Scottish COVID-19 Inquiry

Organisational Witness Statement

Central Scotland Care Homes ("CSCH")

Introduction

1. This statement has been produced for the Inquiry's consideration for and on behalf of the Central Scotland Care Homes ("CSCH") group.

2. The focus of this statement is the impact of the pandemic on care home residents, relatives and staff members. It is not intended to address the implementation of official guidance or the strategic response to the pandemic. Some aspects of guidance and the strategic response are referred to in order to place organisational evidence of impacts in context. The sections on Lessons Learned and Hopes for the Inquiry do however make wider observations based on CSCH members' experiences of the pandemic.

3. This statement is intended to provide a broad thematic overview of the impacts of the pandemic on care home residents, relatives and care staff as observed by CSCH members. Some examples are given to emphasise observations. Detailed evidence on experiences in individual organisations and care homes can be given by the individual witnesses put forward by each of our group members.

4. CSCH is made up of three distinct care home operating businesses: Keane Premier Group Limited, Oakminster Healthcare Limited and Thistle Healthcare Limited. CSCH has been established for the sole purpose of providing evidence and submissions to the Scottish Covid-19 Public Inquiry on behalf of its members.

5. Together, the members of CSCH operate 21 care homes throughout the Scottish central belt, with the majority concentrated in the Greater Glasgow area. They are small to medium sized care home operators, with the maximum occupancy of their homes ranging from 24 to 106. They employ varying numbers of staff across their homes, with around 30 to 140 staff members assisting with the care of their residents at the smallest and largest homes respectively. CSCH's staff care predominately for elderly residents who have a range of needs

and care requirements, including those with dementia. They also operate some homes that provide care for younger residents with conditions such as Alzheimer's and Alcohol Related Brain Damage (ARBD) as well as Young and Physically Disabled (YPD) care.

6. The majority of referrals to CSCH care homes come from the local authority via the Health & Social Care Partnership (HSCP). They also accept private applications, but these make up the minority of applications for all group members.

Keane Premier Group Limited

7. Keane Premier Healthcare Limited (Keane) has been operating for 15 years. It is a subsidiary of Keane Premier Group Limited. There are two separate companies under Keane Premier Group Limited; one is Keane Premier Healthcare Limited which operates residential care homes, and the other is Keane Premier Support Services Ltd which offers care at home services.

8. All six of Keane's residential care homes fall under either the Greater Glasgow and Clyde or South Lanarkshire health boards. Across all of Keane's residential homes, it employs a total of 290 staff and provides homes for a combined total of 209 residents. The homes provide 24-hour nursing and care to residents who are frail, elderly or have cognitive impairments such as dementia. Prior to Covid, the company had no financial or care standards issues. It was well organised. There were some staffing issues generally, and these persist now, but such issues have been commonplace in the care sector for many years.

Oakminster Healthcare Limited

9. Oakminster Healthcare Limited (Oakminster) was formed on 10 April 1996. Today, it operates five residential care homes which are home to a combined total of 303 residents. Care is delivered by a team of approximately 275 staff. Its homes provide residential care, nursing care, YPD care and it also operates two intermediate care units.

10. The intermediate care units contain only contract beds, which are paid for by the local authority. They are effectively an extension of the hospital and are only used for the individual to be assessed whilst the next step in their journey (e.g. rehabilitation, another care home, or sheltered accommodation) is decided on.

Oakminster aims to help intermediate care residents on to the next stage in their journey within 28 days, but this timescale can be exceeded if the individual needs of a resident require a longer stay or there are delays in their care pathway.

11. Oakminster's care team consists of full-time, part time and agency staff. It uses agencies such as Staffscanner, Pegasus, Florence and Search.

12. The majority of Oakminster's residents are referred to it by social work and the local authority, only a small minority of its residents are admitted following private applications. It estimates that private applications account for less than 20% of admissions.

Thistle Healthcare Limited

13. Thistle Healthcare Limited (Thistle) has been operating for more than 20 years. Thistle residential homes provide nursing care to predominantly elderly people, including those with dementia, but three of its services provide support for younger adults with alcohol related brain damage (ARBD). The majority (around 90%) of its referrals come from Health & Social Care Partnerships (HSCP) via social workers but it also has a number of private placements. Thistle does not provide any domiciliary care. It operates eight care homes but also has three associated homes which are owned by different companies: these are Morningside, Woodside and Millbrae. It has capacity for 790 residents across its homes and employs over 1000 staff members.

The Situation Pre-Pandemic

14. Prior to the pandemic, CSCH members' focus was to provide high quality care in comfortable and homely surroundings. They championed a person-centred approach to care. In relation to elderly residents in particular, it was (and still is) recognised that when a resident is admitted to a care home they bring with them their hopes, dreams, aspirations, ambitions, individual needs and a lifetime of memories and personal experiences. Our members recognise that residents are admitted due to need rather than want, and they therefore aim to provide a service that ensures comfort and peace of mind for residents and family members alike in their time of need. Tailored services are matched to residents' needs and personalities.

15. Every resident is different, and each of our members' residents are treated with that in mind. They aim to provide top-class levels of care in order to ensure that every resident is treated with dignity, security and respect in comfortable surroundings that maximise quality of life. The staff at all levels in all of our members' care homes take great pride in the work that they do and the benefit that it has to residents and family members.

16. Prior to the pandemic, residents of CSCH and their relatives' satisfaction was high. There were no issues with care quality and inspection grades were good. In the years running up to the pandemic, some of our group members had won or had been shortlisted for national awards in recognition of the quality of their care services. Relationships with the relatives of CSCH residents were positive. Our members valued relatives' contribution to the care of their residents greatly.

17. Pre-pandemic, CSCH members operated an open-door policy. Visiting was allowed at any time. Some relatives would visit every single day. Our group members tried to protect mealtimes, which is the standard approach in care homes as visitors can be disruptive to some residents' eating routines. Some residents would eat better when their relatives were around, however, and our members would work with those families to make specific arrangements. It was (and still is) recognised that family members are a vital part of the care team who should be encouraged and embraced.

18. The main operational challenges our members faced pre-pandemic related to recruitment, particularly of staff nurses. Recruitment of nurses can be challenging and some of our group members required to rely on agency nurses to ensure sufficient staff numbers. Despite these challenges our members' homes were always sufficiently staffed and care was delivered to meet the needs and personal wishes of residents and their families.

Pandemic – Immediate Response in March 2020

19. In the weeks before the pandemic was declared, business contingency plans were reviewed and updated based on information from official sources and guidance that was available at the time. Risk assessments and care plans were also reviewed and updated. The intention behind these reviews was to brace for the impact of the pandemic. It is now clear that the country was not prepared for the scale and complexity of the challenges that the pandemic would bring.

Lockdown of Homes

20. All CSCH members made decisions to lock down homes earlier than the first government mandated lockdown. Our members had become increasingly concerned about the spread of the virus and the impact that it appeared to have on the elderly and infirm. In light of media reports from both home and abroad and industry communications about the virus, it was decided that urgent action required to be taken in order to protect residents. Keane and Oakminster locked down their homes on 12 March 2020. Thistle locked down its homes on 13 March 2020. These decisions were made by senior management as an emergency response. The lockdowns were implemented with immediate effect on the day the decisions were made. Notices were placed on the front doors of homes, advising that the homes were in lockdown and no visitors were allowed, in case anyone turned up unaware of the decisions that had been made.

21. The aim of the early lockdowns was to protect vulnerable residents from the virus. When lockdown decisions were made, CSCH members attempted to contact family members of residents as quickly as possible to inform them. They used telephone communication as a first resort and, in cases where they could not reach family members, email communications were sent. These communications were followed up with letters where communication by other means had been unsuccessful. Unfortunately, because of the speed with which the lockdown decisions were made and implemented, some family members did not receive the messages and turned up at homes hoping to visit their loved ones on the day that the lockdown decisions were made. This led to some family members learning of the lockdown decisions at the door of the homes. It is acknowledged that this will have been frustrating and distressing for the family members in question. It was an unfortunate and unavoidable result of the speed with which the decisions to lockdown were made and implemented.

22. The vast majority of family members were in agreement with the lockdown decisions that had been made. In the weeks before the national lockdown was announced, visiting numbers were lower than usual because family members were worried. They were accordingly willing to exercise caution. The feedback in general at that time from relatives was that CSCH members had made the right decision. The first national lockdown was announced by the Prime Minister 10 days later. CSCH members consider that their decisions to lockdown were vindicated by the subsequent national lockdown and that their proactivity saved lives.

Changes to care of residents

23. For several months following the initial lockdown residents were encouraged to stay in their rooms in order to give every resident the greatest amount of protection from the virus based on the information available at the time. At no stage were any residents locked in rooms.

24. All residents during this initial period had the majority of their care delivered in their rooms, including mealtimes. There were some exceptions made in certain homes for certain residents who would not eat as well when alone. In these cases, where space allowed, some residents would dine in the same room at single-seat tables which were sufficiently far apart to conform to social distancing guidelines. Mealtimes were staggered to minimise the number of residents that were in communal dining areas at any one time.

25. Residents' care plans and risk assessments were changed immediately to reflect that their care became one-to-one care only. The need to care for residents on a one-to-one basis was challenging because staff were unable to monitor as many residents as often as they had been able to pre-pandemic when they would gather in the common areas. It was very difficult for staff to perform their increased care duties and also keep relatives updated on their loved ones.

26. The activities and social events that were regular features of home life pre-pandemic could no longer take place in the same way or with the same degree of frequency. Senior management and staff in CSCH homes worked together to devise alternatives that would allow for some level of social interaction and entertainment to continue. The homes could no longer have external entertainment, hairdressers or beauticians and so they had to improvise where they could. An example of this was where bingo games were played in the corridor of homes and residents would come to their doorways to play. Some staff members provided hairdressing and beauty services although the availability and quality of these varied depending on the skills of staff within each home.

Changes to working practices

Remote Working

27. CSCH members had access to Microsoft Teams and other video conferencing facilities prior to the pandemic but they were rarely used. When the decisions were made to lock down care homes, use of video conference

meetings became commonplace. It enabled communication to take place regularly between management and home managers without the need for travel between locations. Some senior management roles could be performed entirely remotely but some still required attendance at care homes. The approach to remote working by senior management in our group members varied. Some of our members kept their head office open throughout the pandemic whereas others worked remotely at the height of the pandemic. The common theme was that movement of staff between office locations and care homes did not take place unless it was completely necessary and in keeping with official guidance that was in place at the time.

28. Given the resource pressures created by the pandemic, some managerial staff that were qualified nurses elected to redeploy and moved from managerial roles back into care providing positions to help the staff on the ground in CSCH members' care homes. It was noted by one of our members that having the operations teams and managers on the floor was beneficial to staff morale.

Guidance

29. CSCH members have never before had to deal with such a rapidly changing landscape of sector guidance and recommended practice. Guidance documents were lengthy and took time to digest. Guidance was issued regularly and often at times that made it difficult to implement quickly, such as late on Fridays.

30. Guidance would be issued to care home managers and those in senior management roles such as operations directors or service directors. Our members would hold meetings between senior management and home managers to discuss guidance and agree how it would be implemented. It then fell to home managers to cascade instructions to staff within their homes. This was viewed as the most effective way to manage the volume of information that was being received. It simply would not have been possible for every member of staff to read all of the guidance documents that were being issued while ensuring that care continued to be delivered.

31. There were numerous challenges with implementation of guidance as it was possible to interpret much of it in different ways. Local Health Boards were often interpreting the guidance one way, but their interpretation would be open to challenge because the guidance was ambiguous. This inevitably led to inconsistencies in application of guidance between care homes of different sizes and in different locations.

Transfer of residents to and from hospital

32. Keane recalls that transfers of residents from care homes to hospital were commonly discouraged at the outset of the pandemic in order to free up NHS beds, however Keane does not recall any outright refusals by the NHS/ambulance service to take residents to hospital. This group member reports one resident being returned to one of its care homes on 12 March 2020 (prior to the care home's own lockdown and the government lockdown) who was not tested before being discharged to the home. There was an outbreak in the home shortly thereafter, but Keane cannot confirm that the outbreak was linked to this hospital discharge given the absence of testing at that time.

33. Oakminster recalls that shortly before lockdown, in early March 2020, a resident was admitted to hospital. The resident was diagnosed with pneumonia and given treatment, before being discharged back to the care home in late March 2020. There was no mention of Covid-19 on the discharge letter however this was before hospitals were testing for the virus. There were positive Covid-19 cases in the home shortly before and shortly after the resident's return, but it is not known whether the resident had the virus and, if so, whether the resident contracted it in hospital or in the home. By this stage the first wave of the pandemic was underway, and the national lockdown had been imposed. None of Oakminster's residents were being taken to hospital during the early stages of the pandemic and no GP would visit. This resident subsequently died in late April without having seen a GP or received hospital treatment. The resident was prescribed end of life medication which proved to be inadequate for the levels of pain experienced. A member of staff from the home reports that they could not get the resident's "pain under control; it was the one death that will stay with me during that time."

34. Later, in October 2020, a resident was admitted from hospital because Oakminster had been advised by the hospital that the resident had a negative test result and that there were no Covid-19 cases on the ward. Shortly after the resident's arrival at the home, the hospital phoned Oakminster to advise they had since had a positive result on the ward. Upon Oakminster re-testing the new resident, the resident was found to be positive. Unfortunately, by that time other residents on that floor had caught covid and the floor was locked down to contain the outbreak.

35. Oakminster also reports a resident who passed away in February 2021. It is not known whether the resident had Covid-19 or not. The GP refused to attend because there was an ongoing Covid-19 outbreak within the home. The resident was prescribed end of life medication and passed away peacefully. Oakminster believes

that the resident should have seen the GP and been offered hospital admission but due to the outbreak in the home this was not an option that could be given to the resident or their family.

36. Thistle recalls one particular resident who was discharged from hospital into one of its care homes. Thistle was advised by the hospital that the resident was Covid negative before the transfer was made. The resident tested positive for Covid-19 very shortly after arriving at the home and subsequently died. The resident had been placed in isolation upon arrival and so the virus was not transmitted to other residents.

37. Thistle also recalls several instances where residents were refused admission to hospital. On one occasion, a paramedic and an A&E consultant jointly refused to take a resident to hospital with no reason given other than "clinical assessment." On another occasion, a resident was taken to hospital in an ambulance by paramedics, however upon arrival an A&E consultant refused admission based on their age, general frailty and having a DNACPR in place. The resident was returned to the care home and was placed on end of life care the next morning. Some residents who were refused admission to hospital were cared for by the Hospital at Home team, who could provide oxygen and antibiotics, however not all residents were given this opportunity due to the capacity of the team.

Infection Prevention and Control (IPC)

37. CSCH members have always recognised the need for infection prevention and control (IPC) and have practiced it to high standards. That said, our members feel it is important to highlight that care homes are the homes of their residents. They are not clinical hospital settings. They have carpets for homeliness, warmth and comfort. They have furniture that is homely, and residents keep personal effects in their rooms. They have communal areas for gathering, dining and socialising. They are very different from hospitals in many respects. Whilst our members have always been very conscious of and diligent regarding the cleanliness of their homes, it is simply not possible to keep a care home as clinically clean as a hospital.

38. Prior to the pandemic our members did not routinely use masks. Gloves and aprons were commonly used, especially when there was a norovirus or flu outbreak, or they were caring for infectious people. When there were outbreaks of norovirus or flu, our members would promote isolation and restrict visiting and there would be a poster placed outside regarding restricted visiting to the home. That has always been the approach taken in care homes. Not all of our members commonly used alcohol hand sanitizer pre-pandemic, although hand washing has always been an important aspect of IPC for all of our members. The use of alcohol hand sanitiser significantly increased during the pandemic.

39. CSCH members were well versed in infection prevention and control pre-pandemic. It is something that care staff are well aware of and are routinely trained in. It is an important part of the running of any care home and the Care Inspectorate has always scrutinised IPC measures during inspections.

40. During the pandemic, the principles of IPC were the same, but the importance placed upon it was greatly amplified. Pre-pandemic there were no PPE stations or hand gel dispensers set up throughout the homes, but now they are always available and accessible to everyone.

41. The level of IPC expected during the pandemic required a completely new way of working for care home staff. It felt like Public Health Scotland expected staff to know how to work to standards that they had never been held to before. The nurses at one of our members' care homes said at one stage, "we're not infection control nurses – we haven't been trained in IPC, we are trying our best." Nursing staff were not IPC specialists, so the pandemic presented a steep learning curve for everyone working in care homes.

42. There was a huge amount of additional cleaning required to meet the standards that were expected during the pandemic. Some CSCH care homes started using chlorine tablets which are used in hospitals to clean the floors. The instructions for the tabs required those homes to change the water once every four rooms. In addition, they had to keep additional detailed records of cleaning. This presented significant additional work for staff and placed further strain upon resources, which reduced the ability to provide the same level of attentive care to residents compared with pre-pandemic.

43. The IPC guidance surrounding PPE required significant additional work to implement. For example, when delivering meals to Covid-19 positive residents who were in their rooms, staff had to don and doff PPE at each of their doors, take a tray of food in, then clean the tray when they took it back to the kitchen.

44. CSCH members trained staff in the use of PPE as an IPC measure, covering things like hand washing techniques and appropriate application and removal/disposal of PPE, although the expectations were ever changing. At one point, one agency advised one of our members that care homes should dispose of visors after use, but another agency advised that they should be washed and reused. IPC guidance was rapidly changing, and contradictory interpretations often emerged when consulting external agencies for support.

PPE

45. Our members had varying experiences of PPE availability and use during the pandemic. Prior to the pandemic, the only PPE regularly used in care home settings was gloves and aprons.

46. Supplies at Oakminster were plentiful before the pandemic, and it was able to secure sufficient stocks at an early stage in the pandemic. PPE was held centrally at head office and distributed to each of its homes as and when required. Oakminster ensured that all of its homes had sufficient PPE supplies by making bulk orders as early as possible during the pandemic. Its first bulk order was placed in early March 2020. The price of some PPE items more than quadrupled when the pandemic hit. For example, a box of gloves before the pandemic cost £1.99 but once the pandemic hit a box of the same gloves cost £7.99. Bulk orders for Oakminster would cost around £22,000. It required to purchase insurance due to the value of the orders and the fact that some other providers had had orders commandeered in transit and diverted to the NHS.

47. As a result of its decision to purchase in bulk at an early stage, Oakminster did not have to clean or re-use PPE at any time during the pandemic. Staff members did not report any serious issues about wearing masks, although wearing them constantly as they required to do was very uncomfortable and added an additional element to the many difficult issues that arose as a result of the pandemic. Additional training was provided to staff on how to "don and doff" PPE and posters were placed throughout homes as reminders of the correct way to use PPE.

48. Thistle had ample PPE to cater for its needs pre-pandemic, however masks were not standard PPE and existing stocks were quickly depleted. When the pandemic first hit, Thistle faced significant challenges in securing visors and masks for immediate delivery. The official guidance in the early stages of the pandemic was that masks were not necessary. Thistle did have sufficient supplies to provide staff with one mask each per shift and this situation prevailed for a further two to three weeks until a delivery of a sizeable shipment of masks was received.

49. Securing continuous and sufficient supplies on an ongoing basis was not without issue. Thistle was advised by suppliers that shipments intended for delivery to care homes were being commandeered by the NHS. Often, expected supplies were not delivered, which exacerbated the situation further. Eventually local PPE hubs were set up, which was positive, but there were limits on how much PPE could be obtained from the hubs.

50. Prior to the pandemic, each unit within each of Thistle's care homes had a central PPE station and a small supply available in each bedroom, dependent on risk assessments. Each care home placed monthly orders for their own PPE stock. During the pandemic, Thistle set up multiple PPE stations within each unit within each of its care homes along the main corridors. Alcohol gel and PPE disposal bins were placed all around each home. A unique challenge that was faced was that residents with cognitive impairments would sometimes wander to the PPE stores and take items out, so those PPE items could not be used and had to be discarded. At one point Thistle received guidance from the Care Home Assurance Team that there should be PPE stations in every fifth room, however the Care Inspectorate disagreed with this.

51. Thistle created a Covid-19 course which was mandatory training for all staff. It covered PPE use (especially mask use) and IPC.

52. During the initial stages of the pandemic, Keane had to top up its supply of masks and started using visors. It struggled to access masks and visors in the early days, however as the pandemic progressed, it was generally well stocked with PPE. There was however one notable occasion when a staff member took a minibus to collect a supply of PPE from the NHS distribution hub in Hamilton. He had taken the minibus because he was hoping to fill it with PPE stocks so that the homes would have significant supplies, but when he arrived, he was only given a single carrier bag of PPE. The supplies that were available from hubs were not always in keeping with demand.

53. Staff reported feeling unsafe wearing PPE as colleagues were still contracting covid despite its extensive use. It made them feel very vulnerable especially when dealing with Covid-19 positive residents and outbreaks.

54. CSCH members found that wearing PPE changed the dynamic between staff and residents, especially residents with cognitive impairments. Some were fearful of the staff when they had their gowns on, and their faces covered as they did not recognise them and often struggled to hear them.

Impacts on Residents and Relatives

Lockdowns, Isolation and Visiting Restrictions

55. The primary impacts observed on our members' residents during the pandemic were as a result of the isolation created by lockdowns, self-isolation requirements and visiting restrictions.

56. Whilst the lockdown decisions were necessary to protect residents from the virus, the lack of family contact and social connection with other residents had profound negative impacts on health and wellbeing.

57. In addition, isolation was required when residents tested positive for Covid-19. Residents would have to be barrier nursed in their rooms for 14 days at the height of restrictions.

58. The isolation of residents exacerbated their difficulties. Not seeing people, especially friends or family initially and then only being able to wave at family through a window affected their moods. There was also a lack of stimulus for residents from activities they would have enjoyed prior to the pandemic. It all affected the residents' mental health.

59. Our members observed that the residents who understood what was happening were quite anxious, but it was also difficult for residents who did not have capacity because it was very confusing for them. Dementia sufferers in particular could not understand why daily life in the homes was the way it was.

60. Our members noted a significant increase in the attention that people living with dementia required during the pandemic. Before the pandemic, they were able to walk about within care homes. People living with dementia often wander around care homes. It is not aimless wandering; they are clearly moving with purpose, albeit that purpose may not be firmly rooted in reality. It did however add a significant additional difficulty when it came to care of people living with dementia during the pandemic. Some of them had to be encouraged to stay in their rooms to prevent movement as the risk to them and others within the home of catching or spreading the virus was too great.

61. Due to the lack of physical visits during the early stages of the pandemic, our members resorted to use of iPads or other tablet computers to allow video call communication between residents and family members. All of our members' homes either had tablets pre pandemic or were able to obtain them when the pandemic hit. There were some local authority initiatives that allowed tablets to be applied for in order to improve contact between residents and their loved ones. Some residents found video calls to be uplifting in a small way, but many found them to be difficult, frustrating and confusing.

62. Communication with relatives became far more difficult. Pre-pandemic, when visiting was commonplace, relatives could obtain updates during visits from the nurses that dealt directly with the care of their loved ones.

During the pandemic our members' staff had many additional responsibilities to deal with, and the increased requirement for communication with relatives was one of these. Every additional responsibility squeezed resources, and the simple reality was that staff were not able to update families on the care of residents as often as they would have liked to. Family members were understandably becoming frustrated by this, and some would call regularly for updates. Staff members did their best to provide meaningful updates in the limited time that they had available, ever conscious of the rapidly changing care landscape.

Visits

63. Visits to residents by relatives prior to the pandemic were a vital aspect of care provision, both in terms of maximising resident happiness and reducing the workload of care home staff. When the pandemic hit, the decision to lock down homes was essential, but it was not known how long the lockdown would need to last. Once the first national lockdown was relaxed for the majority of the public, the position within care homes remained heavily restricted. The impacts on residents and family members, as a result of the length of time visiting remaining reduced or restricted, were profound.

64. Visiting was heavily restricted in the early stages of the pandemic. Guidance did not permit visits. Subsequently window visits were allowed, and then garden visits were introduced in late 2020. Eventually indoor visits were permitted again. Our group members followed the guidance on visiting carefully, interpreting as best they could in the fast-paced environment of the pandemic and with the safety of residents as the primary consideration. This required very unnatural conditions to be created in relation to visits and clearly affected the residents and their relatives. Our members wonder with hindsight whether they should have made concessions, but the guidance at the time felt like strict rules that they had no option but to apply as rigidly as possible.

65. Families were clearly confused and frustrated by visitation guidance. Care home managers were struggling to keep track of the guidance on visitation because it was broad, unspecific, constantly changing and open to interpretation. When assistance was sought from external agencies there were different interpretations offered, and some agencies stated that it was for the care homes to interpret and implement the guidance as they saw fit. Our members felt that some external agencies were trying to wash their hands of the responsibility for implementation. Again, this resulted in a cautious approach to allowing and managing visits within care homes. This approach was borne out of concern for vulnerable residents and a fear of allowing the virus to enter and spread if visiting restrictions were not imposed and enforced.

66. When window visits were permitted, the availability of such visits depended on the design and layout of each care home. Window visits were facilitated by most of our group members. Window visits were frustrating and of limited benefit to residents and relatives. They caused some residents distress because they did not understand why their families could not come in to see them.

67. One of our group members was unable to allow window visits at any point because its homes are converted former school buildings which have elevated windows. The frustration that residents and family members felt because of this was evident. One family member was so desperate to see their loved one that they brought a ladder to the home and climbed up onto a ledge to talk to them through the window. They did not ask the home if they could do this, they simply turned up with a ladder and set it up. As soon as they were spotted by a member of staff, they were ordered to come down immediately. This is offered as a poignant example of how unprecedented the pandemic was, and the type of behaviour that resulted in response to the unnatural restrictions placed on care homes, their residents and family members.

68. Care homes were permitted to allow garden visits following guidance issued in the winter of 2020. It was far from ideal to have elderly residents potentially exposed to winter weather. Our Group members bought gazebos and heaters to create as comfortable a setting as possible. Some of the homes built wooden structures outside for garden visits, but that could not be done everywhere. The visit facilities depended on the location and layout of the home as well as the amount of external space available. Each home had to consider how best to facilitate such visits. The homes had not been built with this type of restricted visiting in mind, so each home had to improvise as best it could.

69. Group members implemented booking systems for visits to control attendance levels. It was necessary to do so in order to minimise risk, but it created further additional work for staff. In addition, due to the rules on social distancing, the residents and relatives required to be supervised during visits. They were not allowed to have any physical contact with their family members. It has been described as akin to being in a prison with no contact allowed and a guard supervising them. This was uncomfortable for the residents, relatives and care home staff alike. Our members appreciate that relatives will have felt like they were not trusted. The reality was that our group members have a professional duty of care towards their residents, and they felt that they had to make sure that social distancing and guidance on visiting was adhered to.

70. In around December 2020, when physical touch was not allowed, one of our Group members developed the "cuddle curtain" so that people could hug their relatives during garden visits. It was a large plastic curtain with arm holes that allowed people to stand at each side and hug. It was able to be fully sanitised between uses. It provided some benefit, and improved visits to an extent, but could be difficult for the residents without capacity because they did not understand why it was necessary. This was used on a case-by-case basis and the staff knew the residents well, so they knew which residents were likely to benefit from its use and which would not.

71. The visiting rules were different depending on the local authority. Guidance in Glasgow could be different from guidance in Lanarkshire. This was especially so when combined with legal restrictions such as lockdown levels which changed depending on Covid-19 infection rates in particular areas. At one point people living in North Lanarkshire were not allowed to travel to South Lanarkshire. Our group members had to follow the rules and restrictions that applied locally, wherever their care homes were situated. It was extremely difficult to keep up to date with the constant changes.

72. Essential visits and their definition proved to be a particularly distressing and difficult concept to manage with family members. Pre-pandemic there was no such concept as "essential visits". The guidance on what constituted an essential visit changed as the pandemic progressed, but the guidance was not clear enough and was open to interpretation. This inevitably led to care homes having to interpret the guidance on an ongoing basis and take a case-by-case approach to requests by relatives for essential visitor status. This caused significant and understandable frustration for family members who were denied visits when they truly believed that they were "essential", but the circumstances were not considered to meet the definition.

73. The ability to allow essential visits was also heavily affected by whether or not there was an ongoing Covid-19 outbreak at a care home. Where a home was locked down due to an outbreak it caused further tensions between care home staff and family members. The lockdown level assigned to individual areas as the pandemic progressed also affected visitation rights, especially for visitors travelling from a location that was at a higher level. Lockdown levels changed often depending on infection rates in specific areas. As a result, managing the expectations of family members about essential visits and when they would be granted was extremely challenging, frustrating for all concerned and further increased the workload for care staff, to the detriment of residents and their families.

External Medical Visits

74. Most of our members' care homes have GPs linked to them. Pre-pandemic, GPs who were linked to a care home would generally visit that care home weekly or twice weekly to see residents with minor ailments. For homes which did not have a linked GP, the GP would attend the care home upon request only. Community Psychiatric Nurses (CPN's) and physiotherapists would also visit regularly. When the pandemic hit, this all stopped abruptly. Our members were able to contact external medical professionals by telephone, but physical visits no longer took place.

75. The impact of this on the residents was that they were not receiving any medical services. GP visits, physiotherapists, dental care and foot care were no longer able to be delivered in person. Telephone consultations could take place, but they were not the same. This clearly reduced the overall quality of care that residents were able to receive.

Testing

76. Testing residents who were living with dementia has been described by staff members as "horrible". Staff members wanted to conduct tests as quickly as possible to minimise distress and discomfort to residents, but sometimes they were unable to obtain the cells they needed as they could not get the swab far enough up the resident's nose. The residents would often grab staff members' hands to stop them. They clearly hated it and often did not understand why the test had to be done. The tests were invasive for everyone, but for those that did not understand why they were needed, the impact would have been worse. Initially, the guidance did not allow any flexibility in deciding not to test in these circumstances but eventually there was a recognition that residents should not be forcefully tested.

End of Life Care

77. In ordinary times, care homes pride themselves on the standard of end-of-life care they provide. A huge amount of time and effort goes into understanding the needs and wishes of residents and their families so that end of life care can be delivered in a personal, compassionate, dignified, intimate and comfortable way. During the pandemic, due to the visiting restrictions, social distancing, PPE and IPC requirements, many aspects of end-of-life care had to be compromised. Residents died without their families by their sides. Some deteriorated extremely quickly and died alone. For some of our members, end of life "just in case" medication, which requires to be prescribed by a clinician, was not always available or able to be delivered in time. Some residents therefore had extremely uncomfortable passings without the aid of palliative medicines, or where "just in

case" medication proved insufficient for pain control but the resident was not able to be admitted to hospital. The experiences that those residents will have had in their final moments are incomprehensible.

78. Prior to the pandemic, when a resident died in a care home, our members would phone the relative immediately and give them the option of coming in to attend to their loved one. They would prepare the body before relatives came in to see their loved one. They would cleanse them and make sure things like rosary beads were in their hands. They would make sure the room and the setting were appropriate and in keeping with the residents' wishes.

79. During the pandemic, the process when a resident died remained the same, however staff had to put the body into a body bag, which was very unpleasant and upsetting for them. The rules did not permit our members to handle the body in the same way as they did before the pandemic.

80. Managing access for relatives at the end of life was very difficult. In the early stages of the pandemic the lockdown restrictions meant that families could not be with their loved ones when they were dying. People were standing at windows while their loved one was passing away. There was a lack of dignity and intimacy at such an important part of life. Eventually, the guidance allowed "essential visitors" at the end-of-life, and then later essential visitor status was given to family members of people with cognitive impairments like dementia who were suffering from distress as a result of the pandemic. It was up to the individual care home to risk assess how rigid to make the visitation rules but there was an expectation in the guidance not to overcrowd, so consideration had to be given to the fact that homes could not have too many people round a bed.

81. Having to facilitate visits whilst also maintaining social distancing and cleaning up after visits put more pressure on staff. Staff could not be as attentive as they ordinarily would be to the needs of relatives due to the additional duties that they required to perform. When there were visitors in the home, they had to wear PPE. They also required to evidence a negative PCR test and their temperatures were taken before they were allowed into the care home. When it related to end-of-life care and essential visits, the additional measures in place removed the dignity and the intimacy and did not always allow the personal wishes of residents to be implemented in their final hours. The impacts on those residents and their family members were profound. Many relatives have had the memories of their loved ones tarnished by the circumstances of their passing.

DNACPRs (Do Not Attempt Cardiopulmonary Resuscitation)

82. DNACPRs and the approach to them by GPs varied significantly between our members' homes. Most of our members' homes have specific GPs assigned to them and the approach to DNACPRs varied depending on the GP. As such, evidence of DNACPR requests has been addressed in individual statements submitted by staff of CSCH group members.

83. The common thread that runs through all of our group members' experiences of DNACPRs during the pandemic is that they felt like care home residents were simply written off. CSCH members found the issuing of blanket DNACPR instructions to be inhumane and deeply concerning.

Anne's Law

84. The members of CSCH are aware of the campaign for Anne's law and are wholly in support of it being enacted in the terms sought by the campaigners. The resident whose name the campaign bears was Anne Duke, who resided in one of Thistle's care homes. Thistle wishes to offer a testament to her:

"Anne was a much-loved resident at Whitehills. What we loved and admired most about Anne was her fun personality, even through challenges this never faltered, Anne always had a sparkle in her eye and a smile. We knew that Anne had a deep love of music, dancing and singing to her favourite song "Tiger Feet" was a daily occurrence. We loved seeing her react to the first few beats of the song and then see her start dancing.

Anne had a great sense of humour and loved to hear jokes and anecdotes, usually reacting with a laugh and 'my God!'

During Anne's time in Whitehills we were lucky to be able to get to know her family. Anne was at her happiest when her kids and grandchildren were with her. It was always heartwarming to see how very much loved Anne was by her family, their bond and commitment was unbreakable. We were privileged to have one of Anne's daughters visit on her wedding day and felt honoured to help support Anne to be part of this family event.

Anne brought a lot of love and affection to our home and is dearly missed by us all."

85. Prior to the pandemic, Anne's relatives had been a regular and vital part of her care team, as was the case for many of our members' residents. The benefit that regular family contact brings for care home residents cannot be overstated. Having that removed from residents during the pandemic created some of the most profound impacts that our group members observed. Many residents withered before their eyes when deprived of the nourishment that seeing, touching and speaking to their loved ones would bring.

86. The removal of relatives from care home settings during the pandemic also increased the burden on our members' staff and further stressed their ability to provide the same standards of care. Every additional responsibility squeezed capacity during the pandemic. Family members have always helped care homes immensely by taking care of their loved ones during visits. They carry out so many tasks that are small, but hugely important. They assist with feeding and dressing the residents, with organising rooms and tending to the residents' needs. These tasks all take time. Family members are therefore enormously helpful in that they free up nursing and care staff to perform other tasks that only they can carry out. To use a football analogy; the family are the "12th player". Having that removed during the pandemic meant that all of those small but important tasks had to be carried out by care home staff, which further exacerbated the squeeze on capacity.

87. It is absolutely critical that the importance of the relationship between family members, residents and care homes is safeguarded. CSCH members fully support measures being put in place to ensure that in the future, even in the face of a deadly pandemic, the right of residents to be visited by nominated loved ones is preserved. This will be of double benefit to residents as it will not only guarantee that they continue to receive the nourishment of family, but will also ensure that the capacity of care home staff to meet their complex care needs is not diminished.

Impacts on Staff

88. CSCH members have observed a broad range of mental and physical impacts on staff members as a result of the pandemic. Some contracted Covid-19 and continue to suffer from Long Covid. One staff member contracted Covid-19 and sadly passed away. She was 58 years old.

89. The experience of staff members on the front line has been described as "like nursing in a warzone". The sheer number and nature of additional responsibilities imposed upon care home staff as a result of the pandemic, combined with the staffing issues that were compounded by illness and isolation requirements when staff

tested positive, led to the biggest squeeze on resources that the sector has ever faced. There was no hope of maintaining care standards compared with pre-pandemic, despite the best efforts of staff.

90. Emotional stress was the biggest issue reported by staff. Workers in the care sector are used to doing a difficult job in a fast-changing landscape where staff resourcing issues can often require short notice changes to daily routines. Care staff tend to be very resilient people by nature and build upon that resilience through experiences at work, however the pandemic was on a completely different scale in terms of the pressures it placed upon them. Staff were quickly burned out due to lack of rest or respite. In addition, staff had to communicate regularly with angry and upset family members, while still providing care for residents.

91. Some staff stayed in the care home when staff numbers were low due to positive tests. They also worked extra days and longer hours to ensure that there were sufficient staff numbers. The increased working hours, as well as the enormous changes to working practices and additional responsibilities that had to be taken on, further compounded the mental and physical exhaustion of staff members.

92. In addition, the experience of nursing patients that died of Covid-19 was particularly unpleasant and traumatic for staff. Many have buried their experiences deep and prefer not to talk about them. Revisiting their experiences in providing evidence to the Inquiry has been emotional and difficult for the staff members that have done so.

93. Many staff members left care altogether, for example to work as supermarket checkout assistants. Those jobs were understandably appealing to them as they were better paid and removed them from the very difficult reality of nursing during the pandemic. Care staff do not work in the sector because of the pay, they do it because they have personalities that are suited to it. They are caring people and want to make a positive difference to residents. The immense stress, anxiety and frustration that nursing in the pandemic placed upon care staff sadly resulted in many great carers leaving the sector for good. They were pushed to breaking point and beyond, so they decided to remove themselves from the setting. Our members do not blame any of them for making that decision; people can only cope with so much and they were battling a perfect storm on a daily basis. Even the most resilient staff found themselves questioning whether they could go on.

94. Care staff were deeply concerned for their families. Some of them moved out of their family homes in order to protect their loved ones. One staff member in particular moved into a property owned by the company for three months at the beginning of the pandemic. He had packed his bags and said goodbye to his family, not

knowing if he would see them again. He was in a senior management role but was a trained nurse and felt compelled to use his skills as a clinician to help residents. He did not have to go onto the front line, but he did. It was an admirable response, but it significantly impacted him and his family.

95. The disparity between restrictions on care homes and the general public caused significant anxiety among care staff. When restrictions were relaxed for most members of the public, care homes remained heavily restricted. Window visits were allowed and then garden visits were allowed. However, at the same time, the staff were coming in and out of the home each day, and were going out for their food shopping in their spare time. When the Eat Out To Help Out Scheme was introduced in August 2020 it created a very confusing situation for care home staff because they were being told by the UK Government that they should dine out to help the economy but there were still significant restrictions on care home residents and families in terms of visiting. Many of our group members' staff were reluctant to socialise outside of work for fear of contracting the virus and causing an outbreak when they attended work. These self-imposed restrictions on socialising had a negative impact on the staff affected and contributed to their feelings of burnout.

Testing

96. Testing caused a lot of stress and anxiety for staff. They were extremely worried about the possibility of testing positive and the potential to be the source of an outbreak that led to deaths. If staff members tested positive, they reported feeling extremely guilty even though they had done nothing wrong. They would be worried about who they may have infected before finding out. The nature of the virus meant that there could be positive tests for asymptomatic staff members so they may have been working with residents without any feeling of being ill.

Administrative Burden

97. The volume of additional paperwork that our members had to complete during the pandemic has been described as "staggering" and "immense". They had to complete forms for any suspected positive Covid case; a form for all confirmed positive test results; another form to notify an outbreak; and a multi-page notification for each resident that died. There were requirements to report the same information to various agencies that appeared unnecessary. Our members wondered why there was no system that allowed them to send a single report that all relevant agencies could access.

98. During the pandemic our members received calls from various agencies. The level of contact varied between members and homes depending on their size, location and type of care. Our members have reported a range

of frequencies of calls from the Care Inspectorate, Health & Social Care Partnerships and Police Scotland in which they were asked for statistics. Our members found this approach to be an additional burden which was inconsiderate of the fact they were delivering care in the midst of a pandemic. It was offensive to staff that these agencies were calling from offices seeking figures when care homes were dealing with the difficult reality of providing care. It was an approach that felt deeply insensitive.

99. Our group members also had to keep health check forms, visiting schedules and lateral flow test results. They had to keep a detailed and regularly updated log of PPE stocks because it was being used so rapidly.

100. All of this placed huge additional burdens on staff who had to absorb the additional work. It was exhausting and contributed to the many added pressures upon care staff.

Operation Koper

101. In addition to the increased paperwork noted above, our members had to deal with the onerous reporting obligations for Operation Koper, which required them to complete a lengthy questionnaire for each suspected or confirmed Covid-19 death, along with answering various additional questions and providing next of kin information. In June 2020 the Lord Advocate issued a direction to Police Scotland to report all suspected or confirmed Covid-19 deaths to the Crown Office & Procurator Fiscal Service for consideration. The first requests of this kind from Police Scotland were received by CSCH members in the Autumn of 2020.

102. CSCH staff members found the police involvement to be deeply distressing. They continue to feel anxiety about it today. No decisions have yet been made by the Lord Advocate about whether any action will be taken. Care staff continue to live with uncertainty over what may happen. Many parts of society and business sectors appear to have moved on from the pandemic, and most without fear of their actions being scrutinised in court proceedings. CSCH members and their staff continue to endure the looming prospect of action being taken against them. The impact that Operation Koper has had and continues to have on their mental health is significant and should not be overlooked.

103. The vast majority of interactions with Police Scotland were pleasant and professional, but at times there was a lack of appreciation that care staff knew the residents that had died and had been hugely affected by the circumstances of their passing. The manner of investigation accordingly felt clinical and significantly affected the care staff that had to provide information to Police Scotland.

Media Attention and Public Support

104. Our members observed significant impacts on staff mental health as a result of the way cases of Covid-19 in care homes were portrayed in the media during the pandemic. Staff members felt that the tone of the reporting was very unfair and presented a one-sided view. It significantly impacted staff morale when there were outbreaks that were covered in the media. They were giving their all to provide the best care that they could in extremely difficult circumstances, but they were being vilified in the media.

105. In order to help staff with this, some members introduced team debriefs so that before staff went home from work, especially on days where they had a poor shift or there had been a death, they were able to talk about it and make sure they did not go home feeling like that burden was on their shoulders.

106. The local community is reported by our members to have been a positive and welcome influence on morale, despite the media attention that our members were receiving. The headlines in the news were not reflected in our members' experiences of the community support they received. Local restaurants sent food such as pizza and curry to the care homes. Some members of the community sent Easter eggs to homes. It was heartwarming, especially when compared to the way care homes were being portrayed in the media.

Inspections

107. Prior to the pandemic, our members generally had annual Care Inspectorate inspections. The vast majority of care homes were consistently rated 4 (out of 6) or higher during these inspections. These inspections did not give rise to any significant enforcement issues. Our members had good relationships with the Care Inspectorate. If the Care Inspectorate made any recommendations which would improve the outcomes for residents, our members were always willing to take those on board. It was a collaborative and collegiate approach to the common goal of upholding the highest standards of care.

108. The Care Inspectorate introduced Key Question 7 for inspections during the pandemic which asked, "How good is our care and support during the COVID-19 pandemic?". This was the only question that they were graded on during the pandemic. The timing and frequency of inspections of care homes during the pandemic was irregular. Some homes were inspected early in the pandemic whereas some were not visited for many months, even years. Some inspections were carried out remotely using video calls. On those occasions the Care Inspectorate would ask a member of staff to walk around the home with an iPad so they

could remotely observe things such as social distancing and IPC. The value of those types of inspection was heavily affected by the quality of the cameras available on the devices used and they were no substitute for in-person inspections.

109. When physical inspections did take place, the Inspectors were joined by infection control specialists from Health Improvement Scotland. Some of our members were concerned about the risks that inspectors may bring Covid-19 into the home. One home in particular asked the inspectors when they had last been tested for Covid. They advised they were tested "when required". The home and staff were concerned by this because the inspectors were going in and out of residents' bedrooms.

110. Our members noticed increased scrutiny of IPC during the pandemic. Issues were being raised that never would have been pre-pandemic. Inspection was far more extensive and forensic than had ever been the case before. Our members describe inspectors lifting and unzipping mattresses to check for stains. Criticisms were made of items, such as personal possessions of residents, that were arranged in rooms to make them feel homely. The inspectors did not seem to appreciate that for the residents, it was their home.

111. Our members felt that expectations of inspectors were unrealistic, and the IPC standards that care homes were being marked against were clinical hospital standards. An example was when a resident had dropped some rice crispies on the floor during breakfast. The inspector said that was an infection risk but did not consider that it was immediately after breakfast and staff had not had the chance to clean the resident's room yet. In another home, during an inspection a resident with cognitive impairment had returned to their room, sat on their bed and soiled themselves, and the inspectors raised it as an issue because it had not immediately been attended to, when it had happened only minutes before. In another home there was a resident with a Zimmer frame that had a dried in mark on it. The inspectors claimed there was contamination and a risk to life.

112. CSCH members do not feel there was an appropriate balance struck during pandemic inspections between the clinical needs of residents and the wider care and well-being needs of residents. They were too focused on IPC and did not give sufficient consideration to the practical realities of life in care homes.

113. Our members asked the inspectors whether they had ever worked in care homes. They said some of them had but many had not done and did not have experience of IPC in care home settings. This included the infection control specialists from Health Improvement Scotland.

114. Staff morale was very often lowered by inspections during the pandemic. They were working incredibly hard in the most testing circumstances and were doing their level best, but they were still being told that they were not doing enough. The way inspections were carried out during the pandemic was not helpful, and often felt counterproductive to our members. It did not seem to be guided by industry knowledge and there was little common sense applied where needed.

115. All of the above issues with inspections made care home staff feel anxious, exasperated and downtrodden. The relationship between our members and the Care Inspectorate was adversely affected as a result of the approach taken to inspections during the pandemic. They felt like they were being held to standards that were impossible to attain.

Post-Pandemic

Lessons Learned

116. Our members feel strongly that family members should never again be kept from their loved ones to such an extent. The decisions to lockdown and restrict visiting may have been made in the face of an unfamiliar and fast developing global pandemic, but the consequences of those decisions beyond the hope that they would reduce infection rates were not properly considered. Emergency responses to future pandemics need to look holistically at the problem, associated risks and the likely impacts of proposed solutions.

117. Our members feel that it is strange to hear much of the information that was published at the height of the pandemic being repeatedly described as "guidance" during the Inquiry. It may be guidance rather than law, but to our members, during the pandemic, it was portrayed as though it was mandatory. The care industry is a heavily regulated sector. If care homes deviate from accepted practice, they are met with a heavy hand by the Care Inspectorate. If shortcomings lead to injury or death in care homes, they are open to investigation by the Care Inspectorate, HSE or Police. They are always exposed to civil claims in such cases and can be prosecuted where there are particularly bad failings. All of this needs to be remembered when considering whether the strategic pandemic response was appropriate. Care homes and their staff had no immunity from prosecution extended to them during the pandemic, which inevitably led to a very rigid and risk averse approach to their implementation of guidance. Anybody delivering care in a medical setting should be treated

the same in a future pandemic. Care homes should not have been treated differently from the NHS in this regard.

118. Guidance should therefore be clearly distinguished from law in both professional and public understanding. There should be a mechanism for challenging any future pandemic guidance issued. Guidance should be given a clear status as optional and not mandatory. It should be designed to assist decision makers in organisations but not to tie their hands. Where guidance has not considered the practicalities of a particular industry or setting then decision makers in private organisations should be empowered to depart from it without fear of repercussions, provided their reasons for doing so are appropriately documented.

119. Care homes are a vital part of the national care framework. The NHS could not function without them. There simply would not be enough hospital capacity to treat all those who are unable to obtain adequate care at home or in the community but are not critically unwell to the extent of requiring hospital admission. Care homes are therefore a key component in any functioning modern society. The requirement for infection prevention and control needs to be balanced with the quality of life enjoyed by care home residents. It must be recognised in any future pandemic that care homes settings are fundamentally different to hospital settings and imposing similar levels of IPC expectation risks undermining the fundamental purpose of care homes which is to maximise quality of life for their residents.

120. CSCH members state that the ethos of health and social care policy in these times is that collaboration fosters improvement. They therefore wish to pose the question as to why they were not consulted either before or during the pandemic? If the Scottish Government had sought their opinions, valuable knowledge could have been harnessed and used to inform guidance. The reality however was a one-way street of information. It is appreciated that the pandemic took hold at rapid pace, and consultation may not have been possible in advance, but the lack of proper preparation for a pandemic created that impossibility. There needs to be greater consultation with the care sector in future.

Hopes for the Inquiry

121. CSCH members wish to play their part in bringing about positive change for the benefit of care home residents and their families. Our group members are however trepidatious due to their experiences during the pandemic and the way they have been portrayed in the media, as well as the looming potential of litigation. In deciding whether to participate in this Inquiry, our members had to overcome fear of pushing their heads

above the parapet and calling for change, because they are independent companies that receive no government support. When things go wrong, they are investigated by regulators and exposed to civil damages claims. In serious cases they may face prosecution. Our members nonetheless feel strongly that their organisations should be heard and that they can bring considerable benefit to the Inquiry. They hope that it will be evident that they did their best at all times to care for their residents. They did so with reference to a government and public health guidance framework which was ill conceived and not fit for purpose. Care homes and their staff should not be punished for working to the best of their abilities when the tools they were given were blunt.

122. CSCH members hope that the Inquiry leads to government and industry decision makers listening to care home operators when they are creating new standards and guidance, which would be to the benefit of residents and family members, who are the very people that the system exists to support.

123. CSCH hopes that the Inquiry will make a recommendation that Anne's Law should be enacted in the terms sought by the campaign.

124. CSCH hopes that the Inquiry will make recommendations that question the necessity and proportionality of Operation Koper.

125. CSCH hopes that the Inquiry will ultimately make recommendations that have a positive and lasting impact on the people of Scotland and serve as an appropriate legacy to all those that tragically lost their lives, or continue to suffer immensely, as a result of the Covid-19 pandemic.

Central Scotland Care Homes ("CSCH")
14 January 2024

This statement can be spoken to by the following witnesses:

Daren Tyczynski – Care Service Director – Keane Premier Healthcare Limited
Lissa Di Giacomo – Managing Director – Oakminster Healthcare Limited
Scott Finnigan – Group General Manager (Operations & Quality Improvement) – Thistle Healthcare Limited