advisory Group ("CPAG") and reference was made in blogs published by Scottish Care to the need for a human rights-based approach to be adopted in relation to visiting in care homes.

31 The opening of care homes to visitors took a long time to be enacted by the Scottish Government. Scottish Care wrote a robust letter to all those on the CPAG on 18 June 2020 calling for care homes to be opened to visitors.

32 It was of course traumatic for families to be separated from their loved ones, and the impact of this is incalculable. However, it should not be forgotten that staff also found enforcing such restrictions distressing. Scottish Care heard from care home staff that managing visiting in care homes was extremely challenging. Staff did not want to have to stop families seeing each other. Care home staff told me that before the pandemic they had good relationships with residents and their family members and they felt that having to enforce visiting restrictions was damaging these relationships. Staff have also told me that they felt terrible when they had to prevent two people being present, and allow just one, when it came to a resident's end of life.

33 Nevertheless, there were also times when family members were abusive towards care home staff because they were preventing them from seeing their family member in the care home. Whilst in some sense understandable, this highlighted the almost impossible position care home staff were being placed in as the gatekeepers of contact. However, in the most part, care homes were simply following the guidance that was available at the time.

34 Some family members of residents of care homes contacted Scottish Care directly for advice and support in relation to the guidelines on visiting and the difficulties they were having, e.g. with securing essential visits at their relative's care home. We always aimed to be constructive and would speak to the relevant care home where we felt this may help. However, sometimes we were only able to confirm that the care home was following guidance. Other family members got in touch to say that they were supportive of the restrictions as they were concerned for the safety of their relative in the event that the footfall was to increase within their care home. They argued that whilst PPE provided protection, the more people who were coming and going then the greater the risk of harm because PPE did not provide full protection. In some cases, family members were critical of those who were challenging these restrictions. At a local level care home staff were consistently having to balance the demands of those wanting to increase access to relatives and those who wanted to limit access (out of a sense of fear). This was far from easy.

35 I am aware that different care homes took different approaches to the interpretation of the guidance and some were more 'risk adverse' than others. If a care home was being particularly cautious in relation to admitting visitors, it was usually due to the fact that they were terrified of the potential consequences if there was an outbreak of COVID-19 in their home. When Operation Koper was

announced, care homes became terrified that they would be prosecuted in the event that a resident died of COVID-19 had they not followed guidance to its letter.

36 Care homes were also concerned about civil liabilities that may have arisen if they did not follow guidance. One member asked Scottish Care if they could choose not to follow guidance and we had to respond advising that this may have an impact on whether their insurer was willing to indemnify them in the event that they made a claim.

37 The Scottish Government was not willing to indemnify care homes, as it did with NHS, in respect of liabilities connected with the pandemic. Had it done so, I believe that care homes would have been much more flexible when it came to visiting.

38 Due to the risks faced by the social care sector during the pandemic, insurance premiums increased exponentially and a number of insurance companies withdrew their cover for the sector. Scottish Care's members have reported that by the end of the Covid-19 pandemic there were far fewer companies providing insurance to the social care sector than there were before the pandemic began. A care home cannot continue to be registered unless it is insured and the increased costs of insurance premiums risked the sustainability of some of Scottish Care's members' businesses.

Restriction of socialisation within care homes

39 In addition to the restriction of visitors, for large periods during the pandemic care homes were prohibited from using their communal space to enable residents to socialise or engage in activities together. Care homes in normal times are vibrant normal busy locations, however, they became empty shells with no one congregating and chatting. This had a negative impact on residents' wellbeing especially those who were living with dementia and for whom the routine of normal activity was so fundamental.

PPE

40 Obtaining access to adequate PPE was a key concern for care providers in Scotland at the outset of the pandemic. Scottish Care alerted the Scottish Government and NHS National Services Scotland ("NSS") on 5 March 2020 that there were critical shortages of PPE in the care sector, that costs for available products had become exorbitant and that there was a need for a national, flexible and responsive delivery mechanism.

41 Scottish Care sought to resolve issues relating to the availability of PPE for the care sector by escalating concerns, which included engaging in constructive discussions with the then Cabinet Secretary for Health and Sport.

42 **NR**, a Scottish Care consultant whose position was funded by the Scottish Government, liaised directly with NSS in relation to the issues faced by the social care sector and Scottish Care helped NSS to develop solutions to support the sector. The establishment of PPE hubs by NSS on or around

17 March 2020, which were replaced by direct delivery to care homes followed by a triage system, eased the pressure faced by the sector in connection with obtaining PPE.

43 Scottish Care also worked to resolve issues in relation to the amount of PPE that was initially being allocated to social care providers at PPE hubs. NSS based its modelling for the demand for PPE on the number of staff and the number of 'sessions' for which PPE was required. A session was initially defined as a two-hour period which did not adequately take into consideration the role of those providing care in care homes or at home care. The impact of this was that difficulties arose in relation to the allocation of PPE. Social care staff are not able to calculate PPE requirements based on two-hour periods because within any given two-hour window they may have to attend to several residents within a care home or make several visits to individuals receiving care at home. Social care staff needed to change PPE between contact with each individual to whom care was being provided, or more often depending on the nature of the care being provided.

44 This was an issue which was resolved very quickly and by 26 March 2020 NSS had begun proactively asking for Scottish Care's input on decisions relating to PPE that affected the social care sector. However, there continued to be practical issues with social care staff accessing sufficient supplies of PPE. For example, Scottish Care received reports of members being provided with insufficient supplies of gloves at PPE hubs as those staffing the hubs did not appreciate the number of times per day that social care staff members would have to change gloves.

45 Scottish Care also liaised directly with PPE suppliers throughout 2020 to establish supply chains for the social care sector and supported consortium purchasing of PPE by a group of providers. From March 2020 until the end of 2020, Scottish Care provided a weekly update for its members with the latest PPE prices and supplier information.

46 PPE is a critical part of infection prevention and control and it is important to ensure that there are sufficient supplies available for both the health and social care sectors. PPE also impacts the practicalities of care delivery. It often affects interaction and communication with the people to whom social care is provided, particularly people living with dementia and people with hearing impairments. Consideration must be given as to what can be done to minimise any negative practical effects and how more accessible forms of PPE can become more routine in availability and use.

47 Scottish Care members raised concerns at Scottish Care surgeries about the lack of clarity at a local level as to which type of PPE should be worn by staff and when. Scottish Care frequently raised this issue with the Scottish Government and Public Health Scotland ("PHS") by email and engaged extensively with them to seek to clarify guidance about the PPE that was to be worn by those working in care homes and those providing care at home.

48 On 30 March 2020, Scottish Care, RCGP Scotland and RCN Scotland wrote jointly to the Cabinet Secretary for Health and Sport to express concerns in relation to the availability of PPE to those providing care in the community, which was limited as a result of them not being considered key

workers and the guidance being different in terms of PPE for those providing care in the care home setting and those providing care at home services. Together these organisations called for guidance recommending a consistent approach regarding the level of PPE required across both acute and community settings.

49 On or around 19 May 2020 confusion was caused by conflicting guidance being issued in relation to the type of gloves that should be used when providing personal care to social care service users. National guidance was that vinyl gloves should be used but some HCSPs were specifying that nitrile gloves, which were substantially more expensive, were required. There was no national guidance in place specifically for social care providers. Scottish Care liaised with National Services Scotland who agreed to issue further guidance on this issue on 22 May 2020.

50 Although NSS worked constructively with Scottish Care to quickly reduce the PPE supply issues faced by the care sector, during the first phase of the pandemic these issues had a significant impact on the care sector and created real practical challenges for providers and staff in what was already an extremely challenging time.

51 The inconsistency within national guidance on what PPE should be worn and in what contexts led to an unnecessary politicisation of its use and unmerited criticism of the sector. By way of example, statements were made by trade unions suggesting that some independent social care providers were not allocating the appropriate PPE to their staff. However, providers were acting in accordance with national guidance which prescribed different PPE requirements for staff working in social care than for those working in healthcare. There was a lack of awareness that the PPE guidance for care home settings was different to that within hospitals. There were occasions when media outlets shared photos taken of staff providing care on social media with comments stating that they were not using PPE in the right way. Social care providers and frontline staff felt that they were being unfairly criticised when access to PPE and the use of specific items of PPE was not within their control. Such negative attention had a determinantal impact on the morale of individuals who were on the frontline caring for some of the most vulnerable citizens in Scotland, a matter which I expand upon below.

52 There was also a lack of clarity for those providing care at home services on when PPE should be worn. This arose from the fact that guidance had yet to be produced to take account of the circumstances in which such services were being provided. This lack of guidance had a significant impact on care at home providers' ability to procure PPE as, without a mandate requiring specific PPE to be worn, providers did not have priority access to PPE. Care at home staff were left questioning why they, and those they provided care for, did not appear to merit the same level of protection as those in clinical and care home settings.

53 A UK-wide prioritisation of PPE for the NHS led to real difficulties amongst social care providers in being able to purchase PPE and there were occasions on which PPE meant for the social care sector was requisitioned for the NHS upon entry into the UK. Pressure was being put on private providers to secure PPE and they were being criticised in the media for not providing staff with such PPE but this

approach at times made it almost impossible for them to deliver what was being asked of them. This sense that the social care sector was 'second-class' to the NHS persisted throughout the pandemic.

54 Private and third sector providers' issues with securing access to PPE were at times compounded by a lack of engagement with the sector by local authorities and Health and Social Care Partnerships ("HSCPs") to prevent the prioritisation of in-house supply. Some of Scottish Care's members felt that these bodies were prioritising the supply of PPE to the services which they owned. Scottish Care was informed of these concerns and raised them with local authority and HSCP PPE teams and the Scottish Government. It was felt by Scottish Care members that this helped the situation in terms of engagement with the sector and the issues being faced in securing access to PPE.

55 There was a lack of recognition of the threats posed by what is now known to be an airborne virus and the nature of asymptomatic spread and this contributed to the delay in the introduction of guidance mandating specific PPE in care settings. Airborne and asymptomatic transmission was being discussed by the UK Scientific Advisory Group for Emergencies in February 2020 and concerns were being raised by the sector about the airborne nature of the virus in March 2020. However, messaging from the UK and Scottish Governments focused on a cough and touch risk within two metres and continued to do so for some time.

56 These issues undoubtably increased the risk of COVID-19 outbreaks in care settings, despite the use of standard infection prevention and control measures. As a result, the risks to those working in the social care sector were also increased during this time.

57 When PPE became available in care homes staff had concerns that what they were being provided with was not sufficient to protect them or the residents for whom they cared due to the fact that they were regularly seeing health professionals wearing full PPE, whether that was in the media or if such individuals visited the care him in which they worked. For example, if a GP attended the care home they attended in full PPE, whereas the care home staff only had an apron and a mask. I understand that there were occasions on which family members of those in care homes expressed concerns at, or were critical of, the level of PPE being worn by care staff (having seen staff during video calls or window visits with their relatives), as it looked different to what they were seeing in hospitals on TV. Such concerns were understandable in the circumstances but arose from a lack of appreciation by the media and the general public that guidance prescribed different PPE requirements for different settings.

Guidance

58 Scottish Care first published guidance for its members in relation to COVID-19 on 24 February 2020. That guidance contained general information about the virus which was based on Public Health England advice which had been published at that time. It also contained specific information for social care providers in relation to the development of standard operating procedures, PPE and resilience planning. This was the first guidance in relation to COVID-19 developed specifically for the social care

sector in Scotland and was amongst the first in Europe. Scottish Care then directed its members to guidance produced by the Scottish Government, PHS, COSLA and the Care Inspectorate.

59 There was also a degree of uncertainty about the status of guidance. As referred to above in relation to visiting, providers took different approaches to the interpretation and implementation of guidance. For some care homes the guidance provided comfort and reassurance but to others it was seen as overly restrictive. It may have been easier in some ways for care homes if the Scottish Government had formalised the guidance and removed any dubiety about its status.

60 In response to a number of outbreaks of Covid-19 in care homes, on 5 May 2020, the then Cabinet Secretary Jeane Freeman said that she was concerned the guidance was not being followed by care homes. She said that the guidance for care home providers was *"really clear"* and that *"private care home providers have not, in some instances, appeared to follow the guidance that we require them to follow."* Whilst the Cabinet Secretary referred to "*some instances*", the media seemed to interpret this statement as a criticism of the sector as a whole. This perpetuated the negative narrative that was developing in relation to care homes and led to increased scrutiny of the sector. Members also did not agree that the guidance was clear - there was no clarity as to the status of the guidance and its content was often open to interpretation. There were also occasions on which providers struggled to follow guidance that they could not agree with. For example, some found it extremely difficult to comply with the restrictive measures in place in respect of end-of-life visiting. Some providers made the decision not to abide by the guidance in relation to these visits which required family to wear masks and sit two metres away so that they could allow families to be together in a meaningful way. Those working in care homes did this knowing that they risked losing their jobs or a report being made about them to the Care Inspectorate and/or the relevant infection prevention and control team. However, they took the view that it was more important for residents and their families to be together at the end of life without restrictions.

61 The impact of the constantly changing guidance on care home managers is often underestimated. Guidance was often issued by PHS late on a Friday afternoon and it would either be immediately actionable or would come into force on a Monday morning. Initially updated guidance did not contain a summary setting out what had changed and what remained the same. The previous version of each piece of re-issued guidance was pulled off the Scottish Government and PHS websites, which we appreciate was to avoid potential confusion, but it meant that managers could not always compare and contrast the new guidance with previous versions to see what had changed. Therefore, care home managers had to spend their evenings and weekends reading the new guidance and identifying what had changed and what that the implications of this were for their home, staff or residents. Managers felt enormous pressure to ensure that they interpreted and implemented the guidance correctly and the timing of its release added to this pressure.

62 The pressure on care home managers to ensure that they were following the most recent guidance was compounded by the announcement by the then Lord Advocate in May 2020 that the death of any care home resident due to COVID-19 or presumed COVID-19 was to be reported to the Procurator

Fiscal. The investigations associated with these reports became known as "Operation Koper". This decision and the subsequent reporting and investigation of such deaths has caused considerable trauma within the care home sector. Scottish Care recognises that this decision arose from a legitimate desire to provide assurance to the general public, however, its impact led to many skilled and experienced managers and staff leaving the sector, which undoubtedly contributed to a less resilient response to the pandemic. I also know of nurse managers who have given up their management roles and returned to roles as staff nurses due to the pressure they were under as care home managers during the pandemic.

63 The fear and stress from Operation Koper is still ongoing within care homes as the police continue their investigations into care home deaths. I believe this operation to be wholly disproportionate and damaging.

64 As restrictions ease for the general public, I got the sense that care home managers felt as if they, and the residents for whom they cared, had been abandoned by the Scottish Government as care homes continued to be subject to much stricter guidance than the rest of society. This was especially the case in relation to visiting restrictions where people felt there were rules for wider society and another set of rules for the care sector.

Caring for individuals with dementia

65 The restrictions and guidance that were put in place had a significant impact on individuals with dementia. The guidance produced for care homes during the pandemic did not fully or adequately take into consideration the experience of someone living with dementia in a residential care setting. Such guidance was not subject to appropriate equality and human rights assessment and instead a one size fits all approach was adopted.

66 In particular, guidance setting restrictions or imposing periods of isolation appeared to have been produced without proper consideration of the difficulties it would pose for those with dementia and those caring for them. It is extremely challenging to isolate a resident with dementia to their room as they often like to pace and may have a set route that they take each day. This is a form of pattern behaviour, which is common to those with dementia. Disturbing this can cause the individual significant distress and lead to neurological harm.

67 As noted above, the activities usually arranged in care homes had to be cancelled. Such activities are not only for entertainment or socialisation but often are designed to help with the cognitive function of those with dementia. The withdrawal of these often contributed to the cognitive decline of residents with dementia.

68 Scottish Care's members reported that visiting restrictions had a significant impact on those with dementia, as did the enforcement of social distancing when visiting resumed. The loss of touch as a

result of these restrictions was detrimental as it provides physical reassurance for someone with dementia.

69 Staff in care homes understood the importance of routine for residents with dementia and restricting such routines was challenging for them, not least due to the distress it caused residents.

70 The impact of withdrawing support from people who had dementia in the community was catastrophic as it not only disturbed their routine but hastened their deterioration. Such impacts included the loss of familiar and regular contact with known staff who were able to support individuals and their family carers, the diminution of contact with specialist primary and social care services, and the lack of respite services and day opportunities available to people living with dementia.

Testing of residents on admission

71 Testing for COVID-19 was available before the first national lockdown, but testing stopped being made available to the public on 13 March 2020, which is when the first death in Scotland due to COVID-19 occurred. I understand that this was due to there not being enough tests to make them widely available.

72 Scottish Care advocated from early March 2020 that there needed to be robust clinical assessment and testing of residents entering care homes both from the community and acute NHS settings. At the outset of the pandemic this was not in place and there was an urgency to discharge elderly residents from care homes, which contributed to the spread of COVID-19 within care homes and the impacts on residents, families and staff associated with such outbreaks.

73 In a number of public statements and in meetings with officials and ministers Scottish Care stated that the lack of trust which had developed between many providers and discharge teams meant that there would be a reluctance to accept individuals being admitted back to or into care homes. This lack of trust had developed over a number of years, especially during times of pressure in relation to delayed discharge in acute settings. In such times, the care sector noted that proper discharge practices were not always followed. For example, care home staff experienced individuals being discharged into their care without notes and at times without their required medication. It was also common for individuals to be discharged late on Fridays when it was difficult for care staff to rectify these issues. In some cases, although an individual had been assessed as requiring residential care, it became clear to care home staff within hours of the individual arriving that they required 24-hour nursing care. In some, but not all, areas of the country care sector staff felt that there was a lack of partnership working from colleagues in hospital discharge teams. These factors had created a 'trust deficit'.

74 There were times during the pandemic when care homes were concerned about accepting new residents due to their lack of confidence in the discharge practices that were being adopted at the time. The concerns were for the health and safety of their existing residents and their staff. There was a sense in the care sector that pressure was being put on providers who were signatories to the

National Care Home contract to admit new residents (even though the obligation under that contract is only to accept residents who are appropriately assessed).

75 Due to the trust deficit and the absence of testing for new or returning residents, as an organisation Scottish Care advocated that all individuals entering a care home should be treated as if they were COVID positive and therefore barrier nursed for an initial fourteen days, if possible.

76 It took some time for the Scottish Government to make a policy decision that stricter measures should be adopted and for this to be reflected in guidance from PHS. Scottish Care was still addressing instances of poor discharge practices with CPAG, with Professor Graham Ellis and with Hugh Masters in May and June 2020 despite the official policy having changed by this time. Scottish Care received reports from members that COVID-19 tests had not been performed on individuals who had been admitted to care homes despite operators having received assurances to the contrary and that some acute settings were not following the guidance in relation to discharge practices which were in place at that time.

77 It also took some time for policy and practice to move towards testing both symptomatic and asymptomatic individuals, despite early calls from Scottish Care for all residents to be tested.

78 Initially, the media was critical of care home providers for not making themselves available to take new residents to reduce the pressure on the NHS. However, within weeks there was a change in perspective and questions were being asked about why individuals were being discharged to care homes.

79 Due to an urgency to discharge patients from hospital, there were also times when residents who had been admitted to hospital were discharged back to their care home earlier than they would have been in normal circumstances and in conditions which would have ordinarily deemed them unfit for discharge. Scottish Care members raised concerns with us about people being discharged into care homes late in the evening, without their medical notes and without the necessary medication. This placed additional caring responsibilities on staff at a time when it was difficult to secure a visit to a care home by a GP or other medical professional.

Testing following an outbreak

80 The initial practice adopted in relation to testing following the confirmation of a COVID positive individual in a care home had an impact on the ability of care homes to manage outbreaks.

81 During the earliest responses by HPS and HSCP, local authority and/or NHS Incident Management Teams only a proportion of care home residents were tested during an outbreak and initially only those who were symptomatic. Accessing tests was a huge challenge for care home managers and staff and the lack of whole home testing made their use essentially confirmatory rather than preventative.

82 Separately, the lack of testing in homes where there was no known COVID positive individuals resulted in a failure to adopt a preventative approach to potential spread and outbreaks especially in those areas where there was known to be high community transmission.

Restriction of medical care for care home residents

83 The clinical guidance titled "*Nursing Home and Residential Care Residents and COVID-19*" that was issued by the Scottish Government on 13 March 2020 caused considerable confusion within the residential care sector and led to a belief that individual residents who were COVID positive should not be transferred to hospitals.

84 Although this guidance was later clarified, the practice of care home staff being strongly discouraged from seeking to transfer COVID positive residents to hospital remained. In many instances it was appropriate for the resident to remain in their care home but the presumption of a blanket ban in transferring residents was unhelpful and placed enormous pressure upon care home staff.

85 Many members of care home staff reported to Scottish Care a sense of 'clinical abandonment' in the first phase of the pandemic. Many care homes struggled to access GPs and/or to get GPs to come into care homes to treat residents. It appeared to those in the social care sector that a presumption had developed amongst medical professionals that no external clinical visits should be taking place. Scottish Care worked with senior officers of the RCGP to address this but as late as December 2020 it was in contact with Scottish Government officials regarding instances of GPs refusing to enter care homes.

86 This restriction of clinical care was hugely damaging to residents with ongoing and developing clinical conditions and resulted in marked deterioration in the health and wellbeing of residents. It also increased the strain on care home staff who could not obtain appropriate medical care for residents.

87 The health and wellbeing of residents was impacted by the absence of speech and language therapists, physio therapists and podiatrists as well as dentistry and ophthalmology. Speech and language therapists in particular have an important role in care homes as they work with people with dementia to help them to continue to communicate and to help them maintain their ability to swallow.

Infection prevention and control guidance

88 IPC measures applicable in acute care settings such as hospitals were imposed, via PHS guidance, to care homes. When this guidance was created, there was a lack of input from specialists with an understanding of IPC in a care home setting. As a result, the guidance did not appreciate the important differences between these settings – care homes are residents' homes and must be treated as such. This means that residents will have personal items on display in their room and all surfaces cannot be clear and sterile in the way that would be expected in hospital settings.

Oversight of care homes

89 In May 2020 the Cabinet Secretary for Health and Sport announced arrangements for "*enhanced professional clinical and care oversight of care homes*" which instructed Health Boards and HSCPs to establish multidisciplinary teams to scrutinise and support care homes.

90 While the introduction of these arrangements was ostensibly an attempt to support stretched care homes, it led to considerable confusion within the sector.

91 The Care Inspectorate suspended routine inspections at the outset of the pandemic to reduce the footfall in care homes. However, from June 2020 inspections with a focus on IPC were introduced by the Care Inspectorate. Therefore, care homes may have received an IPC focused inspection from the Care Inspectorate and an IPC team newly established by an NHS Nurse Director. This approach frequently resulted in contradictory advice and guidance being provided to care home staff.

92 Generally, those in the IPC teams were from an NHS background and did not have any expertise in relation to the operation of care homes. They were tasked with applying guidance that was suitable for acute settings, as referred to in paragraph 80 above. This led to a clinical approach to care homes from practitioners often did not have the experience to take into account the nuances of the context in which this guidance was being implemented. An example of this was the failure of those from a clinical care background to recognise care homes as the homes of individuals with dementia. Personal items, which were often critical for residents' wellbeing, were assessed as infection risks and removed from residents' rooms often causing real upset to these residents. In reports these items were described as "unnecessary clutter".

93 Social Care staff felt that their experience and expertise was not respected by those who provided oversight and that their autonomy to make decisions in the best interests of their residents was reduced. There seemed to be a complete lack of a proportionate implementation of IPC guidance which respected the needs and autonomy of individual residents.

94 Over time the model of 'oversight and support' improved in some parts of the country and it has been described as one of collaborative improvement. However, Scottish Care undertook research in 2021 which evidenced the considerable harm that resulted from such a confused oversight and scrutiny model being imposed upon the sector. This included a significant reduction in staff morale during an already challenging time. The results of this research were published in Scottish Care's report "*The Ingredients for Growth: Care Providers Experience of Regulation and Oversight*" in November 2021. It remains the case that the introduction of such support models and the large teams attached to them at a cost in the millions of pounds is considered by most in the care home sector as unnecessary and counterproductive and yet further evidence of the clinicalisation of care settings.

Impacts on health and wellbeing of care home staff

95 As outlined above, strategic decisions during the pandemic often made it difficult for care home staff to provide effective support for those in their care and increased pressure on the sector. This had a psychological and emotional impact on those working within it.

96 Care home managers were also responsible for the safety of their staff and were concerned for their wellbeing which added to their stress and anxiety throughout the pandemic.

97 At the outset of the pandemic, it was known that COVID-19 posed an increased risk to those with multiple co-morbidities and those over the age of 70, with that risk continuing to escalate with age. As a result, people knew that a high number of older people were likely to die. The knowledge of that for those caring for older people was terrifying.

98 I'm aware of care homes where staff moved into the home at the beginning of the pandemic order to protect their residents and their own families. There was one care home in Forfar where the staff moved into the home for a month. The care homeowner and the manger moved in, but they did not force staff to move in – they did so by choice. The staff were interviewed by the BBC and spoke of how they missed their children. I do not think it was expected that the pandemic would last as long as it did.

Loss of residents & colleagues

99 The first death recorded death from Covid-19 in Scotland was on 13 March 2020. The rate of Covid-19 in care homes did not escalate until the beginning of April and from the Care Inspectorate data it can be seen that there were two or three months of significant rates of fatalities in care homes.

100 Scottish Care began to hear from its members about the trauma being experienced by their staff as a result of what they were witnessing. We hosted a webinar with guest speakers from the NHS specifically in relation to bereavement on 21 May 2020 to support our members. It was clear at that early stage that the level of bereavement experienced by staff was causing a lot of stress. As the pandemic progressed it became clear that the level of bereavement experienced by staff amounted to trauma.

101 Staff generally know the residents for whom they care and support very well and often develop bonds with them. This was particularly important during the pandemic when residents were unable to see their families and friends. Staff were often with residents when they died and have referred to COVID deaths as being distressing for the individual and, as a result, distressing to witness.

102 There were also staff members within the social care sector who died of COVID-19 - this had a huge impact on their colleagues.

103 I am aware of instances in which care home staff attempted suicide as a result of the stress and pressure they were put under during the pandemic. In one such instance a manger of a care home felt that they were being blamed for the deaths of people in the care home and was under a huge amount of pressure from overzealous inspections. In another, a nurse in a care home was suffering from trauma as a result of having lost so many residents from whom she had cared. Having heard from frontline staff about the trauma that the sector encountered, I believe there will be many individuals within the social care sector who will have suffered to a similar extent.

Testing of staff

104 From March 2020 Scottish Care advocated that it was critical that priority was given, even in the context of limited test availability, to staff working in care homes who were likely to pose the greatest risk to those being supported in these settings.

105 The failure to prioritise testing for social care staff resulted in staff having to take longer absences from work after coming into contact with a person who was COVID positive. In contrast, by mid-March 2020 NHS staff were receiving tests following such contact so that they could return to work after a 48-hour period. This resulted in the care sector having to operate with a reduced workforce despite the increased challenges it was facing. This led to staff shortages and also had negative financial impacts on social care staff who were, given their role, unable to work during such periods of self-isolation.

106 When testing became available, there was a period of time during which social care staff who had close contact with someone who had tested positive for COVID and received a negative test result still had to isolate for 10 days. Whilst this was not a significant issue it highlights the inequality of treatment between NHS staff and the social care sector. This put pressure on workforce availability with staff being off longer than they needed to be.

107 Initially different testing implementation models were adopted in different areas of Scotland which led to inequalities in approach and timescales. It was not until summer 2020 that systematic testing was available for care home staff. Until then care home staff had to follow the same practice as the general public and use drive through testing centres, which were often far away from where they were based. Care staff had to do this in their own time, incur travel costs and may have lost earnings to do so. This was in contrast to the position adopted for NHS staff who were able to be tested at their workplace. Over time testing became more routine and 'on site' testing of staff at the care homes in which they worked became normative in all areas. Eventually, the testing regime that was established was robust and worked well.

Vaccination of staff

108 The Joint Committee on Vaccination and Immunisation advised the Scottish Government in relation to prioritisation for the vaccine programme. When the vaccine was developed, priority was given to care home residents from December 2020 with NHS and care home staff being second in terms of priority

under the vaccine programme. Scottish Care dedicated significant focus to encouraging care sector staff to take up the vaccine and to addressing anti-vaccination messaging and myths.

109 Scottish Care continually advocated for more accessible models for vaccination to be adopted in order to make access as easy as possible for social care staff, for example by introducing peer vaccination by qualified nurses in care homes. Enabling clinical staff within care homes to vaccinate individuals would also have allowed residents to be vaccinated by staff that they knew and trusted which would have reduced the stressed caused, particularly to those with dementia.

110 The uptake of the vaccine amongst staff providing social care in the community was less than it could have been and Scottish Care called for the use of innovative models such as utilising community pharmacies in order to increase uptake. However, such practices were not adopted and an NHS dominant roll out was the preferred approach. Whilst this was effective in its first year, it increasingly failed to meet the needs of social care staff in care homes and in the community in subsequent years and for boosters.

111 During the first roll out of the vaccination, care home staff were able to receive the vaccine in their workplace when the vaccine was also being provided to residents. However, when residents received their boosters, staff were often not offered their booster at the same time.

112 In subsequent roll outs, there was also a reduction in vaccine centres and for those living in remote areas this substantially reduced the accessibility of boosters. There are indications that lack of accessibility coupled with the rising costs of living and fuel has had a substantial impact on the number of people being vaccinated.

113 There was also a reduction in communications and media attention focused on the importance of staying up to date with the COVID-19 vaccine. Scottish Care asked the Scottish Government to run campaigns that were specifically targeted to staff in social care, as it did during the first roll out. However, this approach was not adopted. Scottish Care ran its own campaigns in order to encourage social care staff to continue to be vaccinated but each vaccine roll out resulted in a reduced take up.

Staff morale

114 There was a negative view of the social care sector at the start of the COVID-19 pandemic which was perpetuated by regular negative media coverage. This included stories about care homes "*letting in the virus*". This impacted staff who were working hard to protect residents, but it also caused fear and alarm to family members of residents. A member reported that on one occasion members of the media followed a staff member home. Scottish Care raised the impact that such media attention was having on the social care sector in meetings of the National Contingency Planning Group ("NCPG") in April 2020 and we issued guidance to care homes after we received evidence that there were individual journalists posing as family relatives.

115 The national media concentrated on the impact the COVID-19 pandemic was having on NHS staff and did so in a way which was supportive of the NHS. People started clapping for the NHS and it took three weeks for the narrative to change to it being in support of health and social care workers. There was not the same type of praise for social care staff who were putting themselves at risk in care homes and in care at home settings as there was for NHS staff – instead staff often felt as if they were vilified by the media.

116 Prior to the pandemic, staff felt proud of working in social care however Scottish Care has been told that some no longer feel this way due to a perceived change in public opinion of the sector, which in some instances was evident within their own communities. I heard of a care home worker in a village in the north of Scotland who was shouted at when they were in a local shop and were asked to leave because they worked in a local care home - those shouting at them referred to the care home as a *"death farm".* One carer told me that she had asked her children not to tell people that she worked in a care home due to fear of what people would say to them.

Lessons learned

117 The Scottish Government's pandemic planning exercise, Operation Signet, did not involve the independent social care sector. As a result there was a clear lack of operational knowledge of the sector in the early stages of the pandemic.

118 The failure to have the voice of care home and homecare providers at the table during national resilience planning meetings prior to the pandemic meant that the initial interventions were often insensitive to the sector. However, once the pandemic began Jeane Freeman engaged directly and consistently with Scottish Care and following the first wave of the pandemic in June 2020, she established the Mobilisation Recovery Group which was a joint NHS and social care group focused on strategic planning to assist with recovery from the pandemic.

119 Scottish Care attended a number of groups established by the Scottish Government, such as the Clinical Practice Advisory Group for Care Homes, and the National Contingency Planning Group which was established by COSLA and later merged with the Pandemic Response in Adult and Social Care Group which was jointly chaired by COSLA and the Scottish Government. However, these groups had a strategic focus and there was a continual failure throughout the pandemic by national and local government bodies to engage with the independent care sector in relation to the direct operational pandemic response. This meant that the resulting interventions were often insensitive to local circumstances and unsuccessful in meeting their objectives because they did not reflect the reality of the management of the pandemic for these providers.

120 In autumn 2022, the then Cabinet Secretary for Health and Social Care Humza Yousaf established a Ministerial Assurance Group to address winter pressures and delayed discharge challenges and Scottish Care and other provider representative bodies were invited to fully participate in key senior strategic planning. However, this group has been disbanded by the current Cabinet Secretary for

Health and Social Care, Michael Matheson which means there is no forum in which the NHS and social care providers can discuss winter resilience or any issue which affects both the health and social care sectors. It remains the case that there is no representative from the independent social care sector on the Scottish Government's Social Care Gold Command Group which has responsibilities for emergency planning, resilience and operational response during emergencies, despite the fact that approximately 85 percent of care home provision and approximately 55 percent of care at home provision in Scotland is delivered by independent providers.

121 The keeping of provider bodies at arm's length during the pandemic was a critical error and meant that opportunities to benefit from the knowledge and experience of the sector were repeatedly missed.

122 This resulted in an inadequacy of guidance, lack of contextual awareness around clinical needs for example residents who had dementia and the operational realities of delivering care home and homecare services. The application of practice appropriate in one area (typically an NHS acute setting) to another area was assumed. The felt presumption of Scottish Government in its guidance was that the social care sector is an extension of a clinical NHS environment and it is not. It is still the case that the group overseeing pandemic preparedness does not have anyone in it from a direct social care delivery perspective. There is also no equivalent role to the Chief Medical Officer for social care within the Scottish Government.

123 Had it been invited to participate at an earlier stage, I believe that Scottish Care could have helped the Scottish Government to foresee some of the challenges that arose in the care sector which would have helped to mitigate the subsequent impacts. I consider that it is essential that representatives from the social care sector are involved in future pandemic planning exercises.

Signed: **Personal Data**

Date: 6th March 2024