UK Covid-19 Inquiry Before Baroness Heather Hallett

Module 6 Hearings: June and July 2025

WRITTEN OPENING STATEMENT

on behalf of

THE SCOTTISH GOVERNMENT

Introduction

1. In this Inquiry, it is often said that Covid-19 did not discriminate. Everyone in society was affected. Yet, the Scottish Government recognises that some suffered more than others. Nowhere was this more true than in the adult social care sector. In care homes, families lost loved ones. Restrictions on visiting caused much pain and suffering. Carers strove to provide care, in often difficult circumstances, and were themselves at times exposed to the virus. Some lost their lives. The Scottish Government unhesitatingly acknowledges the profound impact of the pandemic on the adult social care sector. It passes its sympathies and condolences to the bereaved. It pays tribute to the workforce, and to unpaid carers.
2. In this Opening Statement, we look at the specific themes that the Inquiry will consider in evidence. We discuss impacts. We examine the structure of the adult social care sector in Scotland; the complex and sometimes difficult decisions that the Scottish Government had to make, on issues such as visiting and testing; and we explore, and attempt to clarify, the rationale behind, and the impact of, the discharge of patients from hospital into care homes.

Structure of the adult social care ('ASC') sector in Scotland

3. ASC in Scotland provides help with day to day living, because of illness, disability or older age. It can be provided in many settings, including at home, in care homes or in the wider community. The population receiving social care and support is diverse, with wide ranging needs and circumstances.

Statutory responsibilities

4. In contrast to its relationship with the NHS in Scotland, the Scottish Government does *not* have direct *statutory responsibility* for the delivery of ASC. Since 1948, Local Authorities have been responsible for ASC support, in various forms, and Health Boards have been responsible for health services. ASC in Scotland is delivered by a wide range of partners, including the public, independent and third sectors. However, the Scottish Government is responsible for the *strategic framework* for ASC, including bringing forward related legislation.
5. Local Authorities and Health Boards have a statutory duty to work together to manage health and social care services collectively. This requires the local integration of adult health and social care services, with Health Boards and Local Authorities deciding whether to include other services in their integrated arrangements. Statutory partners are required to delegate certain functions to a local Integration Authority ('IA'). The scope of delegated functions may vary, but must adhere to the statutory minimums set out in regulations. In most areas, the IA is an Integration Joint Board ('IJB'), which includes members from both the Local Authority and Health Board. Of Scotland's 32 local authority areas, 31 have deployed the IJB model and only one, Highland Council / NHS Highland, has deployed the 'lead agency' model. Each IA has a Chief Officer who leads the development and implementation of their area's strategic plan, and reports to the IJB and to the chief executives of their Health Board and Local Authority.
6. Local Authorities and Health Boards must plan and deliver adult community health and social

care services. The IJB develops a strategic plan, which is implemented by the Health and Social Care Partnership ('HSCP') in their area. While IJBs are bodies corporate, HSCPs are, in effect, the 'umbrella' term for the employees and partners of the Authority and Board, who deliver the services planned by the IJB. Each of Scotland's 31 HSCPs deliver ASC, adult primary health care and unscheduled adult hospital care. They maintain quality of care, safety, and well-being by ensuring compliance with regulations, coordinating services, monitoring staffing levels and addressing care home and care at home issues.

7. The Scottish Government has a number of statutory duties and powers relating to ASC. It is under a broad duty to continue to make provision, or secure that provision is made, to protect public health in Scotland under s.1 of the Public Health etc. (Scotland) Act 2008, and has various powers in connection with this duty. This does not (currently) include the power to issue directions to care providers. However, the Scottish Government has the power under various enactments to issue directions to Local Authorities, Health Boards and IAs.
8. During the pandemic, the Scottish Government made significant changes to its structures, which have continued into the post-pandemic period. This includes the establishment of a Directorate for Social Care and National Care Service Development, within the wider DGHSC family of directorates, and a dedicated Minister for Social Care.

Staffing and bed capacity of the ASC sector in Scotland

9. As at 31 March 2020, there were 1,081 care homes in Scotland, with a total capacity of 40,940 places. In 2019/20, there were around 238,000 (1 in 25) people in Scotland who were receiving social care and support, with around 91,880 people receiving care at home. The majority of people (77%) requiring social care services or support were aged 65 or over. People residing in care homes tended to be older, with around 90% of residents aged 65 or older, and around 50% aged 85 or older. Around 82,000 people requiring social care services or support had a physical and/or sensory disability. Around 16,000 people had a learning disability. There were around 90,000 people with dementia in Scotland. 62% of people requiring social care services or support were female. 98% of people requiring social care services or support (where ethnicity was known) were white.
10. The Public Health Scotland ('PHS') care home census reported that as of 31 March 2021, there were 1,068 care homes for adults and 40,609 registered places, with an estimated percentage occupancy of 82%. In terms of the impact of Covid-19 on care homes, there was a decrease in the number of care homes, from 1,102 in 2019 to 1,068 in 2021. This is in line with the long-term trend, with numbers continuing to decrease consistently (to 1,020 in 2024). In 2020 the number of care homes remained stable, at around 1,080.
11. The number of care home residents has been on a generally decreasing trend over the past decade or so, from 36,578 in 2013, to 33,352 in 2022, before increasing slightly in 2024 to 34,113. While 2020 data is not available, there was a decrease of 6% in the number of long-stay residents between 2019 and 2021, reflecting the loss of residents, and the closure of care homes to new admissions during the pandemic. The recent increase in long-stay residents in 2024 brings the figures towards pre-pandemic levels. Over the past five years, the relative number of people receiving social care support from home has been fairly stable, at around 17 per 1,000 population (around 92,000 people in 2019/20).
12. In December 2019, there were 206,400 people employed in the social care sector, with many more supporting delivery through multidisciplinary health and social care teams.
13. Scottish Government figures from 2024 found that the number of unpaid carers living in Scotland was estimated to be around 700,000 to 800,000. People are more likely to be providing unpaid care in their later working years (especially females).
14. There were a number of changes to the structure and capacity of the ASC sector during the

pandemic. In relation to staffing capacity, the Scottish Social Services Council ('SSSC'), which regulates the social services workforce in Scotland, reported that as at 31 December 2020, 43% of services with vacancies reported having problems filling them; down six percentage points from the previous year. The Scottish Government worked alongside the SSSC to set up a system to help social care services in Scotland recruit and deploy staff to increase the social care workforce capacity.

15. The ASC workforce has been increasing gradually over the past decade or so, with a headcount of 122,840 in 2013, compared to 132,310 in 2023 (an increase of 8% over the ten-year period). The largest increase is across housing support/care at home, where there was a 23% increase from 62,170 in 2013, to 76,720 in 2023, with a notable 5% increase in 2020 alone. However, the number of care home staff reduced gradually from 52,430 in 2013, to 50,410 in 2023, with a notable decrease of 4% in 2021. The number of care home staff has remained around this level since then. Day care service workforce numbers have decreased by 37% in the past decade or so, from 8,240 in 2013 to 5,180 in 2023. In 2020, numbers dropped by 8%, and then again by 7% in 2021, and 11% in 2022. This figure has continued to decrease after pandemic restrictions were lifted.

Impact of the Covid-19 pandemic on people's experience of the ASC sector in Scotland

16. The impact of Covid-19 did not fall on everyone equally. It exposed and exacerbated existing inequalities. The Scottish Government acted to mitigate these inequalities where it could. It continues to learn how best to prepare for, and respond to, future emergencies.

Impact on those in receipt of ASC and their families

17. Care homes were recognised by the Scottish Government to be a substantially higher risk setting for Covid-19. Those requiring care were often older, more vulnerable, had multiple co-morbidities and/or required frequent close care and support interactions. In the early stages of the pandemic, the Scottish Government's priority was to ensure measures were in place to prevent ingress of infection and minimise transmission in care homes. Decisions taken in this sphere involved incredibly difficult trade-offs. The complexity surrounding decisions is reflected in findings of the *'Technical report on the COVID-19 pandemic in the UK'* (INQ000203933):

    "… reducing risk of transmission in care homes involved some of the most complex trade-offs of risk to individuals of any part of the pandemic. These included considering the needs and rights of individuals as well as those of the wider resident population. This in turn meant balancing the risk of COVID-19 outbreaks in a very vulnerable group with maintaining staffing, access to healthcare, close contact needs of residents, visiting by relatives and friends in what are often the last months of life, and dignity and quality of life among a group with high prevalence of dementia."

18. Various steps were taken by the Scottish Government to mitigate the impact of reduced visiting on people living in care homes and their families, as touched on in more detail below. This included developing more detailed advice in guidance around specific strategies for supporting people, as well as advice on the use of technology, which was supported by the Digital Approaches in Care Homes programme. Sustainability funding was made available to ASC providers for a range of COVID-19 associated costs incurred, including those associated with supporting safe visiting. The Scottish Government also provided funding to Alzheimer Scotland to operate a helpline to provide advice and support to families of people who were resident in care homes during the pandemic, and to establish a national counselling service in response to the trauma experienced by people living with dementia and their carers.

The ASC workforce, including unpaid carers

19. The important and valuable contribution of all ASC workers cannot be understated, particularly since the impact of the pandemic was so keenly felt by them. Not only were there pre-existing structural issues affecting ASC workers, such as lack of uniform access to occupational sick pay and staffing/capacity issues, but carers were at a relatively higher risk of being exposed to, or transmitting, the virus. Unpaid carers also faced significant difficulties, as many had to step into the gap to support vulnerable friends and family members as support services closed or reduced capacity during the initial 'lockdown'. This meant that the number of people providing care increased and many existing carers took on more intensive caring roles, while also losing the opportunity to take breaks from caring.
20. The Scottish Government was aware of the issues and risks that ASC workers faced, acknowledged the concerns raised by workforce representatives, and sought to protect and support these key workers. Similarly, the Scottish Government engaged with unpaid carers and representative groups to understand the issues faced and to provide guidance and support. In addition to the infection prevention and control ('IPC') measures outlined elsewhere in this statement to support ASC workers and carers, a range of practical, wellbeing and financial measures were put in place from early in the pandemic by the Scottish Government:
    a. The payment of the 'Real Living Wage' to ASC workers had been a longstanding policy aim of the Scottish Government. Through collaborative working with the Convention of Scottish Local Authorities ('COSLA'), Scottish Care and other partners, the Scottish Government ensured there was no delay to the payment of this uplift due to the pandemic. The uplift was delivered from 1 April 2020.
    b. The Social Care Staff Support Fund ('SCSSF') was set up on 27 May 2020 to ensure that social care workers, who were absent from work due to coronavirus or self-isolation, received their expected income. The SCSSF was extended on 11 January 2021 to cover ASC workers who had to shield between 23 March 2020 – 31 October 2020, who were eligible for the UK Government's Coronavirus Job Retention Scheme, but whose employer did not apply to the scheme.
    c. A 'Social Care Worker Death in Service Payment Scheme' was created on 30 July 2020. This offered financial support, namely a one-off payment of £60,000, to a nominated next of kin following a Covid-19-related death.
    d. The 'Self-Isolation Support Grant' ('SISG') was introduced on 13 October 2020 for those who were required to isolate any time after 28 September 2020. SISG provided a grant of £500 to low income workers who experienced reduced earnings as a result of them, their child, or the person they were caring for being required to stay at home. After the requirement to self-isolate ended, from 1 May 2022 the grant changed to a one-off payment of £225 for workers who tested positive or carers of those who did.
    e. A one off 'Thank You' payment of £500 was announced on 30 November 2020. ASC staff, personal assistants, social care staff working in children's residential services and social workers who had been employed since 17 March 2020 were eligible.
    f. Between January and March 2022, the entry costs for new staff seeking to join the ASC workforce, such as SSSC registration fees, were covered by the Scottish Government.
    g. ASC staff were designated as key workers as part of the UK Government announcement on 19 March 2020. This was confirmed in guidance issued the same day by the Deputy First Minister to COSLA and the Society of Local Authority Chief Executives and Senior Managers ('SoLACE'). In addition, the Cabinet Secretary for Health and Sport and COSLA issued a joint communication on 30 March 2020 confirming this position unequivocally.
    h. £5 million was allocated in 2020/21 for a comprehensive package of national support to the ASC workforce, amongst others. This included a National Wellbeing Hub, digital therapies,

Coaching for Wellbeing, the National Wellbeing Helpline, funding for psychological therapies and a new Workforce Specialist Service. In January 2021, £500,000 was allocated to territorial Health Boards and HSCPs to enhance practical support for staff. Further funding was available to take forward Covid-19 recovery actions, leading into a new National Wellbeing Programme. The recovery action plan included the prioritisation for support of the wellbeing of social care staff, with staff needs recognised as distinct from those of health. Another area of staff support around mental and physical health were Wellbeing Conversations. These were intended to be regular, supportive, coaching-style, one to one conversations that focused on the wellbeing of staff holistically.

i. In July 2020, guidance was developed to provide individuals and employers with an individualised and evidence-based approach to understand how Covid-19 affects certain groups in the population, and what employers could do to make the workplace as safe as possible. This recognised that underlying health conditions and ethnicity, viewed in isolation, did not accurately predict vulnerability to Covid-19. To that end, an Occupational Risk Assessment guidance and tool were introduced. Scotland's National Clinical Director wrote to Social Care Provider Representative Organisations on 31 July 2020 and urged employers and staff to be active participants in this individualised risk assessment process.

j. In term of unpaid carers, in April 2020, a £500,000 fund was established to help local carer organisations transition to remote working, so that they could continue to support unpaid carers during lockdown. In June 2020, over 84,000 eligible carers were given extra financial support through the Coronavirus Carer's Allowance Supplement ('CCAS'), and an extra £300,000 was allocated to expand support for young carers. In January 2021, an additional £750,000 was allocated to local carer centres, with a further £28.5m overall allocated for local carer support in 2021/22. A second payment of the CCAS was made in December 2021. In January 2022, £4m was allocated to help organisations working with unpaid carers, with a £0.5m fund being established in April 2022 to help local carer support organisations to invest in improving their capacity.

Key decisions, their impact and the context in which they were taken

21. When considering key decisions made, it is important to have in mind the relevant background. That background includes the Scottish Government's deep understanding of the social care sector; its engagement with the sector during the pandemic; and its consideration of the likely impact of decisions. These points provide context for the decisions that were taken. We expand on those points here.

Knowledge and Experience

22. *Prior to the pandemic*, within the Scottish Government, there existed a *wealth* and *breadth* of specialist knowledge of the ASC sector, upon which Ministers were able to draw. By way of example, Ministers were supported by policy officials from dedicated social care divisions; by professional advisers who were embedded within the various directorates; by advisory groups that assisted in the development of policy and informed decisions; and by a range of social care data and analysis. Thus, in this way, prior to and then during the pandemic, Ministers and senior officials were kept fully informed about issues of concern. The Cabinet Secretary for Health also had regular, often daily, direct contact with senior social care policy officials and with professional advisers, including the Chief Social Work Adviser ('CSWA'), CNO and CMO.

Communication, consultation and engagement

23. The Scottish Government considers that, *prior* to the pandemic, there *was* extensive and meaningful engagement and consultation with the ASC sector. This applied both to specific policy issues, and wider sectoral reform. *During* the pandemic, this engagement intensified. The

Scottish Government's attitude to engagement reflects its views of the importance of an *inclusive* approach. In the case of Covid-19, the approach took the form of ensuring, from the outset, that *all parties* were involved in advising on support for the sector. Requests to participate in advisory groups were welcomed, and comprised a wide range of stakeholders from across the public, private and independent sectors. Indeed, such was the level of consultation that many organisations expressed concern as to their capacity to participate in the large number of advisory groups established.

24. From early February 2020, meetings took place between the Scottish Government and the social care sector. They involved the Cabinet Secretary for Health and Sport and officials, COSLA and HSCPs. Pre-pandemic, Scottish Government officials had attended the COSLA-convened National Contingency Planning Group (NCPG), a multi-stakeholder social care group, which has existed since 2011 to support contingency arrangements in social care. On 12 March 2020 the group was convened in relation to Covid-19, and until June 2020 held weekly meetings attended by the Scottish Government and a range of other stakeholders.
25. A wide range of groups was convened to bring stakeholders together, to discuss and prioritise actions, and to advise on the development of guidance. Two main stakeholder groups were established by the Scottish Government: the Clinical and Professional Advisory Group for Adult Social Care ('CPAG'); and the Care Home Rapid Action Group ('CHRAG'). The latter was subsequently replaced by the Pandemic Response Adult Social Care Group ('PRASCG'*)*.
26. CPAG was established in April 2020, with an initial remit to provide clinical and professional advice and guidance for protecting the care home sector. The remit was later expanded to include the wider ASC sector. The group, which was commissioned by the CMO and CNO, brought together over 60 representatives, the majority from within the care sector. These included Executive Nursing Directors, CSWA, Scottish Care, COSLA, the Care Inspectorate ('CI'), Health Protection Scotland ('HPS'), Scottish Directors of Public Health ('DPHs'), Allied Health Professionals, Royal College of General Practitioners, Coalition of Care and Support Providers in Scotland, and other social care providers.
27. The role of CPAG was to engage with the sector, and to co-produce guidance and advice. This was aimed at preventing Covid-19 outbreaks as much as possible, providing support to care providers, and people living within care settings. CPAG meetings were held twice weekly until 21 May 2020, and changed to weekly meetings until 29 April 2021. Over 80 meetings of CPAG were held during the course of the pandemic, with the last held in December 2022. In addition to the main CPAG group, a number of CPAG sub-groups were formed in response to specific issues. Prior to the establishment of CPAG, there were regular meetings between Scottish Government and stakeholders, such as care providers, and there were regular meetings with regulators such as CI and the SSSC, and with Trade Unions.
28. CHRAG was established in April 2020 to bring together representatives from across the health and social care sector, to monitor data on developments in the care home sector, and to react quickly to developing issues and scenarios. CHRAG comprised key partners with operational oversight and delivery responsibility for care homes, including representatives from COSLA, SoLACE, Scottish Care, CI, and the Scottish Government. CHRAG received daily updates, and was tasked with activating any local action needed to deal with emerging issues, as well as informing and coordinating a wider package of support to the sector.
29. CHRAG's objectives included the identification of issues for urgent resolution, the agreement of actions that member organisations themselves would implement; and the making of collective recommendations to statutory and other bodies. CHRAG initially focused on the delivery of national polices on ASC within the care home sector. This included initiatives such as the enhanced requirement on testing, IPC, PPE, and strategies to support workforce resilience such as the social care workforce recruitment portal, financial monitoring and support for social care.

CHRAG was a vital forum for enabling a collaborative approach among stakeholders, in understanding the impact of the pandemic on the care home sector, and the collective support required to respond to emerging concerns. CHRAG met weekly between 30 April 2020 until 27 August 2020.

30. Thereafter, CHRAG was re-formed as PRASCG, which first met on 10 September 2020. The primary remit of PRASCG was to support the immediate pandemic response to issues arising in the *wider* ASC sector. Thus PRASCG's remit was expanded from CHRAG's narrower focus on care homes. Like its predecessor, however, PRASCG was a useful forum in bringing together a wide and diverse range of stakeholders, to consider issues facing the ASC sector, and the implications for the development of national and local responses required to support it. PRASCG continued to meet until June 2022.
31. The Scottish Government is not aware of any significant challenges to the working relationships it had with stakeholders during the pandemic. The ASC sector is complex and diverse, and so priorities and interests of stakeholders may not always be aligned. In many cases, there were varying views on how issues should be addressed. Sometimes, stakeholders felt that subsequent decisions or guidance either went too far, or did not go far enough. This is to be expected in most consultative processes. Yet, divergence of views as to how to address specific issues did not hinder dialogue and positive engagement with stakeholders, which continued throughout the pandemic.

Consideration of impact

32. Although decision-making on how best to support the sector often took place within a dynamic and rapidly changing environment, there was a strong willingness from Ministers, policy and clinical advisers to involve care sector representatives as early as possible in decisions and draft guidance. There may have been occasions when the opportunity for consultation was limited, due to the need for urgent decisions to be made, or guidance to be published. Also, it was not always possible to carry out full impact assessments, in advance of policies being introduced, particularly in early 2020. Nor would it have been appropriate to delay decisions, in the emergency phase of the pandemic where decisions needed to be taken urgently, in order to carry out full impact assessments. Yet, there was *early* recognition in Scotland that measures to combat the spread of the virus would affect certain groups more than others.
33. The pandemic highlighted issues already faced by disabled people. However, the pandemic created new discriminations, and often left disabled people isolated and excluded. Through engagement with Disabled People's Organisations (DPOs), the Scottish Government learned of various issues, such as extra barriers that made shopping less accessible, leading to difficulties obtaining food and medication; the removal or reduction of social care packages; and difficulties experienced in lip reading by deaf people/BSL users, caused by the use of masks. The Scottish Government took steps to resolve such issues. For example, on 28 April 2020 the Cabinet Secretary for Health and Sport set out details of a range of measures to improve the position for people whose care home packages had been removed. This included an agreement with COSLA regarding an uplift in ASC contracts, workforce resilience efforts and daily contact between officials and HSCP Chief Officers. Further, by the end of September 2020, the Scottish Government had made £57.6m available to support local authorities' response to food insecurity, to ensure that people were able to access food and essentials.
34. In June 2020, Scottish Ministers established a Social Renewal Advisory Board ('SRAB') to focus on tackling poverty and disadvantage, and advancing equality. SRAB's independent report was published in January 2021 and included 20 'Calls to Action' across themes of (i) Money and Work, (ii) People, Rights and Advancing Equality and (iii) Communities and Collective Endeavour. The Scottish Government's initial response to the report was published on 23 March

2021. It set out details of work underway to address SRAB's recommendations, including £25m in additional investment to take forward a number of actions.

35. Ministers were briefed on the risks associated with social distancing, and the impact of various NPIs in relation to those with dementia and Alzheimer's. In relation to NPIs, there was a concern that those with dementia would not sufficiently understand or remember what was being asked of them at any given time. In relation to care homes, guidance contained mitigations for those who had dementia. For example, the Scottish Government guidance of 13 March 2020 included mitigating factors to consider, when implementing the guidance around IPC and social distancing. This included the use of volunteers or third sector charitable organisations, to support the work of activity coordinators; access to spiritual care; and use of video technology for accessing relatives and others
36. The Scottish Government *"Dementia and Covid-19 – National Action Plan to Continue to Support Recovery For People with Dementia and their Carers"* was published in December 2020. It set out the measures which had been taken to support those with dementia, their carers and families; contained feedback from impacted individuals and their families; and listed priorities for further action. The Plan included a series of 21 commitments, including measures regarding the resumption of day services, access to rehabilitation, the use of telecare and addressing digital exclusion.

Discharge from Hospital

37. It is important to understand the background to, and context in which, patients were discharged from hospital. It has long been recognised that patients, particularly the elderly and those with co-morbidities, should not remain in hospital when assessed as clinically 'ready' for discharge. To remain longer than necessary in a hospital environment exposes them to risks to their health and well-being. 'Risks' include a loss of mobility and mental acuity, social isolation and delirium. A 'delayed discharge' occurs when a patient (aged 18 years and over, and clinically ready for discharge), cannot leave the hospital because they do not have access to the necessary care, support or accommodation; or funding is not available, for example, to purchase a care home place. The concept of delayed discharge has been recognised by reports and studies as existing in every developed healthcare system. Scottish figures for January 2020, published on 3 March 2020, showed a total of 1,640 people 'delayed' in hospital. The principal reasons for delay were varied, but included the making of arrangements that would allow patients to return to their own homes, the availability of care home places, and delays caused by the assessment of patients' needs.
38. Accordingly, in the early part of 2020, it *already* being a matter of consensus that hospital was not an appropriate environment for patients who were clinically ready for discharge, it was increasingly understood that patients who were elderly and who had co-morbidities, would be more vulnerable to the most serious consequences of Covid-19. Further, and considering the projected 'reasonable worst case scenario' modelling, should a hospital environment become overwhelmed by Covid-19 patients, such patients would be exposed to even greater risks. Thus, in early March 2020, two priorities loomed large: in light of the expected demand on hospitals, to mobilise and create capacity within the NHS; and to ensure the appropriate, safe and supported discharge of patients, for whom hospital was already, and increasingly, a high risk environment.
39. We reiterate here an important point. As already mentioned, while the Scottish Government has powers of *direction* in relation to the *NHS in Scotland*, it *cannot direct* providers of *social care*. It *cannot*, and did not, *compel* care providers to accept admissions from hospitals. Rather, the Scottish Government asked local authorities to put *additional effort* into reducing delays in discharging those assessed as clinically fit.

40. In essence, this meant that the issue of delayed discharge had to be solved at a local level. This was achieved largely through the operation of the Public Bodies (Joint Working) (Scotland) Act 2014. The Act obliges local authorities and NHS Boards to work together to form IJBs, and gives them statutory responsibilities to coordinate local health and social care services. Services are delivered on behalf of the IJBs by HSCPs, which exist in all of the territorial NHS Board areas in Scotland. Services are delivered according to local need and priorities. We have mentioned these bodies at §5-6 above.
41. On 4 and 5 March 2020, the Cabinet Secretary for Health and Sport met with representatives from COSLA. They discussed the need to engage all partnerships in Scotland, to enable a consistent, coherent approach. Following that meeting, on 6 March the Scottish Government wrote to all Chief Officers of IJBs, CEOs of territorial Health Boards and CEOs of local authorities, with a request to reduce the overall Scottish delayed discharge number from 1650 to 1250, by 9 April (although the delayed discharge 'baseline' figure for the week of 4 March 2020 was sitting at 1,612). It would be wrong to suppose that the letter presented a stark choice between hospital and a care home. Rather, the letter recognised the pressures on local health and social care systems of both seeking to prevent avoidable hospital admissions in the first place; and trying to facilitate the safe and appropriate return *home* of people who were clinically ready for discharge. The requested reduction of 400 was achieved. By letter of 27 March, a further request was made to reduce delays by an additional 500 by the end of April 2020. That request was also met.
42. In Module 3, the Inquiry heard evidence as to how capacity was created within the NHS and social care system in Scotland. A 'tiered' response was adopted, in which the Scottish Government sought to increase capacity, through key decisions, such as the cancellation of elective and non-urgent healthcare; the pausing of cancer screening programmes; and the employment of retired health staff, final year medical students and nursing students. On 11 March, following a meeting between the Scottish Government and NHS Board Chief Executives to discuss NHS preparedness for the impact of Covid-19, the Scottish Government asked each NHS Board to devise 'Mobilisation Plans'. Each Board was urgently required to state the ways in which they would, for example, increase general bed and ITU capacity, scale back elective care, and (working with their local partners) institute a 'whole system response'. The Scottish Government did *not* consider the reduction in the delayed discharge figure as the *principal* means to create capacity in the face of the reasonable worst case scenario and modelling. However, all options were being considered to create vital capacity and resilience within the NHS at that time.
43. At the meeting of 11 March, there was consensus that there was a need to reduce the number of people who were delayed in hospital, particularly in the face of the predicted demand on the NHS in Scotland. 'Good practice' measures were to be used to achieve reductions. These included, for example, programmes like 'Home First & Discharge to Assess', a multi-agency approach to working across health and social care systems, aimed at reducing unnecessary, prolonged stays in hospital, and based on the simple philosophy that people are best in their own homes.

The Impact of discharge from hospital

44. As can be seen, steps taken by the Scottish Government to encourage a reduction in the delayed discharge number were effective. Hundreds of patients, who were clinically ready for discharge, were able to leave hospital. We submit that there is little evidence that would allow one to conclude that this *increased* the risk of the introduction of Covid-19 into care homes. There are a number of reasons for this. In the first place, great efforts were made to ensure that patients were safely discharged. Guidance issued between March and May 2020 by the

Scottish Government and HPS, and addressed to the social care sector, contained provisions directed at the safe discharge of patients. For example, guidance stressed the importance of social distancing, and of the need for *clinical* screening prior to discharge from hospital. It must be borne in mind that discharge decisions are *clinical decisions*, made on a case-by-case basis. In late March, guidance introduced the need for an appropriate, *clinical* plan to be prepared for each patient who was to be discharged. Further, guidance provided that patients who were known to have had contact with other Covid-19 cases, but who were not displaying symptoms, and all patients who had had no contact with Covid-19 cases and who were not displaying symptoms, should be isolated for periods of, respectively, 14 and seven days. Further, not all patients who left hospital were discharged into care homes. Between March and June 2020, around 63% of patients were discharged from hospital back to their own homes following a period of delay.

45. In addition, it is important to reflect on the available statistical and epidemiological evidence, when considering the impact on care homes. A report by PHS titled 'Discharges from NHS Scotland Hospitals to Care Homes between 1 March and 31 May 2020' was commissioned by the Cabinet Secretary for Health and Sport on 18 August 2020. It was published on 28 October 2020. A revised version, that included updated data and analysis, was published on 21 April 2021. The reports are detailed, and warrant examination. Yet the overarching conclusion arrived at in both reports was that no statistically significant association had been found between hospital discharge, and the occurrence of a care home outbreak (although a small effect could not be ruled out). The report noted that *care home size* was much more strongly associated with the risk of an outbreak than all other care home characteristics, including hospital discharge. In common with comparable analyses in England and Wales, the report found that ingress of infections to care homes was primarily attributable to staff footfall and, as noted, related directly to care home size.

Decisions after March 2020

46. On 21 April 2020, the Cabinet Secretary for Heath and Sport made an announcement in the Scottish Parliament, in which she set out a number of new measures. The package of enhanced measures and support was informed by a 'Deep Dive' on care homes, led by the First Minister on 14 April 2020. The Deep Dive brought together key government officials and external stakeholders, to discuss ways to ensure the safety and wellbeing of care home residents and staff. In particular, and for present purposes, on 21 April the Cabinet Secretary announced that Covid-19 patients discharged from hospital to care homes should provide two negative tests prior to discharge. Further, that other new admissions to care homes should also be tested. Both sets of patients should be isolated for 14 days. These measures were in addition to those directed at, for example, social distancing and IPC, both of which already formed part of Scottish Government and HPS guidance.
47. At the outset of the pandemic, testing capacity in Scotland was limited (at around 320 tests per day). Accordingly, the allocation of testing had to be prioritised. The initial priority for testing was NHS and social care staff, to allow them to continue to deliver care. Priority was also made for the purposes of hospitalised patient diagnostic testing, and outbreak management in closed settings. As capacity increased, testing could be offered to other groups, based on clinical advice, with respect to the operation and impact of the virus. By 21 April 2020, testing capacity in Scotland was sufficient to allow the aforesaid new measures to be introduced.
48. Knowledge surrounding asymptomatic transmission had developed, from a position where It was thought likely that person to person transmission, when it did occur, mostly involved transmission of the virus from people with symptoms. Advice provided to the Cabinet Secretary, approved by the CMO, prior to her announcement in the Scottish Parliament on 21

April 2020 stated that *"some patients may have an essentially asymptomatic episode of Covid-19 infection, or be in the pre-symptomatic period at the time of admission*" and that *"There is some debated evidence that people can be infectious prior to onset of symptoms."* The same advice also noted that *"current tests cannot reliably detect infection prior to the onset of symptoms."*

49. That notwithstanding, there was a real appreciation within the Scottish Government as to the vulnerability of the care home population. Therefore, the aim and desire was to provide maximum support and oversight to a sector that was largely operated by private sector providers, in relation to which (as already mentioned) statutory powers of direction were not available. The Cabinet Secretary's announcement was implemented in April 2020, via guidance issued by PHS, and communication with NHS Boards regarding testing arrangements. As a result, there now existed a presumption that everyone being admitted to a care home should provide a negative test before admission (unless a full risk assessment had been completed, and it was in the *clinical* interests of the individual to be moved).
50. This testing provision was complimentary to other IPC measures, such as isolation. An isolation period of 14 days applied to the admission of Covid-19 recovered patients from hospital settings, with the 14-day period commencing from symptom onset or first positive test (if the symptom onset was undetermined), and absence of fever for 48 hours (without use of antibiotics). In respect of non-Covid-19 recovered patients, the patient could be discharged to the care home, prior to the (single) test result being available, on condition that the care home was able to support all required care needs during the isolation period following discharge, until the negative test result was received.
51. Guidance specifically stated that where a long-term care facility homed a resident who had tested positive for coronavirus, further admissions should be halted, and that anyone suspected of having symptoms of Covid-19 should be managed in line with other HPS guidance, and in particular should be isolated in their own room. It advised that residents should stay in their room as much as possible, with meals to be served in rooms, where possible, and that communal activities should be reduced by 75%. Whilst not complete isolation, anyone arriving from a hospital to a care home would effectively be isolated in their room on the basis of this advice. HPS guidance recognised that, although isolation in a single room was advised, that may not always be possible. In that case, alternative measures were advised.

Visiting

52. As discussed above, in the early stages of the pandemic, due to concern at the risk of the rapid spread of infection within care homes, measures were focused on trying to prevent the *ingress* of infection, and on the prevention of transmission. It must be remembered that, at this time, there were no effective treatments for Covid-19. Vaccines had not been developed. There was limited availability of testing. Therefore, in guidance dated 13 March 2020, it was recommended that routine visiting should be paused, but essential visits should be supported.
53. On 15 May 2020, Scottish Government guidance further expanded on essential visits, stating that visiting must be restricted to essential visitors only. Essential visitors include appropriate health and care staff based on resident need, for a person receiving end-of-life care, to support someone with a mental health issue such as dementia, a learning disability or autism, where not being present would cause the resident to be distressed; and where a relative is visiting someone at the end of life.
54. As more became known about the virus, and protections were put in place to support care homes, there was general agreement on the need to facilitate the gradual opening of care homes to support wellbeing. On 25 June 2020, the first, stand-alone Visiting Guidance for Adult Care Homes in Scotland was published. The guidance comprised an overarching framework

for the safe reintroduction of visiting, with stages moving from essential visits and outdoor (garden) visits only, to limited indoor visiting, culminating in routine visiting in the home. This guidance provided a framework to support national and local decision making on the movement through four stages of visiting.

55. Thereafter, further iterations of guidance were published, to encourage progress through the stages to supporting indoor visiting and visits out of care homes. In February 2021, to support a full return to indoor visiting, the Scottish Government published, 'Open with Care – Supporting Meaningful Contact in Adult Care Homes'. The guidance drew on recent advice from the WHO, which published a paper agreeing that visiting should be supported, as long as a range of IPC measures were in place. The guidance was updated in September 2021 to support named visitors during Covid-19 outbreaks. This ensured that people, including essential carers, could remain connected even in an outbreak situation.
56. It is important to have regard to the *actual guidance* that was *produced* by the Scottish Government, in contrast to the measures that *individual* care homes chose to put in place. For example, as mentioned, Scottish Government guidance to care homes did *not* restrict end of life visiting. From the outset of the pandemic, the Scottish Government was clear that end of life visits should be supported.
57. Building on lessons learned during the pandemic, the Scottish Government has taken further steps to ensure that people can remain connected to their loved ones even in outbreak situations. This includes the introduction, in April 2022, of two new health and social care standards on visiting. These standards, which are used as a basis for inspection by the CI, set out the expectation that people living in care homes should be able to see someone who is important to them, even during an outbreak, and be able to name a person or persons who can directly participate in meeting their care needs. The Scottish Government has developed legislative provisions on visiting (known as 'Anne's Law') within the Care Reform (Scotland) Bill. If enacted, it will impose a duty on the Scottish Ministers to exercise an existing, regulation-making power, so as to require providers of care-home services for adults to facilitate visits. The Scottish Government continues to engage with Care Home Relatives Scotland, and other stakeholder groups, to develop and deliver Anne's Law.

Aspects of the management of the pandemic in adult residential and nursing homes

IPC training

58. The National Infection Prevention and Control Manual ('NIPCM') was launched by Scotland's CNO. It has existed, supplemented by updates, since January 2012. It is considered best practice in all health and care settings for IPC practices and procedures. It is readily accepted that it was not, prior to the pandemic, attuned to ASC settings, particularly around language. In response to these concerns, in conjunction with extensive stakeholder engagement (including consultation with care homes), Antimicrobial Resistance & Healthcare Associated Infection Scotland developed a care-home specific manual and cleaning specification. During the pandemic, the Scottish Government published further clinical guidance to support the care home sector with IPC. This supplemented the NIPCM and advice issued by PHS.
59. The Scottish Government established a CPAG sub-group to consider recommendations in respect of IPC training for staff in care homes. That led to the creation of a training package relating to IPC guidance, focussing on the NIPCM, the care home environment and cleaning.
60. On 21 April 2020, the Cabinet Secretary for Health and Sport set out to the Scottish Parliament the additional steps that were being taken to support care homes. In particular, the statement provided for an enhanced role for DPHs across Scotland. This enhanced role for DPHs included

assessing care home adoption of, and training on, IPC measures. It also specified for weekly reporting to the Scottish Government around these areas.

61. On 17 April 2020, in advance of that statement, the DG Health and Social Care had written to Chief Executives of NHS Boards. That letter requested contact with every care home, and an assessment around care home adoption of, and training on, IPC measures. Additional measures involved direct contact with care homes and visits on a risk prioritised basis. From 17 May 2020, these arrangements were further accentuated through the establishment of enhanced, professional and clinical care home oversight teams. This additional support, which included support for IPC practices, was to be provided by the Scottish Government, Local Authorities, territorial Health Boards, and the regulatory and improvement support bodies.

The understanding of the transmission risk presented by staff and steps taken to address it

62. Restricting staff movement within and between care settings was recognised as critical to minimise the risk of infection. HPS (and later PHS) and Scottish Government guidance recommended measures to support care homes in restricting staff movement. Care providers were asked to follow certain steps. Wherever possible, care homes were asked proactively to divide themselves into the smallest viable independent units, so as to reduce risk of spreading the virus amongst residents and staff, create small staff teams to provide continuity of care through working with the same service users and to consider making temporary adaptations to the physical environment. Scottish Government guidance advised that staff should not work in more than one facility and movement between care homes, for example by agency staff working across multiple facilities, should be restricted. To that end, agency staff for care homes with confirmed Covid-19 cases had to self-isolate for 14 days before moving to another setting. As explained further below, the Scottish Government's ASC Winter Preparedness Plan for 2020-21 outlined the proposed approach and national and local support for restricting staff movement across social care settings to limit transmission of the virus.
63. As discussed above, PHS was commissioned by the Cabinet Secretary for Health and Sport to lead on work to understand the pathways and outcomes for people who, between 1 March and 31 May 2020, were discharged to a care home, and their Covid-19 status. The analysis found, in common with comparable analyses in England and Wales that ingress of infections to care homes was primarily attributable to staff footfall and, as noted, related directly to care home size. It noted that, while staff working across multiple locations, and interacting with high numbers of residents, increased transmission risk, there was, other than in exceptional cases, no strong evidence on risks from visitors.

Testing for Covid-19 amongst staff and residents

64. On 17 March 2020, in a statement to Parliament the First Minister and the Cabinet Secretary committed to testing critical frontline NHS staff and those others essential to maintaining critical infrastructure, including social care workers. That decision was based on clinical advice and information regarding testing capacity. This message was reiterated in the Cabinet Secretary's statement to Parliament on 24 March 2020, in which she said that *"NHS Boards will prioritise testing, based on where the pressure is felt most in their workforce and in social care."*
65. On 9 April 2020, the Cabinet Secretary requested NHS Boards, Local Authority Chief Executives and IJB Chief Officers to review arrangements in place to allow all critical staff within the health and social care sector to access testing (where there was sufficient capacity). NHS Boards consequently put in place local pathways with HSCPs, to enable social care staff to access testing, including 'pipelines' for the private sector social care workforce. Following the 'Deep Dive' on Care Homes of 14 April 2020 mentioned above, and the receipt of further clinical advice, on 15 April the First Minister announced that Scotland would move to a system

where, in addition to testing first residents who became symptomatic, any symptomatic patient in a care home would be clinically assessed and, where appropriate, offered testing for Covid-19. On 17 April 2020 updated guidance was issued by HPS to the ASC sector. It set out the local arrangements for testing of care home residents and social care staff, as well the arrangements for self-isolation of social care staff.

66. On 19 April 2020 the Cabinet Secretary wrote to care homes, via the CI and Scottish Care, outlining that care home staff and residents were priorities for testing. On 20 April 2020 the CEO for NHS Scotland wrote to all territorial Health Board CEOs, DPH, Chief Officers of HSCPs and Chief Executives of Local Authorities, regarding the enhanced system of assurance for care homes for residents and staff. The letter reminded recipients that they required to provide assurance, by 24 April 2020, that within each area *"there is a robust pathway for workers, or people in their households, to testing with a single point of access; and that has been clearly communicated to all employers in social care; both within the care home setting and employers providing care at home."*
67. Over the summer of 2020, as more tests became available, whole care home testing was implemented to assess the intensity of infection once an outbreak had been identified, to inform IPC measures, and to assess when an outbreak was successfully controlled (thereby enabling the reduction of response measures). On 1 May 2020 the First Minister announced enhanced outbreak investigations in care homes. In homes where there had been a confirmed case, all residents and staff were to be offered testing, whether they were symptomatic or not. In care homes where there were no cases, sample testing was also announced. Testing was expanded further, with the commencement of routine asymptomatic staff testing. This was initially confined to high risk settings (staff in healthcare and care homes). On 23 June the Scottish Government announced that, from 8 July 2020, health and social care staff were to be offered weekly PCR testing.
68. Following this announcement, the Scottish Government established a Short Life Working Group, aimed at supporting efforts to roll out PCR testing to care home staff. This included representatives from Scottish Government, care home providers and NHS National Services Scotland ('NSS'). Where issues were raised, the Scottish Government worked with NSS and territorial Health Boards to resolve them. Between 6 July 2020 and 19 July 2021, the group met 26 times. On 10 July 2020, the SSSC and CI announcement regarding testing was discussed, noting the need for clarity about the impact on registration should staff refuse to take a test, responsibilities of care home managers and how guidance applied to agency staff.
69. In December 2020, asymptomatic testing was expanded to include designated care home visitors and visiting professional staff. Visitor testing was initially introduced in 12 'early adopter' care homes, before being fully rolled out in January 2021. Testing arrangements for care at home workers were rolled out from January 2021.
70. In March 2022, asymptomatic testing in social care was paused, with the exception of care homes. The vaccination programme had helped to reduce transmission and mitigate risks. All remaining 'routine' testing of health and social care staff continued until 30 August 2023. Routine asymptomatic testing for admissions to care homes from hospitals remained until 3 June 2024. Ministers chose not to end asymptomatic testing of patients being discharged into care homes earlier, in line with the approach taken by the other four nations and advice from the CMO.

Restrictions on access to visits by healthcare professionals

71. The Scottish Government's clinical guidance for care homes indicated that essential visits, including healthcare visits, should be supported. The 13 March 2020 clinical guidance stated that care homes "*might need to consider visits from appropriate health and care staff as essential*". This was reinforced more strongly in the 26 March 2020 and 15 May 2020 guidance

which made clear that visits from healthcare teams should be classed as essential. Scotland's CMO wrote to GP practices on 17 April 2020, emphasising the importance of GP support to care homes, and on 20 May 2020 to territorial Health Board Chief Executives, Medical Directors and DPHs, highlighting the significant impact of Covid-19 in the care home sector, and encouraging the recipients to consider ways to provide support.

72. Scottish Government clinical guidance promoted the use of remote 'NHS Near Me' technology to provide access to GPs and community teams. As part of the Digital Approaches in Care Homes programme between November 2020 and May 2021, Care Homes were offered iPads and MiFi devices to enable their residents to access video consultations with a health professional as well as communicate with their loved ones
73. However, in collaboration with stakeholders, clinical and professional advisors, the Scottish Government continually revised and updated guidance to reinforce messaging on the importance of face-to-face contact. This was done, for example, through implementing the staged approach to enhancing wellbeing activities and visits in care homes, including communal living, first published on 3 September 2020. Further guidance, titled 'Open for Care' on 14 April 2021, emphasised the importance of involving a wide range of professionals and people in the life of the care home and set out principles to support the staged return of visiting professionals to care homes.

Availability, accessibility and adequacy of Personal Protective Equipment ("PPE") including changes to the way PPE was accessed

74. The sourcing and provision of PPE pre-pandemic depended on the social care delivery model. Typically, local authority-run care homes would be supported via Scotland Excel, which is the Centre of Procurement Expertise for the local government sector serving Scotland's 32 local authorities, while independent and third sector providers would be expected to source PPE using their normal supply routes. During the pandemic social care providers received new support in relation to PPE in two ways. The first was through recouping pandemic-related PPE costs from Local Authorities via funding from the Scottish Government, initially under the COSLA Principles of Sustainability Funding published on 31 July 2020. There was no set date to when such payments could be backdated. Eligibility was determined by whether the PPE costs incurred were additional costs as a result of the pandemic. Later, these payments were made through the more defined 'Covid-19 Financial Support for Adult Social Care Providers' scheme (often referred to as 'Sustainability Payments').
75. In addition, from March 2020, in direct response to the pandemic, PPE from the national stock was provided free of charge for top-up and emergency provision for social care support needs where normal supply routes were unsuccessful. This PPE was distributed through two routes:
    a. Local PPE Hubs were established in every HSCP area and supplied by NSS. Providers and carers could access PPE from these hubs if they could not get PPE through their normal supply routes;
    b. A National PPE support centre which could be accessed in emergency situations when neither normal supply chains nor the Local PPE Hubs were able to meet a provider's or carer's needs.
76. A one-off delivery of a week's worth of stock was provided directly to around 1,100 Adult Care Homes between 18–23 April 2020. On 27 April 2020, the local PPE Hubs expanded their provision to support the whole social care sector with all of its PPE needs where normal supply routes had failed; and also extended PPE support to unpaid carers and social care Personal Assistants ('PAs'). These matters were explored in depth during Module 5.
77. Also as explained in Module 5, NSS worked collaboratively with the Scottish Government and producers to develop and make available a wider range of PPE sizes (particularly FFP3 masks),

making it easier to ensure that the majority of health and social care workers could get items that fitted.

Winter Planning

78. A range of new measures were introduced by the ASC Winter Preparedness Plan 2020–21, including measures relating to staff movement, fair work, increased testing and outbreak management. Territorial Health Boards and Local Authorities, including through multi-disciplinary oversight teams, were asked to: build in mutual aid between social care providers; provide local level planning and co-ordination to support workforce capacity; manage and limit the impact on individual members of the workforce; and provide professional advice.
79. It outlined the proposed approach and national and local support for restricting staff movement across social care settings to limit transmission of the virus. The Plan stated that "*providers will now be required to demonstrate that they have done everything they can to limit staff movement*." The Plan also made clear that Local Authorities must balance the Covid transmission risk of restarting some supports and services, with ensuring that social care packages allow people to live fulfilling lives.
80. The Adult Social Care GOLD group was established in November 2020, to support the resilience of the care sector and ensure that people and providers were getting the support required to maintain quality service through Winter 2020. The emergence of the Delta variant required additional responses to support action to reduce community transmission. Care home staff were required to undertake twice weekly LFD asymptomatic testing as well as weekly PCR tests, reflecting an increase in testing capacity.
81. In December 2021, concern around the Omicron variant led to further measures being introduced to minimise risk of transmission. It led the Scottish Government to introduce daily asymptomatic LFD testing, in addition to baseline testing arrangements for social care staff. There was no better defence than the vaccine, and making sure residents and workers were vaccinated was key.

Funding regimes/packages and support made available to the ASC sector and their timing

82. In 2019-20 annual social care expenditure was £5.2 billion, most of which was on ASC (£4.0 billion, or 77%). In contrast to some other parts of the UK, since 2009-10 expenditure on ASC increased in real terms by 7% in total, and by 5% per capita. Of this, IAs received funding of £561 million for Covid-19 in 2020-21 and £712 million in 2021-22 including funding for Covid-19 Financial Support for Adult Social Care Providers (initially called 'Sustainability Payments'), in addition to wider social care support such as reducing delayed discharges, loss of income and staff costs. An initial £50m in 'Sustainability Payments' support was announced on 12 May 2020, with a further £50m on 3 November 2020. After this, the focus turned from provider sustainability to financial support covering additional pandemic-related costs. This support continued until after the end of the Relevant Period. As noted above, the Scottish Government also provided considerable financial support directly to the ASC workforce and unpaid carers.
83. IJBs agree their budgets with Local Authority and territorial Health Board partners, who in turn distribute funding to them to form a single, pooled health and social care budget. The Scottish Government has allocated additional recurring investment each year from 2015-16 to 2022-23 for ASC. This additional investment in social care has continued to increase each year and by 2022-23 the Scottish Government had increased its cumulative recurring investment in social care and integration to £1.6 billion per year.
84. The Scottish Government received additional funding for the Covid-19 response via Barnett consequentials in areas that are devolved to the Scottish Government. Allocations of £1.8 billion were made in 2021-22 to territorial Health Boards and IAs to meet costs of the pandemic and

remobilising health services. This was on top of the £1.7 billion already provided to territorial Health Boards and IAs in 2020-21.

IPC and access to/adequacy of PPE for those providing care in the home (including unpaid carers)

85. On 26 March 2020, following initial guidance issued in March 2020 by HPS, the Scottish Government issued Guidance for Care at Home, Housing Support and Sheltered Housing. The guidance outlined a range of protective measures and precautions, including use of face masks, and provided links to further guidance, such as the NIPCM Scottish Covid-19 IPC addendum, and signposting to additional resources.
86. Local PPE Hubs were established to ensure social care support providers had access to adequate PPE. In response to concerns raised by people who could not access the local PPE hubs, and who were receiving or providing social care support from home, an 'enhanced' Hub model was set up. This created a more stable and equitable distribution of PPE for social care support, and extended PPE to unpaid carers, PAs and non-registered social care services.
87. On 30 March 2020 the Cabinet Secretary for Health and Sport and COSLA wrote to local authorities and HSCPs, outlining their expectation that people should continue to receive care, and that funding should be made available to local authorities to allow them to prioritise care. The letter made clear that access to appropriate PPE would be provided and gave details of how to access PPE if needed.
88. Care at home and community-based services were also eligible for sustainability payments, which were provided on the basis of planned activity, where this was not able to be delivered due to Covid-19. This helped with financial pressures, including additional IPC and PPE costs.

End of Life Care

89. One of the reasons people in Scotland and elsewhere made so many sacrifices in their day-to-day lives was to protect those most at risk from the worst effects of Covid-19. Scotland's ASC workers, including those providing care in residential, nursing, domiciliary and unpaid care settings, worked tirelessly throughout the pandemic to support the most vulnerable in society. Tragically, it was not only the recipients of care, but also those providers of care, who in some cases came to lose their lives as a result of Covid-19.
90. The pandemic adversely impacted end of life care in Scotland in many ways. The witness statement of Judith Kilbee of Scottish Covid Bereaved (INQ000520272) outlines some of those significant and regrettable impacts. Examples include family members not reaching their loved ones in time for end of life visits, patients not receiving medical treatment in time to alleviate suffering at the end of their life, and, in some cases, poor communication from care homes at the end of a loved one's life.
91. As noted above, reducing the risk of transmission in care homes involved some of the most complex trade-offs of any part of the pandemic. While this does not detract from a negative impact on an individual level, it sets in context the nature of the balance that required to be struck in a situation where there were often no risk free options. However, as mentioned, the Scottish Government position from the outset of the pandemic was that 'essential' and 'end of life' visits should be supported, and a flexible, needs-based approach should be taken. At times, it was necessary for Scottish Government to intervene (alongside partners such as the CI and local Health Protection teams) to ensure that this approach was adopted in practice.

Use of Do Not Attempt Cardiopulmonary Resuscitation Notices ('DNACPRs')

92. In 2016, the Scottish Government produced updated guidance for health and social care professionals on Cardiopulmonary Resuscitation ('CPR') decisions. The guidance emphasises the importance of ensuring that decisions relating to CPR are made on a case-by-case basis,

with the individual and their loved ones where possible. The guidance makes clear the importance of health and social care staff having timely and sensitive conversations with individuals to plan for their care and support needs, should their health deteriorate. Pre-pandemic, Anticipatory Care Plans ('ACPs') were widely promoted by Scottish Government and Healthcare Improvement Scotland ('HIS') within the health and social care sectors, including care homes.

93. This substantive guidance *did not change* during the pandemic. The Scottish Government did, however, play a key role, alongside other organisations, in supporting the communication of guidance around the importance of ACPs and good DNACPR practice.
94. On 3 April 2020, the Scottish Government published its 'Covid-19 Guidance: Ethical Advice and Support Framework' ('Ethical Framework'), outlining the key principles to underpin the approach to ethical decision-making during the pandemic. It was updated regularly to take account of feedback and concerns, and to support good practice around decision making in challenging circumstances. The Scottish Government worked closely and extensively with a wide range of stakeholders, who provided constructive advice and support in developing the Equality Impact Assessment that accompanied the guidance and communications to support consistent adoption of best practice.
95. In response to concerns raised early in the pandemic over the use of DNACPR forms, on 10 April 2020 the Scottish Government's CMO, the BMA and the RCGP issued a joint letter to GP practices to provide advice and support on ACP conversations. The letter stressed that a 'blanket' approach to DNACPR conversations *should not* be taken, with discussions proceeding according to individual clinical circumstances. It made it clear that no one should ever feel pressured to agree to a specific care plan, or agree to a DNACPR form, if they were not comfortable doing so. Furthermore, there was no requirement for health professionals to have a DNACPR discussion as part of this conversation, unless the patient wished to discuss it, or the clinician felt strongly that it was necessary to raise for the patient's wellbeing. The Scottish Government reiterated that it expected everyone supported by health and social care services to be treated with sensitivity, dignity and respect at all times, including during conversations with individuals and their loved ones on the subject of ACPs. On 17 April 2020, a further such joint letter was sent to GPs to reinforce this message and set out how they could more effectively support care homes.
96. On 5 May 2020, the Scottish Government wrote a letter (for distribution to all clinical teams) to Chief Executives and Medical Directors of territorial Health Boards, regarding the use of DNACPR with younger patients, those with a stable long term physical need, a learning disability or autism, which underlined the need to adopt an individualised approach in consultation with family and/or paid carers. The Ethical Framework was updated in July 2020 to emphasise this point and make clear that health conditions or disabilities that are unrelated to a person's chance of benefiting from treatment must not form part of clinicians' decision-making regarding accessing treatment.

Analysis of statistics

97. The Scottish Government's Covid-19 Health and Social Care Analysis Hub worked together with partner agencies to collect and report Covid-19 data on a daily and weekly basis during the pandemic. The Scottish Government carefully monitored official statistics on deaths in Scotland (including Covid-19 deaths) that were collated and published by National Records of Scotland ('NRS'). NRS was the official source of information on Covid-19 deaths in care homes. "Deaths involving Covid-19" were deaths where Covid-19 had been identified by a doctor as being involved in the death, either as the underlying cause of death, or as a contributory cause

of death. “Care home deaths” figures published by NRS also included the number of deaths which occurred in hospice settings.

98. Between 3 June 2020 and 5 April 2022, the Scottish Government published CI information on Covid-19 care home deaths. The figures were collected and published on a weekly basis, and included all care home deaths for adults in Scotland notified to the CI during that week. Care homes were required to specify whether Covid-19 was noted as confirmed or suspected on the death certificate. Although NRS data (on deaths in care homes) and CI data (on deaths of care home residents) are similar, NRS data was based on location of death. Care home residents who died in hospital were included in the figures for deaths in hospital. CI data included any death of a resident, including those in hospital. There were also different time lags between the date of death and the date the death was registered, or the date it was notified to the CI. Occasionally a service may have given notice of a death that had occurred several weeks earlier. This was attributed to the week in which the CI was notified. While one *could* have regard to excess death figures, the Scottish Government has not been able to calculate an accurate and robust excess death rate for care home residents during the Covid-19 pandemic, for the reasons stated at §971-972 of the Module 6 DG HSC statement (INQ000614179).
99. NRS data shows that between 16 March 2020 (where first death was recorded) and the week beginning 27 June 2022, 4,274 deaths were recorded where Covid-19 was the underlying cause of death or as a contributory cause of death, and location of death was care home. Note that care home residents who died in hospital will have hospital recorded as the location of death and they will not be included in this figure. No data is available for those receiving care within in the community (care at home, telecare etc), since the death certificate does not record information about care being received at the time of death. Death certificates also do not specify who was receiving end of life care.

Changes to the Regulatory Inspection Regimes within the Care Sector

100. As the national agency responsible for regulating care services in Scotland, the early stages of the pandemic saw a rapid transformation of the work of the CI, from a ‘business as usual position’ to an emergency response, with associated changes to its assurance and scrutiny activity. As part of its response to the pandemic, the CI developed guidance on how it would carry out its registration and scrutiny role during the emergency period. The proposed change in approach was sent to the Scottish Government, with approval sought and then obtained on 13 March 2020. Ministers were accordingly aware that the CI intended to ‘scale down’ its inspections of care homes. The rationale was clear and aimed at minimising the risk that CI staff would spread infection of Covid-19, while recognising that their inspectors might also be at risk of infection themselves.
101. As mentioned, on 14 April 2020 the First Minister led a Scottish Government Resilience Room (‘SGoRR’) ‘Deep Dive’ on care homes. This brought together key government officials and external stakeholders to discuss ways to ensure the safety and wellbeing of care home residents and staff. One of the actions was for the CI to re-institute some inspections to follow up their current telephone approach for greater assurance and support. Following this, the Cabinet Secretary for Health and Sport wrote to the CI on 29 April 2020 requesting a timeframe for resumption of its inspection programme. Despite some initial concerns, CI resumed unannounced, on-site inspection visits to care homes from 4 May 2020 onwards.
102. Scottish Ministers outlined new arrangements for enhanced professional and clinical care oversight of care homes in a letter to key partners issued on 17 May 2020. Local oversight teams were required to ensure, amongst other duties, that joint inspection visits (of care homes) were undertaken as required by the CI and HIS.

103. These inspections were undertaken on a targeted basis, with a focus on the physical and healthcare needs of residents, taking into account priorities and concerns identified by local oversight teams. HIS assisted with clinical aspects of inspections of care homes (e.g., IPC). The presence of HIS inspectors, and the healthcare and IPC expertise that they provided, brought additional assurance to care home inspections. HIS contributed to over 200 inspections (including continuation, monitoring and follow up visits), equating to approximately 30% of the total number of inspections carried out by the CI.
104. The Coronavirus (Scotland) (No. 2) Act 2020, which came into force on 26 May 2020, placed new duties on the CI in relation to reporting to the Scottish Parliament on its inspection activities, findings, and care home deaths. The provisions required care homes to report on the number of deaths in the service.

Conclusion

105. We hope that this Opening Statement has helped to explain the role that the Scottish Government plays in the delivery of social care in Scotland, and to clarify the rationale behind, and impact of, some of the decisions that the Scottish Government had to take.
106. We finish by again recognising those who suffered, and who continue to suffer, and by again paying tribute to those who delivered all forms of social care during the pandemic.

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