Witness Name: Scottish Care

Statement No.:

Exhibits:

Dated: 10th December 2024

UK COVID-19 INQUIRY Module 5

CORPORATE STATEMENT OF SCOTTISH CARE

I, Dr Donald Macaskill, c/o Scottish Care Ltd Bld 372, Ground Floor Offices, 22-27 Alpha Freight Glasgow Airport, Prestwick KA9 2QA, 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.

Scottish Care

2. 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 Bld 372, Ground Floor Offices, 22-27 Alpha Freight Glasgow Airport, Prestwick KA9 2QA. It was established some 25 years ago.

3. 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.

4. 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. Approximately 60% of our members provide residential and nursing care home services, with the remaining 40% providing services to people in their own homes or in supported accommodation. The majority of clients our members support are older adults although in the community the provision includes adults with disabilities, those with neurological conditions, those with mental health support needs and those who are supported by drug, alcohol and addiction services. The services delivered are predominantly for older persons living with a range of conditions, including dementia, other neurological conditions as well as with the impacts of frailty. Scottish Care represents more of such providers than any other representative body in Scotland. They employ staff from all backgrounds and operate across the whole geography of Scotland delivering 85% of all residential care for adults and the majority of care at home for older adults.

5. 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.

6. Scottish Care is a charity with a Board of Trustees who ensure good governance and set the strategic direction of the organisation. Its senior management comprises a Chief Executive and Deputy Chief Executive who report directly to the Executive Board of Trustees. There is a small group of national support staff, some of whom are grant funded comprising thirteen persons. Other staff members, at the time of writing, number 26 other persons the majority of whom are part of our Partners for Integration team and work mainly in the roles of Independent Sector Leads and are located across the country in the majority of Health and Social Care Partnerships.

7. 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.

8. 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.

Pre-pandemic PPE practice

9. Before the Covid pandemic resilience and contingency planning was undertaken by individual members and this was primarily influenced by whether a care home was delivering nursing care or residential care, and the extent to which clients with respiratory conditions and other conditions were being supported in the community. In normal times members would have a baseline stock of Personal Protective Equipment (PPE). However, as most care organisations, not solely those operating building-based care and support, have limited storage facilities, and that PPE (such as masks) has a time-bound shelf-life, any additional stock of PPE which would be retained by members would be a minimum. We have no evidence as to the extent of stock

available, but it is a reasonable expectation that the vast majority of providers would have base supplies to meet expected and anticipated need.

10. As part of preparation for Brexit and especially in the light of the risk of a no-deal Brexit situation preparation had begun on addressing the risk of gaps in availability should there be trade restrictions, as the vast majority of PPE used in the sector came from outwith the United Kingdom. Such preparations were at a very early stage before the pandemic, but they included a direct engagement between Scottish Care and NSS.

11. Scottish Care is not aware of any published standards or guidance re the availability of PPE before the pandemic.

12. Before the pandemic virtually all PPE used by our members was purchased either directly (typically by larger organisations) or much more commonly through suppliers and intermediaries.

During the pandemic

13. At an early stage of the pandemic I met with Scottish Care's Executive Committee in February 2020 – this was a pre-arranged meeting, but the timing aligned with the heightened awareness of the impact of Covid-19. At this meeting we discussed what was happening in other countries and the conversations that Scottish Care had had with the Scottish Government at that time. By this time, Scottish Care had been in informal discussions with HPS about the need to create guidance for care homes, but Scottish Care was concerned about the time that it was taking for such guidance to be produced. Therefore, Scottish Care decided that it would produce its own guidance in the interim.

14. 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 as well as guidance which was based on the procedures for norovirus and flu outbreaks in care settings. It contained specific information for social care providers in relation to the development of standard operating procedures, personal protective equipment ("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 for the sector.

15. After this initial publication, Scottish Care did not produce any further guidance during the pandemic and instead directed its members to guidance produced by the Scottish Government, PHS, COSLA and the Care Inspectorate.

16. 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 by means of an embedded consultant 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.

17. 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.

18. Scottish Care primarily became aware of concerns over the supply of PPE through our regular surgeries with members and through direct contact from providers. We also undertook a weekly survey of our members and shared the findings of this survey with the Care Inspectorate who then took over the running of the survey.

19. The first survey on clinical consumables commenced in early March with the first results for 10 March 2020. We requested that the Care Inspectorate put a version of this survey out through their channels which would have a wider reach. They then reported the results back to us and to our colleague who was working with NSS. The version from the Care Inspectorate went live in early April.

20. We used the comments and results from our survey together with comments in our surgeries and on discussion boards to inform our input into meetings and to share with NSS and Scottish Government colleagues. We provided overarching summaries rather than sector or geographically specific information. The survey was per service rather than per organisation.

21. The survey focussed on availability and did not relate to the quality of that which was available or provided nor did it relate to price. This survey lasted for the initial period until the establishment of PPE hubs and stopped in July and despite discussions about restarting in the Autumn, we did not reinstate it as after the Hubs were established there was a significant drop off in responses plus other data collection routes meant it wouldn't add value at that stage.

22. Issues of PPE quality arose during surgeries and webinars and where necessary were raised in routine meetings with NSS and the various Scottish Government meetings senior staff attended throughout the pandemic.

23. Scottish Care had a consultant whose position was funded by the Scottish Government, and who 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. We found the working relationships with NSS to be constructive, respectful and professional.

24. 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.

25. 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.

26. 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 as far as we were able to receive and access these.

27. 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. However, it can affect 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 effects and how more accessible forms of PPE can become more routine in availability and use.

28. 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") 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.

29. 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.

30. 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 HSCPs 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.

31. 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.

32. 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, but the reality was that these staff were wearing the appropriate PPE for the context and as required at the time. 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.

33. 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.

34. 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.

In the context of the issues being explored by Module 5 it is my view that the social care sector remained throughout the pandemic as a second priority in comparison to the acute and secondary NHS sector. Indeed, I would argue that given the lack of any

social care representative on the Pandemic Preparedness Committee of the Scottish Government established at the end of the pandemic, that this remains the case. I have no confidence that were we to face a new pandemic tomorrow that social care, its workforce and those who use its supports and services would not continue to be a secondary priority.

35. 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 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.

36. 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.

37. 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.

38. 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 dressed head to toe PPE, whereas the care home staff only had an apron, vinyl gloves, 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.

Care at Home

39. In the early stages of the pandemic due to the lack of guidance for care at home, there was a lot of uncertainty about what PPE should be worn by carers. Initially there was no general requirement for those providing care at home to wear PPE which had an impact on care at home providers' ability to source PPE. There were shortages of PPE across the country and, as there was no guidance mandating the use of PPE for care at home, providers did not have priority access to the PPE supplies that were available. As at 26 March 2020, HPS guidance for care at home was that PPE was to be worn by those providing care at home only if the person receiving care was suspected of having Covid-19 or had tested positive for Covid-19.

40. As part of their role, those providing care and support at home are required to travel between different houses. Many of our members said they were concerned about the risk of transmitting COVID-19 between those they cared for and also the risk of taking COVID-19 home to their families. These fears had an impact on the mental wellbeing of those providing care at home services.

41. At this time, social care workers were regularly seeing healthcare workers wearing full PPE. In the event that a district nurse or other health care professional came to a service user's home, they would be wearing full PPE. This made those providing care at home feel like second class citizens by comparison as they were expected to attend homes and provide personal care, which often involves close contact with those for whom they care, without or with a lesser degree of PPE.

42. Guidance mandating that social care staff, including care at home staff, should wear face masks was first introduced on 29 April 2020. However, at this time social care providers faced limited access to PPE due to market supply issues. To support members in navigating this complex landscape, a member of Scottish Care's staff was tasked with sourcing PPE and it became their full-time job. Other members of Scottish Care staff were delivering available PPE to care providers in their local areas. We do not have detailed information on the PPE that was being delivered by local staff but recall that this was for instance masks from schools delivered to care homes in Ayrshire; gifts of alcohol gel from local distilleries in Aberdeenshire, and a more

coordinated approach by a consortia of providers in Aberdeen. These were all local initiatives, and we do not possess detail of what was purchased or the costs etc.

I recall being told by providers during one of our surgeries that some of what the consortia had ordered and indeed some of what individual mid-size providers had ordered had been requisitioned at port of entry by the UK Government for use by the NHS. Priority was given to the NHS and social care staff questioned why their health or the health of the people they were supporting did not seem to be considered to be as important. This took an emotional toll on social care staff.

Scottish Care was not informed directly of this practice by UK Government, and I am unaware of compensation or replacement, if any. Obviously when the co-ordinated system of hubs became established this was no longer an issue.

43. NHS National Services Scotland ("NSS") took on the role of procuring PPE for the social care sector. However, its experience was of procuring PPE for use in hospital wards for which PPE was allocated based on the number of staff and the number of 'sessions' for which PPE was required. A session was defined as a two-hour period. Social care visits were (and are) often scheduled to last only 15 minutes. Social care staff needed to change PPE after contact with each individual to whom care was being provided, or more often depending on the nature of the care being provided. This resulted in shortages in the amount of PPE allocated to social care providers. Scottish Care worked with NSS who quickly resolved these issues and discussed the calculations that needed to be carried out to ensure staff had sufficient PPE in April 2020.

44. Care at home staff were sometimes attending homes in which there were other people living with the individual receiving care. This meant the potential for close contacts for staff was not limited to those receiving care. This caused additional concerns for staff and, when PPE became available and staff were being told that they had to wear it, often no one else in the house they were in would be wearing PPE. This made some staff feel unsafe.

45. Some providers raised concerns that although their staff had procedures to follow for the disposal of PPE, it appeared (as a result of discovering PPE in the general waste) that these procedures were not being followed by others visiting the home.

46. When it became a requirement for care at home staff to wear PPE it was at times difficult to find a balance between the use of PPE for protection and the impact it had

on some people receiving care. When wearing PPE people cannot see their carer's facial expressions and it often makes understanding what is being said more difficult for those who have hearing loss. More than 70% of those over the age of 70 have hearing loss, therefore this issue is likely to have affected a significant number of people receiving care at home. This caused communication barriers, uncertainty and fear, which in some instances caused people to communicate their feelings in a non-verbal manner that put the care worker at risk.

Re-usable PPE

47. The issue of whether or not members re-used PPE including gowns during the pandemic never became one of significance during our engagement with members so we can only estimate that this was not a major issue especially after the development of the PPE Hubs. We have likewise no information as to whether or the extent to which PPE was re-used after the pandemic but would consider this not to be the case except in extremis.

Infection prevention and control ('IPC') guidance

48. As has been stated passim Scottish Care engaged on numerous occasions with those who developed the Guidance on the use of PPE in care settings primarily through our involvement in the Pandemic Response in Social Care and Clinical and Professional Advisory Groups.

49. In almost all the interactions with IPC professionals we sought to underline the requirement for guidance to reflect the nature of care home and homecare life rather than for what was often essentially guidance developed for an acute NHS setting to be replicated and slightly edited for use in social care settings. A whole range of factors were involved in this, not least of which was the importance of underlining that a care home was primarily a home and not a clinical setting; that residents in a care home were often individuals who lived with dementia and that they had rights and autonomy which needed to be respected, and that the practices of a sterile NHS secondary care clinical setting were not appropriate in a homely environment.

50. At various times the lack of consistency and the continually changing Guidance on PPE far from instilling confidence on the part of frontline staff and managers, served to do the opposite. This was perhaps most evident in the issues noted above in relation to the use of gloves.

Testing

Testing of residents on admission.

51. 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.

52. 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.

53. 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'.

54. 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).

55. 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.

56. 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.

57. 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.

58. 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.

59. 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 people at risk, and put 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

60. 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.

61. 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. This made it difficult for care home managers and staff to access tests and the lack of whole home testing made their use essentially confirmatory rather than preventative.

62. 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.

Testing of staff

63. 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. This was directly raised with the Cabinet Secretary and at all forums and meeting we were involved in as well as in the media. I expanded on this in my oral statement at Module 2a hearings.

64. 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.

65. 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.

66. 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.

Care at Home Testing

67. Scottish Care advocated for social care staff to be given the same priority access to testing as health care staff. In April 2020, it was announced that care home staff and residents would be given enhanced testing access, however, this was not extended to homecare staff. We again continued to advocate for extending testing to homecare staff and making this access easier in the meetings of PRASC and CPAG and all other meetings as well as on media.

68. At this time, homecare staff were experiencing high levels of anxiety and distress associated with the fear of carrying COVID-19 unknowingly between the homes of the vulnerable people they were supporting. Scottish Care made representations to the Scottish Government at various meetings that testing could help to reduce such fears as well as help to ensure critical homecare workers were off work for shorter periods of time when they or a family member were suspected of having COVID-19 but testing proved that they did not.

69. Inconsistencies between testing for care home and care at home staff persisted and Scottish Care was still calling for homecare staff to be able to access testing on the same basis as care home staff in September 2020.

70. When PCR tests were required, accessing testing sites was difficult as it often required individuals to travel which proved to be a barrier for those homecare workers who did not drive. In care homes staff would test in the home, but there was no consideration of how those providing care at home could access testing. It took a number of months for care at home staff to be granted enhanced access to testing and it was not until January 2021 that priority post boxes were designated for care staff to post their PCR tests without having to travel to a testing facility.

Vaccination

71. 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.

72. 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.

73. 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.

74. 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.

75. 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.

76. 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

Lessons learned

77. Scottish Care undertook a research project in 2020 in the midst of the pandemic after the first wave and before the second wave. This took place utilising an online and survey format from the early summer 2020 until the end of the year with a visual report on thematic findings published every few weeks within that period. The overarching title for this asset was 'Collective Care Futures'. The work had four strands namely, Critical reflection: key insights around the learnings from the experience of COVID-19 for each thematic area, including immediate priorities (windows of opportunity); Critical evaluation: key insights on enablers of change and innovation and resulting implications for practice, planning and reform processes; Creative modelling: preferable future scenarios for the independent care sector related to themes and contexts (care homes and care at home) and finally a Roadmap: now, near, next pathway to guide the future, highlighting priority areas for practice, policy, research with supporting actions, outcomes and people required to enable implementation.

    The thematic areas covered were technology, care practice delivery, regulation, partnership and workforce.

78. A second phase completed the following year resulted in the publication of a report entitled 'Coileanadh: Social Care Future Care Leadership.'– Future Landscape'

    "Coileanadh" is a report by Scottish Care that envisions a transformative future for Scotland's social care sector.
    The report identifies eight key concepts and 39 actionable steps, organised into three primary focus areas:

    1. Philosophy and Culture: Advocates for a shift towards a rights-based, person-centred approach that values individuality and promotes well-being.
    2. Policy and Partnership Enablers: Emphasises the importance of collaborative efforts among stakeholders, including policymakers, care providers, and communities, to create a cohesive and supportive care environment.
    3. Practice-Based Change: Focuses on implementing sustainable changes in care practices, ensuring that services are adaptable, innovative, and responsive to the evolving needs of individuals.

    The report underscores the necessity of adopting a life-course perspective, normalising the aging process, and fostering societal appreciation for the contributions of older adults. It also highlights the critical role of relationships and partnerships in

understanding and supporting the health, social, and well-being needs of communities. By addressing these areas, "Coileanadh" aims to overcome existing implementation gaps and articulate the essential components of a National Care Framework for Scotland.

Engagement and involvement

79. 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 ignorant to the specific needs and contributions of the sector.

80. 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 which included issues of PPE, testing and vaccination, nevertheless 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 perhaps especially in relation to PPE, infection, prevention and control guidance, testing and vaccination.

81. 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. There remains an ongoing failure to include operational social care partners in matters relating to vaccination and testing. The whole scene is dominated by the mantra that the NHS knows best. Nevertheless, the full and thorough engagement of the sector would require the sector and its representatives to be properly resourced to achieve this aim.

82. 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.

83. 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.

84. 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 and in operational resilience and emergency response.

Importance of adequate PPE

85. 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. Mechanisms to triage and deliver supplies across Scotland should be developed in accordance with the lessons learned throughout the COVID-19 pandemic.

86. 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.

Testing

87. Testing must be used as a preventative method to control outbreaks as well as a diagnostic tool.

88. Given the vulnerability of those residing in care homes, it is essential that all individuals being admitted from clinical or community settings are adequately screened and tested as appropriate prior to being admitted to a care home.

89. Different testing implementation models adopted in different areas of Scotland led to inequalities in approach and timescales. Therefore, a clear approach must be developed for application across the country subject to being tailored to address specific local requirements (e.g. in remote areas or in areas with poor transport links).

Guidance

90. Keeping updated with constantly changing guidance not least on PPE was a significant challenge throughout the pandemic. The introduction of potentially conflicting information and short guidance implementation periods placed additional pressures on the social care sector, increased workload and heightened anxiety and stress.

91. A clear pathway for updating and communicating guidance throughout the social care sector should be developed.

92. Guidance should not be issued without consultation with the relevant sector. This will help to avoid unintended consequences arising from such guidance and will reduce the frequent need to update and replace guidance that developed during the COVID-19 pandemic. Critically its development should always include the end user voice and participation.

Vaccination

93. The pandemic has shown us that the uptake of vaccination within the homecare and care home sector is best achieved through the full engagement and involvement of providers who are best at motivating and encouraging staff and in addressing any ant-vaccination messaging not least on social media. This engagement is still sadly lacking.

94. The lessons of the pandemic also evidence that vaccination strategies succeed where the vaccination is 'brought' to the person being vaccinated rather than expecting frontline workers to 'go to the vaccine.' There needs to be better use of peer vaccination in the care home sector and the use of community pharmacy for care at home staff. In my estimation we are still reliant on an NHS Board level model for vaccination delivery which is failing to maximise response and uptake.

Signed.

Personal Data

Dr Donald Macaskill

Chief Executive, Scottish Care.

10th December 2024