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UK COVID-19 INQUIRY
MODULE 6

WITNESS STATEMENT OF THE DIRECTOR GENERAL FOR HEALTH AND SOCIAL CARE

This statement is one of a suite provided for Module 6 of the UK Covid-19 Inquiry and these should be considered collectively. In relation to the issues raised by the Rule 9 notice dated 16 July 2024 served on the Scottish Government, in connection with Module 6, the Director-General for Health and Social Care will say as follows: -

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Overview

1. This statement provided by the Director-General for Health and Social Care is one of a suite provided for Module 6 to the UK Covid-19 Inquiry and these should be considered collectively as they cover different aspects of the Scottish Government response.

2. The Scotland Act 1998 ('the 1998 Act') (as amended by the Scotland Acts 2012 and 2016) made provision for a Scottish Parliament and a Scottish Executive, later renamed the Scottish Government (SG) under the Scotland Act 2012. The Executive was made up of Scottish Ministers and was accountable to the Parliament. Prior to the establishment of the Scottish Parliament in 1999 under the 1998 Act, the Scottish Office oversaw many public services in Scotland as part of the UK Government. This included having policy responsibilities for such areas as health and local government. Devolution was intended to allow the people of Scotland to choose political representatives and leadership that reflected their views and priorities.

3. Scottish devolution is based on a "retained powers" model of devolution in which – broadly – the power to make legislation about matters not "reserved" in the 1998 Act is "devolved" to the Scottish Parliament. This includes broad executive and legislative competence over most aspects of health, care and social services. Scottish Ministers have executive powers, including to make secondary legislation (such as regulations and orders), and responsibilities to which they are accountable to the Scottish Parliament. Those are in areas where legislative competence is devolved to the Scottish Parliament and a range of "executively devolved" powers and duties in relation to matters (for example, many areas of transport) for which the competence to make primary legislation is reserved.

4. The Module 2/2A statement provided to the Inquiry on 22 June 2023 by the Director General (DG) Strategy and External Affairs [CL15/001 – INQ000215495] sets out a further detailed explanation of the competence of the Scottish Parliament and Scottish Ministers under the 1998 Act.

5. This statement provides in-depth and wide-ranging information on the structures in place for adult social care (ASC) provision at the start of the pandemic, how these structures changed during the relevant period (1 January 2020 to 28 June 2022), as well as providing insight into how the ASC sector was impacted by Covid-19, and the attendant responses from the SG. This statement covers the following broad areas:

- The organisational structure of ASC in Scotland
- The roles and responsibilities of SG in relation to the ASC pre and during the pandemic
- The decision-making framework and process in place during the pandemic
- Liaison with other response partners and ASC stakeholders
- The structure and capacity of the ASC sector
- Pre-pandemic plans and guidance
- Guidance issued to the ASC sector during the pandemic.
- The decision-making process re: the March 2020 discharge policy
- The impact of the March 2020 discharge policy
- The change of strategy re: discharge in April 2020
- Care workforce
- Care in the home and disabled people
- Testing decision making, policy and guidance
- Infection Prevention Control (IPC) and PPE
- Visiting restrictions and access to healthcare
- Changes to regulatory inspection regimes
- Policy and guidance relating to Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions
- How data informed decision making, advice, policy and guidance formulation and challenges and developments in data during the relevant time period
- An overview of the various lessons learned exercises and reports commissioned by SG in response to Covid-19 which are relevant to the ASC sector
- Recommendations.

<u>The role of Scottish Government in Adult Social Care (ASC)</u>

6. ASC in Scotland is delivered by a wide range of partners across Scotland, including the public, independent and third sectors. Unlike health, the Scottish Government

does not have direct statutory responsibility for the delivery of ASC. However, the Scottish Government is responsible for the strategic framework for ASC, including bringing forward related legislation.

7. 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.

8. Since 1948, Local Authorities have been responsible for ASC support in Scotland, in various forms, and territorial Health Boards have been responsible for health services. A wide range of partners, including from the public, independent and third sectors, are involved in the delivery of social care services across Scotland.

9. Under the Public Bodies (Joint Working) (Scotland) Act 2014 (the 2014 Act), Local Authorities and Health Boards work together to manage a range of health and social care services collectively. The 2014 Act requires the local integration of adult health and social care services, with statutory partners (territorial health boards and local authorities) deciding locally whether to include children's health and social care services, criminal justice, social work and housing support services in their integrated arrangements. Statutory partners are required to delegate certain functions to a local Integration Authority (IA). The territorial Health Board and Local Authorities set out in their integration scheme which of their functions they intend to delegate to the Integrated Joint Board (IJB) – the scope of delegated functions will vary according to local decision making but must adhere to the statutory minimums set out in the Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Regulations 2014 (for Health Boards) and the Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Regulations 2014 (for Local Authorities). In most areas, the IA is an IJB which includes members from both the local authority and territorial health board. Of the 32 local authority areas in Scotland, 31 have deployed the IJB model and only the area shared by The Highland Council and NHS Highland has deployed the lead agency model. Two Local Authorities – Clackmannanshire and

Stirling – work together as a single IJB, meaning that there are 31 IAs in total (30 IJBs and 1 lead agency) that, between them, cover the whole of Scotland. Further detail regarding the lead agency model is provided at paragraph 93 below.

10. Local authorities and territorial Health Boards are required by law to plan and deliver adult community health and social care services, including services for older people. The IJB develops a strategic plan which is implemented by the Health and Social Care Partnership (HSCP) in their area.

11. Each of Scotland's 31 IAs has a Chief Officer (as defined in the 2014 Act). Further detail regarding the role of IAs is provided at paragraph 93 of this statement. The role of each Chief Officer is to lead the development and implementation of the strategic plan in their area, and to integrate and transform health and social care services for their local communities. Chief Officers provide senior leadership and engage regularly with the Scottish Government. Chief Officers report to their IJB, in its role as board of governance for integrated services, and to the Chief Executives of the territorial Health Board and Local Authority, in their roles as providing senior oversight of the delivery of integrated services locally.

12. IJBs prepare the strategic plan for integrated functions and budgets in line with the requirements of the 2014 Act, and strategic plans must be reviewed at least every 3 years. The strategic plan is then implemented by the local HSCP. Whilst an IJB is a legal entity (a "body corporate"), an HSCP is not an entity in itself, but is an operational approach to delivering services; it is an umbrella term for the employees of the Local Authority and territorial Health Board who deliver the services that are planned by the IJB.

13. Each of Scotland's 31 HSCPs deliver adult social care, adult primary health care and unscheduled adult hospital care. They maintain quality of care, safety and the wellbeing of residents through ensuring compliance with regulations and coordinating services, monitoring staffing levels and addressing any issues care home and care at home issues in their locality. Staff from both Local Authorities and the territorial Health

Boards work together in partnership to deliver the IJB's strategic plan, alongside local communities, the third sector, other care providers in the local area, under the Chief Officer (as described above at paragraph 10).

Scottish Government's statutory duties in relation to ASC

14. The Scottish Government has a number of statutory duties relating to ASC. A summary of those statutory requirements and duties applicable to other relevant public bodies is provided below, with further detailed explanation of the Scottish Government's statutory duties provided at later parts of this statement. Scottish Ministers do not have the power to issue directions to care providers. However, Scottish Ministers can issue directions to local authorities, territorial Health Boards and IAs as set out in more detail below.

Social Work (Scotland) Act 1968

15. The 1968 Social Work (Scotland) Act ("the 1968 Act") was a landmark piece of legislation which embedded the vision of social work as a universal, community-based service. The passing of the 1968 Act, heralded a commitment by central and local government to provide a comprehensive and community oriented social work service, focused on providing early help, working in partnership with the communities served, and prepared and empowered to act to protect the vulnerable and those in crisis. It brought social work professionals from different fields of practice together within new local authority social work departments.

16. Local authorities have a duty under the 1968 Act to assess a person's social care support needs and decide if they need to arrange any services. Any assistance should be based on an assessment of the person's social care support needs and should take account of their preferences where possible.

17. There is provision under section 5(1A) of the 1968 Act for Scottish Ministers to issue directions to local authorities, either individually or collectively, as to the manner in

which they are to exercise any of their functions under the Act or any of the enactments listed in section 5(1B) of that Act.

National Health Service (Scotland) Act 1978

18. The National Health Service (Scotland) Act 1978 ("the 1978 Act") places a duty on the Scottish Ministers to promote a comprehensive and integrated health service, designed to secure improvement in the physical and mental health of the people of Scotland and the prevention, diagnosis, and treatment of illness. They may do anything which they consider is likely to assist in discharging that duty. The Scottish Government Directorates for HSC have responsibility for health policy, social care policy, public health and the administration of the NHS. This includes setting the standards for governance in NHS Scotland. The Director-General for Health and Social Care (DG HSC) (who is also the Chief Executive of NHS Scotland) leads the Directorates. Section 2(5) of the 1978 Act sets out powers of Scottish Ministers to direct territorial Health Boards to take a specific action.

Scotland Act 1998

19. The 1998 Act established the Scottish Parliament and gave it the power to legislate on certain matters. Section 28(1) of the 1998 Act provides that "subject to section 29, the Parliament may make laws, to be known as Acts of the Scottish Parliament".

20. The 1998 Act does not set out what is devolved, but instead lists 'reserved matters' for which the UK Parliament retains responsibility. Health and social care are devolved matters. Insurance as a reserved matter is discussed later in the statements at paragraph 467 onwards.

Adults with Incapacity (Scotland) Act 2000

21. The Adults with Incapacity (Scotland) Act 2000 ("the 2000 Act") introduced a system for safeguarding the welfare and managing the finances and property of adults who lack capacity to make some or all decisions for themselves. This includes adults who

have a mental disorder or a physical disability, which means they cannot communicate and are not able to do things like: make decisions, communicate decisions, understand decisions and remember decisions.

22. It is underpinned by principles which anyone taking action under the 2000 Act must apply when deciding which measure will be the most suitable for meeting the needs of the individual. The principles must also be used whenever decisions need to be made on behalf of the adult. Section 9 sets out the Mental Welfare Commission's functions under the 2000 Act and Section 10 sets out the functions of local authorities in this regard.

Regulation of Care (Scotland) Act 2001

23. The main aim of the Regulation of Care (Scotland) Act 2001 ("the 2001 Act") is to improve regulation and in turn standards of social care services. The 2001 Act established the Scottish Commission for the Regulation of Care and the Scottish Social Services Council (SSSC), the latter being a public body which regulates the social service workforce in Scotland. The 2001 Act makes provision for the registration of social workers and other social service workers within the SSSC. The SSSC sets standards for the practice, conduct, training and education of this workforce. Where people fall below the standards of practice and conduct they may be removed from the register and will no longer be able to provide social care services. The provisions of the 2001 Act relating to registration and inspection of care services have been repealed and replaced by the Public Services Reform (Scotland) Act 2010.

24. The regulatory changes undertaken by SSSC during the pandemic are described at paragraph 907 onwards.

Civil Contingencies Act 2004

25. The Civil Contingencies Act 2004 ("the 2004 Act") does not set out specific statutory duties for Scottish Ministers. Instead, the 2004 Act imposes a series of duties on local bodies in England and Wales, Scotland and Northern Ireland (to be known as

"Category 1 responders"). Category 1 responders are listed within schedule 1 of the 2004 Act. Category 1 responders in Scotland include local authorities, territorial Health Boards and IAs. The 2004 Act was amended via the Civil Contingencies Act 2004 (Amendment of List of Responders) (Scotland) Order 2021 to include IAs as Category 1 responders. This came into force on 17 March 2021. Category 1 responder duties include the duty to assess the risk of an emergency occurring and to maintain plans for the purposes of responding to an emergency, under section 1(1). The 2004 Act also provides the mechanism to impose duties on other local bodies (to be known as "Category 2 responders") to co-operate with, and to provide information to, Category 1 responders in connection with their civil protection duties.

26. Under the 2004 Act, Scottish Ministers have the power to require a Category 1 responder to perform a function for the purposes of preventing an emergency, reducing, controlling or mitigating the effects of an emergency or taking other action in connection with an emergency (section 5). Under section 1, the Scottish Ministers can provide by order that a particular event or situation (or class of event or situation) is to be treated as falling within (or outside) the definition of emergency.

27. Section 3(2) of the 2004 Act enables the Scottish Ministers to issue guidance to Scottish Category 1 responders and Scottish Category 2 responders (those persons and bodies listed in Part 4 of Schedule 1) about the extent of the duties imposed under section 2(1), the manner in which such duties are to be performed and regulations made under section 2(4).

28. Under section 8 of the 2004 Act, Scottish Minsters can also do what could be done under section 5 (orders about general measures) and section 6 (regulations relating to disclosure of information) by way of direction where there is insufficient time for secondary legislation to be made.

29. Section 11(1) enables the Scottish Ministers, a Scottish Category 1 responder or a Scottish Category 2 responder to enforce duties under the 2004 Act by way of proceedings in the Court of Session.

30. Scottish Ministers also have the power to make regulations and issue guidance in relation to cross-border collaboration regarding category 1 and 2 listed responders under section 15 of the 2004 Act.

Adult Support and Protection (Scotland) Act 2007

31. The Adult Support and Protection (Scotland) Act 2007 ("the 2007 Act") gives greater protection to adults at risk of harm or neglect. Part 1 of the 2007 Act deals with the protection of adults at risk of harm. This defines adults (16 and over) as being at risk if they are:

- Unable to safeguard their own wellbeing, property, rights or other interests
- At risk of harm (as further defined in section 3(2) of the 2007 Act), and
- More vulnerable to being harmed because of a disability, mental disorder, illness or physical or mental infirmity.

32. Section 4 of the 2007 Act places a duty on local authorities to make inquiries if it knows or believes that: the person is an adult at risk and that it might need to intervene. In these cases, local authorities have powers to:

- Visit and interview people
- Arrange medical examinations
- Examine records
- Consider a Protection Order.

Public Health etc. (Scotland) Act 2008

33. The Public Health etc. (Scotland) Act 2008 ("the 2008 Act") sets out the duties of Scottish Ministers, territorial Health Boards and local authorities to continue to make provision, or secure that provision is made, to protect public health in Scotland. These duties are without prejudice to existing duties imposed on the Scottish Ministers and territorial Health Boards in the 1978 Act and existing environmental health legislation.

34. Scottish Ministers have the power to provide assistance, including financial assistance, to persons who exercise functions in relation to public health. "Protecting public health" is defined in section 1 of the 2008 Act as the protection of the community or any part of it from infectious diseases, contamination or other such hazards which constitute a danger to human health and includes the prevention and control of, and provision of a public health response to, such disease, contamination or other hazards.

35. Scottish Ministers have various powers in connection to this duty. This includes the power to direct a territorial Health Board or a local authority to exercise its public health functions where it is necessary for the purpose of protecting public health, under section 8. This power applies where the Scottish Ministers consider that a territorial Health Board or a local authority has failed, is failing or is likely to fail to exercise the functions conferred on it by the 2008 Act or has failed, is failing or is likely to fail to exercise them in a manner which the Scottish Ministers consider acceptable. Under section 9, the Scottish Ministers may direct that the functions of a territorial Health Board or a local authority be performed by a person other than the territorial Health Board or local authority whether or not they have made a previous direction under section 8. However, if a direction to a territorial Health Board or a local authority has been given under section 8, the Scottish Ministers may not give a direction under this section unless the period specified in the first direction has expired or that direction has been withdrawn.

36. Furthermore, under section 11, Scottish Ministers, if they are satisfied that it is necessary to do so, have the power to direct resources between territorial Health Boards, between local authorities and between territorial Health Boards and local authorities, in connection with the performance by the recipient board or authority of its functions relating to the protection of public health. Under section 12, Scottish Ministers have the power to amend the lists of notifiable diseases and notifiable organisms within schedule 1 of the 2008 Act.

37. Scottish Ministers may also appoint a person to carry out a public health investigation under section 21, and give such additional powers to investigators as they consider necessary under section 25.

38. Section 94(1) allows the Scottish Ministers to make regulations for the purposes of, or in connection with, giving effect to The International Health Regulations 2005 ("IHR 2005") (and recommendations under IHR 2005) as well as other international agreements relating to the spread of infectious disease and contamination, so far as they have effect in or as regards Scotland. The IHR 2005 are a legally binding international agreement intended to prevent, protect against, control and respond to the international spread of disease without unnecessary interference with international traffic and trade.

39. Scottish Ministers, territorial Health Boards and local authorities, are required, under section 116, to carry out their functions under the 2008 Act in a manner that encourages equal opportunities and the observance of equal opportunities requirements, as defined in the 1998 Act. "Equal opportunities" means the prevention, elimination or regulation of discrimination between persons on grounds of sex or marital status, on racial grounds, or on grounds of disability, age, sexual orientation, language or social origin, or of other personal attributes, including beliefs or opinions, such as religious beliefs or political opinions. "Equal opportunity requirements" means the requirements of the law for the time being relating to equal opportunities.

Equality Act 2010 – the Public Sector Equality Duty

40. Under the Public Sector Equality Duty (PSED) outlined in section 149(1) of the Equality Act 2010, Scottish Ministers are required to have due regard to the need to: eliminate discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act; advance equality of opportunity between persons who share a relevant protected characteristic and those who do not, and foster good relations between persons who share a relevant protected characteristic and those who do not.

41. Scottish Ministers are also required to report on progress regarding the PSED under the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012. This includes a duty to report progress on mainstreaming the equality duty under regulation 3 and a duty to publish equality outcomes and report progress as set out in regulation 4.

Additionally, Scottish Ministers are required to assess the impact of all new and revised policies and practices against the three needs of the PSED and to publish within a reasonable time the results of the assessment of any such policy and practice that they decide to apply, under regulation 5.

Public Services Reform (Scotland) Act 2010

42. The Public Services Reform (Scotland) Act 2010 ("the 2010 Act") was introduced to simplify and streamline the public bodies in Scotland to deliver improved public services and better outcomes for the people of Scotland. The 2010 Act established Social Care and Social Work Improvement Scotland (known as the Care Inspectorate (CI) as the care services regulator and Healthcare Improvement Scotland (HIS), a national healthcare improvement organisation (further information about HIS is provided at paragraph 102). Oversight and Inspections are described more fully at paragraph 890 onwards.

43. The 2010 Act provides the statutory basis for both bodies along with associated powers and duties including those of the Scottish Ministers. Under Chapter 2, Part 5 of the 2010 Act, the CI has the power to inspect any social service. This is defined in section 46(1) to mean both care services and social work services. The CI powers and duties in relation to care services are contained in Chapter 3 of the 2010 Act and are summarised below:

- Sections 53 to 58 refer to powers of inspection of care services. Section 55 of the 2010 Act provides a power for Scottish Ministers to request an inspection, which the CI must comply with
- Sections 59 to 61 refer to registration of care services
- Sections 62 and 63 refer to improvement notices and also powers of direction to care homes during an emergency (Sections 63A and 63B were both added and repealed by the Coronavirus (Scotland) (No 2) Act 2020 on 27 May 2020 and 1 October 2022, respectively)
- Sections 64 to 75 refer to powers to cancel a registration and conditions on registration

- Section 76 gives Ministers the power to prescribe the fees which may be imposed by the CI in connection with registration
- Section 78 gives powers to Scottish Ministers to place additional functions on the CI, and to impose, in relation to care services, any requirements which they consider appropriate for the purposes of Part 5 of the 2010 Act (this is discussed further in relation to visiting care homes and Anne's Law at paragraph 1016 of the statement)
- Section 77 to 82 refer to regulations, complaints and offences
- Sections 82A to 82F refer to care services: safe staffing (the guiding principles for health and care staffing set out in section 1 of the Health and Care (Staffing) (Scotland) Act 2019 – details provided below)
- Section 114 sets out the statutory duty of co-operation on scrutiny between CI and HIS
- Sections 115 to 117 refer to joint inspections.

44. Joint inspections of care homes are described in more detail in paragraph 890 onwards of the statement. The HIS powers are contained within sections 108 to 110 of the 2010 Act (sections 108 and 110 making extensive amendments to the 1978 Act).

Social Care (Self-Directed Support) (Scotland) Act 2013

45. The Social Care (Self-Directed Support) (Scotland) Act 2013 ("the 2013 Act") makes provision regarding the arranging of care and support to provide a range of choices to people for how they are provided with support. The 2013 Act came into force on 1 April 2014 and is grounded in a human rights based approach. The 2013 Act places a duty on local authorities to offer people who are eligible for social care a range of choices over how they receive their support. It provides a legal basis for choice over care and support.

46. The functions of local authorities are described at section 11, and sections 12 and 13 and 16 to 19 of the 2013 Act make further provision as regards local authorities' powers and duties in this context (with sections 17 and 18 making amendments to the 1968 Act). Responses to the Inquiry relating to the role of Personal Assistants within

Self-Directed Support (SDS) are described in paragraphs 254 to 256 of this statement.

The Public Bodies (Joint Working) (Scotland) Act 2014

47. The Public Bodies (Joint Working) (Scotland) Act 2014 (the 2014 Act) was passed by the Scottish Parliament in February 2014 and became an Act on 1 April 2016. This provided the framework for the integration of health and social care services in Scotland.

48. The 2014 Act requires territorial Health Boards and local authority partners to enter into arrangements (an integration scheme) and to delegate functions and resources to ensure the effective delivery of integrated health and social care. The 2014 Act sets out what functions and budgets must be delegated, and which may be delegated. Each IA is required to produce a strategic commissioning plan that sets how they will plan and delivery services in their area in the medium-term, using integrated budgets under their control. The 2014 Act makes further provision in relation to certain functions under the 1978 Act.

49. The integration of health and social care is the Scottish Government's programme of reform to improve care and support for those who use health and social care services. This helps to ensure a consistent provision of quality, sustainable care services for people in Scotland who need joined-up support and care, particularly people with multiple, complex, long-term conditions.

50. The Scottish Government has established a set of national outcomes, which apply across health and social care, and for which NHS boards and local authorities will be held jointly accountable. The 2014 Act also put in place a set of integration planning principles. Scottish Ministers may issue directions to IJBs (and by extension HSCPs) using section 52 of the 2014 Act.

The Carers (Scotland) Act 2016

51. This sets out the duties of local authorities to provide information and support to carers. This includes the duty to offer an adult carer support plan or young carer statement to identify each carer's personal outcomes and needs for support, and the provision of support if carers meet the eligibility criteria. The support provided to unpaid carers by the Scottish Government is detailed at paragraphs 539 to 557.

Health and Care (Staffing) (Scotland) Act 2019

52. The Health and Care (Staffing) (Scotland) Act 2019 ("the 2019 Act") received Royal Assent on 6 June 2019 but did not come fully into force until 1 April 2024. The Scottish Government published guidance on 1 April 2024 to support the implementation of the 2019 Act [CL15/002 – INQ000591935]. The aim of the 2019 Act is to provide a statutory basis for the provision of appropriate staffing in health and care services, enabling safe and high-quality care and improved outcomes for service users and people experiencing care.

53. The 2019 Act sets out how overarching principles should be applied across health and social care, including in the commissioning of services. It also specifies different duties for territorial Health Boards, local authorities, IAs and the Scottish Government to report publicly on compliance with the 2019 Act.

54. Provisions include: the principle that the main purpose of staffing is to provide safe, high-quality services and the best outcomes for service users. There is a duty on the NHS and social care providers to make sure that, at all times, there are suitably qualified and competent staff working in the appropriate numbers.

55. The 2019 Act confers duties on the Scottish Government to take all reasonable steps to ensure registered nursing supply, with an annual report to the Scottish Parliament on this and to consult with appropriate professional bodies and trade unions when writing guidance on the legislation.

56. Other powers include the CI developing and maintain staffing methods for care homes for adults (in the first instance), in collaboration with relevant trade unions and

professional bodies. In addition, the CI may carry out reviews of the operation of the legislation and report to Scottish Ministers.

Coronavirus Act 2020

57. The Coronavirus Act 2020, which received Royal Assent on 25 March 2020, gave powers to respond effectively to the progress of the Covid-19 pandemic. The purpose of the Coronavirus Act 2020 was to enable the government to respond to an emergency situation and manage the effects of a coronavirus pandemic.

Coronavirus (Scotland) Act 2020

58. The Coronavirus (Scotland) Act 2020 ("the 2020 Act"), passed on 1 April 2020, was introduced to respond to the emergency situation caused by the Covid-19 pandemic and complements and supplements the Coronavirus Act 2020. Due to the impacts of the pandemic, the SG considered that the unexpected shift in resourcing and prioritisation required a number of obligations and duties on public services in Scotland to be shifted temporarily, to reflect the importance which the SG placed on responding to the coronavirus outbreak and protecting the health of people living in Scotland.

59. Schedule 3, Part 2 of the 2020 Act concerns Vulnerable Adults. Schedule 3, Part 2, paragraph 11(1) pertains to the care of adults with incapacity and contains modifications to section 13ZA of the 1968 Act. These modifications were primarily aimed at ensuring local authorities could provide services more swiftly to incapacitated persons. When local authorities carry out functions under section 13ZA they are obliged to follow the principles set out in section 1 of the Adults with Incapacity (Scotland) Act 2000 – the provision limits the application of all of these principles.

60. Schedule 3, Part 2, paragraph 11(2) of the 2020 Act amended the Criminal Procedure (Scotland) Act 1995, such that it permitted guardianship orders to continue to run where they would have otherwise expired.

61. Schedule 3, Part 2, paragraph 11(3) of the 2020 Act amended the Adults with Incapacity (Scotland) Act 2000 to both extend the period of a s47 certificate authorising treatment of incapacitated adults and to make further provisions to ensure guardianship orders did not lapse and leave gaps in the care of vulnerable persons.

Coronavirus (Scotland) (No.2) Act 2020

62. The purpose of the Coronavirus (Scotland) (No.2) Act 2020 was to respond to the emergency situation caused by the Covid-19 pandemic. The Act complements and supplements the Coronavirus Act 2020(1) ("the UK Act"), passed by the UK Parliament on 25 March 2020, and which the Scottish Parliament gave its consent to on 24 March 2020, and the 2020 Act, passed by the Scottish Parliament on 1 April 2020.

63. The Coronavirus (Scotland) (No.2) Act 2020 introduced provisions relating to the creation of a Social Care Support Fund (see schedule 1, Part 4 paragraph 7(1)), care homes and territorial Health Board directions (see Part 7 of that schedule) and at Part 8 of that schedule set out the powers to purchase providers of care home services and care at home services. This Act also established new reporting requirements for CI reporting of inspections and deaths (see Part 9 of that schedule) and made provision for delivery of electronic notices to care services (in schedule 4, Part 4, paragraph 5). Further discussion regarding specific provisions made under the Coronavirus (No.2) (Scotland) Act is provided at paragraph 886.

Scottish Government Organisational structure

Ministerial responsibilities

64. Currently four Ministers hold portfolio responsibility for aspects of health and social care. There is overlap between Ministerial responsibilities therefore details of all the responsibilities held by each minister follow.

65. The Minister for Public Health and Women's Health is responsible for:

- Abortion
- Child and maternal health
- Community audiology
- Community optometry
- Community pharmacy
- Dentistry
- Food Standards Scotland
- Healthy weight
- Medical records
- Mesh
- Mobile healthcare
- MyNHS Digital
- National Pharmaceutical Agency
- Palliative care
- Pharmacy First
- Population health
- Public health and healthy working lives
- Sensory impairment/loss
- Sexual health
- Women's health
- Vaccination programmes.

66. The Minister for Social Care, Mental Wellbeing and Sport is responsible for:

- Adult support and protection
- 'Anne's Law' delivery – legislative provisions to support visiting in care homes
- Care Inspectorate
- Care, support and rights
- Child and adolescent mental health
- Dementia
- Forensic mental health services and reform
- Independent Living Fund
- Mental health wellbeing

- Mental Welfare Commission
- National Care Service
- Self-directed support
- Social Care and Integration
- Social prescribing
- Social service workforce
- Sport and physical activity
- Suicide prevention
- Survivors of childhood abuse.

67. The Minister for Drugs and Alcohol Policy is responsible for:

- Alcohol harm prevention, harm reduction and recovery
- Alcohol treatment
- Reducing drinking at hazardous and harmful levels
- Reducing drug related deaths
- Supporting the rehabilitation and recovery of those living with drug or alcohol dependency
- Tackling and reducing the harm of problem substance use.

68. Ministerial post holders for the period from January 2020 to 28 June 2022 are listed below:

Cabinet Secretary for Health

- Jeane Freeman (Cabinet Secretary for Health and Sport) – June 2018 to May 2021
- Humza Yousaf (Cabinet Secretary for Health and Social Care) – May 2021 to March 2023

Ministers for Health

- Clare Haughey, Minister for Mental Health – June 2018 to May 2021

- Joe FitzPatrick, Minister for Public Health, Sport and Wellbeing – June 2018 to December 2020
- Mairi Gougeon, Minister for Public Health and Sport – December 2020 to May 2021
- Maree Todd, Minister for Public Health, Women's Health and Sport – May 2021 to March 2023
- Kevin Stewart, Minister for Mental Wellbeing and Social Care – May 2021 to March 2023

69. As specified in the Civil Service Code, in the same way that Ministers are accountable to Parliament, civil servants are accountable to Ministers. The DG HSC is Caroline Lamb, who has been in post since January 2021. The DG HSC is responsible for the Health and Social Care Directorates, also referred to as the DGHSC family.

70. The DG HSC is a member of the SG's Corporate Board, the designated Portfolio Accountable Officer for Health and Social Care Directorates and the Chief Executive of the NHS in Scotland. As Accountable Officer, the DG HSC is personally answerable to Parliament and has a personal responsibility for the propriety and regularity of the finances under their stewardship and for the economic, efficient and effective use of all related resources. Accountable Officers are responsible for putting in place frameworks for SG Executive Agencies, non-ministerial offices and SG sponsored bodies that set out their own accountability arrangements. All DG HSC post holders from January 2020 to date are listed below:

- Malcolm Wright- June 2019 to May 2020
- John Connaghan – Interim CEO, April/May 2020 to January 2021
- Elinor Mitchell – Interim DG, April/May 2020 to December 2020
- Caroline Lamb – January 2021 to date.

71. The organisational structure for the Directorate General for Health and Social Care family of directorates (DGHSC) has been previously provided to the Inquiry [CL15/003 – INQ000469941].

72. The Directorate for Health Finance and Governance also sits within DGHSC. The Directorate (previously Health Finance, Corporate Governance and Value) was an established Directorate prior to the pandemic and operates as a dedicated financial management service for the DGHSC family. The Directorate works within internal and external stakeholders (territorial Health Boards and HSCPs) to:

- Devise and implement financial strategy for the health and social care portfolio
- Financially manage territorial Health Boards, delegated health functions within the HSCPs and internal health Directorates
- Devise and implement policy and structured investment in NHS infrastructure
- Provide advice, insight and intelligence to Ministers and policy colleagues on inter- and cross-portfolio matters.

73. Richard McCallum was the Director of Health Finance and Governance from March 2021 until 19 August 2024, having been the interim Director between December 2019 and March 2021.

74. Below follows detail regarding the Directorate and Divisional structures in Scottish Government responsible for ASC in Scotland, both prior to and during the pandemic. Divisions are led by Deputy Directors, who report to Directors. Directors lead directorates and report to their portfolio Director-General.

Scottish Government ASC Divisional Structures

75. During the course of the pandemic, there was significant restructuring within the DGHSC family to maximise Scottish Government's support to the ASC sector, including the establishment of a dedicated ASC Directorate and several new social care divisions, including an ASC Pandemic Response Division. An organogram, showing the structures for divisions responsible for ASC as at October 2019, October 2020 and February 2022 is provided [CL15/003A – INQ000592031].

76. At the outset of the pandemic, the Community Health and Social Care Directorate, led by Elinor Mitchell, had lead responsibility for ASC within DGHSC. There were two Divisions within this Directorate with responsibility for ASC:

- The Social Care Support Division (led by Deputy Director, Jamie MacDougall)
- The Health and Social Care Integration Division (led by Deputy Director, Alison Taylor).

77. These divisions had responsibility for a range of ASC strategic policies, including:

- Adult care home policy
- Adult care at home policy
- Unpaid carers
- Older people's policy
- Sponsorship of the CI
- Sponsorship of the Independent Living Fund
- Integration of health and social care
- Delayed discharge policy
- Community hospital policy
- Equipment and adaptations policy
- Intermediate Care and Hospital at Home policy
- Survivor Support.

78. During the early stages of the pandemic, both the Health and Social Care Integration and Social Care Support Divisions came together to support the pandemic response. A Care Homes Pandemic Division was subsequently formed in late April 2020 under Frank Strang and supported by professional adviser NR The decision to make these changes was made by Elinor Mitchell, in her role as Director of Community Care, in response to the significant impact of the pandemic on people living and working in care home settings.

79. The Care Homes Pandemic Division oversaw the provision of support to the care home sector during the early stages of the pandemic and offered a single point of

advice and policy support. The Division also helped to co-ordinate advice for care homes from other parts of SG, for example such as the Chief Nursing Officer (CNO) Directorate (CNOD) and Chief Medical Officer (CMO) Directorate (CMOD). Wider ASC policy was managed by the SG Health and Social Care Integration Division with support as required from the Care Homes Pandemic Division.

80. By October 2020, as initial demands on the Care Homes Pandemic Division had settled, it was possible to move to a single structure – to provide holistic pandemic support across the ASC sector. The remit of the Division was therefore widened on 1 October 2020 to include provision of support across all of ASC and was renamed the Adult Social Care – Responding to the Pandemic Division and was led by Deputy Director Anna Kynaston. The ASC – Responding to the Pandemic Division had responsibility for public assurance and engagement, support for stakeholder groups, in addition to providing support in relation to ASC guidance, testing, vaccination, PPE, winter planning and future wave planning. These changes were led by Donna Bell (then Director for Mental Health and Social Care).

81. From June 2020, the Directorate for Mental Health and Social Care was established under Donna Bell to reflect the challenges of this period of the pandemic, which were primarily in relation to care home resilience and providing wider support for the sector in addressing Covid-19 issues and risks.

82. In October 2020 the Directorate was restructured by Donna Bell to support recovery and renewal, whilst continuing to support the pandemic response (please see above in relation to the Care Homes Pandemic and ASC Response Divisions). The revised structure had four social care divisions and two mental health divisions, in addition to a division supporting the work of the Independent Review of ASC. The social care divisions were as follows;

- Responding to the pandemic – led by Deputy Director Anna Kynaston (replaced Frank Strang) which had responsibility for; public assurance and engagement, support for stakeholder groups, providing support in relation to adult social care guidance, testing, vaccination, PPE, winter planning and future wave planning

- Remobilisation, Recovery and Reform – led by Deputy Director Kate Hall, which had responsibility for the Self-Directed Support Framework, Fair Work, social care workforce, commissioning and procurement, independent support and advocacy, Adult Support and Protection legislation, EU exit planning
- Policy and Delivery – led by Deputy Director Gillian Barclay, which had responsibility for Hospital At Home, discharge planning, equipment and adaptations, service improvement, Getting It Right for Everyone (GIRFE) – Access to Care, Models of care and support and eligibility criteria
- Governance, evidence and finance – led by Deputy Director Iain MacAllister, which had responsibility for engagement with IJBs, financial support, research, scrutiny, governance legislation, CI sponsorship and Independent Living Fund sponsorship.

83. In September 2020, a division was formed to support the Independent Review of Adult Social Care and was led by Deputy Director Alison Taylor. This Division was disestablished in March 2021, following publication of the report of the Independent Review of Adult Social Care in February 2021 [CL15/004 – INQ000280640].

84. The divisions set out at paragraph 81 above were then revised in September 2021. This reorganisation brought a further focus to the Directorate on workforce issues, the integration of health and social care, regulation and inspection, and deeper work on remobilisation, as well as ongoing work on pandemic response. The divisions were as follows:

- Adult Social Care Workforce and Fair Work Division – led by Deputy Director, Ian Turner. Responsible for supporting and developing policies for the social care workforce including fair work, workforce planning and development, recruitment, leadership, skills and training across the adult social care workforce, including personal assistants
- Improving Social Care Quality Standards and Delivery Division – led by Deputy Director Simon Cuthbert-Kerr. Responsible for adult social care policy including leading on care at home, unpaid carers, care home charging policy, Self-Directed Support, assisted communications and Getting It Right For Everyone (GIRFE)

- Regulation Improvement and Integration Support Division - led by Deputy Director Iain MacAllister. Responsible for the sponsorship of the CI and the Independent Living Fund, Adult Support and Protection, financial support for social care providers (sustainability payments), cross-cutting work to strengthen regulation and improvement in social care and engagement with IAs
- Resilience and Pressure Unit - led by Deputy Director Gillian Barclay. Responsible for responding to the significant challenges being placed on operational delivery of social care in Scotland
- National Care Service Development – Deputy Director Anna Kynaston. Responsible for the development of the National Care Service
- Adult Social Care Pandemic Response – Deputy Director Jennifer Veitch. Responsible for engagement with the adult social care sector on pandemic response and guidance on areas such as face masks, testing and care home visiting and embedding good practice and improvement based on learning from the pandemic and building foundations for the recovery of the sector.

85. In December 2021, further changes were made to Directorate structures to reflect the challenges of this period, which included the Omicron outbreak, an increasing workload for taking forward social care reform activity and the additional support required for the development of the National Care Service. A separate Directorate for Mental Health was established and led by interim Director Hugh McAloon. All social care divisions subsequently formed part of a new Social Care and National Care Service Development Directorate, led by Director Donna Bell. This Directorate

    continues to lead on social care policy within SG and leads on the creation of a National Care Service, a cross-government priority, with the aim of transforming community health and social care support and services, empowering people to thrive, with human rights at the core.

Scottish Government's role in funding ASC sector

Overall Social Care Funding

86. The Scottish Government's funding comes from a combination of devolved taxes and revenues, and the Block Grant transferred to the Scottish Government from the UK Government, which accounts for the majority of the funding. The fiscal relationship between the Scottish and UK Government is set out in the Statement of Funding Policy (2021) (SoFP) and in the Fiscal Framework Agreement (2016) provided [CL15/005 – INQ000102912] and [CL15/006 – INQ000102914]. The 2016 Fiscal Framework Agreement [CL15/006 – INQ000102914] was in place during the period of the pandemic, and was updated in 2023.

87. The Barnett formula is the administrative mechanism used by HM Treasury to determine annual changes in the block grant allocated to the devolved administrations in Scotland, Wales and Northern Ireland, reflecting changes in spending levels allocated to public services in England, England and Wales or Great Britian, as appropriate. Under the Barnett formula, the Scottish Government's block grant is any given financial year is equal to the block grant baseline plus a population share of changes in the UK Government spending on areas that are devolved to the Scottish Parliament. Details of how the Barnett formula works can be found in the UK Government's Statement of Funding Policy [CL15/005 – INQ000102912].

88. In 2019-20, immediately before the pandemic, annual social care expenditure was £5.2 billion, most of which was on adult social care – £4.0 billion (77%), as set out in the Audit Scotland Social Care Briefing published in January 2022, provided [CL15/007 – INQ000510074].

89. The Independent Review of Adult Social Care [CL15/004 – INQ000280640] analysed the £3.8 billion spent on adult social care in 2018-19 and provided a breakdown of funding and expenditure sources. The vast majority of funding, approximately 84%, is from the public sector, either local authority funding or from central government, with the remainder coming from those contributing to the cost of their own care and from charges to service users. Almost two thirds of expenditure was on services for older people.

90. The table below, extracted from Scottish Government budget data, shows the additional recurring investment each year from 2015-16 to 2022-23. This additional investment in social care has continued to increase each year and by 2022-23 Scottish Government had increased its cumulative recurring investment in social care and integration to £1.6 billion per year.

Fiscal Year	New recurring annual investment in-year - £m	Cumulative recurring annual investment - £m
2015-16	+130	130
2016-17	+250	380
2017-18	+107	487
2018-19	+64	551
2019-20	+160	711
2020-21	+100	811
2021-22	+73	884
2022-23	+719	1,603

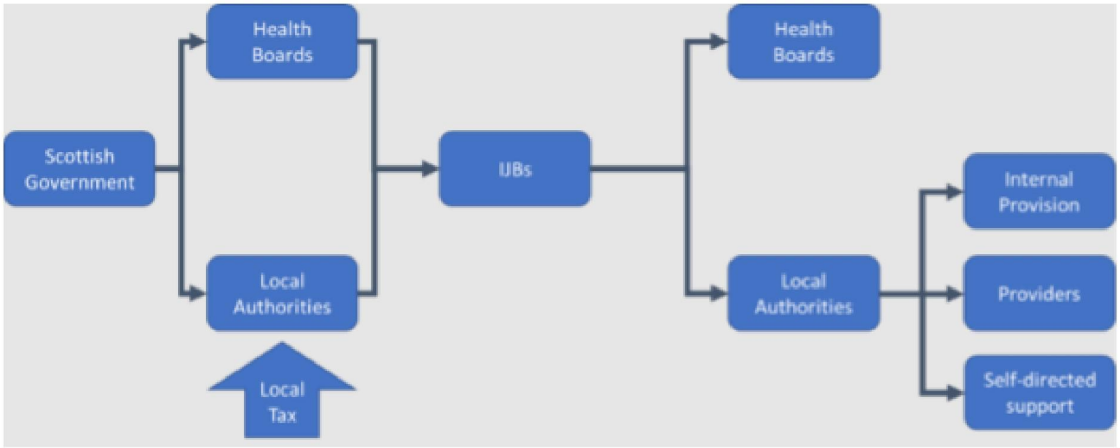
91. This funding is directed towards health and social care integration through a mix of routes, including territorial Health Board baseline funding, local government funding, and through in-year budget transfers from the HSC portfolio to local government. Funding flows are discussed below in greater detail. It supports a range of objectives, including funding Free Personal and Nursing Care, delivering the Real Living Wage for adult social care workers in the third and private sectors, implementing the Carers (Scotland) Act 2016, expanding social care services and developing new models of care.

92. The Independent Review of Adult Social Care [CL15/004 – INQ000280640] noted that despite the fiscal effects of austerity, IAs and Local Authorities had increased expenditure on adult social care in real terms since 2009-10 by 7% in total and by 5% per capita. This was in contrast to the position in England, where expenditure had fallen in real terms by 1% and 6% respectively.

Financial flows under Health and Social Care Integration

93. The way in which health and social care services are planned and delivered across Scotland is set out by the Public Bodies (Joint Working) (Scotland) Act 2014. 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. Where a lead agency arrangement is used, funding is delegated by, either, the territorial Health Board or Local Authority to the other partner to oversee delivery of integrated services. IAs – whether an IJB or a lead agency - are then responsible for planning, commissioning and budgeting for services. They make directions to territorial Health Boards and Local Authorities on what services are to be delivered and how they are to be delivered and make payments to them from the pooled budget to fund them.

94. The diagram below illustrates the financial flows in the majority of areas, where the IA is an IJB. Under the lead agency model the structures and flows are different, but the principle remains the same: territorial Health Board and Local Authority contributions are gathered into a pooled budget and the IA is responsible for planning, commissioning and budgeting for services.



Covid-19 Specific Funding

95. The Scottish Government received additional funding for the Covid-19 response via Barnett consequentials in areas that are devolved to the Scottish Government.

96. The Scottish Government also provided non-recurring funding to address the additional costs of responding to Covid-19 to support remobilisation of services and support.

97. 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.

98. 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.

99. IJBs were given funding allocations in 2020-21 and 2021-22 to support a range of Covid pressures. These were ring fenced allocations specifically for Covid. Where these were not spent in the financial year in which the funding was provided, these were carried forward in an earmarked reserve to be available to use in the following financial year for Covid pressures. As the Scottish Government did not receive any additional consequentials for the Covid-19 response from the UK Government in 2022-23, this accounting treatment was particularly useful to maximise the impact of Covid-19 consequentials received and allow unspent funds at 31 March 2022 to continue to fund ongoing costs across the sector in 2022-23.

The Scottish Government's role in regulating the ASC sector

100. The Scottish Government is responsible for developing the legislation for the regulatory framework in Scotland. Within the ASC sector, there are a number of regulatory and assurance bodies with responsibility for regulation. A number of these

bodies are sponsored by Scottish Government and/or are accountable to Scottish Ministers. Further detail on each body is provided below.

101. The CI is the national agency responsible for regulating care services in Scotland. This includes registration, inspection, complaints, enforcement and improvement support. The CI was established by the Public Services Reform (Scotland) Act 2010. The CI works with other scrutiny and improvement bodies, such as HIS, HM Inspectorate of Constabulary in Scotland (HMICS), HM Inspectorate of Prisons for Scotland (HMIPS), HM Inspectorate of Prosecution, Education Scotland, the Mental Welfare Commission and Audit Scotland to look at how social work and social care is provided. Although sponsored by the Scottish Government, the CI operates independently from Scottish Ministers. Detailed information on the CI's role during the pandemic, including oversight and inspection policies and engagement with Scottish Government, is set out at paragraph 890 onwards.

102. HIS is the national healthcare improvement organisation for Scotland and was established under the Public Services Reform (Scotland) Act 2010. It took over the functions of NHS Quality Improvement Scotland and the regulatory functions of the Care Commission in relation to independent healthcare services. HIS is the national scrutiny and improvement body for all health services and is accountable to Scottish Ministers for the delivery of its strategic objectives. It is a public body which is part of NHS Scotland and supports health and social care organisations to redesign and continuously improve services to ensure that people experience high quality health and social care. During the pandemic HIS and the CI worked more closely together on joint inspections of care homes 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. Detailed information on HIS's role during the pandemic, particularly regarding oversight and inspections of care homes, is set out at paragraph 890 onwards.

103. The SSSC is the professional regulator of the social care workforce and has a statutory role in setting standards for the practice, conduct, training and education of social workers, social care and early years workers. It was established by the Regulation of Care (Scotland) Act 2001. The SSSC was established to ensure the

social services workforce/ social care professionals are registered and regulated against agreed standards as set out in published of Codes of Practice. Where people fall below these standards SSSC can investigate and implement sanctions (including removal) where necessary. SSSC is a non-departmental public body, sponsored by the Office of the Chief Social Work Adviser of the Scottish Government. During the pandemic, the SSSC undertook changes to regulatory practice to provide flexibility within the social care workforce and to address workforce capacity challenges. Detailed information on SSSC's policies and role during the pandemic is set out at paragraph 907 onward.

104. Public Health Scotland (PHS) is Scotland's national public health body, leading and supporting work across Scotland to prevent disease, prolong healthy life and promote health and wellbeing. During the pandemic PHS - and its predecessor Health Protection Scotland (HPS) working with Antimicrobial Resistance & Healthcare Associated Infection (ARHAI) Scotland - provided advice and guidance for social care settings, including care homes. This included advice on testing, IPC measures in social care, including PPE, and visiting in care homes. PHS is jointly sponsored and has dual accountability to both the Scottish Government and to local government via the Convention of Scottish Local Authorities (COSLA). Its predecessor, HPS, was not jointly accountable to both COSLA and Scottish Government. This is a unique feature for a Scottish public body and requires a commitment to shared decision making, planning, and performance management in relation to the work of PHS. Detailed information on the role of HPS is provided throughout this statement.

Key ASC strategic policies

105. A chronological list and description of all of the key ASC strategic policies for which the DGHSC has responsibility for between 1 March 2020 and 28 June 2022 is provided [CL15/008–INQ000510053].

Decision making framework and process during the pandemic

106. At Scottish Government level, strategic decisions relating to the response to Covid19 were made by Scottish Ministers. DG HSC and HSC Directors, including those responsible for social care divisions, were amongst the advisers who attended meetings where advice was discussed, agreed and submitted to Scottish Ministers. Officials from across DGHSC provided a breadth of Ministerial submissions and advice across a wide range of key areas, including adult social care. All decision making was undertaken using the "four harms" approach, the four harms were as follows:

- Harm 1: direct Covid-19 health harms – primarily, the mortality and morbidity associated with contracting the disease
- Harm 2: broader health harms – primarily, the impact on the effective operation of the NHS and social care associated with large numbers of patients with Covid-19, and its knock-on effects on the treatment of illness
- Harm 3: social harms – the harms to wider society, in terms (for example) of education attainment as a result of school closures
- Harm 4: economic harms, for example through the closure of businesses.

107. The Director of Covid Public Health, senior members of the Covid Public Health team, along with senior clinicians and other DGHSC family Directors contributed to the Scottish Government's Four Harms Group (in line with the terms of reference and agreed membership of that group, provided: [CL15/009 – INQ000232945], [CL15/010 – INQ000103003].

108. For DGHSC family officials and clinicians, typically this would primarily involve providing advice at the Four Harms meeting, chaired typically by the DG Strategy and External Affairs (DG SEA) on matters in relating to harms 1 and 2, and contributing to discussion on harms 3 and 4. The output from these meetings informed production of advice to Cabinet. Minutes from relevant Cabinet meetings will record those discussions. In short, the views of officials would be fed in at the

Four Harms meetings, typically on a Friday, and fed through the drafting process for the Cabinet paper the subsequent week, typically on a Tuesday.

109. Ministers and senior officials were kept fully informed about issues of concern within the ASC Sector during the pandemic through a range of sources, including status updates and policy advice from ASC policy officials and analysts, expert advice from SG professional advisers, daily situational reports provided by the DGHSC Group Covid-19 hub and reports from the various advisory groups. The Cabinet Secretary for Health also had regular, often day to day, direct contact with senior social care policy officials and with professional advisers, including the CMO, CNO and Chief Social Work Adviser (CSWA).

110. The Director of the Community Health and Social Care Directorate, and subsequently the Director for Mental Health and Social Care and Director of Social Care and National Care Service Development, represented the Directorates across a range of DGHSC senior governance and decision-making bodies, including the Health and Social Care Management Board, which is the main decision-making body of DGHSC. Officials from the Directorate regularly briefed Scottish Government health and social care ministers on challenges facing the ASC sector and liaised closely with colleagues across DGHSC to address issues of concern in relation to the sector both in the run up to and during the pandemic. DGHSC officials and Ministers also regularly engaged with Chief Officers and care sector representatives on a range of ASC issues to understand current challenges faced by the sector, and how the Scottish Government might assist in resolving them.

111. There were daily meetings within DGHSC at official level (including the Health and Social Care Management Board (HSCMB); daily huddles with senior officials; Ministerial meetings etc). There were also weekly four harms meetings which often required pre-meetings with DGHSC Directors and senior clinicians (such as CMO or Deputy CMO (DCMO). Additionally, DG HSC held preparation sessions to support the Cabinet Secretary for Health's attendance at Cabinet (every Tuesday) or at Scottish Government Resilience Room (SGoRR).

112. In terms of pre-meeting briefing, where possible best practice was followed in terms of ensuring briefing was provided well in advance of any significant meeting

to allow appropriate time for consideration and review. During the pandemic the pace of briefing increased substantially, and the time allowed for preparation and consideration of advice shortened accordingly. Submissions were used to communicate information and advice to ministers on policy developments and issues. The intention of Ministers was to make decisions or agree action in response to a submission to best serve the people of Scotland.

113. The Inquiry has asked specifically for Scottish Government's view on the impact of streamlined decision-making processes which were in place during the pandemic, including on the ability of Ministers to understand and question advice on ASC issues and the opportunity for expert advisers to discuss matters directly with Ministers. For the reasons set out above, we do not take the view that the need for streamlined decision-making had a significant adverse impact, including in relation to Ministers' ability to understand and question advice on ASC issues. As noted above, Ministers and senior officials were kept fully informed about issues of concern within the Adult Social Care Sector during the pandemic through a range of sources, including status updates and policy advice from adult social care policy officials and analysts, expert advice from SG professional advisers, daily situational reports provided by the DG Health and Social Care Group Covid-19 hub and reports from the various advisory groups. The Cabinet Secretary for Health also had regular, often day to day, direct contact with senior social care policy officials and with professional advisers, including the CMO, CNO and CSWA.

Scottish Government's understanding of the ASC sector during the pandemic

114. Covid-19 presented a major challenge for the adult social care sector, both within care homes and the wider community. The challenge of managing Covid-19 within care homes was particularly acute due to both the increased risks of the virus to older and more vulnerable people and the increased risk of outbreaks within care home environments. The Scottish Government had a deep understanding of the ASC sector within Scotland, prior to and during the pandemic, for the reasons summarised below:

- Dedicated social care policy support – Scottish Ministers were supported by policy officials from dedicated social care divisions from the outset of the pandemic and

throughout. Senior officials within the Social Care Directorates represented the Directorate across a range of DGHSC senior governance and decision-making bodies, including the HSCMB, which is the main decision-making body of DGHSC. Officials from the Directorate regularly briefed SG health and social care ministers on challenges facing the adult social care sector and liaised closely with colleagues across DGHSC to address issues of concern in relation to the sector both in the run up to and during the pandemic. Both DGHSC officials and ministers also regularly engaged with Chief Officers and care sector representatives on a range of adult social care issues to understand current challenges facing the sector and how SG might assist in resolving them.

- Professional advisers – Scottish Government Ministers and social care policy officials were supported throughout the pandemic by professional advisers with specialist knowledge of the adult social care sector. These advisers were embedded within the Community Health and Social Care Directorate, Mental Health and Social Care Directorate, Office of the CSWA, CNOD and CMOD and provided important support on key issues, particularly in relation to IPC and wider care home guidance for the sector.

- Advisory groups – Scottish Government established a wide range of advisory groups to assist in the development of policy and to inform decisions in relation to the management of Covid-19 within the adult social care sector. This included high level groups such as the Clinical and Professional Advisory Group for Social Care (CPAG), the National Care Home Rapid Action Group (CHRAG) and the Pandemic Response Adult Social Care Group (PRASCG) which provided fora for discussion on a range of issues of concern to the sector, in addition to policy specific groups on issues such as testing, PPE, visiting, workforce and carer policies. These groups brought together Scottish Government policy, operational and clinical leads with a range of stakeholders across the sector, including COSLA, IA Chief Officers, Third and Independent Sector and representatives of care providers, including Scottish Care, the Coalition of Care and Support Providers in Scotland (CCPS) and unpaid carers. These advisory group meetings were in addition to regular bilateral and ad hoc meetings between SG ministers and officials with a range of

representatives from the Adult Social Care Sector throughout the pandemic. Further details regarding these groups is provided at paragraphs 149 onwards.

- Data and modelling sources – Throughout the pandemic a range of social care data and analysis were widely and regularly communicated to Scottish Government officials and Ministers to aid decision making and used in a wide range of briefings and papers. This included providing daily Covid-19 briefings (seven days per week) from 2020 to 2022 on key Covid-19 statistics to Ministers, senior clinicians and policy leads. This is discussed in detail from paragraph 929 below.

115. In addition to being represented on the key advisory groups, senior representatives from external organisations met regularly with the Cabinet Secretary for Health and Sport, including Chief Officers, Trade Unions, COSLA, British Medical Association (BMA) and Royal College of Nursing (RCN) representatives. The Scottish Government is therefore not aware of any concerns relating to Ministers' understanding of, or ability to ask questions about, advice received in relation to the ASC or for expert advisers to meet directly with Ministers.

Data and modelling to support decision making

116. Throughout the pandemic a range of social care data and analysis were widely and regularly communicated to Scottish Government officials and Ministers to aid decision making. This included providing daily Covid-19 briefings (seven days per week) from 2020 to 2022 on key Covid-19 statistics to Ministers, senior clinicians and policy leads.

117. A Covid-19 Health and Social Care Analysis (HSCA) Hub was established by the Scottish Government in March 2020. It led on work to develop, collect, report and brief daily on Covid-19 data to inform the response to the pandemic. The HSCA Division became a key provider of data, analysis and evidence in the Scottish Government throughout the pandemic, working in close collaboration with SG Central Analysis Division (CAD), PHS and other analysts across government.

118. Further detail on the range of data and process of collecting, analysing and presenting it, including challenges faced, is provided later in this this statement at paragraph 929 onwards.

Liaison with other response partners and ASC stakeholders

119. The Scottish Government works with a wide range of organisations who have a role or interest in the delivery of social care in Scotland and maintained strong links with key stakeholders pre-pandemic, particularly around national policy development.

120. Local operational delivery of social care was, and remains, the responsibility of IAs. In recognition of the urgent need to ensure a collective and coordinated response to the issues facing the ASC sector in the early stages of the pandemic, Scottish Government's engagement with the ASC sector intensified. This included engagement with a wide range of social care stakeholders, organisations representing care home providers and other organisations/sectors who provide vital support to the social care sector. This resulted in widespread consultation at Ministerial and senior official levels with care sector groups, relatives and unpaid carers, in addition to stakeholder participation via a range of existing and newly established Scottish Government-led social care advisory groups. A list of key stakeholders follows below.

COSLA

121. As noted above, Local Authorities have statutory responsibility to provide social care services in Scotland. COSLA is the national association of Scottish councils and acts as an employers' association for its 32 member authorities. COSLA works on local authorities behalf to focus on the challenges and opportunities they face, and to engage with governments and others on policy, funding and legislation. COSLA is also responsible for the National Care Home Contract (for older people requiring public funding).

122. COSLA representatives participated in a number of fora set up in response to the pandemic and met regularly with Ministers and SG Officials. For example, COSLA

cochaired the PRASCG with Scottish Government and were members of the Care Home Rapid Intelligence Group. COSLA representatives also attended the Scottish Government Adult Social Care GOLD Group, which provided strategic oversight of national pressures across social care delivery in Scotland and collective national-level response and action.

Society of Local Authority Chief Executives (SoLACE)

123. SoLACE is the UK's leading membership network for public sector and local government professionals. They currently represent over 1600 members across the UK and have regional branches across the country. Scottish Government officials convened weekly meetings with SoLACE, IJB chief officers, and NHS chief executives from 20 May 2020. SoLACE were members of the CHRAG and the SG Adult Social Care (ASC) GOLD Group.

HSCP, IJB and Chief Officers of IJB

124. Further detail regarding the specific functions of HSCP, IJB and Chief Officers is provided at paragraphs 9 to 13 above; however, during the pandemic engagement with these bodies and individuals was sustained and vital. As well as engagement at Chief Officer level, HSCP staff formed an important part of the multi-agency care

home oversight teams established, as part of changes to the assurance and oversight regime, during the pandemic (for further detail regarding these multi-agency teams, see paragraph 903 onwards.

Scottish Care

125. Scottish Care is a membership organisation and the representative body for independent social care services in Scotland. The body represents over 400 organisations, which totals almost 900 individual services delivering residential care, nursing care, day care, care at home and housing support services. Its membership

covers private, not for profit and charitable provider organisations and includes organisations of varying types and sizes, amongst them single providers, small and medium sized groups, national providers and voluntary organisations and associations.

126. Scottish Care had an important role during the pandemic as the primary interface between care service providers and the Scottish Government and participated in a range of Scottish Government social care advisory groups, in addition to regular meetings with Scottish Ministers and Scottish Government officials on social care issues.

The Coalition of Care and Support Providers in Scotland (CCPS)

127. CCPS represents the not-for-profit social care providers in Scotland. Its membership has remits spanning care and support for children, young people and families; disabled people; older people; people with learning disabilities; people in the justice system; people experiencing homelessness. CCPS were members of a range of SG advisory groups and regularly raised issues of concern to their members with the Scottish Government during the pandemic.

Scottish Trades Union Congress (STUC)

128. STUC is the national trade union centre in Scotland, representing over 540,000 trade unionists in Scotland, including social care workers. STUC met with Scottish Government Ministers and officials during the pandemic on a range of issues, including social care workforce matters, and participated in SG advisory groups. Scottish Government also met with individual trades unions whose members included social care staff, including the GMB (General and Municipal Workers' Union), Unison and UNITE.

Care Home Relatives Scotland (CHRS)

129. CHRS brought together those with loved ones in nursing and residential homes during the pandemic. Following the introduction of visiting restrictions in care home settings the group worked with the Scottish Government to make improvements to visiting guidance. SG continues to work with CHRS in relation to the implementation of 'Anne's Law', which is discussed in more detail at paragraph 1016 below.

Scottish Directors of Public Health (SDsPH)

130. The SDsPH group consists of Scottish Directors of Public Health (DPH), or acting DPH; and the Medical Directors / DPH of National Agencies. The group's objectives include:

- To provide leadership and advocacy nationally on matters affecting the public's health
- To plan, initiate and co-ordinate matters relating to public health in Scotland
- To act as a coherent professional team and knowledge network and a means of disseminating relevant information
- To facilitate collaborative working across Scotland via leading and managing the Scottish Public Health Network
- To provide close liaison with the CMO and the Scottish Government health directorates, in particular the CMO's and Health Improvement directorates
- To liaise with the Faculty of Public Health in Scotland, relevant public health bodies nationally/internationally
- To influence public health priorities
- To provide a source of mutual support to individual SDsPH.

131. SDsPH played a vital role in working to protect the health and wellbeing of their local communities including those using social care services. Alongside PHS, they provided advice and support to Scottish Government in developing the national

response about which the Scottish Government regularly met with SDsPH. A care home working group comprising local HPTs, IPC leads, Scottish Government clinical advisers and others, was established and coordinated by SDsPH to consider the ongoing public health response required in adult care homes. A SDsPH representative sat on the CPAG group (see further paragraph 150 onwards for details of CPAG).

NHS National Services Scotland (NSS)

132. NHS NSS are a national NHS board operating in nine different sectors across Scotland. These include legal, clinical, procurement, blood transfusion, digital, counter fraud, specialist and screening services. NSS provide essential services, support and advice to support the health of Scotland's population. They support stakeholders in territorial Health Boards, social care organisations and across the public sector to deliver their services more efficiently and effectively. They offer shared services on a national scale, using best-in-class systems and standards, along with consultancy and support to help public bodies join up health and social care. NSS played a vital role in the supply of PPE to the ASC sector during the pandemic and were key members of the Adult Social Care PPE Steering Group (see further, paragraph 193).

Antimicrobial Resistance and Health Associated Infection (ARHAI) Scotland

133. ARHAI Scotland is a clinical service providing national expertise for infection, prevention and control (IPC), antimicrobial resistance (AMR) and healthcare associated infection (HAI) for Scotland. ARHAI Scotland sits within NHS NSS. ARHAI Scotland played a vital role in providing IPC advice to Scottish Government for healthcare settings and provided IPC advice to PHS to enable them to develop COVID guidance for social care settings. During the pandemic ARHAI Scotland developed the Care Home Infection Prevention and Control Manual (CH IPCM). ARHAI Scotland was a member of CPAG group and the CPAG IPC subgroup and regularly liaised with social care stakeholders. Scottish Government officials in CNOD met with ARHAI

Scotland regularly to discuss their role around the national and local response in context of the emerging pandemic picture.

National Records Scotland (NRS)

134. NRS is a Non-Ministerial Department of the Scottish Government. Their purpose is to collect, preserve and produce information about Scotland's people and history and make it available to inform current and future generations. NRS is the national source of a range of official statistics in Scotland, including on deaths. During the pandemic, NRS published a range of statistics on Covid related deaths including age, gender, location of death, local authority and comorbidities such as diabetes and dementia.

Early in the pandemic

135. There was substantial consultation between Scottish Government and the social care sector in the early stages of the pandemic. On 10 February 2020, SG officials, at the direction of the Cabinet Secretary, met COSLA social care leads to discuss emerging risks relating to the then novel Coronavirus and the Cabinet Secretary's request for social care specific guidance, minute provided [CL15/011 – INQ000509903].

136. On 21 February 2020, the Cabinet Secretary for Health and SG ASC officials held meetings with HSCP Chief Officers to discuss Coronavirus and to emphasise the importance of territorial Health Boards, HSCPs and social care providers working closely together to enhance the overall resilience of the sector.

137. A resilience event for health and social care providers was also held on 21 February 2020, with speakers and attendees from the social care sector, including Scottish Care and HSCPs. This event was originally organised to support resilience planning in the context of EU Exit, but was expanded to include wider resilience planning in the context of Coronavirus.

138. On 6 March 2020, a joint letter from the Cabinet Secretary of Health and COSLA spokesperson for Health and Social Care Cllr Stuart Currie was issued to all social care staff to provide an update on Covid-19 and to provide information on the measures that were being taken to address risks [CL15/012 – INQ000520444].

139. Scottish Government officials 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. The NCPG discussed emerging issues and the approach to providing collective support to the social care sector. The group convened on 12 March 2020 in relation to Covid-19 and held weekly meetings subsequently with a range of stakeholders including the Scottish Government. As other Covid-19 resilience structures for social care were put in place by the Scottish Government from April 2020, the NCPG role around collective support for the sector in relation to Covid-19 ended in June 2020. These new groups included the SG-led CHRAG stakeholder group established in April 2020, which included many of the NCPG members.

140. From 12 March 2020, the Scottish Government held regular teleconferences with IA Chief Officers across Scotland, to discuss issues relating to the impact of Covid-19 on the sector. Before the pandemic, the Scottish Government held monthly meetings with the Chief Officers. From 23 March to 20 April 2020 these were stepped up to daily calls.

141. New pandemic groups were established to bring stakeholders together to discuss and prioritise actions to support the sector during the pandemic and to advise on the development of guidance (which are discussed in more detail from paragraph 149 onwards).

142. Scottish Ministers, particularly the Cabinet Secretary for Health and Sport, also regularly engaged directly with a range of key stakeholders, such as:

- Care home representatives (such as Scottish Care, CCPS and COSLA)
- Care home relatives and carers organisations
- Regulatory bodies, such as CI

- Trade Unions, including both the Scottish Trade Unions Congress (STUC) and individual Trades Unions, including GMB, UNISON and UNITE.

143. Ministers and officials greatly valued the contributions from these stakeholders and made substantial efforts to ensure that there was widespread consultation. In some circumstances, particularly those where urgent decisions or guidance was needed, consultation may not have been as detailed or lengthy as would otherwise have been the case. This was particularly the case early in the pandemic.

144. For example, the Scottish Government guidance for care homes covering March to May 2020 was drafted in response to concerns raised by a range of organisations - including care home sector representatives, Care Inspectorate, COSLA and IJB chief Officers about the need for more practical guidance for the sector. Given the urgency in producing this guidance to the sector there was limited scope for consultation on the first iteration on 13 March 2020 [CL15/013A – INQ000280689]. However, as outlined above at paragraph 140, there was consultation in advance of publication with stakeholders about what they would want to see in this guidance at the resilience and NCPG events discussed above. There was also substantial consultation in relation to subsequent iterations of the guidance, including through the SG advisory groups discussed above, over the period until publication of the final iteration of the guidance on 15 May 2020.

145. In particular, the CPAG comprised a range of health and social care stakeholders (including Scottish Care, CCPS, care home providers such as **Irrelevant & Sensitive** **Irrelevant & Sensitive**, CSWA officers and IA Chief Officers) and had a formal role to consider and review Scottish Government guidance for the sector.

146. The Scottish Government considers that there was widespread and meaningful engagement and consultation with the ASC sector pre-pandemic, in respect of both specific policy issues and wider sectoral reform. During the pandemic, this engagement intensified and this statement outlines the extent of sector participation via the stakeholder and policy advisory groups, direct and regular access that ASC sector representatives had with Ministers and senior level officials throughout.

147. Our approach to engagement reflects our view that it was important, from the outset, to take an inclusive approach, ensuring that all parties were involved in advising on support for the ASC sector. Requests to participate in advisory groups were welcomed, and groups such as the CPAG and CHRAG comprised a wide range of stakeholders from across the public, private and independent sectors. The level of consultation was such that many organisations expressed concern about their capacity to participate in the large number of advisory groups established. The Scottish Government is not aware of any significant challenges to the working relationships it had with ASC sector stakeholders during the pandemic. As noted above, the ASC sector is complex and diverse, and the priorities and interests of stakeholders may not always be aligned. In many cases, there would have been varying, even opposing, views on how issues should be addressed and circumstances where stakeholders felt that subsequent decisions or guidance either went too far, or did not go far enough, depending on their perspective. However, this is usually the case in most consultative processes and divergence of views on how to address specific issues did not hinder dialogue and positive engagement with stakeholders, which continued throughout the pandemic.

148. Overall, 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 guidance aimed at supporting the sector. There may have been occasions where the opportunity for consultation

was limited due to the need for decisions or guidance needed to be made or published urgently. Nevertheless, Scottish Government maintained dialogue and engagement with care sector representatives throughout the pandemic through both direct engagement at ministerial and official level and regular participation in the Scottish Government Covid-19 social care advisory groups.

Stakeholder and policy advisory groups

149. A wide range of stakeholder groups were convened to bring stakeholders together to discuss and prioritise actions to support the ASC sector and to advise on the development of guidance. Two main stakeholder groups were established by Scottish Government:

- CPAG
- CHRAG, subsequently replaced by PRASCG.

The Clinical and Professional Advisory Group for Social Care (CPAG)

150. CPAG was established in April 2020 and Terms of Reference are provided [CL15/013 – INQ000343806]. Its initial remit was to provide clinical and professional advice and guidance for protecting the care home sector during Covid-19 and this was later expanded to include the wider adult social care sector. The group, which was commissioned by the CMO and CNO, and chaired by a CMO and CNO representative, brought together over 60 representatives from:

- Care sector representatives, including Scottish Care, CCPS, COSLA
- Scottish Government officials, including CMO and CNO representatives, social care policy officials, dementia and learning disability policy officials, clinical and social work SG professional advisers; equality policy officials.
- Representatives from IJBs, IAs and HSCPs
- Assurance bodies, including PHS, HIS and CI
- Special Health Boards, including Scottish Ambulance Service, NSS and NHS Education Scotland (NHS NES)
- Representatives from Health bodies, such as RCN and BMA
- Representatives from Universities, Charities, Social Work, General Practice and Palliative Care.

151. Membership of CPAG grew as additional services or areas of expertise were identified and where it was important to the delivery of clinical or professional care in the sector.

The role of CPAG was to engage with the sector and co-produce guidance and advice aimed at preventing Covid-19 outbreaks as much as possible. CPAG did not manage individual care home outbreaks after they had happened, but did use lessons learned for future guidance updates using feedback from Health Protection Teams and Incident Management Team meetings.

152. CPAG was a forum for collaborative and focused guidance and policy development. When officials were developing an approach to policy or guidance, consultation could be conducted efficiently with a wide range of stakeholders and appropriate solutions developed. Members also brought issues to the attention of the Group so that appropriate solutions could be discussed and considered. This approach enabled a more significant degree of collaboration than would otherwise have been feasible under the circumstances.

153. CPAG meetings were held twice weekly (from its first meeting on 23 April 2020) until 21 May 2020 and changed to weekly meetings until 29 April 2021. Meetings were then scheduled fortnightly from then on. Over 80 meetings of CPAG were held during the course of the pandemic, with the last meeting of CPAG held in December 2022.

154. In addition to the main CPAG group, a number of CPAG sub-groups were formed in response to specific issues (as set out below).

CPAG Sub-Groups

Data, Analysis and Research Group (DAR) Sub-Group

155. The DAR Sub-Group group was chaired by the CMO's Clinical Adviser on Ageing and Health met on a weekly basis from June 2020 to October 2021. Membership comprised of representatives from; CI, Health and Social Care Analysis, Office of the Chief Statistician, National Records of Scotland, PHS, Care Home Data Academics, the Scottish Centre for Administrative Data Research, Social Care Data Academics, Academics with a focus on older people, RCN and territorial

Health Boards. Terms of reference are provided [CL15/014 – INQ000509952]. The group's aim was to:

- Deepen knowledge of the Care Home population from data
- Help to understanding the risks and opportunities
- Reduce morbidity and mortality through better understanding of the impact of Covid-19 and its implications
- Inform policy leads for the commissioning and assurance of care homes.

The Open with Care Oversight Group

156. This sub-group was established in March 2021 to monitor and support the implementation of the Open with Care – Supporting Meaningful Contact in Care Homes guidance published on 24 February 2021 [CL15/015 – INQ000147437]. This group comprised of national and local partners and used a range of feedback, data and evidence to discuss progress and learning, to identify where more support was required, to broker improvements to implementation at a national level. It was not used a as a forum to discuss or resolve local issues, or issues within individual care homes. Changes to visiting guidance were also discussed. For example, at its meeting on 14 September 2021, an update on changes to visiting guidance was provided – including details of 'named visitors'. Representatives of care home providers provided views on current risk appetites and tools such as a booking system and traffic light system.

157. Key issues discussed at this group included;

- Ongoing monitoring of data and feedback from normalising the Open with Care guidance]
- Consideration of findings from monitoring of the introduction of named visitors during outbreaks policy

- Advice on the policy aims of, and mechanisms to, deliver Anne's Law (legislative provisions on visiting) and proposals to strengthen the H&SC standards by late November 2021.

158. Membership comprised of representatives from: residents and families representative organisations, care home providers, sector organisations, CCPS, Scottish Care, CI, SDsPH, Academia, HSCPs, PHS, Nursing sector, SSSC, Health Care Home Relatives Scotland, Chief Officers, Social Work Scotland, Scottish Government and professional leads from nursing and social work. The Terms of Reference are provided [CL15/016 – INQ000509969]. The group reported to the CPAG and the terms of reference stated that the group would meet every four weeks, with additional meetings as necessary.

The National Anne's Law Oversight Group

159. The Open with Care Oversight Group was then renamed in September 2021 to become the National Anne's Law Oversight Group, following the publication of a Programme for Government commitment to introduce legislation on care home visiting. Legislative provisions on care home visiting were included in the National Care Service (Scotland) Bill introduced in the Scottish Parliament on 20 June 2022. The proposed legislation is now known as the Care Reform (Scotland) Bill and if enacted will impose a duty on the Scottish Ministers to exercise an existing regulationmaking power to require the providers of care-home services for adults to facilitate visits. This is to implement what is popularly known as Anne's Law.

160. A revised Terms of Reference was prepared, provided [CL15/017 – INQ000509906]. The first meeting under its new name was held on 8 December 2021.

161. This group brings together care providers, families and professionals who support care homes, to provide advice on local and national mechanisms for supporting meaningful connection in Scotland's care homes. This includes the adoption of

existing policies, such as the new HSC Standards, as well as the development of legislative provisions on visiting within the Care Reform (Scotland) Bill).

162. The group is chaired by a Social Work Adviser within the Scottish Government Office of the CSWA and membership is comprised of representatives from:

- Care home providers
- Care home representative organisations (such as Scottish Care)
- Family representatives
- Organisations that support families (such as PAMIS, Alzheimer Scotland, Age Scotland, the National Autistic Society)
- Public Health and IPC advisers
- PHS
- DPH
- Local authorities and HSCPs
- CI
- SSSC
- COSLA
- Nursing representatives
- Social Work representatives
- Academia (geriatrician)
- Scottish Government officials and professional advisers.

163. Key issues discussed include updating the H&SC Standards, updates to the Open with Care guidance (including name visitors). For example, the meeting on 21 March 2022 there was a discussion regarding updates to the Open with Care guidance (including named visitors), progress in implementing Open with Care – including local feedback and proposals for reviewing the remaining restrictions. On 10 May 2022 there was a discussion regarding the visiting statistics and a review of the visiting questions included in the Safety Huddle Tool. On 29 June 2022 there was a historical overview of the visiting data available since the Open with Care Guidance was published – and current visiting status.

164. Copies of minutes from the Open with Care and Anne's Law Oversight Groups have been provided to the Inquiry.

CPAG Engagement Sub-Group

165. This group met on a monthly basis from January 2021 to December 2021, to provide a forum for engagement with families/friends on the work of CPAG, including care home visiting. It was jointly chaired by a Scottish Government official and a Scottish Government professional social work adviser from the dementia policy team. Membership comprised Scottish Government officials, Care Sector representatives, PHS, DPH and representatives of agencies supporting families. Key areas of discussion were: Sharing experience of care home visiting, exploring ways to involve care home residents in the group; local decision making framework for visiting; accessibility of information around care home visiting. The group combined with the 'Open with Care' group from December 2021 [CL15/018 – INQ000509905].

The Care Home Assurance Short Life Working Group

166. This Working Group was set up following a discussion at CPAG where Scottish Care had indicated that territorial Health Board care home oversight and assurance visits could be improved to support better collaboration and best practice around support to the sector, staff and residents. The group met on a monthly basis from 2 November 2021 until 9 November 2022. The group identified and highlighted prevailing challenges around staff wellbeing and oversight and assurance visits from NHS boards and identified and promoted best practice. The Scottish Government participated in the Group, which was jointly chaired by the Executive Nurse Director

NHS Forth Valley and National Director for Scottish Care, with membership from CNOD, CSWO, CI and care providers [CL15/019 – INQ000322882].

The IPC Sub-Group

167. This sub-group was chaired by Scottish Government and ARHAI Scotland and met on a monthly basis from 29 April 2021 until 30 November 2022 to provide clinical and professional advice for the ASC/care home sector regarding all aspects of IPC [CL15/020 – INQ000324253]. The work of this group focused on supporting the ongoing COVID-19 pandemic but also looking to future IPC resilience as part of the broader, longer-term work plan for care homes and care at home. Scottish Government representatives included CNOD, Mental Health and Social Care directorates, CSWO, and representatives from care sector organisations. Themes included learning from best practice in international context and within Scotland, identifying and recommending IPC support requirements for care homes and care at home, identify support needs for implementation guidance and tools in care homes and care settings.

Care Home Nursing National Working Group

168. This Working Group was established following concerns raised by CPAG members about shortages of registered nurse staffing levels within the sector and the potential quality and safety implications of this for people who had been assessed as requiring on going nursing care. It was agreed at that meeting that a sub-group of CPAG and other stakeholders would meet to discuss concerns raised and agree short, medium and longer-term recommendations. The Group was initially chaired by a Professional Advisor in Scottish Government's Chief Nursing Officer Directorate but going forward was co-chaired by an Executive Nurse Director and Chief Officer. The first meeting took place on the 10 August 2021 and last meeting was in April 2022. A summary of the group is provided [CL15/021 – INQ000322893].

The Healthcare Framework for Adults and Older People Living in Care Homes Reference Group

169. This Reference Group was established in November 2021 at the request of the CPAG. The term of reference are provided [CL15/022 – INQ000509907]. The group met monthly from 9 November 2021 until 9 June 2022 when the Scottish Government

Healthcare Framework for Adults Living in Care Homes 'My health – My Care – My Home' was published [CL15/023 – INQ000323023]. The group considered evidence and best practice and learning from the pandemic to develop a holistic model of healthcare support that is appropriate for adults and older people in care homes, setting out principles for best practice and to make recommendations to Scottish Ministers. The group was co-chaired by General Practitioner Professional Advisor, CMO Directorate, Scottish Government and the Executive Nurse Director, NHS Forth Valley. The group used evidence, best practice and learning from the pandemic to develop a holistic model of healthcare support appropriate for adults and older people in care homes [Scottish Government representatives included, CMO, CNOD, CSWO, CPO, and other members included representatives of the care sector across Scotland. Themes covered: Prevention, anticipatory care, Urgent/emergency care, palliative and end of life care. Since the Framework was published a Framework implementation group has been established and continues to meet.

Vitamin D in care homes Short Life Working Group (SLWG)

170. The Scientific Advisory Committee on Nutrition (SACN) advised in 2016 that people at higher risk of vitamin D deficiency, including people living in care homes, should take a 10 microgram (mcg) or 400 unit daily supplement of vitamin D throughout the whole year. During the Covid-19 pandemic it was highlighted that care home residents were possibly being at greater risk of vitamin deficiency due to lack of exposure to sunlight. As a consequence, the CMO issued a letter to care homes in January 2021 reminding them about the SACN advice, letter provided [CL15/024 – INQ000510011]. Following feedback from care homes, it was suggested that more detailed guidance should be developed to support implementation of this existing recommendation, building on the existing advice contained in the Care Inspectorate's guide "Eating and drinking well in care: good

practice guidance for older people". The CMO and the Chief Pharmaceutical Officer (CPO) asked that a CPAG subgroup or SLWG be established to consider the issue of vitamin D supplementation and access for people living in care homes. The SLWG was chaired by a professional GP adviser to CMOD and the head of Effective Prescribing and Therapeutics Division in SG. The group met on a tri-weekly basis and considered and made recommendations regarding how care home residents should be offered vitamin D supplementation, and more detailed guidance to support implementation, terms of reference provided [CL15/025 – INQ000509908].

171. The group met between 24 June 2021 and 23 September 2023. The SLWG focused on themes concerning vitamin D supplementation for people living in care homes and oversaw a pilot of the use of draft guidance in some care homes in NHS Ayrshire and Arran territorial Health Board. As a result of the work of the group, in December 2023 guidance was issued to care homes on supporting people living in care homes to be offered vitamin D where appropriate. The guidance remains in place today, provided [CL15/026 – INQ000510011].

Care Home Rapid Action Group (CHRAG)

172. The national CHRAG was established in April 2020 to bring together representatives from across the system to monitor data on developments in the care home sector, reacting swiftly to developing issues and scenarios [CL15/027 – INQ000322925]. At the time it was recognised that swift collective action was required to support care homes for whom the impact of the pandemic was particularly acute in the early phase. A dedicated group focusing on care homes was therefore established.

173. The CHRAG comprised key partners with operational oversight and delivery responsibility for care homes. Prior to that Scottish Government and many stakeholders attended the COSLA chaired NCPG. The CHRAG received daily updates and was tasked with activating any local action needed to deal with issues

as they emerged, as well as informing and coordinating a wider package of support to the sector. Membership included representatives from:

- COSLA
- SoLACE
- Scottish Care
- CI
- PHS
- Chief Officers
- DPH
- RCGP (Royal College of General Practitioners)
- BMA
- RCN
- SSSC
- Scottish Government.

174. The objectives of CHRAG were to:

- Develop a clear understanding of the national and local picture on a regular basis. Receive and disseminate frequently information and data on a range of metrics. These are likely to include: staffing, infections, deaths, outbreaks, and emerging issues and areas of best practice
- Identify issues for urgent resolution, agreeing actions which member organisations themselves will take and making collective recommendations to statutory and other bodies on solutions/actions
- Make proposals to Scottish Government and the care sector leadership for other national level actions
- Drive good two-way communication within the whole system and with the public on care home issues, including by ensuring best practice and guidance from the clinical group or elsewhere, is communicated promptly and effectively to the sector and the public
- Seek to enhance local collaboration by both helping to tackle any obstacles and spreading good practice.

175. The CHRAG initially focused on the delivery of national polices on adult social care within the care home sector. This included initiatives such as the enhanced

requirement on testing, IPC, PPE, strategies to support workforce resilience such as the social care workforce recruitment portal, financial monitoring and support for social care. Many such initiatives were also deployed in the wider social care sector through the additional, policy-specific advisory groups set out below.

176. 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. This included developing and reviewing bespoke data collection mechanisms such as the DPH weekly care home returns and CI data to fully understand the challenges and to enable national and local partners to provide direct tailored support to the sector.

177. CHRAG met weekly from 30 April 2020 until 27 August 2020 with 17 meetings taking place during this time. Thereafter, it was reformed as the PRASCG which first met on 10 September 2020. More detail regarding PRASCG is provided below.

178. The CHRAG focused on care homes and did not consider wider social care matters until it was re-formed as the PRASCG (in September 2020), as detailed and specific oversight of care homes was required due to the challenges facing care homes during the early stages of the pandemic. However, many of the issues and policy responses discussed at CHRAG were also applied to the wider care at home sector – for example policies relating to testing, PPE, IPC and workforce support. Wider social care support was also considered in the policy-specific forums detailed below, including those relating to testing, PPE, IPC and workforce support. With the oversight of care homes well established, it was considered beneficial to bring all those with responsibilities across the wider social care sector together under the PRASCG group.

Pandemic Response Adult Social Care Group (PRASCG)

179. As noted above, the CHRAG initially focused on care homes but in September 2020 was widened to cover wider adult social care within PRASCG. The PRASCG provided a multi-stakeholder focal point for the work being undertaken to support the effective delivery of adult social care provision during the pandemic, terms of reference provided [CL15/027 – INQ000322925]. The Scottish Government co-chaired PRASCG with COSLA and the group met:

- Weekly from 10 September 2020 until 1 February 2021
- Fortnightly from 18 February 2021 until 27 May 2020
- Monthly from 27 May 2021 until its final meeting on 23 June 2022.

180. The primary remit of the group was to support the immediate pandemic response to issues arising in adult social care, including within Adult Social Care Homes; Care at Home; Supported Living Arrangements; Day Care and Respite provision; Citizens in Receipt of Direct Payments and Employing Personal Assistants; and Support for Unpaid Carers. PRASCG supported these sectors through:

- Enhancing existing collaborative working across adult social care sector leaders
- Sharing intelligence and identifying key issues for resolution related to the pandemic (supported by relevant data/metrics/evidence as appropriate)
- Sharing intelligence and identify key issues that continued to hamper recovery from Covid-19
- Ensuring learning from the pandemic shaped the future as the sector recovered.

181. PRASCG combined the care homes work with wider work on support for the adult social care sector much of which had been considered in other forums described above. PRASCG had similar membership to CHRAG and comprised of representatives from:

- Territorial Health Board Chief Executives

- HIS
- COs HSCP
- CI
- Coalition of Carers in Scotland
- SSSC
- Scottish Care
- CCPS
- PHS
- SG Pandemic Response Division, MHSC Directorate
- SG Recovery and Remobilisation Division, MHSC Directorate
- SG Governance, Finance, Performance and Intelligence Division, MHSC Directorate
- SG CNOD
- SG CMO
- SG Professional Advisers, Scottish Government
- GMB Union
- RCN
- Unpaid Carers.

182. Key areas that the PRASCG considered and advised upon included:

- Winter preparedness and future wave planning
- System resilience around areas such PPE, Testing, Vaccination Programme, Workforce, Finance
- Current and ongoing assurance, inspection and improvement
- Implementation and performance
- Planning around COVID waves

183. Multidisciplinary team held oversight for care homes and ASC including mutual aid along with any 'hot issues' raised by members. Details of the hot topics raised can be found in the minutes [CL15/028 - INQ000544457]. The hot topics raised

changed according to the prevailing pressures at the time, largely related to; guidance on testing, vaccination, workforce issues, application of IPC guidance, PPE, communications strategy, care homes visiting.

184. Like its predecessor, PRASCG was a useful forum in bringing together a wide and diverse range of stakeholders to consider issues facing the adult social care and the implications for the development of national and local responses required to support the sector. It was also a useful forum to provide members with, and seek views on,

policy plans. This was often facilitated by members of other COVID-19 related social care working groups providing updates at PRASCG meetings. For example, Scottish Government officials supporting the financial sustainability group provided regular updates at PRASCG. Similarly those involved in other work and/ or working groups such as testing, vaccination and PPE provided regular updates at PRASCG. A number of short life working groups were convened in response to identified challenges or issues, such as Social Care Workforce recruitment [CL15/029 – INQ000510009].

185. The chairs of CPAG from the CMO and CNO Directorates and relevant policy officials attended PRASCG to provide members with updates on the work of CPAG, which helped ensure coordination and alignment between the groups.

Policy specific advisory groups

186. In addition to the groups listed above, there were a number of policy-specific advisory groups that provided advice and guidance to the Scottish Government on a range of important ASC issues, as set out below.

Adult Social Care GOLD Group

187. This group provided strategic oversight of national pressures across social care delivery in Scotland and collective national-level response and action through effective

oversight, support and where necessary coordination to enable a resilient response to be provided.

188. The 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. Its high level mission (as set out in the Terms of Reference, provided [CL15/030 – INQ000510014] was to "*establish an early warning system that complements oversight arrangements and prioritises the protection of adults and the resilience of services*."

189. The group was chaired by the Director of Mental Health and Social Care, with membership was drawn from:

- SG
- COSLA
- Health and Social Care Scotland
- Social Work Scotland
- SoLACE
- CI
- PHS.

190. The group reviewed all available data on outbreaks and sectoral performance to identify trends, issues or areas of concern. Suggested themes for consideration were; outbreak management and local challenges (including Covid-19 vaccination delivery), adult protection concerns, short-term sustainability (resilience of wraparound care), medium/long-term sustainability of residential services (i.e. health and wellbeing of ASC staff, care home occupancy rates), improvement requirements and to maintain awareness of winter management of hospital discharge. The group met twice per week (Tuesday and Friday) and the Cabinet Secretary for Health and Sport received a weekly summary of the GOLD Group's outputs.

191. The Terms of Reference were revised in January 2022, provided [CL15/031 – INQ000510050] to state that it would make decisions based on agreed strategic objectives (as set out in the letter from John Burns dated 10 December 2021) to:

- Maintain urgent and emergency care to maintain life and limb services
- Maximise capacity in our HSC system
- Support the workforce.

192. The group's remit was to provide strategic oversight of national pressures across social care delivery in Scotland, consider collective national-level response and action through effective oversight, support and (where necessary) coordination, to review current and projected data, intelligence and modelling, to consider planning and readiness covering activity to support resilience across HSCPs in Scotland and to set future directions and standards for Local Oversight Groups. This Group met from 20 November 2020 to 15 November 2022, minutes are provided [CL15/032 – INQ000591970]. The main topics and themes considered by the group included;

    - Outbreak management and local challenges;
    - Risk management, including the level of hours of unmet need and outstanding care assessments;
    - Staff availability including vacancies, Covid and non-Covid related absence rates
    - Adult protection concerns
    - Short-term sustainability
    - Medium/long-term sustainability
    - Improvement requirements
    - Maintaining awareness of hospital discharge flows.

Adult Social Care PPE Steering Group

193. The Steering Group was responsible for governing the PPE Hub partnership agreement between SG, COSLA, NSS, HSCPs, Coalition of Carers in Scotland, Scottish Care and National Carer Organisations (as agreed by all parties on 13 May 2020) [CL15/033 – INQ000147351]. The Steering Group comprised of internal and external stakeholders from the social care sector and monitored the use of the PPE

Hubs and levels of supply and demand, in addition to addressing ad-hoc issues of concern raised by Steering Group members.

194. This group sat from 12 May 2020 until 22 July 2022 and was chaired by Scottish Government and NSS officials under the terms of the agreement, all partners were to share commercial information (where necessary) to inform when collective purchasing power or targeted purchasing would allow for more efficient use of the public purse. Minutes are provided [CL15/034-INQ000591969].

Adult Social Care Testing Board (ASCTB)

195. The ASCTB was an internal Scottish Government SLWG, with membership from policy officials and clinicians, to provide oversight of the implementation and delivery of the expansion of testing in social care in line with Standard Operating Procedure (SOP) requirements [CL15/035 – INQ000147405]. The aim of the SLWG was to allow discussions with those who had a direct role or oversight in the delivery of Covid-19 testing to ASC and community bases cohorts. The Board sat from 27 January 2021 to 26 July 2021, minutes are provided [CL15/036 – INQ000147405]. Topics discussed included:

- Development of SOPs for testing pathways
- Progress on rollout of testing
- Issues around testing in different settings
- Change in type of tests, such as the move to Orient Gene 7s
- Consideration of clinical and public health advice for enhancing testing in some settings due to transmission rates, e.g. a review of the care home testing strategy.

196. A summary report was developed in October 2021 for the ASCTB which highlighted the actions taken place over the course of January to July 2021 to rollout testing in ASC and the resulting outcomes [CL15/035 – INQ000147405]

197. The report noted that 10 meetings had taken place since 27 January 2021 and that that the immediate work of the SLWG was finished. It indicated that the Pandemic Response Unit for ASC would continue to have responsibility for the delivery of testing

advice for the sector (with input from clinicians), with NSS leading on day to day delivery and implementation. Any stakeholder concerns regarding these matters could also be raised via the PRASCG.

198. The report also noted that the scale of expansion of testing in the social care workforce was estimated to be approximately 103,280 staff being able to access PCR and 131,300 staff being able to access LFDs from the following groups.

- Care Home Staff (PCR and LFD)
- Care Home Visitors (LFD)
- Visiting Professionals to Care Homes (LFD)
- Care at Home Staff (LFD or PCR)
- Short Break/Respite Staff (LFD)
- Children and Young People's Community Services Staff (LFD)
- Mental Health Services Staff (LFD)
- Residential Accommodation for Children Staff (PCR)
- Homelessness Services Staff (PCR)
- Addiction Services Staff (PCR)
- Social Workers (LFD)
- Learning Disability Services Staff (LFD)
- Women's Shelters Staff (LFD)
- Personal Assistants (LFD)
- Care Inspectors (LFD)
- Sheltered Housing Staff (LFD)
- Adult Day Care Services Staff (LFD)
- Drug and Alcohol Residential Rehabilitation Services Staff and Residents (LFD)

ASC Care Recruitment Campaign Advisory Group (CAG)

199. The ASC Recruitment CAG supported the successful delivery of the ASC recruitment campaign being delivered by the Scottish Government and the SSSC [CL15/037 – INQ000509909]. This Group was set up by SG under the office of the CSWO (Chair), and included representatives from Local Authorities, HSCPs, DWP Scotland, Inclusion Scotland, Scottish Autism, COSLA, Disclosure Scotland, CCPS, Skills Development Scotland, SSSC, The Richmond Fellowship Scotland and Turning Point Scotland. The group first met in September 2021 and its objectives were to:

- Support the development, implementation and evaluation of the social care recruitment campaign
- Provide expert guidance for the development of the marketing campaign, its content and target audience
- Develop and maintain links with key stakeholders to support the social care campaign to increase effectiveness.

200. Final decisions regarding the content and messaging for the marketing campaign were subject to final SG policy, marketing and Ministerial approvals [CL15/038 – INQ000592017].

Working Group for Social Care Provider Sustainability Support

201. This working group was established by the Scottish Government in October 2020, as a forum to inform the development of a revised approach to financial support for social care providers for the Covid-19 pandemic between December 2020 and 31 March 2021 [CL15/039 – INQ000509910]. The Group was Chaired by the Director Mental Health and Social Care and membership included representatives of primary care trusts and local authorities. Themes included ensuring consistency of approach through funding and assurance processes, and workforce implications. The group met

every 3 weeks for 6 months, with its future reviewed in June 2021, minutes are provided [CL15/040 – INQ000592019].

Care Home Data Monitoring Group

202. The Group monitored Red Amber Green (RAG) ratings of care homes. This sub group of the CHRAG was established to hold more frequent calls to monitor available data, with the ability to convene the wider group at any time. The agenda and purpose circulated prior to the first meeting is provided [CL15/041 – INQ000437452]. Themes included developing clear understanding of national and local picture and identifying issue for urgent resolution. Meetings took place between May and June 2020. Membership consisted of representatives from the Scottish Government, CI, the Office of the Chief Statistician, NRS, PHS, Academia, HSCPs, RCN , Scottish Care, and the Scottish Centre for Administrative Data Research and the group was chaired by Frank Strang, minutes are provided [CL15/042 – INQ000544457]. As discussed at the CHRAG meeting on 11 June 2020 and further correspondence [CL15/042A – INQ000324065], it was agreed that the future of the group would be discussed at the CHRAG to minimise potential duplication and overlap with other groups. It was subsequently proposed and agreed that a new Data Analysis and Research (DAR) CPAG sub-group would be formed to consider these issues (as discussed above at paragraph 155).

Carers Leads Network

203. This network considered carer-related issues throughout the pandemic. The network had already been in place since 2017 and was used for opportunities for discussion, peer support and intelligence gathering rather than for making decision about social care support. This was an informal network which included representatives responsible for carer support from each local authority/IA in Scotland. These meetings were facilitated by Scottish Government and the content led by carer leads. Terms of reference were not required as it was an informal group, minutes are provided [CL15/043-INQ000592021].

Carers Rights and Support Steering Group (formerly the Carers Act Implementation Steering Group)

204. The Carers Act Implementation Steering Group oversaw work to improve and expand support under the Carers (Scotland) Act 2016, including working in partnership to deliver the agreed implementation plan, enhance carer support, embed good practice and identify and address challenges and opportunities, terms of reference provided [CL15/044 – INQ000509913]. The group was renamed the Carers Rights and Support Steering group on 15 December 2021 and given a broader remit to focus on wider carers issues across social care and broader SG policy. A key theme for this group was the development of legislation prioritising supporting carers looking after someone with a terminal illness.

205. Membership was provided by representatives from HIS, Minority Ethnic Carers of People Project (MECOPP), COSLA, CI, SSSC, HSCPs, Carers Trust, Carers Scotland, The Alliance, Young Scot and Scottish Government.

Additional groups

206. There were a number of other non-social care specific Scottish Government convened advisory groups which were coordinated by other teams in Scottish Government but provided advice relevant to the social care sector (including on matters such as testing, vaccination and IPC). These groups included:

- Covid-19 Advisory Group – convened by the CMO and chaired by Professor Andrew Morris
- Clinical Guidance Cell – convened by the CMO and chaired by Professor Tom Evans
- Scientific Advisory Board on Testing – chaired by the Chief Scientist (Health)
- Covid-19 Nosocomial Review Group (CNRG) – an advisory group convened by the CNO and chaired by Professor Jacqui Reilly. The group supported Scottish

Government and senior clinical advisers to interpret the Scientific Advisory Group for Emergencies (SAGE) outputs and other emerging scientific evidence in relation to nosocomial infection (in the context of Scotland). The group met 40 times between 7 May 2020 and 17 November 2022.

Cooperation and joint working with UK Government and other devolved administrations

207. The four nations Health Ministers met regularly from 20 April 2020 onwards. Regular quadrilateral engagement also took place with UK Cabinet Office officials and DGHSC officials, who led on different policy areas, between January 2020 and April 2022. There was also frequent direct engagement with each of the four nations at a policy level.

208. The four nations forums offered an opportunity for policy colleagues across the devolved administrations (DAs) to share issues and provide updates on work to support the ASC sector. These focused on emerging issues such as; sustainability funding, visiting in care homes and testing. Separate topic-specific groups were also established regarding data, PPE issues and visiting. In relation to visiting, an informal four nations care home visiting group met fortnightly to discuss the policy response required. This group still meets regularly to consider policy and legislative work on visiting following the pandemic.

209. On testing, the Scottish Government collaborated on the rollout of asymptomatic testing within social care settings through a working group organised by the UK Government's Department of Health and Social Care (DHSC). Officials from the four nations also met regularly to discuss care home visiting, initially meeting fortnightly before moving to a monthly frequency. The pre-existing UK-wide Adult Social Care Policy Working Group met regularly throughout the pandemic, organised by the DHSC, and continues to meet regularly to discuss and collaborate on policy developments within social care across the four nations. The Scottish Government understands that copies of material relevant to this group can be provided by UK Government DHSC colleagues.

210. Throughout the pandemic, Scottish Government Health and Social Care Analysts (HSCA) worked closely with counterparts in the devolved administrations to discuss Covid-19 data, generally in the context of four nations comparisons. HSCA were also represented on Four Nations Vaccine Statistical meetings, which the DHSC chaired. A small number of Social Care indicators were added to the weekly Cabinet Office return (which contained mainly information about general cases, deaths, ventilators available etc.). To ensure that clinical advice was in step with the latest emerging evidence, the Senior Medial Adviser (now DCMO) also attended the SAGE Social Care Working Group as an observer, and information was then disseminated within the Scottish Government.

International collaboration

211. Although Scotland is not a member state of international organisations, such as the World Health Organisation (WHO) and the World Health Assembly (WHA), information provided by these international organisations was provided to SAGE, the Health Protection Network, as attended by the CMO and then shared with relevant areas across Scottish Government.

212. In particular, the Covid-19 Advisory Group, chaired by Professor Andrew Morris, (formerly Chief Scientist to the Scottish Government (2012-2017)) considered the scientific and technical concepts and processes that were key to understanding the evolving COVID-19 situation and potential impacts in Scotland. The Advisory Group applied the advice coming to the four nations from SAGE and other sources of evidence and information and used it to inform local decisions in Scotland during the pandemic.

213. Scottish Government clinical and professional advisers were linked with UK and global networks via their existing professional networks and membership of groups such as the SAGE Social Care Working Group. Scottish Government IPC advisers were members of the UK IPC cell which had links with wider global networks and evidence.

214. Bodies and organisations advising Scottish Government were members of other UK and international networks. For example, PHS were linked into wider UK and global health networks, whilst ARHAI Scotland had links with the UK IPC Cell and WHO. These UK and international links were important, as they ensured that advice and guidance incorporated WHO guidance and provided a consistent approach across the UK, where appropriate.

215. Scottish Government analysts also updated colleagues across the Scottish Government on the progression of Covid-19 in other UK nations and internationally. Analysts reported back from SAGE SCWG to groups in Scotland including CPAG and Social Care GOLD. In addition, see for example, papers regarding UK Government International Comparators Joint Unit on Care Homes (22 May 2020) (ICJU(20)036) which looked at comparator countries. The International Long-Term Care Policy Network's (ILTCPN) Covid-19 Mortality in Long Term Care: a UK Comparison" Report of August 2020. The Open with Care visiting guidance was informed by publications such as the ILTCPN "Safe Visiting at care homes during Covid-19: A review of international guidelines and emergency practices during the Covid-19 pandemic" (February 2021) and 'Factors associated with SARS-CoV-2 infection and outbreaks in long-term care facilities in England: a national cross-sectional (Shallcross et all (Lancet, February 11 2021).

216. In addition to engagement with other UK nations through the informal four nations care home visiting group, officials also engaged with other international nations on an ad-hoc basis. For example, Scottish Government officials liaised with their counterparts in Ontario, Canada to understand their plans to develop legislation relating to care home visiting, which informed the Scottish Government's approach to supporting the full return to indoor visiting in care homes. Following the publication of the Open with Care visiting guidance in February 2021 [CL15/015 – INQ000147437], officials were invited to attend a virtual international forum event to present the 'Open with care' care home visiting approach and campaign in Scotland. Furthermore, officials engaged with counterparts in the Irish Government who were interested in Open with Care guidance and the approach to visiting more generally.

Establishment of PHS – April 2020

217. The Inquiry has asked for comments on a view that the opening budget and staffing levels for PHS were not sufficient. In response, the Scottish Government would acknowledge that all public health agencies required additional funding and staff to support the sustained pandemic response. The response had additional facets such as prolonged National Incident Management for Covid in various settings, the Covid vaccination programme, and national contact tracing and testing. As set out in advice provided to the Cabinet Secretary for Health and Sport on 9 October 2020, PHS approached sponsors on 11 September 2020 to discuss urgent resourcing issues, pending further recruitment. Further meetings took place in late September to discuss proposals to pause or deprioritise planned workstreams [CL15/045 – INQ000243974].

218. Baseline funding is provided each year by Scottish Government Health and Social Care Directorates to territorial Health Boards and other NHS bodies, such as Public Health Scotland. The purpose is to fund staff and any operations and actions necessary to deliver national and local priorities for health and wellbeing services, including statutory functions. In addition to baseline funding, Boards and NHS bodies receive additional funding from Scottish Government by way of in-year allocations which are provided to ensure delivery of specific programmes, projects and outcomes.

219. The 2020/21 budget for PHS was £80.6 million. The opening budget was set prior to the pandemic and comprised a core recurring budget of around £35 million with additional in-year funding of around £26 million. This was supplemented significantly during that financial year along with the staffing position. The budget rose to £95.9 million for 2021/22.

220. In its first year of operation, PHS received a further £14.3 million in allocated funding for specific programmes (including £0.7 million in non-core funding for accounting adjustments), and £11.3 million of funding to support the Covid-19 response. Total revenue resource provided in year was therefore £73.5 million. Core capital funding of £0.4 million was also provided and used in full to fund acquisition of assets. Specific Covid-19 funding provided in-year funded work pertaining to:

- Additional staff resources in health protection and analytics
- Digital transformation to support response
- Genomic research and activity
- Marketing campaigns
- National Contact Tracing · Covid-19 surveillance in schools
- Serology.

221. As at 30 June 2020, PHS employed 1,065 staff, which rose to 1,143 as of March 2021. The following months saw a focused recruitment campaign with posts advertised across a range of posts within PHS, such as Information Analysts, Project Managers/Support Officers and Consultant – Health Care Scientists.

222. The Inquiry has also referred to concerns expressed around the impact of introducing a new management structure following the formation of PHS and how this affected the pandemic response. The Scottish Government's view is that previous

public health reform messaging had consistently focused on the need to tightly integrate the three domains of public health (which are health improvement, health protection and health services). This was to bring together the breadth of public health practice in Scotland, and to support better engagement and communication with communities. It was judged that the advantages offered by a single national public health body and a more coherent national response outweighed the risks of organisational change. Furthermore, PHS had already been established as a Special Health Board by the Public Health Scotland Order 2019 (as of 7 December 2019) and the new PHS Chair and Chief Executive appointed. To delay or stop PHS becoming operational on 1 April 2020, and the subsequent transfer of staff on the same date, would have required the above-mentioned legislation to be repealed or amended significantly following parliamentary consideration and Transfer of Undertakings (Protection of Employment) (TUPE) transfers stopped.

223. The Scottish Government also recognised that no senior managers in Scotland or elsewhere had extensive experience of managing a pandemic of this scale and longevity. However, all of the NHS Health Scotland senior leadership team transferred into PHS, except for the Chief Executive who retired on 31 March 2020. Together with other key appointments the PHS senior leadership team comprised of individuals who held extensive experience in roles within local government, NHS Scotland and Public Health England. This included resilience and public health protection planning, specialist clinical/public health and data/analytical expertise. The interim Chair of PHS,

Professor Jim McGoldrick, was previously Convenor of the SSSC and a Board Member of the CI. The PHS Board also had members with significant clinical and public health expertise.

224. All staff and functions from the legacy bodies transferred across to PHS with the exception of the ARHAI Scotland staff and function of HPS, which remained within NSS and a number of corporate services staff from NHS Health Scotland, who transferred to NSS under a shared services arrangement.

225. The decision to retain ARHAI Scotland in NSS was taken prior to the pandemic. This was signalled in the public consultation document inviting views on the proposals for a new national public health body in Scotland, which was issued on 28 May 2019 [CL15/046 – INQ000510051]. The consultation document stated that, due to recent infection incidents and the associated independent external review, the Cabinet Secretary for Health and Sport needed to further consider what provision may be needed at a national level in relation to IPC. It was stated, therefore, that decisionmaking around the ARHAI component would require further consideration.

226. The Clinical and Protecting Health Directorate in PHS and ARHAI Scotland within NSS continued to work together closely throughout the pandemic. This followed previous practice within Health Protection Scotland. PHS and NSS also collaborated on delivery of significant new programmes such as the Covid vaccination programme and national contact tracing and testing. NSS also provide

shared services to PHS such as Procurement, HR and Finance Services so the bodies were closely interlinked on a number of levels.

Structure and capacity of the ASC sector

227. In September 2020, the Cabinet Secretary for Health and Sport commissioned an Independent Review of Adult Social Care in Scotland, which reported in February 2021 [CL15/004 – INQ000280640]. The review provided an in-depth analysis of the adult social care sector in the pre-pandemic period, highlighting both the strengths of the system and also the key challenges. A summary of the key findings and recommendations of the Independent Review can be found at paragraphs 980 to 986.

228. The review provided an in-depth analysis of the ASC sector in the pre-pandemic period, highlighting both the strengths of the system and also the key challenges, which included:

- Challenges around recruitment and retention of social care workforce, including concerns that the workforce was seen as undervalued and underpaid
- Difficulties for people accessing social care services and support
- The assessment process for social care is seen as difficult for many and felt intrusive and focused on eligibility - not rights or equality
- Variable implementation of HSC Integration
- An automatic default to care home care in some areas, particularly for frail older people, when people say they would like to live in their own homes for as long as possible
- Need for a greater level of investment in ASC support in Scotland as a whole to meet these challenges.

229. Delayed hospital discharges have been, and continue to be, a longstanding issue for the HSC sector. A delayed discharge occurs when a hospital patient who is clinically ready for discharge from hospital continues to occupy a hospital bed

beyond the date they are ready for discharge. Delayed discharges are not in the best interests of individuals. Unnecessary time in hospital can lead to a significant deterioration in a person's physical and/or mental health, with a potential loss of independence. This, in turn, may lead to a greater use of institutional care. The risk of delayed discharge increases when a patient is admitted as an emergency, and the longer the hospital stay and period of delay, the greater the change of dependency and institutionalisation. Delays also impact on a hospital's capacity to treat other patients.

230. Reducing the rates of delayed discharges has therefore been a priority across health and social care over many years, including the period in the run up to the pandemic. The reasons behind these delays are also longstanding and include:

- Lack of effective admission and discharge pathways, leading to inappropriate admissions and hospital transfers
- Lack of social care provision in the community leading to inappropriate 'social care' admissions and delays in discharge
- Lack of suitable care home beds and poor implementation of the Choice policy requirement to move to interim home to await home of choice
- Complex reasons due to the specific care needs of the person including Adults with Incapacity.

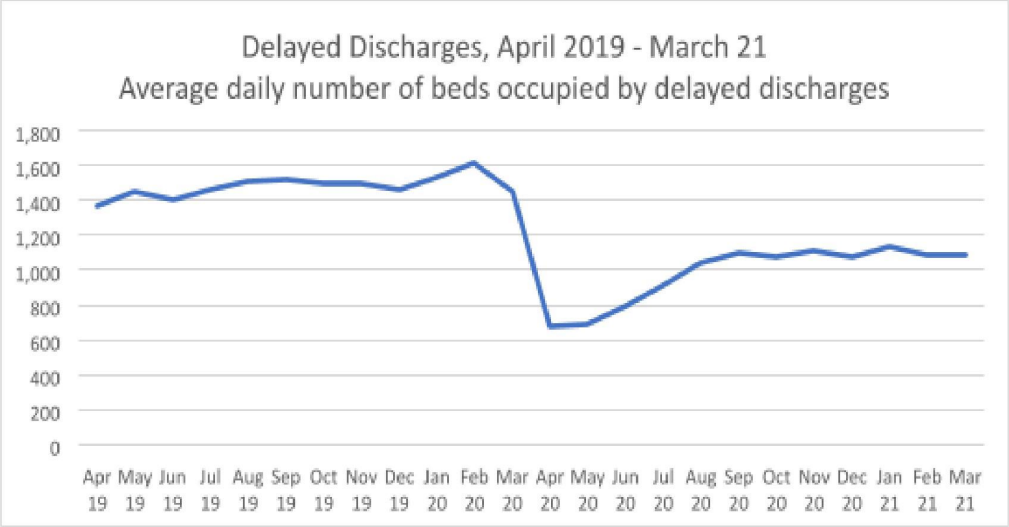
231. Prior to the pandemic various initiatives were put in place to prevent and reduce delayed discharge. This included:

- Expanding 'Home First' approach in many areas including 'discharge to assess' with community teams assessing people in their own homes or care homes rather than in hospital (see further, Ten Actions to Transform Discharge paper from the Joint Improvement Team, provided [CL15/047A – INQ000591974]
- Development of a range of Immediate Care services aimed at avoiding unnecessary hospital admissions and reducing delays in discharge. Examples included rapid response community teams, Home from Hospital support, and bedbased step-up/down intermediate care in care homes

- Expanding the development of hospital at home - providing acute hospital care at home, as an alternative to hospital admission.

232. In support of these initiatives, efforts were required to shift the balance of care and resources to community (a long-standing Scottish Government policy). For example, many areas moved hospital-based Allied Health Professionals such as occupational therapists, physiotherapists to work in Home First teams or equivalent in the community.

233. Data on patients delayed in hospital pre pandemic shows that during the period April 2019 to March 2020, an average of 1,481 patients were delayed at any one time, with an average length of stay of 21 days. Data for previous years shows the number of delays recorded between 1,300 and 1,500 patients each month [CL15/047 – INQ000589679]. This reduced to an average of 982 delays per month, with an average length of stay of 19 days in 2020/21 (see graph below).



234. During 2018, the Scottish Government engaged with people who use social care support, a wide range of local and national organisations, the social services sector, Health and Social Care Partnerships and others to understand and gather

views and evidence on the key challenges within adult social care and what needed to change. As a result of this engagement, the Scottish Government launched the National Programme of Reform of Adult Social Care Support in 2019, which examined the following workstreams:

- The purpose and value of social care support and self-directed approaches
- Consistent experience and expectations
- Models of care and support
- Workforce conditions and skills
- Investment in care and support
- Commissioning and procurement
- Communities, care and support.

235. The voices of people who use social care support led the process and were instrumental in any decisions that were made. The People-led Policy Panel was one of the two leadership groups for the programme. The Panel consisted of 50 members, all

of whom were people who had lived experience of adult social care support, including carers. The other group was the Leadership Alliance, which was made up of key leaders from across the care and support sector. SG worked with the People-led Policy Panel and the Leadership Alliance to consider the evidence gathered to identify priority areas for the programme to focus on.

236. The programme was formally launched in June 2019 but was paused in early 2020 to allow the social care sector to focus on responding to the Covid-19 pandemic. The review was then superseded by the Independent Review of Adult Social Care [CL15/004 – INQ000280640].

237. Figures indicate that, at the outset of the pandemic, there were:

- Around 238,000 (1 in 25) people in Scotland receiving social care and support in

2019/2020 [CL15/048 – INQ000509914]

- Around 59,000 people were receiving care at home during census week 2019/2020 [CL15/048 – INQ000509914]
- On 31 March 2020, there were 1,081 care homes in Scotland, with a total capacity of 40,940 places [CL15/049 – INQ000509915]
- In 2019/2020, the majority of people (77%) requiring social care services or support were aged 65 or over. Younger adults with physical and/or learning disabilities or mental health conditions also received vital support [CL15/048 – INQ000509914]
- People residing in a care home tended to be older, with around 90% of residents aged 65 or older, and 1 in 2 aged 85 plus in 2019/2020 [CL15/050 – INQ000509916]
- In 2019/2020, 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 [CL15/049 – INQ000509915]
- There were around 90,000 people with dementia in Scotland [CL15/052 – INQ000509917]
- In 2019/2020, 62% of people requiring social care services or support were female [CL15/051 – INQ000589678]
- 98% of people requiring social care services or support where ethnicity was known, were white in 2019/2020 [CL15/048 – INQ000509914]
- There were 206,400 people employed in the social care sector in December 2019, with many more individuals supporting delivery through multidisciplinary health and social care teams [CL15/053 – INQ000509918]
- There were around 696,000 unpaid carers living in Scotland, including 29,000 young carers [CL15/054 – INQ000509919].

Social care workforce as at March 2020

238. The social care sector is a major employer in Scotland, providing support and care to people with a wide range of different needs and within a range of different settings. The SSSC publishes data on the social care workforce as part of its legal duties under

the Regulation of Care (Scotland) Act 2011 and the approved provider of official statistics on the social service workforce in Scotland.

239. The SSSC Scottish Social Service Sector: Report on 2020 Workforce Data (30 August 2021) [CL15/055 – INQ000509920] indicates that the size of the workforce had increased to 209,690 – the highest level recorded since reports began. The increase was driven mainly by increases to the housing support/care at home sub-sector. It should be noted that this includes both adult and children social care). Of the 209,690 people, 64% (134,440) were employed specifically within ASC. The stability index of the workforce was 80.8%. This meant just over four-fifths of the workforce remained in the same post as the previous year.

240. The largest employer type differs between local authority areas. For example, services in Orkney, Shetland and Na h-Eileanan Siar (the three island authorities) were provided mainly by the public sector. However, in most areas the private sector was the largest employer. The workforce was mainly employed on permanent contracts (83%).

241. The percentage of men working in the whole social services sector was 15%, although it was around double or greater that proportion in criminal justice and residential children's services. The SSSC data breakdown of gender also shows that 83% of the social service workforce were female and 2% were unknown. In relation to staff by ethnic classification, 74% were white, 1% black, 1% Asian and 23% unknown. The percentage of staff by disability was: no disability 82%, disability 2%, unknown 16%

242. The percentage of men working in the ASC sector (as opposed to the whole social services sector) was 17%, and the SSSC data breakdown of gender also shows that around 80% of the ASC workforce was female and more than 3% were unknown. More than half (52%) of the ASC workforce worked part-time.

243. In 2017, The Fair Work Convention (FWC), an independent advisory body to Scottish Ministers, highlighted a range of challenges for the social care workforce, including lack of security for social care staff; poor terms and conditions; significant difficulties in staff recruitment and retention. The FWC therefore undertook an inquiry into Fair Work

in Social Care and published its report: Fair Work in Scotland's Social Care on 26 February 2019 [CL15/056 – INQ000376409]

244. The FWC inquiry found that the social care sector was not consistently delivering fair work; the existing funding and commissioning systems were making it difficult for some providers to offer fair work and social care workforce did not have a mechanism for workers to have an effective voice in influencing work and employment in the sector. It also found that some social care employees did not have secure employment and were expected to work excessive hours in order to take home a fair wage, with the burden of variations in demand falling heavily on front line staff, who can face zero hour, sessional contracts, working beyond contracted hours and working unpaid overtime to meet the needs of care service users.

245. As noted above, recruitment and retention was, and remains, a major challenge for the social care workforce and was a contributing factor to the sector being stretched and under pressure prior to the pandemic. The Scottish Government's National Health and Social Care Workforce Plan published with COSLA in December 2017 [CL15/057 – INQ000509922], set out how partner organisations would be supported to identify, develop and put in place the workforce needed to deliver safe and sustainable highquality services to Scotland's people. The SSSC also delivered support for recruitment and retention of the workforce including resources on career pathways and

promotional materials for schools, colleges, employment services and employers; management and promotion of routes into careers (Foundation and Modern Apprenticeships); and a network of Ambassadors for Careers in Care.

246. To help address ongoing pay issues the Scottish Government has provided funding since 2016 to ensure that adult social care workers, delivering direct care in commissioned services, are paid at least the Real Living Wage (RLW). During the funding period 2018/19, this commitment was extended to include workers providing overnight adult social care support.

247. The Scottish Government launched a national programme to reform adult social care in 2019 and Fair Work in social care was identified as a key priority.

Consequently, the Fair Work in Social Care (FWISC) Group was established with a commitment, amongst other things, to take forward the recommendations of the Fair Work in Scotland's Social Care Sector 2019 report. A number of workstreams were established to progress actions to improve Fair Work within the adult social care sector. Work to deliver on these workstreams continues to be taken forward in partnership with key stakeholders through the FWiSC Group.

248. Despite these efforts, prior to the pandemic, reports such as the SSSC 2019 Staff Vacancies in Care Services [CL15/058 – INQ000509923], which provides a national overview of vacancy levels reported by care services registered with the CI, indicated that the percentage of services with vacancies was increasing. Challenges appeared to be greatest in care homes for adults, care homes for older people, care homes for children and young people, housing support services, care at home services, and residential special schools, which all had a proportion of services with vacancies significantly above the national average for all care services. Employers reported that vacancies were becoming harder to fill. The Independent Review of Adult Social Care [CL15/004 – INQ000280640] summarised the positions as follows:

> "*We heard much that is impressive, heart-warming and uplifting about the commitment of the workforce to supporting people who use social care support. But we also heard much about a workforce that is undervalued, badly paid for vital, skilled work, held in low esteem in comparison particularly to the health workforce, poorly supported in terms of learning and development, and generally underrepresented*."

249. The Independent Review of Adult Social Care [CL15/004 – INQ000280640] also highlighted the gender imbalance within the workforce as being an important factor: *"The social care workforce in Scotland is so notably disadvantaged because it is highly gendered. The sector is about 83% female. Were it 83% male, it simply would not be marginalised and undervalued as it is. The consequences of this are obvious, and highlighted by the pandemic. Turnover is high at roughly 30% p.a., recruitment is challenging and it is difficult to maintain and improve standards when investment in training and development is low."*

Unpaid carers

250. The Inquiry has asked for an overview of the role of informal carers, such as personal carers. In Scotland we use the term unpaid carers rather than informal carers, to describe those who provide care to family, friends or relatives.

251. Unpaid carers make a vital contribution to ensuring that people throughout Scotland get the care they need. An unpaid carer is anyone who looks after a friend, family member or neighbour due to either: old age; physical or mental illness; disability; or an addiction. This does not include paid care workers or those who are volunteering. 'Looking after' can mean helping with things like shopping, domestic tasks, emotional assistance and personal care. A young carer is someone under the age of 18, or 18 and still at school, who provides care for someone else.

252. The Scotland's Carers Update Release March 2024 published by Scottish Government [CL15/059 – INQ000509924], states that the number of carers living in Scotland is presently estimated to be around 700,000 to 800,000. The latest figures based on the Scottish Health Survey show an estimated total of around 696,000 carers (+/-55,000) living in Scotland – including 28,000 young carers (as per the 20172021 estimate). The latest figures from the Scottish Health Survey 2018-2022 combined also show that for people aged 16 and over, 17% of females and 12% of males are carers and people are more likely to be providing unpaid carer in their later working years (especially females). Over a quarter (26%) of females aged 45-54 and females aged 55-64 provide unpaid care in 2018-2022 combined.

253. The Carers (Scotland) Act 2016 includes duties for local authorities to take account of the impact of having one or more protected characteristics when identifying carers' personal outcomes and needs for support, and in providing carer information and advice services. The Scottish Government funds MECOPP and other national carer organisations to support local carer organisations, which often deliver these duties on behalf of local authorities. Along with other national carer organisations, MECOPP were present at weekly meetings during the pandemic, to ensure that the voices of carers with one or more protected characteristics were head, and that accessible information was made available for them.

Personal Assistants

254. A Personal Assistant (PA) is defined as any person directly contracted by someone in receipt of SDS: Option 1 and/or Independent Living Fund. Therefore, PAs are the employees of the individuals who are in receipt of social care support. These individuals may contract one or more PAs to meet their support needs. Some people contract with PAs via other funding streams such as the Disabled Students' Allowance from the Student Awards Agency Scotland (for non-medical personal help associated with study); the daily living component of the Adult or Child Disability Payment, or by using their personal funds. In summary, the PA's role is to provide support to help their employer live their day-to-day life and personal outcomes.

255. The PA workforce is a heterogenous and fragmented segment of the social care workforce, containing several distinct groups of PAs i.e. full-time, part-time, selfemployed, directly employed, publicly funded, privately funded, urban-based, ruralbased. Consequently, attempts to capture the size and composition of this workforce face a number of obstacles, as there is a lack of regularly collected statistics that are able to sufficiently capture the PA workforce.

256. This workforce is also not registered with the SSSC. The number of PAs who received the Covid-19 'Thank you payments' has been used as a minimum known number of PAs in Scotland (around 4,800 people); however, a more robust estimate is required for workforce planning. Work is currently under way to improve the accuracy of existing data sources and consider additional data sources.

Changes to structure and capacity during the pandemic

257. There have been a number of changes to the structure and capacity of the ASC sector during the pandemic.

258. In relation to staffing capacity, the SSSC reported that as at 31 December 2020 [CL15/060 –INQ000507850], 43% of services with vacancies reported having problems filling them; down 6 percentage points from the previous year. This

proportion has been increasing since the pandemic. In 2022, 63% of services had vacancies, which they reporting having problems filling. This varied by type of service and geographical area: care at home services (63% in 2020 increasing to 78% in 2022), care homes for older people (54% in 2020 increasing to 77% in 2022), housing support services (52% in 2020 increasing to 77% in 2022) and nurse agency services (57% in 2020 increasing slightly to 61% in 2022), were all above the national average for all care services.

259. When services were asked why they had found vacancies hard to fill, the most commonly reported reasons were: too few applicants with experience (60%), too few applicants in general (56%) and too few qualified applicants (52%). These have consistently been the top three reasons between 2020 and 2022 although too few applicants in general has increased from 56% in 2020 to 71% in 2022 while the proportions for the other two reasons have remained largely the same.

260. The ASC workforce has been increasing gradually over the past decade, 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 the housing support/care at home where there was a 23% increase across the ten-year period (from 62,170 in 2013 to 76,720 in 2023). The most notable increase in that period was in 2020 where workforce numbers increased by 5% (from 71,260 in 2019 to 74,870 in 2020), possibly reflecting the need for greater staff numbers to support those at home during the pandemic.

261. However, the number of care home staff has reduced gradually over that same time period from 52,430 in 2013 to 50,410 in 2023. There was little change in care home workforce between 2019 and 2020, however, there was a notable decrease of 4% in 2021 where numbers reduced from 52,920 to 51,010. The number of care home staff has remained at this level since then. Day care service workforce numbers have decreased by 37% in the past decade, from 8,240 to 5,180 in 2023. In 2020, numbers dropped by 8% (from 7,260 to 6,650), and then again by 7% in 2021 and 11% in 2022. This reflects the fact that day care services would have been suspended due to pandemic restrictions. This figure has continued to decrease after restrictions have been lifted.

262. The PHS annual publication of the care home census, reports that as of 31 March 2021, there were 1,068 care homes for adults and 40,609 registered places [CL15/061 – INQ000507842]. This compared to 1,329 care homes for adults and 42,810 registered places in 2011. A 20% and 5% reduction respectively. The estimated percentage occupancy at 31 March 2021 was 82%, compared with 88% on 31 March 2011. During the same period, residents in care homes for older people accounted for 91% of residents in all care homes for adults (30,483 out of 33,334).

263. In terms of the impact of Covid-19 on care homes, the data shows that there was a decrease in the number of care homes, from 1,102 in 2019 to 1,068 in 2021 and this is in line with the long-term trend, with numbers continuing to decrease consistently to 1,020 in 2024. While the care home census was not run in 2020, the CI publish monthly information on all registered services, and this shows that the number of care homes remained stable at around 1,080 throughout 2020 [CL15/062 – INQ000510013].

264. The number of care home residents has been on a generally decreasing trend over the past ten years from 36,578 on 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.

265. The impact of Covid-19 on the number of people receiving social care support from home (per 1,000 population) has been relatively stable over the past five years. However, this figure did dip slightly during April to June 2020, at the start of the pandemic (and a little in winter 2021 when restrictions were in place). This figure recovered in subsequent quarters back to normal levels.

266. The report of the Independent Review of Adult Social Care [CL15/004 – INQ000280640], made recommendations which were wide ranging and focused on improving people's experiences of care as well as changing the way that social care is managed and governed. This has, in turn, led to the process for creation of the National Care Service (NCS). The NCS aims to provide support to anyone in

Scotland who needs it through social work, social care and support for carers. It also aims to address the inconsistency of care provision across Scotland, ensuring those who need it have access to consistently high-quality care and support, and instilling Fair Work principles for our workforce to ensure they are valued for the work they do. Further detail regarding the Independent Review of Adult Social Care and the creation of a NCS is provided at paragraphs 980 to 985 of this statement.

267. As noted above, the Scottish Government also made significant changes to its structures, during the pandemic, 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.

Pre-pandemic plans and guidance

268. In order to support contingency arrangements in social care, especially in relation to the ongoing viability of service providers, a National Social Care Contingency Planning Group (NCPG) has been in existence since 2011. The group is chaired by the COSLA, with representation from Scottish Government, statutory agencies and care providers. We understand that materials relevant to this group can be provided by COSLA. The role of the NCPG was to look at the overall preparedness of statutory agencies in addressing unforeseen circumstances that could lead to the disruption of adult care provision in Scotland. This includes any service disruption or cessation that arises from a business closure, an emergency situation or a public health matter. It plays a particularly important role where care home providers or owners operate across a number of local authority areas. During the early phase of the pandemic, COSLA convened this group to discuss emerging issues and approach to providing collective support to the social care sector. As other Covid-19 resilience structures for social care were put in place by the Scottish Government from April 2020, the NCPG role around collective support for the sector in relation to Covid-19 ended in June 2020.

269. The pandemic plan in place in Scotland for the ASC sector at the beginning of the relevant period was the Health and Social Care Influenza Pandemic Preparedness

and Response, which was developed by the UK Government in 2012 [CL15/063 – INQ000022710].

270. This was issued to the health and social care sectors in Scotland and provided guidance in relation to:

- Pandemic preparedness and response in health and social care
- Roles and responsibilities
- Detection and assessment phases
- Treatment and Escalation phases
- Recovery phases.

271. The guidance recognised the risk of transmission to vulnerable individuals in social care and other settings. It set out the IPC and other measures which should be taken locally by all parties to reduce the risk of transmission. This included advice and guidance in relation to:

- Surveillance - especially in settings where there are higher risks to vulnerable populations
- Segregation, isolation and cohort nursing to limit transmission
- Local risk assessment for required levels of infection control, particularly in communal living environments such as residential homes
- Collaboration and mutual support for high-risk settings
- Use of PPE updated guidance for local organisations during a pandemic.

272. The 2012 pre-pandemic plan/guidance was developed by the UK Government and so was not explicitly tailored to the ASC sector in Scotland, nor to specific sub-sectors such as care homes with/without nursing care. The view within Scottish Government was that both the impacts on social care services, and the actions which might be taken by the sector in preparation, were at a sufficiently high level that there would be sufficiently clear read across to the situation in Scotland. Similarly, in line with the planning assumptions at the time regarding pandemics, the document was focused on

an assumed flu pandemic, without specific consideration of other types of pandemic, although the impacts and responses would have many similarities.

273. As also previously noted, the Scottish Government issued an updated and Scotland-focused version of this document for consultation in 2019, with the final version not issued due to the commencement of the Covid pandemic. That document was drafted at a similar high level and so did not provide additional detail on planning for sub-sectors within social care services in Scotland - aside from providing more detail on the need for the new and emerging multi-agency planning structures in Scotland to work together on pandemic planning, including the needs of social care.

274. The National Infection Prevention and Control Manual (NIPCM) [CL15/064 – INQ000339585] provided practical guidance for clinical settings in Scotland. It describes standard infection control precautions and transmission-based precautions that when used, helps reduce the risk of Healthcare Associated Infection (HAI) and ensure the safety of those in the care environment – those being cared for, as well as staff and visitors. It aims to: make it easy for care staff to apply effective IPC precautions, reduce variation, promote standardisation and optimise IPC practices throughout Scotland; help reduce the risk of HAIs and help align practice, monitoring, quality improvement and scrutiny.

275. The NIPCM was originally published on 13 January 2012 by the CNO and was updated several times, including 17 May 2012, 4 April 2014 and 3 April 2017. The NIPCM was mandated for use in the NHS and was not for adult social care settings. However, it was a source of information and advice which was utilised within social care settings and recommended as best practice.

Business continuity arrangements in social care

276. Pre-pandemic, local organisations were, and continue to be, primarily responsible for planning for and responding to any major incident, including pandemics. Local Resilience Partnerships had a collective responsibility to plan, prepare and communicate in a multi-agency environment and multi-agency planning, which was

key to developing and delivering an integrated response to major incidents, including pandemics.

277. There are also systems in place locally to support business continuity in the health and social care sectors. Business continuity arrangements within social care provision were, and continue to be, managed by local government and care providers as an aspect of contract management. Contingency and business continuity planning requirements are contained in contractual arrangements for social care provision and in relation to the registration of services with the CI. For the purposes of registration with the CI, relevant social care services must maintain contingency plans to safeguard the safety and wellbeing of service users in the event of sudden closure of the service.

278. Standards and expectations in relation to business continuity are also included in COSLA's National Care Home Contract (for older people requiring public funding) as follows:

- The Provider will develop, implement, maintain and hold responsibility for processes and procedures in relation to business continuity
- The Provider shall maintain a business continuity plan which takes account of the supports reasonably expected to be available from statutory authorities including but not limited to, the civil and emergency planning provisions within the Local Authority area
- The Provider shall provide a copy to the Council on request
- The Provider shall notify the Council as soon as reasonably practicable of the activation of said plan.

279. A range of public health organisations provided advice to the Scottish Government around infection control in different settings before and during the pandemic, including HPS (now PHS) and ARHAI Scotland (which sits within NSS).

Guidance issued during the pandemic

280. The Scottish Government played a vital role in the early stages of the pandemic in supporting the care sector to respond to the challenges it faced through the provision of national advice and guidance.

281. In the early stages of the pandemic, little was known about the presentation and impact of Covid-19 specifically within the care home sector. However, there was a general understanding of the vulnerability of the care home population to Covid-19 based on the previous experience of poorer outcomes from other infectious disease outbreaks. The early experience of Covid-19 in other countries, for example Italy and Canada, suggested similar patterns with high consequence impacts for residents.

282. Like other UK nations, the Scottish Government therefore considered that care homes were a substantially higher risk setting for Covid-19. So much of the risk was in older people, many of whom have multiple morbidities, frailty and dementia. People with learning/intellectual disabilities living in residential settings were also at high risk of becoming infected and from suffering severe outcomes from a Covid-19 infection. This was due to the generally higher rates of multiple morbidities than the general population. As is commonly known, the challenges posed by living in an indoor communal setting were also a factor, with the spread of infections occurring very easily in indoor environments due to the close personal care needs of residents. Another challenge was around the atypical presentation of infectious diseases generally within such a population. This was also the case with Covid-19, where residents did not necessarily exhibit the classic symptoms such as a cough rather confusion and being sleepier, among other things, were more common. This meant it

was more complex to understand in the care home population and there was a greater need to be vigilant.

283. SG records indicate that health and social care officials were considering the impact of the then novel Coronavirus within the social care sector in early February

2020, including in response to the Cabinet Secretary for Health's instruction to officials on 6 February 2020 to work with COSLA on preparing Coronavirus guidance for the sector.

284. Records indicate that there were concerns expressed about how any Coronavirusspecific overarching SG/COSLA guidance would interact with plans already in place or being prepared by Regional Resilience Partnerships [CL15/064A - INQ000591985]. Similarly, SG advice following the resilience event on 21 February 2020 [see para 136 above], indicated that the message coming from resilience partners was that they had established guidance and plans for a range of major incidents, including pandemic flu, with concerns around potential duplication. Nevertheless, there was reference to feedback from some social care providers in relation to practical advice on what they should do to prevent the spread of the virus and in the event of a service user or staff member presenting with symptoms. SG officials identified guidance for social care providers from Health Protection Scotland as a next step.

285. The pandemic guidance published by HPS on 12 March 2020 covered social care settings more broadly, rather than care homes specifically [CL15/065 – INQ000280632]. This guidance was based on the NIPCM and included advice on how to prevent the spread of all respiratory infections, including Covid-19, with settingspecific information and advice [CL15/064 – INQ000339585]. This guidance did not cover clinical considerations (such as alertness to symptoms, mitigation to manage the impact of isolation) but focussed on wider protection measures In response to requests from the ASC sector for care home specific guidance, such as those raised at the 12 March 2020 NCPG meeting [CL15/066 – INQ000589680], targeted clinical advice was prepared by the Scottish Government for the nursing home and residential care sector and circulated on 13 March 2020 [CL15/013A – INQ000280689].

286. A Ministerial submission of 11 March 2020 [CL15/067 – INQ000260648] was provided to the Cabinet Secretary for Health and Sport and set out the need for urgent guidance to support the sector. Scottish Government had been informed by Scottish Care that four large corporate care home providers were closing their

doors to new admissions and restricting visitors in response to the situation. It was advised that HPS had been asked to prepare urgent guidance for primary and secondary care.

287. A range of issues highlighted by the sector was set out, including: supplies, provider/service sustainability, costs of temporary services closures and self-isolation, workforce terms and conditions, and a presentation focus nationally and locally on NHS and not social care.

288. The SG Clinical Guidance of 13 March 2020 [CL15/013A – INQ000280689] was aimed at providing both advice and reassurance to the sector and was informed by and complemented the HPS advice which covered wider social care settings. The then Senior Medical Officer for Health and Ageing within CMOD, Professor Graham Ellis, led on drafting the guidance, with policy officials from the Community Health and Social Care Directorate providing administrative support, including seeking and collating comments on the draft for consideration by Prof Ellis and communicating the final guidance to the wider ASC sector. The need for advice to be published urgently inevitably limited the scope for consultation on the guidance with the wider ASC sector. Nevertheless, there was some engagement, albeit limited, with key stakeholders prior to its publication on 13 March 2020 (discussed above at paragraph 144).

289. The 13 March 2020 guidance [CL15/013A – INQ000280689] advised that longterm care facilities should be subject to 'social distancing' to reduce the risk of infecting residents and cases in this vulnerable group, which would operate at 2 levels, (i) reducing visits to care homes to essential visits, and (ii) social isolation in rooms.

290. The guidance was approved by the Cabinet Secretary for Health and Sport on 13 March 2020 [CL15/068 – INQ000250859]. The Cabinet Secretary for Health and Sport, when approving the issuing of the guidance, asked that the Cabinet Secretary for Communities and Local Government and the Minister for Older People and Equalities provide urgent advice on preparations and support for the elderly to avoid isolation and loneliness. Work was already underway at this juncture to define vulnerable individuals and communities and consider what support may be required and this continued throughout the pandemic.

291. The 13 March 2020 guidance [CL15/013A– INQ000280689] was sent to all IJB Chief Officers, Local Authority Chief Executives, IJB Chief Social Work Officers, Scottish Care, CCSP, the CI and SSSC by the Cabinet Secretary for Health and Sport. This guidance included advice relating to;

- Measures to prevent and prepare for infection in residents
- Visiting restrictions
- Social isolation requirements
- PPE and handwashing procedures
- Cleaning of communal areas
- Transitions from hospitals
- Anticipatory Care Plans
- Access to GPs
- Staffing levels
- Measures to mitigate the adverse effects of restrictions on residents.

292. This guidance was subsequently updated two further times on 26 March 2020 and 15 May 2020 provided [CL15/069 – INQ000429281], [CL15/070 – INQ000383486]) to reflect

- Updated HPS guidance on IPC
- Wider developments in understanding the nature of the virus and its likely impact(s)
- Ongoing consultation with stakeholders from the wider social care sector (including through participation in advisory groups).

293. Updated guidance included additional advice in relation to;

- Supporting staff and resident wellbeing
- Ensuring adequate staffing to ensure the safety and wellbeing of residents
- Updates on testing arrangements (following recent announcements on care home admissions and enhanced surveillance testing)

- Education and training
- The role of HSCPs, Local Authorities and territorial Health Boards in ensuring the care home sector was supported.

294. Further detailed explanation regarding the changes included made to the revised guidance issued on 26 March 2020 are set out at paragraphs 359 and 372 to 386, and in respect of the 15 May 2020 guidance, paragraphs 425, 426 and 831.

295. From April 2020, the CPAG, which comprised a range of health and social care stakeholders had a formal role to consider and review SG guidance for the sector. Further detail regarding CPAG is provided at paragraph 150 above.

296. The Inquiry has sought views on the extent to which multiple iterations and/or sources of guidance were consistent and/or confusing for the adult social care sector. As noted above, the Scottish Government Clinical Guidance for Care Homes was published following requests from the sector for care home specific guidance, with a greater focus on clinical considerations and the impact on care homes beyond heath protection and IPC procedures. It was both informed by, and complemented, HPS guidance published in relation to the wider social care sector.

297. The Scottish Government appreciates that changing guidance was, in itself, challenging for stakeholders, particularly for care providers. Understanding of the virus developed rapidly, particularly during the early stages of the pandemic, and a key Scottish Government priority was ensuring that the adult social sector was informed quickly of new developments and the implications this could have on the management of Covid-19 within care homes. There was also a need to respond to urgent requests from the adult social care sector for advice on specific issues. Changes could be announced through updating the main Scottish Government national clinical guidance for care homes, but it may also have involved the preparation of separate specific guidance documents or through Ministerial announcements or statements. The priority was to make sure that developments in understanding the virus were acted upon

quickly and the care home sector informed of the implications for them as quickly as possible.

298. From April 2020, wider engagement between Scottish Government and HPS – which became PHS – in relation to published guidance on care homes was formalised in two ways. First, as noted above, CPAG was established in April 2020 to provide clinical and professional advice on supporting the care home and adult social sector during the pandemic, including related guidance. Second, in June 2020, Scottish Government also put in place a formal review process for HPS/PHS Covid-19 guidance, referred to as the 'Policy Alignment Check' (PAC), which ensured consistency across the guidance publications. Further detail regarding PAC follows at paragraph 310 onwards.

299. From June 2020 onwards, Covid-19 guidance for social care was published by PHS, with Scottish Government publishing standalone detailed guidance for the sector on specific areas, as needed, for example in relation to face masks, care home visiting etc. Scottish Government also developed specific guidance around addressing elements of care home life, for example at Christmas time, that were not covered in PHS guidance. These continued to be co-developed with stakeholder representatives through CPAG. HPS (subsequently PHS) were the lead public health agency responsible for developing COVID public health guidance including for the health and social care sector. The reason why the Scottish Government developed Covid guidance for care homes from March – May 2020 was because the sector required more detailed clinical advice for care home settings beyond that which HPS had provided. As the pandemic progressed PHS started to develop specific Covid guidance for care homes. As a result the SG clinical guidance on care homes was no longer required, with the 15 May 2020 SG Guidance the last iteration published [CL15/070 – INQ000383486].

300. As noted above, SG continued to have responsibility for some guidance which supplemented PHS guidance. This included care home visiting as there was a need to outline in more detail the approach and practical steps required by care homes to support safe visiting. However, the high-level approach was reflected and

referenced in PHS guidance with links provided to the SG visiting guidance to enable more

detailed understanding of the steps required to implement. PHS can provide copies of all guidance it published for the ASC sector.

301. During the pandemic, a specific Scottish Covid-19 Care Home IPC Control Addendum (Covid-19 Addendum) was published on 16 December 2020 to provide further guidance and support for adult care home settings. This provided guidance on a single platform to improve accessibility. The Addendum stated that "*When an organisation adopts practices that differ from those recommended/stated in this national guidance, that individual organisation is responsible for ensuring safe systems of work, including the completion of a risk assessment(s) approved through local governance procedures.*"

302. The Covid-19 Addendum covered matters including:

- Covid-19 case definitions and tirage questions
- Resident placement/assessment of infection risk
- Hand hygiene
- Respiratory and cough hygiene
- PPE - including face mask use for staff, visitors and residents, Aerosol Generating Procedures, Post AGP Fallow Times and sessional use of PPE
- Safe management of care equipment, the care environment, linen, blood and body fluid spillages and safe disposal of waste
- Occupational safety (including car/vehicle sharing for staff)
- Physical distancing
- Resources and tools
- Compendium of additional IPC resources

303. As set out by HPS [CL15/071 – INQ000591972], the Covid-19 Addendum was updated on 25 January 2021, 31 March 2021, 8 July 2021 and 31 August 2021 to

reflect latest guidance regarding matters such as; international travel isolation, the Acute Addendum, the introduction of the 14 day isolation period, Visiting Guidance (including 'Open with Care'), additional resources, changes to testing and self-isolation guidance. On 29 November 2021, the Covid-19 Addendum was replaced by Version 1.0 of the Respiratory Addendum. ARHAI Scotland are responsible for the production of these documents and therefore we would suggest that the Inquiry approach AHRAI directly if they have detailed questions regarding the development of, and any updates made to, the Covid-19 Addendum.

304. The Covid-19 Addendum focussed on IPC practices specific to Covid-19 and it was agreed that the guidance and language contained in the NIPCM needed to be attuned to ASC settings, to support the future and 'business as usual' implementation of IPC and cleaning practices within care homes. In response to these concerns, a care home specific manual and cleaning specification were developed by ARHAI Scotland – in conjunction with extensive stakeholder engagement (including consultation with care homes).

305. The NIPCM for Older People and Adult Care Homes ('the Manual') and the National Cleaning Specification for Older People and Adult Care Homes ('Cleaning Specification') were published on 24 May 2021 and circulated by the CNO and Scottish Government Director of Mental Health and Social Care [CL15/072 – INQ000510054]. The information contained in the Manual was based on the same principles and evidence base as the NICPM; however, the language and context were updated to provide clear and practical advice relevant for adult care home settings – the manual also reflected and linked to Standard Infection Control Precautions as the basic IPC measures necessary to reduce the risk of transmission of microorganisms from both recognised and unrecognised sources of infection. This was set out in the letter of 24 May 2021 which stated that the Covid-19 Addendum was "*published to provide further guidance and support for adult care home settings in response to Covid-19. The Covid-19 Addendum focusses on infection prevention and control (IPC) practices specific to Covid-19 and it was agreed that, the guidance and language contained in the NIPCM needed to be attuned to adult social care settings, to support the future and 'business as usual' implementation of IPC and cleaning practices within adult care homes, which as you know are first and foremost in people's homes. In*

response to this the Manual and Cleaning Specification were developed by ARHAI in conjunction with extensive stakeholder engagement, including consultation with care homes."

306. The 24 May 2021 [CL15/072 – INQ000510054] letter also explained that "to *ensure consistency of practice, during ongoing community transmission of Covid-19, care homes should continue to follow the guidance contained in the Care Home IPC Addendum (Covid-19 Addendum). The Covid-19 Addendum will continue to be mandated for adult and older people care home settings. The reason for this is the Covid-19 Addendum is disease specific policy and guidance which stipulates control measures over and above those that are contained within the Manual, to specifically respond to Covid-19. Therefore, the Covid-19 Addendum has the most appropriate guidance to manage the transmission risk while within the pandemic."*

307. As noted above, the letter of 24 May 2021 [CL15/072 – INQ000510054] stated that both the Manual and Cleaning Specification were mandatory for all HSC staff working in care homes and that the aim of both documents was ease of use by care home staff to support the application of effective IPC precautions (including best practice cleaning processes), to reduce variation and optimise IPC and cleaning practice throughout Scotland, to reduce the risk of infections and to align practice, monitoring, quality improvement and scrutiny. As set out in a further joint letter from the CNO and Director for Mental Health and Social Care Directorate to territorial Health Board Chief

Executives and Nurse Directors on 24 May 2021 provided [CL15/072A – INQ000222892] regarding 'Oversight arrangements and funding allocations for nursing support for care homes' the, "*Manual addresses IPC requirements (which are not specific to Covid-19) for older adults and adult care home settings and will be mandatory for implementation in older peoples and adult care homes. It is aligned to the evidence based NIPCM and the Care Inspectorate will use the Manual when undertaking inspections in adult care homes. It is expected that during ongoing community Covid-19 transmission – the Covid-19 IPC Addendum plus the Manual will be used by care homes. Care homes will continue to need support in relation to IPC to manage Covid-19; and will also need support to effectively implement the Manual, and to fully embed IPC best practices within the care home setting."* The Manual was used

for the basis of inspections as it was not solely focussed on Covid-19 specific IPC measures.

308. Workshops were run for care providers and those that support care homes on the NIPCM and focussed on the environment and cleaning. The CI was involved in facilitating these workshops, alongside ARHAI and others. Prior to this, in May and June 2021, there were four regional events which the CI participated in, which were facilitated by NES about the launch of the cleaning specification. CI and ARHAI may be able to provide further details of training materials used during these workshops and post-workshop assessments.

309. In May 2020, the CI subsequently included further questions to Quality Framework for Social Care (for care homes for adults and older people) which asked views regarding the quality of care provided during the pandemic and the IPC measures put in place [CL15/072B – INQ000510070].

Policy Alignment Check Process (PAC Process)

310. Prior to June 2020, no formal Scottish Government approval, including that from Ministers, was required to changes to the HPS guidance. As an independent authority, HPS approved all changes to its guidance. Scottish Government were consulted on proposed changes to HPS guidance, offering an opportunity to comment and/or express views on the changes being proposed.

311. In June 2020, at the request and approval of the Cabinet Secretary for Health and Sport, the Scottish Government put in place a process for the formal review of changes to guidance – the PAC process. A wide range of guidance was issued and played a significant role throughout the pandemic. It was critical that it was both aligned to and clearly reflected Scottish Government's rapidly evolving policy. This was of particular importance owing to the role it played in ensuring societal compliance with the range of non-pharmaceutical measures to delay or mitigate the spread of the Covid-19 virus.

312. General guidance review requests from the Scottish Government to HPS/PHS were not part of the PAC process. Given the volume of guidance developed and updated routinely and frequently by HPS/PHS, the majority of which involved only minor changes, it was not expected that every guidance change be subject to the full PAC process and minor changes could be confirmed as exempt. The PAC process was intended to ensure that the most current policy position was captured accurately

in guidance before its publication, acknowledging the potential impact of conflicting or out-of-date public health information.

313. The steps undertaken by both the Scottish Government and HPS/PHS colleagues as part of this agreed assurance process ensured clarity in public messaging and confirmation that HPS guidance was aligned with, and correctly interpreted, Government Covid-19 policy. The PAC process was not implemented to duplicate existing HPS governance/editorial change control measures already in place or to challenge HPS professional health protection advice. It also recognised that responsibility for policy resided with the Scottish Government, and that professional public health/health protection guidance was the domain and responsibility of HPS.

314. The flow chart provided [CL15/073 – INQ000509925] outlines the procedures followed within Scottish Government when guidance was received from PHS to be reviewed through the PAC process.

PHS feedback on the Policy Alignment Process

315. The Inquiry has asked about the extent to which the Scottish Government agrees or disagrees with Professor Nick Phin's view that the PAC process "*could have been improved by direct access to key decision makers at the point advice was being sought or when policy was being developed…because what might be considered straightforward or easy to do at a policy level may be challenging or unworkable at an operational level because of lack of awareness of roles and responsibilities and context*" [CL15/074 – INQ000339576].

316. In response, the PAC process was a final assurance check to ensure full alignment of PHS guidance with rapidly changing Scottish Government policy. There was close consultation between Scottish Government policy teams, senior medical officers and PHS officials before any new guidance or amendments to existing guidance were agreed and sent to the Cabinet Secretary for Health and Sport for the final assurance check. This final review by the Cabinet Secretary did necessarily add some additional time before publication of guidance, dependent on the Cabinet Secretary's workload.

Additional support for the ASC sector – 21 April 2020

317. On 21 April 2020, the Cabinet Secretary for Health and Sport set out to the Scottish Parliament further steps, in addition to expanded testing, that were being taken to support care homes in order to; provide additional assurance, oversight and support to prevent the ingress of infection into care homes, the reduction in transmission, the effective management of Covid-19 outbreaks and wrap around support for the sector [CL15/075 – INQ000147429]. At this time, there were no vaccines and only limited therapeutic options available to mitigate the impact of infection and it was recognised that there was a need for continued collective action to support care homes in this early phase.

318. The steps set out in the statement built on the initial experience of implementing measures to support care homes and the wider social care sector and referenced work already commenced (for example DPH support for care homes, PPE and testing support). It was also informed by a 'Deep Dive' on care homes led by the then First Minister on 14 April 2020 [CL15/076 – INQ000509954], which brought together key government officials and external stakeholders to discuss ways to ensure the safety and wellbeing of care home residents and staff. Further detail regarding the 'Deep Dive' is provided at paragraph 884 onwards.

319. The statement set out the enhanced leadership and oversight role for DPHs around the safety and wellbeing of care home residents and staff, building on the important role that DPHs were already providing in discharging their statutory

duties to protect and improve the health of people living within their geographic area. The enhanced role provided for DPHs and health protection teams to work with local IPC Teams, the CI, primary care teams and others to oversee the provision of local support and assurance to all care homes. The package also provided for an assessment around care home adoption of and training on IPC measures, staffing levels, use of testing and weekly reporting to Scottish Government around these areas.

320. On 17 April 2020, the Scottish Government's DG HSC wrote to Chief Executives of territorial Health Boards with a request from the First Minister and Cabinet Secretary for Health and Sport that DPHs take immediate action to deliver an enhanced system of assurance around the safety and wellbeing of care home residents and staff [CL15/077 –INQ000509955]. A follow-up letter on 20 April provided more details around the nature of direct contact with care homes and visits on a risk prioritised basis as well as testing arrangements for workers [CL15/078 – INQ000363375].

321. The 21 April 2020 statement also referred to the enhanced assurance role for the CI across the country, including greater reporting powers [CL15/075 – INQ000147429]. This was in relation to the introduction, on 3 April 2020, of enhanced reporting activity taking place through the CI's RAG system capturing more data and working with DPH locally in their leadership role to support care homes. Further detail regarding the changes to inspection and assurance activity is set out at paragraphs 883 to 899.

322. It was recognised that swift collective action was required to support care homes for whom the impact of the pandemic was particularly acute in the early phase. The role of the CHRAG was particularly important in bringing together stakeholders to understand the impact on the care home sector and the collective support required to respond to need. This involved developing and reviewing bespoke data collection mechanisms, including the DPH weekly returns and CI data, to fully understand the challenges, which enabled national and local partners to provide direct tailored support to the sector.

323. The additional steps around PPE referred to in the 21 April 2020 statement related to the delivery of a top-up supply of PPE provided directly to around 1,100 Adult Care Homes between 18 – 23 April, prioritising those with known outbreaks, and increasing access to NHS PPE to care homes [CL15/075 – INQ000147429]. This built on existing PPE provision from the national stock which was provided free of charge for top-up and emergency provision for social care support needs where normal supply routes were unsuccessful.

324. The Inquiry has asked specifically about the concerns raised by the Chief Executive of Scottish Care with the Cabinet Secretary on 18 March 2020 relating to issues such as PPE, testing, workforce recruitment and related issues; and whether these concerns should have been addressed in advance of the 21 April 2020 statement.

325. As noted above, the 21 April 2020 statement provided an update to the Scottish Parliament on recent activities that were underway or planned on issues such as PPE, workforce recruitment, oversight and assurance and which built on the support already being provided to the ASC sector on these issues [CL15/075 – INQ000147429]. The Scottish Government was aware of concerns in the areas specified through its wider engagement with stakeholders from across the adult social care sector in Scotland and had introduced measures to address them from the very early stages of the pandemic. For example, the decision to provide care providers with PPE through the local PPE Hubs was taken in mid-March 2020, with the Hubs going live on 19 March 2020. Similarly, the Scottish Government Guidance on Care Homes of 13 March 2020 and 26 March 2020 contained detailed guidance and support to the sector in relation to a wide range of key issues raised by the sector in the early stages of the pandemic [CL15/013A – INQ000280689], [CL15/069 – INQ000429281]. The Scottish Government was also intensively engaged with stakeholders to address concerns relating to workforce capacity and recruitment and retention over March-April 2020.

March 2020 Discharge Policy

326. The Scottish Government did not make decisions on whether or not hospital patients should be discharged. Each individual decision about whether, and when, a patient is ready for discharge is a clinical one, made by the clinician in charge of that patient's treatment, typically once the patient has met particular clinical criteria agreed in advance by their consultant. This remained the case throughout the pandemic.

327. Scottish Government and HPS guidance for care homes during this period reflected the fact that there was no reliable test available for pre-symptomatic or asymptomatic patients. International guidance at that period was clear that testing of all hospital discharges was not a sensible use of capacity whilst testing was still being expanded. For example, on 8 April 2020, the European Centre for Disease Prevention and Control updated its Technical Report, which stated that "provided there are

sufficient resources, there is clear benefit in testing asymptomatic patients before they are released from isolation. However, in the context of limited resources for healthcare and laboratories during the Covid-19 epidemic, the testing of symptomatic patients should have priority over the testing of asymptomatic patients before release from isolation" [CL15/079 – INQ000509962]. Further details regarding understanding of asymptomatic transmission at that juncture is provided at paragraph 754 to 771 below.

328. Where someone was most appropriately cared for after discharge was (and is) based on a multi-disciplinary assessment involving the individual and their family and carers. In cases where a patient lacks capacity to make decisions in relation to their care, an appointed guardian or carer with power of attorney will be involved. If somebody is discharged to a care home, it is because that has been assessed as the best place to meet their needs.

329. Guidance to aid clinical decision-making in Scotland from early March 2020 was developed through the Clinical Guidance Cell, terms of reference provided [CL15/080 – INQ000326414]. The Clinical Cell had begun that February as a group of physicians in the field of Infectious Diseases discussing how to deal with cases of Covid-19. Membership was drawn from key organisations and professional communities across Scotland and included representation from the Academy of Medical Royal Colleges and Faculties in Scotland. This group of senior clinicians worked to produce guidance rapidly to support clinical decision-making on the management of Covid-19. The

Scottish Government facilitated this group by providing secretariat support, and the DCMO and Deputy National Clinical Director (NCD) attended.

Delayed Discharge

330. As set out above at paragraph 229, reducing delayed discharge has been a longterm policy aim of the Scottish Government and the other UK administrations. Delayed discharge occurs when a hospital patient, who is clinically ready for discharge from inpatient hospital care, continues to occupy a hospital bed beyond the date they are ready for discharge. Any delay in discharge can have a detrimental effect on a person's health and wellbeing. Timely discharge is an indicator of quality care and demonstrates that care is effective, person-centred and harm free. Reasons for delayed discharge are varied but can include:

- A lack of care or services in the community (such as place in a care home or the need for at home modifications)
- Complex care needs – such as a lack of capacity to make decisions about future health and care
- Slow hospital discharge processes
- Limited capacity in out-of-hospital care.

331. In 2010, an Expert Group on delayed discharge was established to produce a report and recommendations, which subsequently formed the basis of policy and guidance thereafter, report provided [CL15/081 – INQ000547933]. The report found that the cause of delays could be split into the following five broad categories, with a degree of interdependency

- Pathways: Too many people were admitted to hospital when there could be safe and effective viable alternatives; too many people were moved inappropriately around the hospital system; too many people remained in hospital because there was a perceived risk in discharging them.

- Process: This, the report noted, might include all delays in assessment as well as issues such as Adults with Incapacity. Process delays were compounded by system problems.

- Systemic: The patient who is in hospital is considered to be "safe" and ceases to be a cause for concern and focus for community staff who move on to the next crisis, reducing the priority of patient discharge.

- Capacity: This would include patients delayed awaiting care home availability (although data suggested this may in some areas have been driven by flawed process rather than a local lack of provision), care at home capacity or access to specialist services, such as younger adults with brain injuries.

- Resources: There had been a growing number of patients delayed awaiting funding. However, this had the effect of transferring cost to the NHS where the cost of inpatient care is far greater. This, the report concluded, was not a good use of scarce public resources.

332. The main practical conclusions of the report were that the following factors were key to reducing delays:

- Strong leadership and ownership of the agenda at all levels across all of the partner organisations with accountability by a senior executive who is in a strong position to challenge performance and practice.

- Estimated Date of Discharge (EDD) routinely set and discharge planned from the point of admission (or before) with the norm being discharge within hours and days of readiness rather than weeks.

- A personal outcomes approach that tackles every delay, every day and uses data to examine performance and challenge causes of variation.

- A 'whole system approach' that offers appropriate community alternatives to hospital admission, frailty screening to prompt early specialist geriatric assessment

and assertive management of risk by senior decision makers who 'decide to admit' rather than 'admit to decide'.

- Active participation by patients and their carers ensuring that they understand and are able to contribute as appropriate to care delivery and discharge planning, including use and sharing of Anticipatory Care Plans.
- Staff work within an integrated multi-disciplinary and multi-agency framework and use joint Admission, Transfer and Discharge Protocols that clearly set out local processes for assessment, discharge and provision of community services.
- A named person with responsibility for co-ordinating all stages of discharge planning throughout the 'patient journey' including engagement with housing.
- Effective use of transitional and intermediate care services including step down beds and community hospitals so that acute hospital capacity is used appropriately and individuals achieve their optimal outcome.
- Acute hospital is not the optimum setting for assessing an individual's need for long term care and support so, unless unavoidable, no-one should move directly from an acute bed to a long-term care home placement.
- Adoption and communication of a culture of 'Home First' as a default position - wherever possible and safe, patients return to the home they were admitted from and only explore alternatives if this is not possible.

333. The recommendations in the report were categorised as being for local partnerships or for national implementation. The five recommendations relating to national implementation (and therefore directly for the Scottish Government) were that the Scottish Government should work with NHS Scotland Information Services Division (ISD), territorial Health Boards and local authority partners to:

- Raise the profile of Complex Case Delays by taking an annual report to the NHS Scotland Chief Executives Group and to SOLACE, setting out the human and financial costs of these delays, opportunities and progress in reducing such delays;

- Ensure clarity in the use of appropriate codes in ISD Delayed Discharge Census to reflect new plans and expectations for individuals experiencing delays;
- Map delays coded as awaiting specialist services, and review current use of out of area placements or national resources;
- Highlight/publicise information where shared services are being developed and offer support to local partnerships to link local data. Identify and promote good practice tools and approaches;
- Provide support, through the Joint Improvement Team to facilitate peer visits between local complex delay management groups as appropriate.

334. The nine recommendations for local partnerships related to:

- Partnership commitment to minimising delayed discharge
- Focusing on individual outcomes
- Identifying which individuals are affected
- Monitoring performance against target timescales
- Improving systems to optimise flow
- Comparing performance with others

Engagement regarding delayed discharge

335. Scottish Government played a role in supporting the development of related guidance and in making broad strategic requests for reducing delayed discharges –

i.e. asking that HSCPs work to address delays in discharging those assessed as clinically fit – rather than offering nationwide instructions on the discharge of hospital patients to care homes in particular.

336. At the Health and Social Care Management Board (HSCMB) meeting on 22

January 2020, it was noted that delayed discharge figures were "reported as being the highest in four years" and work was underway with IJBs to ensure reductions in these figures, minute provided [CL15/081A – INQ000273991]. In the next HSCMB meeting on 29 January, a written update from the 20 January meeting of the National Performance Oversight Group was tabled, provided [CL15/081B -INQ000326481]. This update covered national performance in relation to key ministerial priorities, including delayed discharges, which, as noted verbally in the 22 January HSCMB meeting, were higher than in previous years (based on the weekly figures from 8 and 15 January 2020).

337. To address this situation, officials from the DGHSC's Integration Division arranged conversations with individual HSCPs to discuss what challenges they were facing in reducing delays in the discharge of patients clinically assessed as ready for discharge.

These individual conversations were held in late January 2020 between a SG Director and representatives from the ten HSCPs known to have the highest numbers of delayed discharges. This work, which was not part of the pandemic response but instead an initiative similar to those conducted in previous years aiming to address high delayed discharge figures that winter, also involved the issuing of individual letters to Chief Officers of HSCPs by Malcolm Wright on 17 February 2020 [CL15/081 – INQ000547933]. These letters sought to summarise the particular challenges faced by those HSCPs based on the conversations which had been held, to suggest provisions or approaches that had worked elsewhere, and to establish what support from SG would assist each specific HSCP.

338. Barriers to timely discharge raised by HSCPs varied across the ten partnerships, but those raised by at least two HSCPs included increases in referrals for social care assessment in their area, complex assessment delays, delays in the guardianship process for Adults with Incapacity and, in the case of two large rural areas, a lack of care home capacity and difficulties with staff recruitment and/or retention. Scottish Government analysis also identified an issue with timely discharge over weekends, with most discharges occurring in practice between Mondays to Fridays, analysis provided [CL15/082 – INQ000620239].

339. There were three main approaches that the Scottish Government sought to encourage in order to address the most common reasons for late discharge at this point in early 2020. Firstly, promoting a multi-agency approach to working across health and social care systems to reduce unnecessary prolonged stays in hospital through Home First (where an initial, short risk assessment takes place prior to discharge, to be followed by a more comprehensive risk assessment carried out at home or in a homely setting) and Discharge to Assess (which focuses on older people in hospital with complex needs where the assessment of their long-term needs can be carried out at home or in a homely setting after discharge, mitigating the known risks to older people associated with prolonged hospital stays). Secondly, encouraging seven-day working, in recognition of the fact that very few discharges were occurring over weekends, leading to batching of referrals to social work that could in turn cause unnecessary increased pressure on social care to assess and secure care packages.

Thirdly, enhanced provision of Intermediate Care Services, a suite of services provided to patients, usually older people, after leaving hospital or when at risk of being sent to hospital, offering a link between hospitals and people's homes and between different areas of the health and social care system, including community services, hospitals, GPs and social care services. A successful integrated service facilitates more people being cared for at home or in a homely setting, reducing unnecessary hospitalisation and supporting timely discharge.

340. Attached to the 17 February 2020 letters was a 'driver diagram' setting out requirements or components that needed to be in place to achieve the aim of reducing delayed discharges (e.g. care at home capacity, intermediate care options, and accurate, shared data) [CL15/083 – INQ000509914]. This was followed by a set of real-life examples from specific HSCPs that had been successful in implementing initiatives or models that supported timely discharge or the prevention of unnecessary hospital admission [CL15/081 – INQ000547933].

341. On 4 March 2020, the Cabinet Secretary for Health and Sport met with COSLA representatives, including their spokesperson for health and social care, together

with SG officials from the Directorate of Community Health and Social Care, to discuss what was described in a note of the meeting as, "the urgent need to minimise hospital bed occupancy arising from delayed discharges in order to prepare for the anticipated peak in COVID-19 cases in the next 3–4 weeks" [CL15/084 – INQ000509926]. Reductions in delayed discharges were agreed in that meeting as a joint priority for

COSLA and SG (confirmed in these terms within a note sent up from the Cabinet Secretary for Health and Sport to the FM) [CL15/085 – INQ000509927]. It was agreed that communications to local systems would be issued "to help mitigate the situation in terms of our capacity to respond", citing the need to relieve pressures in acute settings by releasing beds used by those already clinically assessed as ready for discharge [CL15/084 – INQ000509926]. The following day, the Cabinet Secretary for Health and Sport met with the Chief Officers of the Edinburgh and Dundee Health and Social Care Partnerships, in their capacity as Chair and Vice Chair of the Chief Officers' network, again discussing the need for rapid actions on delays and discussing how best to engage HSCPs.

342. On 6 March 2020, the then DG Health and Social Care, Malcolm Wright, wrote to the Chief Officers of HSCPs, with CEOs of territorial Health Boards and local

authorities in copy, to request that they take urgent steps to reduce the numbers of delayed discharges, provided [CL15/086 – INQ000470123]. The specific request was to reduce the overall Scottish delayed discharge position by 400 (from 1650 to 1250) by 9 April 2020. The CEO for NHS Scotland explained in a paper on NHS Scotland surge capacity for the Planning and Assurance Group prepared the same day, on 6 March, that "delayed discharges are at the highest level for several years at 1650", further noting that, "[w]e have factored in a reduction of 400 delayed discharges at this time to our planning assumptions on additional bed capacity [and] will be working with IJB partners to receive [sic] this reduction (and more) over the next 2/3 weeks" [CL15/087 – INQ000509928]. The letter communicating this target was concerned with reducing delays in the discharge of clinically ready patients generally, rather than with the discharge of patients from hospitals to residential care settings specifically, but it did acknowledge that the availability of care home places was a particular

structural limitation contributing to existing delays to patients being discharged in a timely way, as was care at home provision.

343. The Scottish Government understood from its regular engagement with HSCPs and, most recently and pertinently, from its specific communication with partnerships in January and February 2020 on the subject of factors preventing timely discharge that support for the ten HSCPs with the highest levels of delayed discharges would need to take into consideration their particular circumstances. The 6 March letters therefore again sought to understand the barriers to reducing delays that were specific to each individual HSCP, albeit in a whole-system context (and in the context of the pandemic). At the point of sending the letters, the Scottish Government was aware of key factors identified in January discussions as contributing to delays, including the availability of care home places and the recruitment and retention of care at home staff. It was understood that these factors would still be applicable in March 2020.

344. The principal reason identified as affecting timely discharge at the January census had been delays in establishing care arrangements to allow people to go home, followed by care home place availability and assessment delays. Some reasons for delays were outside of the partnerships' direct control, mainly either 'Code 9' complex cases (which primarily relate to Adults with Incapacity but which also may denote

where particular specialist services are needed that do not exist in the partnership area) or, in a small number of instances, patient/family/carer reasons.

345. The 6 March letter listed five key factors affecting timely discharge that would affect multiple HSCPs' ability to address delays, namely the legislative arrangements on Adults with Incapacity; availability of care home placements and care at home provision; financial resources; Choice of Accommodation protocols (whereby individuals and their carers should be able to exercise choice over their accommodation after being assessed as requiring care); and public messaging.

346. Three weeks later, a letter was issued by Malcolm Wright on 27 March 2020 to Chief Officers, CEOs of territorial Health Boards and CEOs of Local Authorities

acknowledging the efforts made to achieve the reduction in the number of delayed discharges set out in his letter of 6 March 2020 [CL15/088 – INQ000470124]. Numbers at that point had been reduced by over 400. A further request was made in this letter to reduce delays by an additional 500 by the end of April 2020. The letter referenced the monitoring information being provided to Information Services Division (ISD, now part of PHS) by territorial Health Boards on a daily basis and referenced recent communications requesting details of new initiatives, as well as pressures across the system. The method of communicating both the 6 and 27 March requests via letters from Malcolm Wright, the then DG HSC, built on the engagement work carried out earlier in 2020 to identify barriers faced by individual HSCPs preventing timely discharge of clinically ready patients. The latest SAGE data was used to model the potential impacts on the NHS and social care sector, as discussed at SGoRR(M) on 9 March 2020 – minute and papers provided [CL15/089 INQ000510039]. This meeting provided Ministers with an overview of the interventions proposed when moving from the 'Contain' to the 'Delay' phase. SAGE's advice was that the response would need to soon move from contain to delay. SAGE presented illustrative impacts of social and behavioural interventions lasting several months on the a 'Reasonable Worst Case' epidemic – which predicted a peak during April to May. SAGE advised that vaccines were unlikely to be available until early 2021. SAGE advice also outlined potential impacts on public services – for example, SAGE advised that workforce shortages would mean reduced ASC provision (e.g. fewer visits) and the need to prioritise cases at peak. SAGE advised that there could be a risk of providers' (home care) financial collapse. The advice also outlined the additional impacts of the advised interventions (for example, risk of reduced access to primary care, community and pharmacy services; mental health and loneliness due to limited social contact; risk of household transmission; and risk to patients with dementia of a permanent loss of skills from reduced contact and care.

347. Based on their understanding at the time, SAGE's advice was that implementation of two measures (self-isolation and household isolation) would need to begin by the end of the following week to maximise the effectiveness of both measures, with a decision required by 11 March 2020. SAGE advised that individual and household isolation would reduce pressure on the NHS and other services by

delaying and flattening the peak (which would delay the peak when the NHS in each nation is out of winter pressures and the reduction in size/flattening of the peak would allow the response to be managed more sustainably by the NHS and other sectors). It was outlined that a third measure (social distancing for the over 70s and the most at risk) could be introduced later.

348. The Cabinet Secretary for Health and Sport's paper to the Scottish Cabinet on 10 March 2020, "Emerging Evidence to Inform the Covid-19 Response" [CL15/090–INQ000238822] set out steps being undertaken to explore increased capacity (i.e. securing private sector capacity and non-clinical provision) and deploy a wider healthcare workforce. The paper outlined that the HSC workforce was likely be impacted by staff absences, and, whilst it was difficult to model, noted that, "*officials are currently using a 30 per cent projection to factor in both Covid-19, existing illness rates and caring responsibilities.*" An assessment of the week-by-week impact on mitigation measures to alleviate the peak period of attack was being prepared at this point.

349. Mobilisation plans were formally requested by the Chief Performance Officer, John Connaghan, following a meeting of territorial Health Board Chief Executives on 11 March 2020, also attended by the Cabinet Secretary. At the meeting, a paper was presented summarising the information on factors affecting timely discharge gathered during the January/February work. Papers and minutes are provided [CL15/091 – INQ000620240], [CL15/092 – INQ000592025]. As in the February letters, approaches

like Home First/Discharge to Assess and working in partnership to deliver effective intermediate care services were highlighted as important tools in reducing delays.

350. After the meeting, the COO wrote to this group, copying in local authority Chief Executives and Chief Officers of IJBs, requesting that each provide a Local Mobilisation Plan (LMP) setting out preparedness for Covid-19 by 18 March 2020 [CL15/093 – INQ000326477]. Besides other aspects such as increasing ICU capacity and bed capacity, the plans were to cover how territorial Health Boards were working with local partners to reduce delayed discharges. It was also requested that LMPs

include an initial estimate of the costs expected to be incurred in staff, training, equipment, supplies etc. As the mention of financial resources in the 6 March letter indicated, the Scottish Government was aware that extra funding would be important in supporting the response.

351. The COSLA National Contingency Planning Group (NCPG) met on 12 March 2020 [CL15/066 – INQ000589680] to discuss a coordinated approach to responding to Covid-19 issues. The Health and Social Care Planning and Assurance Group met regularly and a Covid-19 H&SC Surge Team was established to develop surge policy and delivery related to how NHS Scotland and broader health and social care services may be impacted and how NHS will respond. Having received and read the LMPs, SG officials conducted follow-up discussions on 23–24 March with Chief Executives and their senior teams in the fourteen territorial health boards, leading to revised LMPs being developed and submitted. The initial plans from boards outlined a variety of measures being utilised or planned for supporting a reduction in delays, including increasing care at home provision, redeployment of staff, mobilising volunteer networks, increasing care home capacity, and bolstering community support/provision [CL15/094 – INQ000591975].

352. A subsequent request was made to HSCPs for additional detail on the community services aspect of mobilisation planning, leading to the sharing of plans specifically from HSCPs that covered, amongst other things, care at home provision, plans for the implementation of Home First/Discharge to Assess, engagement and mobilisation of the voluntary sector and community organisations across communities to support people in their own homes.

353. A submission shared with the Cabinet Secretary on 7 April 2020 summarised these plans and an accompanying financial analysis, which noted that HSCPs were "*indicating that they expect to purchase approximately 1200 care home beds, commission approximately 400 community hospital beds and 235 intermediate care beds to deliver increased capacity across Scotland as well as substantially increased levels of care at home*". In relation to the funding bids set out in the plans, the Cabinet Secretary was invited to "*approve initial allocations at*

no higher than the upper quartile in order to enable Partnerships to progress implementation, noting the further detailed conversations that require to occur with those Partnerships outwith the quartiles".

[CL15/095 – INQ000591979].

354. A letter was subsequently sent from the Cabinet Secretary to Chief Officers of HSCPs on 9 April approving the plans in principle and asking that they engage with officials so that the appropriate funding could be allocated on the basis that additional expenditure was clearly set out, understood and appropriate to deliver the plans [CL15/096 – INQ000591977].

355. Scottish Government clinical guidance to care homes – first published on 13 March 2020 [CL15/013A – INQ000280689] and updated on 26 March [CL15/069 – INQ000429281] and 15 May 2020 [CL15/070 – INQ000383486] – included guidance relating to care home admissions, and transitions from hospitals. The guidance drew from HPS guidance and was updated to reflect greater understanding and knowledge of the virus and its impacts.

356. On 13 March 2020, the Cabinet Secretary for Health and Sport wrote to IJB Chief Officers, Local Authority Chief Executives, Chief Social Work Officers, provider representative organisations (Scottish Care, CCPS) and regulators (CI and SSSC) to provide the guidance. The letter stated that, "*The long term care and residentia care sector is vital to the wider health and social care system. It is essential that it continues to function in an effective way so that people and communities are supported in the right way. It also in some cases provides a safe alternative to more acute settings, including hospital care. It is therefore imperative that care homes continue to take admissions if it is clinically safe to do so.*" Annex A to the letter provided clinical guidance issued by the CMO on 13 March 2020 [CL15/013A – INQ000280689].

"Transitions from hospital

There are situations where long-term care facilities have expressed concern about the risk of admissions from a hospital setting. In the early stages where the priority is

maximising hospital capacity, steps should be taken to ensure that patients are screened clinically to ensure that people at risk are not transferred inappropriately but also that flows out from acute hospital are not hindered and where appropriate are expedited."

357. At this time, there was not sufficient testing capacity to test all patients prior to discharge from hospital (as of 18 March, capacity per day was 780 PCR tests across three NHS labs in Scotland). See further, paragraph 693.

358. This guidance [CL15/013A – INQ000280689] specifically stated that where a longterm care facility had 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. The guidance advised that residents should stay in their room as much as possible, with meals to be served in rooms (where possible). The guidance advised that communal activities should be reduced by 75%. The guidance also included advice regarding visiting (which is discussed in detail later in this statement at paragraph 811 onwards). This guidance reflected the SAGE advice (above at paragraph 347) that older, more vulnerable populations should be protected by social distancing as described at that point in time. 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.

359. Version 1.2 of the guidance, issued on 26 March 2020, recommended all admissions to care homes be isolated for 7 days and, if known to have contact with Covid-19 patients, for 14 days [CL15/069 – INQ000429281]. Clinical decisions around discharge and risk assessments were undertaken locally by health and social care professionals, and paid particular attention to the needs and rights of the patients.

360. As per CMO advice, the 7-day isolation period in place at this point was a precaution aimed at reducing the risk that someone who was screened clinically as symptom-free prior to discharge from hospital and without contact with another

case could be incubating infection that might emerge in the days following their discharge. It was hoped that this would prevent residents with latent or incubating infections from mixing with other residents until it became clear that they were not going to develop symptoms. This aspect of the guidance therefore represented the main way in which care home providers with residents who had been discharged from hospitals could be reassured as far as practicably possible that in the absence of widespread and reliable testing, the risk to other residents and staff from infections not picked up during clinical screening at the point of discharge was minimised.

361. The letter of 13 March 2020 from the Cabinet Secretary for Health and Sport to social care providers, IJB Chief Officers and local authority Chief Executives accompanying the guidance [CL15/013A – INQ000280689] explained that the COSLA National Social Care Contingency Planning Group had met that week to discuss additional support for the social care sector being taken forward by local and national partners, namely actions on:

- Changes to regulatory scrutiny
- Changes to local authority duties to assess
- Changes to workforce registration requirements
- Redeployment of staff
- Steps to ensure access to supplies for social care providers
- Workforce terms and conditions
- Commissioning and procurement
- Process for monitoring the situation.

362. Financial support was not offered directly from the Scottish Government to individual care homes in connection with the 13 March advice, but specific grants were offered to HSCPs at this time where funding was the major barrier to implementing wider mobilisation plans (e.g. by 14 March, a million pounds had been granted to the Edinburgh City HSCP, whose mobilisation plan was, as set out in a briefing to the

Cabinet Secretary for Health and Sport of that date [CL15/097 – INQ000509933], "predicated substantially on doing more of what is usually expected by way of care at home and care home care than the city has been able to provide due to the HSCP's financial position and availability of provision").

363. To ensure access to PPE by HSCPs and social care providers, Scottish Government was working with NHS NSS to establish a triage centre (as discussed at paragraph 800 onwards below).

364. Extensive work was also underway to ensure adequate workforce capacity (which had been raised as a significant issue by a range of stakeholders). As discussed elsewhere, steps were underway to make changes to SSSC approach to workforce regulation.

365. Guidance was issued by SSSC and NHS NES for care settings that may have required the use of volunteers or redeployed workers due to staffing challenges as a result of the spread of Covid-19. A copy of the guidance is provided [CL15/098 – INQ000592032]. The guidance set out what employers needed to consider and put in place to support the safe delivery of services, including resources to induct new workers into different care settings and provision of guidance on minimum training requirements to equip people with the knowledge, skills and behaviours (as well as signposting to the online portal for training).

366. The Cabinet Secretary for Health and Sport updated Parliament on 17 March 2020 stating, "We are also working closely with COSLA, health and social care partnerships and chief officers to get a rapid reduction in delayed discharges. I have set a goal of reducing these by 400 by the end of this month" [CL15/099 – INQ000280668].

367. On 18 March 2020, prior to the issuing of new guidance from HPS, Scottish Government officials were approached by HSCP Chief Officers to ask whether patients could be returned to care homes where positive cases existed in order to reduce pressures on hospital capacity. Initially SG clinical advisers raised concerns about placing residents at perceived risk and did not feel that expediting

hospital flows, even under pressure, was an adequate reason for such a move [CL15/100 – INQ000509936].

368. Scottish Government also sought clinical guidance from health protection colleagues in HPS who felt that the risk could be adequately mitigated given the other measures in place (such as reduction in communal activity and patients being in their own rooms, alongside PPE and IPC measures). HPS colleagues also flagged concerns regarding atypical presentations in the older population which could lead to clusters/outbreaks in care homes, should their symptoms go unrecognised. Copies of correspondence are provided [CL15/101 – INQ000525319], [CL15/102 – INQ000591982], [CL15/103 – INQ000591924]. HPS advice, as set out in correspondence of 24 March 2020 [CL15/103 – INQ000591924], was that facilities should undertake the following steps prior to admission:

From home to social or community care and residential settings:

- *Source information from NHS Inform for current symptom and isolation advice, using the symptom and isolation checker*
- *Discuss with local senior facility healthcare staff and/or a designated senior decision maker in the community (referring to the HUB model) prior to planned admission – including consideration of current isolation guidance for that individual or the household.*
- *People being admitted from home / the community did not need to be tested for Covid-19 and should be managed based on their symptoms.*

Admissions from hospital to social or community care and residential settings

If the individual is deemed clinically well and suitable for discharge from hospital, they can be admitted to the facility after:

- *Appropriate clinical plan*
- *Risk assessment of their facility environment and provision of advice about selfisolation as appropriate (see NHS Inform for details)*
- *There are arrangements in place to get return them to facility (see Appendix 1: safe forms of transport to and from hospital for possible and confirmed cases). Decisions about any follow-up will be on a case by case basis"*

If the individual being discharged from hospital is known to have had contacted with other Covid-19 cases and is not displaying symptoms, secondary care staff must inform the receiving facility of the exposure and the receiving facility should ensure:

- *The exposed individual is isolated for 14 days following exposure to minimise the risk of a subsequent outbreak within this setting.*
- *Individuals being discharged from hospital do not routinely need confirmation of a negative Covid test. Facilities will be advised of recommended infection prevention and control measures on discharge.*

369. The advice from HPS also set out the situations in which social or community care and residential settings could remain open to admissions, which included:

- *Where a single case of laboratory confirmed Covid-19 case had been identified and all appropriate IPC measures were in place (as per guidance)*
- *Where more than one laboratory confirmed case had been identified and following risk assessment and discussion with the local HPT, it was possible to manage cases and ensure all appropriate IPC measures were in place (as per guidance)*

Where there was evidence of a cluster or outbreak (2 or more clinical or laboratory confirmed cases in a 24 hour period which have occurred as a result of crosstransmission) senior facility staff should discuss with the local HPT. In this situation, the facility should close to new admissions and any day care facilities should

be closed. Any derivation from this should be done following a risk assessment with the HPT, as there may be exceptional circumstance where for example the schematic layout of the facility may allow for partial closure.

370. The Cabinet Secretary for Health and Sport met Donald Macaskill on 18 March 2020, in part to discuss Scottish Care's concerns about admissions from a hospital setting. The briefing for the Cabinet Secretary [CL15/104 – INQ000261340] noted that as of 17 March Scottish Care had expressed concerns about testing arrangements in relation to admissions from hospitals and shared the view that they would like all people discharged from hospital to be tested. As per the action note from the meeting [CL15/105 – INQ000509941], the 7-day isolation period was discussed in this context, with the Cabinet Secretary for Health and Sport accepting that part of that could be in hospital.

371. Once CPAG had been established as a stakeholder forum, concerns about care home admissions would typically be raised in that forum. This group allowed the sector to raise issues it had and to seek immediate access to support. Regarding concerns about admissions from hospital settings in particular, at the time of the group's establishment in April 2020, Graham Ellis (then in his role as Senior Medical

Officer) had drafted what was termed the 'hospital passport', a document outlining all practical clinical observations to be undertaken plus test results and recording these in a form to be completed prior to discharge, with further monitoring to be continued on admission to a care home and recorded. This represented a way to try and reinforce the safeguards in place around clinical screening prior to discharge. In the event, staff in the sector expressed in the CPAG forum that they did not see the passport as necessary. The passport idea was therefore not implemented and instead the 'New admission/transfer form' as set out in Annex 1 of the 26 March 2020 clinical guidance was retained [CL15/069 – INQ000429281].

372. On 21 March 2020, WHO released its technical guidance, "IPC guidance for longterm care facilities in the context of COVID-19", which made a number of recommendations for testing suspected cases within care homes and isolating cases in single rooms if possible.

373. At this point, the existing Scottish Government guidance stated that patients suspected of having symptoms were to be managed in line with other HPS guidance and specifically should be isolated in their own room. On 26 March 2020, the Scottish Government clinical guidance for nursing home and residential care residents was issued [CL15/069 – INQ000429281]. The guidance stated that it should be read in conjunction with the updated HPS guidance (Version 1.5) issued on 26 March 2020 [CL15/106 – INQ000189302], and stated,

"If a patient being discharged from hospital is known to have had contact with other COVID-19 cases and is not displaying symptoms, secondary care staff must inform the receiving facility of the exposure. The receiving facility should ensure the exposed individual is isolated for 14 days following exposure to minimise the risk of a subsequent outbreak within the receiving facility.

Individuals being discharged from hospital do not routinely need confirmation of a negative COVID-19 test. Facilities will be advised of recommended infection prevention and control measures on discharge."

374. The rationale for the 14-day incubation period was that this was double the usual incubation period of the virus in the initial stages of the pandemic (an incubation period that changed with subsequent variants). It was a cautious time period intended to exclude the overwhelming majority of infections from developing from initial exposure. On 21 April 2020 the 14-day isolation period was expanded to apply to all new admissions.

375. The guidance in England at this time was considered, which did not specifically provide a view on either stopping or continuing admissions, but did acknowledge "the ability of care homes to provide isolation precautions for individuals living in the home" (i.e. because of single en-suite rooms).

376. The Scottish Government's Senior Medical Adviser advised that the guidance in Scotland was more restrictive than the English guidance on a number of areas, specifically around social distancing measures, owing to fear their guidance would

not be adequate to reduce the risks. For example, the Scottish Government's guidance issued on 13 March 2020 took a precautionary approach and recommended measures to reduce potential risks, including the reduction of visits to care homes to essential visits and social isolation in rooms. We are not aware that the English guidance at the time included all of these measures. These measures were introduced ahead of the lockdown measures for the general public (introduced later in March). For example, the 13 March 2020 guidance stated,

"Based on the current emerging picture around COVID-19, CMO advice suggests that long term care facilities should be subject to 'social distancing', to reduce the risk of infecting residents and their carers in this vulnerable group. This should operate at 2 levels: 1) reducing visits to care homes to essential visits; and 2) social isolation in rooms."

377. Discussions also took place between clinicians, the Cabinet Secretary for Health and Sport and Scottish Care regarding the concerns of care providers about safety at the point of admission, availability of robust PPE and further support and intervention. Care providers questioned when testing would be made available to care home staff and the clinical criteria that would be applied by nursing and medical staff prior to discharge from hospital to care homes. It was advised that some care homes were refusing to readmit residents unless a negative Covid-19 test result could be provided by the hospital prior to discharge. Copies of this correspondence are provided [CL15/107 – INQ000591927]. It had been agreed that the 7-day isolation period would be a mitigation measure where testing was no available, and it was discussed that there need to be clear exemplars as to the levels of discharge criteria. Care homes had specific concerns regarding the levels of dedicated staff and isolation/separate areas to fulfil the 7-day isolation period. In response to concerns the Scottish Government sought to ensure that guidance and any communications issued were clear and that clinical advice was provided on these matters.

378. Scottish Care outlined concerns raised by its members regarding the potential revision to the care home guidance in an email dated 25 March 2020, provided [CL15/108 – INQ000509937]. Providers had specifically raised with Scottish Care concerns regarding the 7-day isolation period (with the need for clear exemplars as to levels of discharge criteria), lack of dedicated staff and isolation/separate areas, crossinfection rates and access to adequate PPE. In particular, they raised the need for barrier nursing of potential carriers transferred from high-risk areas. Scottish Care

advised that at this juncture, they were already aware of care homes having to cease new admissions for reasons of workforce capacity.

379. This advice to the Scottish Government was reflected in HPS guidance published for the sector on the 26 March 2020 [CL15/106 – INQ000189302] and referenced in Scottish Government guidance published the same day [CL15/069 – INQ000429281]. An accompanying document was developed to record observations and clinical judgment. As set out at paragraph 438, further work was underway to increase staffing capacity within the ASC sector.

380. The Scottish Government guidance focused on assessing for symptoms and managing on this basis (including isolation). If the individual was known to have contact with Covid-19 patients, the advice was to isolate for 14 days, and for all other individuals, 7 days. The importance of local risk assessment, particularly around visiting policy, was stressed. The guidance advised that care homes should continue to take admissions if clinically safe to do so.

381. The HPS guidance included advice on measures to be put in place before someone was admitted to a care home, including an appropriate risk assessment of the facility. Little new evidence had come to light in the 13 days since the first guidance had been published on 13 March, but feedback from the residential care sector helped to inform the framing of some of the advice. These stakeholders had asked for more practical detail, which was duly incorporated into the new version of the guidance.

382. A 14-day isolation period was recommended for those known to have had contact with Covid-19 as they posed more risk to others. At this stage in the pandemic, understanding around incubation periods was still developing and it was believed to be between 2 and 14 days. This was outlined in the HPS guidance of 26 March 2020, which stated that, "*The incubation period of Covid-19 is currently believed to be between 2 to 14 days. The incubation period is the time between someone being exposed to an infection and developing symptoms. This means that if a person remains well 14 days after contact with someone with Covid-19 they have almost certainly not been infected.*" [CL15/106 – INQ000189302].

383. While 14 days was recommended for those known to have contact with Covid-19, 7 days was recommended for all people (who had not been exposed to someone with symptoms) being admitted from hospital as a precautionary measure, recognising that there were greater risks of being exposed to Covid-19 in a hospital setting but also the need to balance with the impact of 14-day isolation on wellbeing. This guidance was more restrictive than regulations required for those living in their own homes, and there was therefore a potential equality concern. For this reason, longer isolation without a clear exposure was difficult to justify. Although the incubation period of the virus was variable, in most cases symptoms would appear within 7 days allowing appropriate measures to be taken to prevent further spread.

384. The advice on admissions from hospitals, therefore, stated that there was no need for confirmation of a negative Covid-19 test and that care homes should be advised of recommended IPC measures on discharge. Advice at this time recommended a documented clinical risk assessment for Covid-19 and a screening form was provided, which was intended to provide reassurance to care providers that patients were not displaying Covid-19 symptoms. For care homes with cases of Covid-19, the advice stated that care homes should take admissions if they had 1–2 confirmed cases, but advice and risk assessment would be needed from the local Health Protection Teams. If a cluster of cases were identified, then homes were advised to close to new admissions and visitors (unless the layout of the facility allowed for partial closure).

385. The HPS guidance advised that admissions from the community should be screened for symptoms and a discussion held with clinical staff in the community prior to admission (to assess the need for isolation measures) [CL15/106 – INQ000189302] and that testing was not required (unless symptomatic). The need for a documented clinical assessment for admissions from the community (as per admissions from hospital) was intended to provide assurance for the receiving facility that risks were being managed in conjunction with standard IPC measures [CL15/109 – INQ000591983]. The HPS guidance provided alternative isolation measures to be implemented where patients could not be isolated individually in a single room (which was the preferred option for isolation). The ability of individual care homes to isolate new admissions was considered as part of local discharge discussions.

386. During the development of the 26 March guidance, the proposal on incubation periods was discussed with Scottish Care who were keen to implement the 7-day isolation as a safety measure. The Cabinet Secretary met with the Chief Executive of Scottish Care to discuss their concerns prior to guidance being issued, copy of related correspondence provided [CL15/110 – INQ000509941].

387. On 1 April 2020, the First Minister provided a progress update to Parliament stating, *"The target that we set at the start of the month of quickly reducing delayed discharge cases by 400 has already been met and we are now working to go further. That is of course good for patients, who should not be spending longer in hospital than they need to, but it also makes more hospital beds available for those who need clinical care. Overall, the NHS capacity has around 13,000 beds, and through the reduction in delayed discharge and the postponement of non-urgent elective care, we estimate that at least 3,000 beds will be available to treated Covid-19 patients."* [CL15/114 – INQ000509966].

Discharge to care homes evaluated as 'weak' or 'unsatisfactory' by CI

388. The Inquiry has asked about the discharge of people from hospitals to care homes evaluated as 'weak' or 'unsatisfactory' by CI (also referred to as a poor CI rating). As

noted above, the Scottish Government has no role in individual decisions relating to the discharge of people from hospitals, including to care homes, and did not issue any guidance or instruction specifically in relation to discharge to those homes evaluated as weak or unsatisfactory. Local commissioning authorities have local procedures to be followed in such instances.

389. In general terms, a moratorium is usually in place for admissions to a care home with a poor CI rating, unless this is in the best interest of the person being discharged. For example, if the person had been admitted to hospital from that care home and was returning, and/or if the discharging authority is satisfied that the care home has made sufficient improvements since the CI evaluation (taking account of the advice from the local commissioning authority and others), admissions may be made. We would recommend that the Inquiry contact the CI directly for more detailed information on procedures relating to care homes with a poor CI rating.

390. The Inquiry has asked if SG received or sought reassurance from the CI on this issue. SG officials were in regular contact, often daily, with the CI about a range of care home issues including quality of service, enforcement activity such as the issue of improvement notices, applications to the sheriff courts to cancel a service's registration and other significant issues.

Risks associated with social distancing

391. Early briefings to ministers on the risks associated with social distancing noted the difficulty of communicating measures to people with dementia (for instance, a briefing of 8 March 2020 prepared for SGoRR(M) [CL15/089 – INQ000510039] on interventions listed a number of implementation risks, including the need to meet the communication needs of those with dementia. A separate paper [CL15/111 – INQ000510015] produced by DG HSC to assess the proposed non-pharmaceutical interventions noted that there was a risk of those with dementia not understanding what was being asked of them or retaining that knowledge, adding that engagement with key representative bodies would go some way towards mitigating that risk). The Cabinet Office of the UKG circulated an analysis of intervention measures [CL15/112 –

INQ000101335] ahead of a COBR meeting on 10 March, which noted the specific risk posed to those with dementia from experiencing reduced contact and care.

392. While the guidance issued by the Scottish Government on 13 March 2020 [CL15/068 – INQ000250859] stated that long term care facilities should be subject to social distancing, including by reducing time in communal areas by 75% and socially isolating residents in rooms, that guidance also acknowledged mitigating factors for care providers to consider, when caring for residents in long term care, particularly for patients with dementia:

"Implementing these measures including social distances may have adverse effects that need to be considered. These could include;

- *Increased immobility and higher falls risk for particular patients.*
- *Low mood from social isolation*
- *Boredom*
- *Loss of contact with families.*

These factors may be more marked for residents with dementia. Deploying measures to address and mitigate these factors will be important. This may be best addressed using volunteers or third sector charitable organisations to support the work of activity coordinators adapting to engaging with individuals and to be seen as part of essential contacts. It is of course crucial that they are trained in the correct hygiene precautions. Access to spiritual care may be also be helpful. Use of video technology for accessing relatives and others (some homes are supplying iPads to residents to allow face time) or 'playlist for life' music."

393. As discussed elsewhere in this statement, further iterations of guidance provided more detailed advice around specific strategies for supporting people, particularly the 15 May 2020 Scottish Government Clinical Guidance for Care Homes [CL15/070 – INQ000383486]

394. In June 2020 the Scottish Government produce the first standalone visiting guidance which promoted a staged return to indoor visiting [CL15/113 – INQ000147431]. The Scottish Government continually revised and updated guidance to reinforce messaging on the importance of face to face contact – 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. This guidance proposed a staged approach to the return of people and organisations to care homes, with healthcare professionals able to offer face to face routine care including preventative and rehabilitation visits (with appropriate mitigating actions) from 7 September 2020. Detailed discussion of the approach to visiting is provided later in this statement at paragraph 811 onwards.

395. By February 2021, the SG had developed and announced the 'Open with Care' approach [CL15/015 – INQ000147437], which involved the issuing of new guidance on care home visiting that specifically encouraged and emphasised the benefits of a full return to meaningful contact (in the context of vaccinations being available, widespread testing and effective IPC measures).

National Care Home contract

396. The Scottish Government were aware of care home providers' concerns for the safety of their staff and residents and concerns by care home providers regarding financial sustainability if they were unable to continue to admit new residents.

397. COSLA guidance for commissioners (issued 18 March 2020) [CL15/111 – INQ000510015] specifically considered financial sustainability of providers, stating:

"Ensuring care homes can continue to admit residents where it is clinically safe to do so is a priority. However, if care homes stop admissions because it is unsafe to admit residents this could affect occupancy levels which in turn may impact on their sustainability. The National Care Home Contract is a spot purchased contract with a payment made per resident per week, it does not contain any clauses to protect providers from financial unsustainability during this period. Consideration should be given to making payment based on planned care to ensure they remain operationally viable."

398. A number of other measures to support providers were outlined in this guidance, including flexibility in contract monitoring and tendering processes. This information was circulated to IJB Chief Officers, Local Authority Chief Executives and Chief Social

Work Officers by the Cabinet Secretary for Health and Sport and Councillor Currie, COSLA on 24 March 2020 [CL15/115 – INQ000147437].

Impact of the March 2020 Discharge Policy

399. An initial 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 and published on 28 October 2020 [CL15/116 – INQ000147514]. A subsequent revised version that included updated data and analysis was published on 21 April 2021. The Universities of Edinburgh and Glasgow were both partners in the production of the report.

400. The report presented management information statistics on people aged 18 and over who were discharged from an NHS Scotland hospital to a care home between 1 March and 31 May 2020. These statistics were presented in time periods designed to reflect the key guidance and policy changes during the months in question. Broadly, the purpose of both the original and revised reports was to present findings from the underlying work commissioned to identify and analyse discharges from NHS hospitals to care homes during the first wave of the Covid-19 pandemic.

401. From a practical standpoint, this work was intended to identify sources of transmission of infection in care homes and to provide validated and comparable data, to inform effective action to prevent and control further spread in future. It was noted that territorial Health Boards would be required to validate and enhance the information for their patients as far as possible, building on work that was already being carried out in part as a response to the Lord Advocate Direction of 13 May 2020 around deaths of people in care homes [CL15/117 – INQ000510008]. The 13 May 2020 Direction stated that all Covid-19, or presumed Covid-19 deaths (where the deceased may have contracted the virus in the course of their employment or occupation) and all Covid-19, or presumed Covid-19

deaths, where the deceased was a resident in a care home when the virus was contracted should be reported to the Procurator Fiscal. At the outset of the pandemic, the Lord Advocate had issued a direction that Covid-19, or presumed Covid-19 deaths, did not require to be reported to the Crown, unless there was some other substantive reason for reporting that death.

402. A copy of the correspondence with PHS regarding this commission is provided, which sets out the in more detail the datasets utilised and governance arrangements in place to support this work [CL15/118 – INQ000509943].

403. At that time, there was significant media and public interest in discharges from hospitals to care homes, and the potential impacts that discharges may have had on care home residents and staff. PHS were therefore commissioned by the Cabinet Secretary for Health and Sport to lead on work to understand retrospectively pathways and outcomes for people who were discharged to a care home, and their Covid-19 status between 1 March and 31 May 2020. The three main aims of the commissioned work were therefore:

- To publish aggregated information on numbers and socio demographic details of people who were discharged to a care home during the period, including defining discharged people with definite/possible hospital acquired and definite/possible care home acquired infection, and examining how often hospital acquired cases were the first case in a cluster within a care home
- To examine timing, evolution and patterns of Covid-19 outbreaks in care homes for older people in Scotland, to understand the context of care homes and outbreaks into which people were discharged, including examining viral lineage data where available
- To examine Covid-19 related outcomes of people discharged from hospital to care homes for older people in Scotland in the epidemic period (Covid-19 diagnosis, whether definite/possible hospital/care home acquired, Covid-19 related mortality, other mortality).

404. The most statistically significant factor identified as being associated with outbreaks in care homes was care home size. Of the care homes with more than 90 registered places, 90.2% had an outbreak, compared to just 3.7% of homes with fewer than 20 registered places. It was also observed that outbreaks were more common in older people's care homes (41.1%), private sector care homes (40.4%) and care homes providing nursing care (45.2%). Outbreaks were also more common in care homes defined as high risk using the Risk Assessment Document score (46.6%), a scoring system used by CI inspectors and managers to inform their inspection regimen whereby homes are categorised into low risk, medium risk and high risk based on inspections, complaints, enforcement cases and updates around service quality.

405. The report was referenced in the ASC Winter Preparedness Plan 2020-21: Evidence Paper [CL15/119 – INQ000240708]. The Evidence Paper referenced the report's comments that larger care homes are significantly more at risk than an outbreak when compared to smaller homes and dividing homes, where possible, into smaller self-contained units would be beneficial. The report noted that whilst staff working across multiple locations and interacting with high numbers of residents increases transmission risk, there is no strong evidence on risks from visitors (unless community rates are high or there are poor IPC measures).

406. The overarching conclusion drawn in both the October 2020 and April 2021 iterations of the report was that PHS had not found any statistically significant association between hospital discharge and the occurrence of a care home outbreak, though they could not rule out a small effect. The report noted that care home size was much more strongly associated the risk of an outbreak than all other care home characteristics, including hospital discharge. The analysis found, in common with comparable analyses in England and Wales (see further relevant studies, [CL15/120 – INQ000271757], consensus statement [CL15/121 – INQ000343826], discharge evidence of risk [CL15/122 – INQ000509944] and [CL15/123 – INQ000213185]) that ingress of infections to care homes was primarily attributable to staff footfall and, as noted, related directly to care home size. The report classified discharges based on pre-hospital residency. It found that almost half (46%) of people were discharged back to their usual care home of

residence, while around a third (32%) were moved into a new long-term care home placement. One in seven (15%) were discharged into a care home as a temporary placement, while information was unknown for the remaining 8%. Of those people discharged into care homes, 675 (14%) died within 30 days of discharge. A large majority of these deaths (83%) took place within the care home. Covid-19 was associated with 146 deaths (22%) within 30 days of hospital discharge.

407. Within 30 days after discharge from hospital into a care home, 154 people tested positive for Covid-19, representing 3.5% of all people discharged who had not previously tested positive for Covid-19. Of these 154 people, 26 were discharged to a care home with an existing Covid-19 outbreak and 127 were discharged to a care home before any outbreak had started. One person tested positive during a hospital readmission and the care home to which they were discharged did not experience an outbreak. In total, 54 of the 154 (35%) people testing positive died within 30 days of their hospital discharge. All of these deaths were recorded as being associated with Covid-19 on the death certificate. 106 people were discharged from hospital into a care home where their last test for Covid-19 was positive, of whom 79% had definite community onset i.e. tested positive before admission to hospital or within the first one or two days of admission.

408. The majority (80) of the 106 people were discharged to care homes with an existing outbreak of Covid-19, meaning the discharge could not have caused the care home outbreak. A further seven were discharged 15 or more days after their first positive test and would not have been considered at risk of transmission, while nine were discharged to care homes which did not experience an outbreak of Covid-19. This left 10 people discharged to care homes where an association in the timing of the discharge and care home outbreak required further review using genomic sequencing.

409. This viral genomic sequencing analysis focused on care home outbreaks where a possible or unclear epidemiological association between hospital discharge and care home outbreak was identified. Analysis was limited by lack of sequencing data available from the first three months of the pandemic. There was only sufficient sequencing data in two care homes to examine whether a person

discharged from hospital before an outbreak could have been responsible for starting the outbreak, and only sufficient data in five care homes to examine whether a person discharged from hospital after an outbreak could have introduced a further infection into the care home.

410. The results of this genomic sequencing analysis concluded that the findings were not consistent with hospital introduction of infection in those two care homes where a person was discharged from hospital into a care home before an outbreak. It was also concluded that in those five care homes where a person was discharged from hospital after an outbreak in a care home, the viral lineages of the positive residents discharged from hospital were already present in those care homes prior to the individual entering the care home.

411. PHS would be best placed to answer further questions about the limitations to the data analysed. However, it should be noted again in this context that the version of this report published on 21 April 2021 was itself a revision of the earlier version released by PHS on 28 October 2020 [CL15/124 – INQ000509946]. The April revision specifically aimed to address data limitations in the first version, with updates made as follows:

- Further quality assurance of the data was carried out. This resulted in the removal of six discharges (three individuals) from the analysis. It was noted that this did not impact on the main conclusions from the original report
- Statistical modelling was updated following feedback from users and the Office for Statistics Regulation. This related to additional visuals and commentary to aid interpretation of the findings and again did not impact on the main conclusions from the original report
- Additional analysis focused on outcomes within 30 days for those discharged from hospital (all-cause mortality, Covid-19 mortality and Covid-19 infection)
- Further analysis focused on individuals whose last test before discharge was positive (including relationship with care home outbreaks)

412. Genomic sequencing analysis was added (as described above), comparing the specific samples of those discharged from hospital with samples from care home outbreaks to understand patterns of infection transmission and the relationship between hospital discharge and care home outbreaks.

April 2020 Change in Strategy

413. On 8 April 2020, the question of hospital discharges was revisited in a meeting of the Clinical Guidance Cell, in part to discuss a revised draft of the Public Health England guidance for stepdown of IPC and the discharge of Covid-19 patients from hospital to residential settings, including care homes. The key points of this discussion between clinicians recorded in the minutes were that [CL15/125 – INQ000468153]:

- National guidance was necessary to maintain consistency in discharging patients in a safe way and minimise infection spread
- Given the limited evidence base, any guidance produced by the Cell would need to be regarded as a working document and updated as more evidence emerged, with a clear statement to this end at the beginning of the document
- Good discharge planning based on a person-centred approach was to be encouraged, an individualised approach that would also be appropriate for assessment of risk, and therefore the appropriateness of testing
- There would be a measure of local variation in discharge approaches that would need to be allowed for in guidance (for example, some Boards were considering using hotel accommodation in the context of stepdown)
- Consistency of results from tests was at this time being improved. There was some free testing capacity in the system, but this was considered to need careful stewardship with controls on demand in place.

414. Specifically on testing, the clinicians noted that in their view there could not be a blanket approach to whether one or two tests were required to be taken in advance of discharge. There would need to be some room for local judgement. Second tests could, in their experience, prove to be problematic; members reported cases where a second test came back positive after the first had come back negative. Similarly, the timing of the tests was considered a problematic issue (the specific basis for this view was not noted in the minutes) and again it was noted there would be the need for some latitude in the guidance that was to be developed by the Cell. On the subject of hospital discharges, group members shared their own territorial Health Board's checklists setting out discharge criteria as examples for their peers [CL15/126 – **INQ000510006**].

415. Advice was given to the Cabinet Secretary for Health and Sport and First Minister in an urgent submission of 20 April 2020 [CL15/127 – INQ000249330] from the Director of Community Health and Social Care summarising the position of the CMO on the question of testing all admissions to care homes. The advice provided set out the latest clinical advice, the position in England and feedback from the HSC sector. In England, the guidance on hospital discharges was changed on 15 April 2020 to require NHS trusts to test all patients prior to discharge and admission into a care home.

416. At this stage, all testing within Scotland was in the form of PCR tests. The advice given in this submission was that although these tests were effective at identifying those with Covid-19 when symptomatic, they could not reliably detect infection prior to the onset of symptoms and could not confirm whether a person had had the infection once symptoms had resolved. It was also possible that someone would test negative while still within the incubation period of the virus.

417. Negative tests would therefore, it was posited, provide a level of false reassurance. The recently published guidance in England (within the Coronavirus: adult social care action plan) at that time had committed to testing all residents prior to admission to a care home, but it acknowledged that care homes may still wish to isolate new residents for a 14-day period following admission. Indeed, the advice stated that patients could be discharged to care homes whilst their results

were pending, and would be isolated in the same way as a Covid-19 positive patient until the results were available. The English approach also stated that for individuals entering care settings from the community, individuals would be tested prior to admission but that the care home may still wish to isolate the new resident for a 14day period.

418. The CMO advice therefore also included the observation that a positive test may not have an impact on how care home residents were treated in practice. The advice itself, contained in full within an annex, was to continue with robust IPC policies (including a 14-day isolation period for all new admissions to residential care settings) along with appropriate numbers of staff to support this. The contributors to the full set of advice were listed as CMO, CNO and PHS.

419. In addition to the clinical advice from the CMO, this submission noted the heightened anxiety around care home admission and care homes generally and referred to a slight increase in delayed discharge figures largely driven by said anxiety.

It suggested that offering testing in addition to the self-isolation requirement could "*offer a degree of reassurance that we are committed to understanding and responding to this emerging crisis".*

420. On 21 April 2020, the day after this submission was shared with the FM and Cabinet Secretary for Health and Sport, the latter announced in a statement to the Scottish Parliament that all admissions to care homes from hospital should have a negative test for Covid-19 prior to admission to the home, regardless of symptoms, unless it was in the clinical interests of the patient to be moved and then only after a full risk assessment [CL15/128 – INQ000292544].

421. At this juncture, testing had been available in hospital settings for some time, and clinical decisions around testing were for hospitals and clinicians to make on a caseby-case basis.

422. Where a patient had previously tested positive for Covid-19, two negative tests were required prior to their discharge from hospital. Advice to ministers from clinical advisers prior to this announcement reflected concerns that testing alone

could create a false reassurance and that a key element of protection required was still a 14-day isolation for all residents admitted to a home [CL15/127 – INQ000249330]. For patients being discharged from hospital to a care home who had previously tested positive for Covid-19, if two negative tests could not be provided the patient would need to complete 14 days of isolation (from the date of onset of symptoms, or date of first positive test if date of onset not clear). These measures were introduced to support care home staff and residents and to support care homes to continue to admit patients in a manner which is clinically safe.

423. These policies were reflected in both SG and HPS guidance for care homes. Two specific sets of HPS guidance were updated: (i) Version 1.1 of 'Guidance for stepdown of infection control precautions and discharging COVID-19 patients from hospital to residential settings', provided [CL15/129 – INQ000189405] on 22 April 2020; and (ii)

Version 1.1 of 'COVID-19: Information and Guidance for Care Home Settings', provided [CL15/130 – INQ000189332] on 28 April 2020.

424. The requirement for testing was included in subsequent clinical guidance in addition to the isolation of new admissions as additional protection offered by the identification and exclusion of those who were infective without symptoms and the isolation of any new admissions to minimise the risk of false negatives and emerging infection. Incorporating both in new iterations of the guidance gave an opportunity to reinforce the important health protection advice around continued vigilance and the risks of infectious ingress despite testing policies.

"Discharge is only possible when each patients care needs can be met in their care facility and their respiratory symptoms (other than cough) have resolved. There is no intention to transfer symptomatic patients (other than cough) back to care homes until their symptoms have resolved and they are fit for discharge - this is a separate issue from testing."

425. On 15 May 2020, the Scottish Government and PHS advice on discharge was updated to the presumption that everyone being admitted to a care home should have 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 [CL15/070 – INQ000383486].

426. The guidance reflected the 21 April announcement of the 14-day isolation period for all admissions [CL15/128 – INQ000292544]. This 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 symptom onset undetermined) and absence of fever for 48 hours (without use of antibiotics). Patients could be discharged prior to the test result being available. Advice regarding communal activity and physical distancing remained as before.

427. As more tests became available, whole care home testing was implemented over summer 2020 to assess the intensity of infection in care homes once an outbreak was identified, to inform IPC measures and to assess when an outbreak was successfully controlled and thus enabling the reduction of response measures.

428. On 1 May 2020 the First Minister announced enhanced outbreak investigations in care homes [CL15/131 – INQ000509948]. All residents and staff were to be offered testing, whether they were symptomatic or not, in homes where there had been a confirmed case. Sample testing in care homes where there were no cases was also announced.

429. Testing was expanded further with routine asymptomatic staff testing commencing. This was initially confined to high risk settings – staff in healthcare and care homes – with the Scottish Government announcing on 23 June that health and social care staff were to be offered weekly PCR testing from 8 July 2020 [CL15/132INQ000509949].

430. Following this announcement, the Scottish Government (led by a CNOD professional adviser) established a Short Life Working Group to support efforts to roll out PCR testing to care home staff, terms of reference provided [CL15/133 – INQ000259982]. This included representatives from Scottish Government, care

home provider representatives, care home providers and NSS. Where issues were raised, Scottish Government worked with NSS and territorial Health Boards to resolve them. The group met 26 times between 6 July 2020 and 19 July 2021. On 10 July 2020 the group met to discuss the SSCI and CI announcement regarding testing – in particular the need for clarity regarding the impact on registration should staff reuse to take a test, responsibilities of care home managers and how guidance applied to agency staff.

Care Workforce

431. At the onset of the pandemic, there were already challenges facing the sector such as staff vacancies and delays in hospital due to lack of social care support. There was concern that Covid-19 would result in further pressures, such as increased illness of staff and unpaid carers being unable to care for family or friends. Scottish Government also heard from stakeholders about concerns around financial hardship and staff wellbeing and the importance of ensuring payment of the real living wage.

Support for social care workforce & unpaid carers

432. The Covid-19 pandemic emphasised the crucial role of key workers in social care support and unpaid carers for supporting wellbeing and independent living, as part of an integrated health and social care system. As noted above, the Scottish Government had regular engagement with care sector representatives pre-pandemic on workforce issues and this engagement intensified as the pandemic progressed, ensuring that Scottish Government had a full understanding of workforce concerns and could respond quickly to address them.

433. The Scottish Government recognised the pressures around social care workforce capacity, staff availability through absences due to Covid-19 and those who were selfisolating. The Scottish Government responded to these and other workforce related risks by working with its partners to identify priorities and scope for regulatory change.

It met regularly, often weekly, with representatives of carer organisations, COSLA, HSCPs and trade unions to support the sector and take action.

434. Communication and guidance were issued to the adult social care workforce by the Scottish Government throughout the pandemic using various channels. Communications were usually issued to NHS, Local Authority Chief Executives, Chief Social Work Officers and IA Chief Officers who would then disseminate this across the HSCPs and would cover all relevant social care services across the local authority, Independent and Third Sector organisations.

435. Guidance was issued to ASC workers and employers throughout the pandemic on a range of matters, including self-isolation exemption, testing, risk assessment and mental health and wellbeing, as follows:

- 30 March 2020 – Guidance was issued to HSC and emergency service workers with underlying health conditions. The guidance provided a definition of underlying health conditions with a raised (but not highest) risk of severe disease, and examples [CL15/134 – INQ000510046].

- 30 March 2020 – Joint letter issued by COSLA and the Cabinet Secretary for Health and Sport to Local Authority Chief Executives, IJB Chief Officers, IJB Finance Officers and Chief Social Work Officers, which made clear that social care support workers are "unequivocally key workers" [CL15/135 – INQ000510003], "Social care support workers have diverse roles working in care homes, caring for people in their own homes, and providing essential support to many vulnerable people and families whether employed by the authority, a provider, or directly as a personal assistance." The letter provided links to key guidance and information.

- 28 April 2020 - 'Delivering whole system response to Covid-19 guidance for the deployment of territorial Health Board staff to community settings' published [CL15/136 – INQ000469963]. The guidance was designed to ensure staff could be deployed to community settings safely and effectively and set out high-level principles to be considered alongside local operational arrangements. Territorial Health Boards were asked to share this guidance with any staff being asked to alter their role, and host organisations.

- 24 June 2020 – Guidance for social care workers and employers about the Social Care Staff Support Fund issued. The guidance set out details of eligibility, fund criteria and administration. Further details regarding the fund can be found at paragraph 475 below.

- 21 May 2020 – Joint NHS Scotland and Scottish Government Interim guidance for HSC employers on staff from Black, Asian and Minority Ethnic (BAME) Background issued. The guidance was issued due to emerging evidence that people from BAME backgrounds may be disproportionately affected by Covid-19. The interim guidance was issued to help staff and employers by setting out best practice to support BAME staff [CL15/137 – INQ000510047].

- 27 July 2020 – Covid-19 Occupational Risk Assessment Guidance published – for new risks posed to HSC staff by Covid-19. Also applied to all healthcare students on placement [CL15/138 – INQ000429263]. The tool was designed to support staff and line managers to understand and carry out effective risk assessments and replaced the guidance issued for HSC and emergency service workers with underlying health issues (30 March 2020) and 'Interim guidance for HSC employers on staff from BAME Background' (21 May 2020).

- 30 July 2020 – Coronavirus (Covid-19): social care worker death in service payment guidance issued (which paid a one-off payment of £60,000 to a named survivor of a social care worker who died in service as a result of, or the suspected result of, contracting Covid-19 at work. The scheme paid payments for eligible claims for deaths occurring between 17 March 2020 and 30 June 2022 (the deadline for submitted claims was 30 June 2023).

- 26 February 2021 – Launch of the Workforce Specialist Service (WSS) for regulated HSC staff. The WSS was delivered by NHS Practitioner Health on an interim basis and provided a free, confidential multidisciplinary mental health treatment service for regulated members of the HSC workforce. The WSS formed part of network of services and resources aimed at improving the mental health and wellbeing of HSC staff across Scotland and to supplement staff support services available locally.

- 23 June 2021 – Guidance for local authorities on the payment process for the social care workforce payment was issued (for staff in ASC services registered with CI). A FAQ document for workers was subsequently issued on 22 September 2021.

- 23 July 2021 – Publication of the Framework for the Implementation of Isolation exemptions for HSC staff. This exempted fully vaccinated staff, who had been in contact with someone who had had a positive Covid test, from self-isolation requirements under specific circumstances [CL15/138A – INQ000469955].

- 27 August 2021 – An update to the Framework published on 23 July 2021, which set out the revised national position in operation from 9 August 2021. This change allowed individuals to be contacted through the 'Test and Protect' system to return to work (where they have been doubly vaccinated two weeks prior to exposure, have no symptoms and return a negative PCR test) [CL15/138B –INQ000469956]

- 31 August 2021 – The update to the NIPCM Covid-19 Addendum on physical distancing in HSC was issued [CL15/138C – INQ000410969].

- 22 November 2021 – Revised guidance for pregnant employees issued. Updated guidance was first published in March 2020 (to support both employers and pregnant women in managing the risks associated with Covid-19).

- 25 November 2021 – The Scottish Winter 2021/22 Respiratory Infections in Health and Care Settings - IPC Addendum was launched [CL15/138D – INQ000324257],

- 24 December 2021 – An update on the self-isolation exemption for HSC staff (as implemented 10 December 2021) was circulated. This stated that HSC must be double vaccinated and have had a Covid-19 booster at least 14 days prior to the last exposure to the case, to be eligible to work [CL15/138E – INQ000469957].

- 5 January 2022 – Guidance issued which set out the changes to self-isolation rules (in line with public health advice and testing requirements), to help maximise testing capacity and contact tracing [CL15/138F – INQ000477440].

- 6, 17 and 24 January 2022 – Updates on changes to the self-isolation exemption for HSC staff which provided a policy framework on return to work for HSC staff and testing requirements [CL15/139 – INQ000469958] in line with wider changes.
- 22 February 2022 – Guidance was issued which advised healthcare workers to revert to twice weekly LFD testing [CL15/139A – INQ000477438].
- 19 April 2022 – Guidance was issued setting out the process managers and staff should follow when requesting access to FFP3 respirator masks in place of Type IIR (surgical masks), based on personal preference.
- 16 May 2022 – HIS IPC Standards were published and provided a single set of standards for use across health and ASC from the same date. It was advised this guidance was produced to support the 'Once for Scotland' approach and further integration of HSC [CL15/139B – INQ000315562].

Workforce Senior Leadership Group

436. One of the early steps the Scottish Government took during the pandemic was to set up the Coronavirus (Covid-19) Workforce Senior Leadership Group (WSLG). It was established on 23 March 2020 and chaired by the Director of Health Workforce in the Scottish Government. The WSLG role was to provide national senior strategic leadership and guidance on both key health and social care workforce related issues, terms of reference provided [CL15/140 – INQ000389186]. Its aims were to inform, engage, and take collective action enabling a timely co-ordinated response to COVID-19. It worked in partnership with a wide range of stakeholders across the Health and Social Care network; and ensured timely feedback for the WSLG to address key issues. The WSLG was wound up on 7 March 2023.

437. The group continued to meet as frequently as appropriate and sometimes daily through the phases of the pandemic, reflecting the nature of advice and engagement that was required. Scottish Government adult social care officials attended, and the group expanded to include external social care stakeholders such as COSLA from April 2020. The membership expanded as it was critical that SG worked in partnership

across government. Representatives included employers and trade unions, as well as Social Care representatives from local government through COSLA, the social care sector and Chief Officers from HSCPs. In line with the terms of reference this allowed engagement with local constituencies and for members to ensure their views were shared. Action logs and agendas were shared via email with stakeholders. Copies of minutes and papers have been provided to the Inquiry.

Recruitment and retention

438. Extensive work was undertaken with Scottish Government and its partners to put in place arrangements to increase social care workforce capacity. From the first week of March 2020, the Scottish Government was engaged in discussions about the use of nursing, midwifery and allied health profession students in the workforce. The aim was to increase the health and social care workforce capacity as staff sick absence was expected to be high and health and social care services were also expected to be stretched.

439. This led to Scottish Ministers introducing measures to bolster capacity in the workforce by encouraging new entrants into the ASC sector, whilst allowing SSSC to pause removing individuals from the Register who did not meet qualification deadlines, which meant those individuals were able to continue to work.

440. The Scottish Government worked alongside the SSSC to set up a system to help social care services in Scotland to recruit and deploy staff to increase the social care workforce capacity. On 14 April 2020 the SSSC's Recruitment Portal went live. The portal initially prioritised access to employers, particularly in care homes where there was a critical need. Thereafter it was made available to all social care services across local government; third sector; and independent sectors.

441. To support quicker recruitment, the SSSC played a central role to ensure preemployment checks were undertaken for candidates before they were placed on the portal and matched to an employer. The SSSC's Recruitment Portal remained open throughout the pandemic with 3,167 total expressions of interest received across that span. While the SSSC had a good response from people expressing interest in

helping the sector, only 40 individuals were confirmed as being employed from matches made during the time the portal was live. The portal closed on 01 February 2022.

Staff movement

442. Stopping staff movement in and between care settings was critical to minimise the risk of infection of COVID-19 and other viral illnesses, including flu. To that end, HPS and Scottish Government guidance recommended measures to support care homes in restricting staff movement. For example, the National Clinical and Practice Guidance for Adult Care Homes in Scotland during the Covid-19 Pandemic [CL15/070 – INQ000383486] and HPS COVID-19 Information and Guidance for Care Home Settings published on 26 April 2020 [CL15/141 – INQ0000189331 both contained relevant advice and information. To support delivery, providers were asked to take the following steps:

- Wherever possible, care homes to proactively split into smallest viable independent units to reduce risk of spreading the virus amongst residents and staff
- Creating small staff teams to provide continuity of care through working with the same service users
- Considering whether temporary adaptations may be required to the environment and ensuring careful consideration of whether the needs of people in each bubble could be achieved.

443. Scottish Government guidance advised that staff should not work in more than one facility and movement between care homes e.g. through agency staff working across facilities must be restricted. Similarly, in the delivery of care at home and in other settings, providers were asked to adopt staff cohorting or increased continuity of carers where possible. In addition, agency staff for care homes with COVID-19 were required to self-isolate for 14 days, before moving to another setting.

444. Where staff movement was unavoidable, providers were asked to ensure a robust recording of all and any staff movement. In some care homes, staff took it upon themselves to stay onsite to minimise ingress and egress such was their concern for residents and in some cases their families. While this would have no doubt contributed to the protection of the home, it was not advocated in guidance.

445. There were challenges to adopting such measures to restrict staff movement between and within homes including agency staff in a sector where there were already staffing shortages. Ensuring sufficient workforce capacity to manage demand and provide continuity of safe care was paramount. Implementation therefore required planning and co-ordination across partners at a local level.

446. To support the sector further, the Scottish Government's ASC Winter Preparedness Plan for 2020-21, published on 2 November 2020, outlined the proposed approach and national and local support for restricting staff movement across social care settings to limit transmission of the virus [CL15/142 – INQ000249502]. The Plan stated that "providers will now be required to demonstrate that they have done everything they can to limit staff movement."

Workforce Interventions

447. On 24 March 2020, the Cabinet Secretary for Health and Sport commissioned NHS NES to create a national accelerated recruitment portal. The portal was the gateway to accelerated recruitment across HSC to enable those with relevant skills and experience to volunteer to support services as part of the emergency response. It was developed to help facilitate deployment of emergency registrants across professional groups and support applications from returners and students to priority areas in HSC across acute, primary, community and social care settings.

448. The portal set out three strands for applicants:

- Returning NHS workers will be directed to existing recruitment arrangements in NHS Scotland

- People wishing to offer their support to our public services, including the NHS and local authorities, will be directed to a site co-ordinated by the British Red Cross
- Those looking for opportunities with other charities or community groups in their area will be directed to Volunteer Scotland for information and those were signposted from the Ready Scotland website. The aim was to connect people to where their contribution was most needed in their local community and for some, that may involve roles responding to specific needs in health and social care. The Scottish Government worked closely with local government and a range of partners to co-ordinate the volunteering effort across Scotland.

449. The portal, accessible through the NHS Careers website, went live on 29 March 2020. The campaign was closed to new applications from 1 May 2020, to allow NHS NES capacity to process those coming forward via the Portal for recruitment as territorial Health Board employees; and for Local Authorities and third sector organisations to deploy volunteers as required through the other two volunteering strands.

450. All HSCPs had their own individual business continuity plans, which were implemented to cope with workforce pressures during the pandemic. This included redeployment of staff from non-essential services that were closed at the time into essential services such as care home for adults and care at home services.

Health and Wellbeing of workforce

451. From the beginning of the pandemic, Scottish Ministers set clear expectations that territorial Health Boards, HSCPs and local authorities should promote both the physical and psychological wellbeing of staff whether they operate in a hospital or a community setting.

452. Recognising the pressures facing health and social care staff, and in particular care home staff, led the Scottish Government to develop a range of national and local wellbeing programmes. On 11 May 2020, a new national digital wellbeing hub

was launched to enable staff, carers, volunteers and their families to access relevant support when they need it and provided a range of self-care and wellbeing resources designed to aid resilience as the whole workforce responded to the impact of COVID-
19.

453. Jeane Freeman, then Cabinet Secretary for Health and Sport, recognised the impact of the Covid-19 pandemic on the physical and mental wellbeing of HSC staff when announcing the launch of new national digital wellbeing hub by stating, [CL15/033 – INQ000147351]:

"This is a tremendously stressful time for our health and social care workforce and unpaid carers, juggling the demands of working in highly pressurised emotional environments with concerns for their own safety and that their families. We will do all we can to support them".

454. Organisations from across Scotland worked together with the Scottish Government to create the new platform with a view to helping health and social care workers and carers look after their physical and mental health.

455. Specifically tailored to support the challenges that were being faced by everyone in health and social care, the hub provided advice on self-care and personal resilience to help users to recognise their own 'warning signs'. Comprehensive information about services and resources available at national and local level within territorial Health Boards, HSCPs and local authorities was also available.

456. The document "Re-mobilise, Recover, Re-design: the framework for NHS Scotland", published on 31 May 2020, also outlined staff and carer wellbeing as one of eight key priorities for health and social care mobilisation [CL15/143 – INQ000147375]. The document sets out that the Scottish Government would:

- Support people to recover including their mental health and wellbeing
- Capture the interventions currently in place; identify additional actions required to support staff and include in the plan for recovery

- Emphasise the importance of wellbeing and kindness.

457. This included physical and psychological needs; developing a new compact and new systems to support staff in social care, primary care, community care, mental health, critical care, and acute care settings.

458. In addition, the SSSC also supported the emotional wellbeing of staff and undertook work to ensure support such as being an active member of national wellbeing focus groups; providing support for the 'Wellbeing Champion Network; and promoting the 'Coaching for Wellbeing Programme'.

Financial support for care providers

459. Through engagement with care provider representatives, the Scottish Government became aware of the increasing financial pressures that providers were facing as a result of the pandemic, including loss of income, increased staff costs and costs associated with additional IPC measures, including PPE.

460. To address these concerns, the Scottish Government introduced the 'COVID-19 Financial Support for Adult Social Care Providers' scheme (often referred to as 'Sustainability Payments') [CL15/144 – INQ000241259]. The scheme's aim was to support resilience in the social care sector and reassure the sector that additional costs related to COVID-19 would be reimbursed. This financial support supplemented national reliefs and grants for costs specific to the social care sector.

461. An initial £50 million of support for the social care sector was announced on 12 May 2020. The funding announced was intended to support the sustainability of care providers. A second tranche of funding of £50 million was announced on 3 November 2020. A set of principles to govern the implementation of support payments were developed initially by COSLA and IA Chief Finance Officers, before being reviewed and agreed by Scottish Government and shared with key stakeholders, including

Scottish Care and CCPS. Sustainability payments comprised of the following elements:

- Care Home occupancy: provision of financial support where a care home was impacted by a reduction in occupancy because it was clinically unsafe to admit, or where there was a reduction in admissions, due to Covid-19
- Care at Home and community-based services: financial support was provided on the basis of planned activity where the level of activity expected was not able to be delivered due to Covid-19
- Additional costs as a result of Covid-19: including additional PPE, increased staffing costs, sickness absence costs, IPC measures and testing and vaccination costs.

462. Scottish Ministers and COSLA were key decision makers on financial support. Scottish Ministers had overall responsibility for the effectiveness of the funding and value for money of the scheme. COSLA represented local authorities, who held the contracts with social care providers, and were responsible for administering the payments.

463. Over time, the scope of the financial support scheme evolved in response to prevailing circumstances. The payment mechanism established for sustainability/financial support payments was also used to distribute payments under the Social Care Staff Support Fund.

464. From December 2020, the Scottish Government's focus turned from provider sustainability to financial support covering additional costs incurred by providers due to onset of the pandemic. This new approach was designed to be more targeted on additional cost directly related to the pandemic, more consistent and less administratively burdensome. Support under the new scheme included:

- Under-occupancy and non-delivery of services

- As before, additional outgoings as a result of the pandemic were supported, with new guidance specifying in more detail the types of costs which could be claimed under the scheme.

465. Discussions were supported by Financial Support for Social Care Providers Working Group comprising: COSLA, Scottish Care, CCPS, IA Chief Finance Officers and trades union representatives.

466. The final elements of financial support to adult social care providers ended in March 2023. At this point the only elements of financial support remaining in effect were for costs associated with asymptomatic testing in the social care workforce and staff undertaking vaccinations. This had been the case since October 2022.

Insurance

467. Scottish Ministers became aware of the increasing difficulty of care homes and care service providers obtaining Public Liability insurance during the pandemic in discussion with those representing care service providers. Providers were also seeing significant increases in premiums and added exclusions and endorsements, particularly Covid-related. Scottish Care had raised this issue with the Cabinet Secretary for Health and Sport and explained that the situation had put a great deal of pressure on providers and had potential risks to the viability of some care homes.

468. Following a meeting on 9 December 2020 with Scottish Care, the Cabinet Secretary for Health and Sport wrote to the UK Health Secretary, Matt Hancock, on 18 December 2020 (and again on 19 January 2021) and copied in the Northern Ireland and Welsh devolved administrations about this issue [CL15/145 – INQ000510006], noting that insurance concerns continued to cause care homes to adopt a very cautious approach to both admissions and visiting arrangements. The UK Health Secretary responded on 21 January 2021, setting out steps being taken to develop a

proposal to indemnify registered care providers for losses arising in relation to Covid19 public liability claims with HM Treasury [CL15/146 – INQ000512632].

469. Additionally the Scottish Government liaised with the Association of British Insurers (ABI) to see what could be done to help. ABI strongly advised providers to engage as early as possible with insurers to identify what information was required for renewal. When faced with specific cases, the Scottish Government worked with the ABI to resolve problems. For example, one care home was having difficulty in renewing its policy due to their delaying their renewal to near the expiry date. The Scottish Government engaged with ABI, who were then able to find an alternative insurer.

470. There were other examples of engagement with ABI and the care home sector over changes to policies. One example was in June 2021 when PHS and CMO, based on scientific evidence, recommended to Scottish Ministers that COVID recovered care home residents in hospital could be safely discharged home after 14 days from symptom onset or first positive test without further testing. Such individuals were likely to continue to test positive but not be infectious, so it was recommended that people were safe to be discharged after 14 days. Following concerns raised by the sector about insurance, officials engaged with AIB and with Scottish Care who supported the policy change. While there were mixed views among AIB members on this policy, it was decided on balance to adopt the policy as aimed to prevent poorer outcomes from people staying in hospital for prolonged periods, was backed by science and was already happening in England [CL15/147 – INQ000510055].

471. Another example was around changes to visiting policy. Following feedback from care homes that they did not think their insurer would support a full return to indoor visiting and support named visitors in infectious outbreaks while following public health / IPC measures, Scottish Government officials engaged with Scottish Care and AIB in advance of changes to guidance. Feedback from AIB was in line with the above – providers should contact their insurer or broker if unsure – and additionally that insurers expect providers to follow the public health advice.

472. Subsequently, the Minister for Mental Wellbeing and Social Care also raised the issue of insurance with Gillian Keegan, both by letter and also in meetings. On 3 March 2022, he met with Gillian Keegan MP, then UK Government Minister of State for Care and Mental Health, and Scottish Care to discuss the issue of Public Liability and Employers Liability (PLEL) Insurance in the care sector. Copy of correspondence regarding this matter is provided [CL15/147A – INQ000592042].

473. At the meeting, examples of the increases were given for different sizes and models of care home, with 75% being the approximate average increase in premiums

in the last year. It was hoped that as the pandemic restrictions were loosened, it would encourage the insurance industry to review the risk levels that they used to assess premiums. As insurance is a reserved matter under Section A3, Schedule 5 Part II of the Scotland Act 1998 it was agreed that the UK Government staff would arrange a Four Nations meeting with stakeholders and the insurance industry representatives to find a solution. The Scottish Government does not have a record of this meeting taking place, or any note of the outcomes. The Inquiry may wish to request copies of these materials from the UK Government Department of Health and Social Care who provided the Secretariat for this meeting.

474. The Scottish Government continued to monitor the situation and was not made aware of any specific instances where a care provider had not been able to obtain public liability insurance cover. As part of the annual National Care Homes Contract negotiations between COSLA/Scotland Excel and Scottish Care, increases in Public Liability insurance premiums were reflected in the cost model that underpins it.

Social Care Staff Support Fund (SCSSF)

475. Scottish Ministers set up the SCSSF from 27 May 2020 to ensure that social care workers who were absent from work with illness due to coronavirus or were selfisolating received their expected income (i.e. an amount similar to their usual

salary) and did not suffer financial hardship. This support was developed as it became clear that a large proportion of social care employers did not have occupational sick pay policies and relied on statutory sick pay (which may have caused anxiety about testing positive and resultant reduction in pay for ASC staff). The issue was first raised with SG by ASC stakeholders during a series of weekly calls in early April 2020. Following this Scottish Care highlighted the issue on 9 April 2020 for a meeting of the National
Contingency Planning Group [CL15/148 – INQ000591929], [CL15/149 – INQ000591931]. The issue was subsequently discussed on 15 April 2020 at meeting of the SG Senior Workforce Leadership Group [CL15/150 – INQ000591933] [CL15/151 – INQ000591934]. These issues were discussed during a meeting on 13 May 2020 with the STUC and trade unions where the Cabinet Secretary for Health and Sport was in attendance [CL15/152 – INQ000107206].

476. In addition, with the inception of the Test and Protect policy, it was anticipated that social care workers would likely be among those identified as close contacts of someone who had tested positive for Covid-19, due to the nature of their work. They could also find themselves in this situation on more than one occasion and be required to isolate for 14 days each time. The Cabinet Secretary for Health and Sport wrote to social care employers on 24 June 2020 [CL15/152A – INQ000260096], as part of a wider communication around testing in care homes, to highlight the Fund and its intended operation.

477. Payments from the Fund were backdated to 23 March 2020 and applied to social care workers contracted to deliver care and support in the sector in the following categories of services: support services, care home services, offender accommodation services and housing support services. Eligible workers included those who were ill with confirmed Covid-19; or were self-isolating in line with the latest Scottish NHS guidance, or specific social care IPC guidance issued by Scottish Ministers or PHS.

478. The Scottish Government setup a stakeholder group to agree the scope and eligibility criteria for the Fund. The group included representation from three trades unions, local government (COSLA), CCPS and Scottish Care. In the Summer of 2020, feedback from COSLA and social care stakeholders highlighted some issues with the provider

sustainability payment process, of which the SCSSF was part. Stakeholders felt that the guidance prior to December 2020 was not prescriptive enough. They expressed a view and that the guidance was open to interpretation and lacked clear, actionable steps. This resulted in a lack of consistency in how the guidance was applied. A trouble-shooting process was carried out which helped to identify and resolve local issues. From December 2020, the claim process was streamlined and became consistent across the country. Providers were however asked to keep full records in case they were requested as part of any audit.

479. Staffing costs claimed through sustainability payments encompass the SCSSF, the staff movement policy and other additional staffing arrangements. Consequently, the Scottish Government does not have data broken down to the level of the SCSSF only. The guidance for the financial support for social care providers recommended a light touch approach to gathering evidence, recognising the administrative burden of

claiming additional costs on both commissioners and providers alike, whilst they responded to the pandemic. In the absence of data specific to the SCSSF regular feedback was sought from stakeholders representing the workforce and social care providers to help measure the impact. This indicated that the fund was well utilised.

480. Funds for this policy came from COVID consequentials received from UK Government (as explained above at paragraphs 95 to 99). The SCSSF was demandled, therefore there was no set budget, and no eligible workers would be turned down due to insufficient funds. On this basis there were no concerns raised over the adequacy of the funding made available to meet identified need.

Support for social care workforce

481. Throughout the period of the pandemic the Scottish Government maintained its support to the social care workforce to deliver safe support and care and to have positive mental health and wellbeing. These measures are described in more detail in the following sections.

Adult Social Care Real Living Wage – National Uplift

482. Payment of the Real Living Wage to social care workers has been a key Scottish Government and COSLA policy since 2016. In past years there had been a delay in this payment being made to social care workers as rates are negotiated and agreed locally, with some social care providers spanning multiple local authorities.

483. Given the highly pressurised circumstances social care workers were experiencing during the pandemic, stakeholders representing social care providers and trades unions expressed concern that any delay to the real living wage uplift during the pandemic would not be acceptable. To that end, the Scottish Government and COSLA worked closely with key stakeholders including CCPS, Scottish Care and local government chief finance officers to deliver this uplift and to ensure that social care workers received this without delay to be paid from 1 April 2020.

Shielding social care workers

484. An extension of SCSSF included Scottish Government providing financial support to social care workers who were shielding during the pandemic. This sought to reduce the financial hardship for those who were shielding because of Covid-19 and commenced on 11 January 2021. This fund was specifically for social care workers who were eligible for the UK Government's Coronavirus Job Retention Scheme (CJRS), but were not placed on this by their employer.

485. The Social Care Staff Support Fund (Coronavirus) (Scotland) Regulations 2020 were amended on 24 December 2020 to apply the SCSSF to relevant social care workers who were shielding during the period March to October 2020, or who were assessed by NHS Inform as being higher risk, and agreed with their employer that they could not safely carry out their duties, whose employers did not apply to the CJRS.

486. The Scottish Government established a working group of stakeholders to determine the scope and mechanisms for this provision including representatives from Scottish Care, CCPS, COSLA, the GMB union, RCN, Unite and UNISON. It

also included a Chief Finance Officer from a HSCP. This group met twice to discuss these issues. It was agreed that claims could be made where social care workers were either advised to shield themselves, or were unable to carry out their duties due to the risk from specific health conditions of contracting Covid-19 during the period 23 March 2020 to 31 October 2020 and were not placed on the CJRS.

487. An Equalities Impact Assessment (EQIA) carried out in March 2021 when extending the SCSSF to include shielding workers, [CL15/153– INQ000182728]. It was evident that SCSSF provided up to 80% of their income (in line with that which would have been received under CJRS) to ensure that workers who were required to shield and not placed on the CJRS were not financially disadvantaged (and so less likely to fall into poverty) when compared to their co-workers. It was advised that this will assist with the retention of staff who may have had to leave the sector, which would have had negative effects on people such as the elderly or disabled, who rely on this care to maintain their quality of life.

488. The EQIA demonstrated that eligible individuals, based on sector evidence, may have been more likely to be impacted due to protected characteristics. This meant that:

- The policy provided positive impacts in terms of financial benefits to avoid hardship
- That care must be taken to ensure that messages around impacts on benefits were clearly understood, to avoid any potential negative impacts.

489. In respect of the second point, completing this EQIA led to engagement with stakeholders including DWP, HMRC, Citizens Advice and the Child Poverty Action Group to better understand any benefit implications. This also led the Scottish Government to develop a 'landing page' on the gov.scot website aimed at workers. The text on the landing page was developed with stakeholders, including representatives of all the major social care workers unions, to ensure that the text was clearly understandable and accessible. The Scottish Government also consulted with and invited feedback from these same stakeholders on the EQIA.

Social Care Worker Death in Service Payment Scheme

490. Scottish Ministers published details of the Coronavirus (COVID-19): social care worker death in service payment scheme on 30 July 2020 [CL15/154 – INQ000509901]. This aimed to recognise the increased risk faced by staff during the pandemic and offered financial support to a nominated next of kin who had lost an adult social care worker to a Covid-19-related death while working in a frontline health and social care role during the pandemic. The scheme provided a one-off payment of £60,000. It made payments for eligible claims in respect of coronavirus-related deaths occurring between 17 March 2020 and 30 June 2022. Eligible workers were classed as staff working in adult care homes, residential child care (including secure care), care at home (including housing support), personal assistants, mental health officers, third sector edge of care and social workers (including related paraprofessional roles), as well as bank social care staff, catering staff within social care settings, auxiliary staff in social care settings and agency staff (for death in service only). Further detail regarding the scheme is set out in the advice provided to the Cabinet Secretary for Health and Sport on 3 June 2020 [CL15/155 – INQ000240977].

491. The Scottish Government utilised key external stakeholders to issue communications regarding the Fund to employers including provider membership organisations, Local Authorities, and trades unions to be cascaded to employers and staff. The Scottish Government sent further communications to CCPS and Scottish Care to publicise the scheme to their members.

Thank you payments to care sector

492. On 30 November 2020 the First Minister announced a £500 one off 'thank you' payment for health and social care staff [CL15/156 – INQ000510005]. The Scottish Government worked in partnership with representatives from all key social care stakeholders to agree eligibility criteria, funding allocation methods and delivery timescales. Adult social care 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 to receive the £500 thank you payment.

Self-Isolation Support Grant

493. On 13 October 2020 the Scottish Government introduced the Self-Isolation Support Grant (SISG) for those who were required to isolate any time after 28 September 2020. The aim of the SISG was to provide a grant of £500 to any workers who earned less than the Real Living Wage or were on a low income and who experienced reduced earnings as a result of them, their child or the person they were caring for being required to stay at home to prevent the spread of COVID-19. As the isolation rules changed over time, eligibility for SISG changed to match them. This grant has helped to support people who would otherwise have struggled to be able to afford to comply with the requirement to self-isolate or advice to stay at home. 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 to cover the Scottish Government Health Policy advice to stay at home i.e. the requirement to self-isolate was removed. A limit of three grants in any 12 month period was also introduced at this time. The SISG was closed to new entrants from 6 January 2023.

494. The SISG differed from the SCSSF. As key workers, social care workers provided care and daily living support to people across Scotland throughout the coronavirus pandemic. The nature of this work meant that they came into close contact with people and in many cases were caring for people who contracted coronavirus. The SCSSF supported this specific group of workers who, due to the nature of their work or work environment, may have been expected to self-isolate on more than one occasion as part of IPC. The aim was to ensure that social care workers who were absent from work with illness due to coronavirus or were self-isolating received their expected income (i.e. an amount similar to their usual salary) and did not suffer financial hardship. SCSSF recipients were not ordinarily eligible for SISG because they did not face a loss in income.

Other Support

495. In January 2022, new staff joining the social care workforce had their entry costs paid by the Scottish Government until the end of March 2000. The necessary Protection of Vulnerable Groups (PVG) checks and SSSC registration fees were funded to help encourage more staff into the profession and address winter staffing pressures. Basic PVG checks costs were £59, with SSSC registration costs ranging between £25 and £80 depending on the role. The estimated cost of the scheme was approximately £465,000.

Health and wellbeing support for the ASC workforce

496. The Scottish Government continued to recognise that individuals who work in health and social care experienced high levels of mental ill health, including depression, anxiety and PTSD. As part of the announcement of the Programme for Government 2020, the Scottish Government allocated £5 million in 2020/21 for a comprehensive package of national support to the workforce. 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.

497. The publication of the Health and Social Care: Winter Overview 2021 to 2022 [CL15/157 – INQ000492663] and companion document the ASC Preparedness Plan 2021-22 [CL15/158 – INQ000147362] saw an increased focus on supporting the needs and wellbeing of the social care workforce and unpaid carers. It recognised the pressures that were being experienced across the social care system, in particular with regards to attracting, recruiting and retaining staff.

498. On Monday 20 July 2020, the "wellbeing line" for the health and social care workforce, based within NHS 24's Mental Health Hub, was launched. The health and social care workforce wellbeing line was a separate number, which routed callers to a ring-fenced team of Psychological Wellbeing Practitioners who offered

callers a compassionate and empathetic response based on the principles of Psychological First Aid. They also provided advice, signposting and onward referral to local services if required.

499. The National Wellbeing Hub provided a range of self-care and wellbeing resources for all staff, unpaid carers, volunteers and their families to enhance personal resilience, and signposted to relevant mental health and support services. This included the Workforce Specialist Service, which offered confidential mental health assessment and treatment for regulated health and social care professionals; digital apps to help with stress, anxiety and sleep; and online 'Coaching for Wellbeing'. In addition, grant funding was made available via a new Workforce Wellbeing Fund intended to improve staff wellbeing for staff working in Adult Social Work & Social Care across the public, private and voluntary sectors.

500. The Scottish Government identified the importance of providing on-going support to promote both physical and psychological wellbeing. It worked with territorial Health Boards, HSCPs and social care providers to ensure arrangements were in place for actively promoting rest and recuperation, that there were accessible rest areas for staff (including by exploring options for Scottish Government support for upgrade to the existing health estate to support provision of rest areas), and the continued

provision of practical support measures for staff, such as hot drinks, snacks or mobile catering.

501. In January 2021, £500,000 was allocated to territorial Health Boards and HSCPs to enhance practical support for staff during the second wave of the pandemic. Further funding was available to take forward COVID-19 recovery actions, leading into a new National Wellbeing Programme. The recovery action plan included social care staff wellbeing being prioritised for support with staff needs recognised as distinct from those of health.

Wellbeing Conversations

502. 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. They considered the whole wellbeing of an individual (e.g. physical, mental, emotional, social, financial, lifestyle, safety), They could help identify areas where an individual may need support, signpost them to that support and regularly monitor their wellbeing over time. Learning from the experience of where Wellbeing Conversations were working well, and using tried and tested national tools for stress prevention/management the Scottish Government provided templates, guidance, resources and training to roll these out widely across the health and social care system. These took cognisance of Work Positive managed by PHS, and the Health and Safety Executive (HSE) Stress Indicator and Talking Toolkit.

Occupational Risk Assessment

503. In July 2020, the Scottish Government developed guidance to provide individuals and employers with an individualised and evidence-based approach to understanding how COVID-19 affects certain groups in the population, and what employers could do to make the workplace as safe as possible. This also recognised that underlying health conditions and ethnicity, when viewed in isolation, did not accurately predict an individual's vulnerability to Covid-19. Scottish Government therefore recommended

that an individual assessment should be carried out by line managers that takes multiple personal characteristics into account. To that end, an Occupational Risk Assessment guidance and tool were introduced. Copies of the guidance provided [CL15/138 – INQ000429263].

504. The NCD also wrote on 31 July 2020 to Social Care Provider Representative Organisations [CL15/159 – INQ000510016] and urged employers and staff to be active participants in the risk assessment. This used factors including age, ethnicity, and BMI in addition to underlying health conditions to stratify risk. It was

not intended to view medical conditions in isolation, as this does not accurately predict an individual's vulnerability.

505. The tool was aimed with the individual in mind, to help them to understand their own individual risk factors. The guidance highlighted the responsibilities of the employer to minimise the risks in the workplace, making adjustments where possible, and referring to Occupational Health as appropriate.

Designation of Key Workers

506. The Inquiry has requested the rationale for not classifying social care staff as key workers at the start of the pandemic and the impact. The Scottish Government records suggest that there was no delay to social care workers obtaining key worker status. Social care staff were designated as key workers as part of the UK Government announcement on 19 March 2020 [CL15/160 – INQ000302521]. This was followed by guidance issued, the same day, by the Deputy First Minister to COSLA and SoLACE. In addition, the Cabinet Secretary for Health and Sport and COSLA's Health and Care spokesperson issued a joint communication to local Authority Chief Executives and IA Chief Officers on 30 March 2020 [CL15/161 – INQ000510003], which reinforced the view held that "*Scotland's social care support workers are unequivocally key workers*". This also stated that all of these workers must be regarded as key workers and have access to childcare if necessary to enable them to carry out their critical role, this includes social workers. They were also able to access the appropriate level of PPE if required, for the people they support and later when testing was rolled out. The Annex to the letter of 30 March 2020 provided guidance for personal assistants on how to obtain proof of key worker status, if an employer could not.

507. The Scottish Government understands that there were issues identified by stakeholders involving priority access to some supermarkets for social care workers, particularly in the early stages of the pandemic. As noted above, there were no delays to the classification of social care workers as key workers and this was reinforced by communications from SG and COSLA in March 2020. The decision to both introduce and expand priority access to supermarkets was taken by individual retailers, who

often differed in their approach to whether key workers beyond NHS staff, including social care workers, should have priority access. This was an issue of concern throughout the UK and the Secretary of State for Health and Social Care announced on 14 April 2020 that DHSC had asked supermarkets to confirm that social care workers could have the same priority access as NHS staff, announcement provided [CL15/161A – INQ000581277].

508. The Scottish Government also took steps to ensure that Personal Assistants, who might not have registration cards that prove their key worker status, would have necessary documentation that would enable them to access benefits for key workers (as set out in the guidance provided on 30 April 2020).

Key workers: Stakeholder Views

509. The Inquiry has asked for views on the comment from Roz Foyer of the STUC during Module 2A that not enough was being done to protect key workers who put themselves and their families at risk to provide essential services. Throughout the pandemic period, the Scottish Government engaged with the sector and workforce representatives to hear about the issues and hear experiences including from the STUC, COSLA and care provider representatives.

510. The Scottish Government worked with stakeholders to develop guidance, monitor its implementation and provide support. The Scottish Government engaged with workforce representatives throughout the pandemic, including STUC, to understand the issues facing the social care workforce and worked with them to develop guidance, monitor its implementation and provide support.

511. The Scottish Government took a number of steps in the early stages of the pandemic to protect social care workers. These focused on measures to prevent staff contracting Covid-19 in the workplace, prevention of transmission of Covid-19, detection of Covid-19 among staff and service users, support for staff with Covid-19 and wider wellbeing support around the impact of Covid-19 on staff.

512. The Guidance issued by both Scottish Government and HPS on the management of Covid-19 in care homes and residential settings aimed to protect all those within social

care settings, including staff and residents. The guidance focused principally on preventing ingress of Covid-19 within care homes and other settings and minimising transmission in outbreak situations.

513. As noted above, local PPE Hubs were established in March 2020 which ensured that social care workers across the social care sector had access to PPE support.

514. The Scottish Government also worked with its partners such as the local multidisciplinary oversight teams and CI to obtain assurances around training on IPC measures, staffing levels and use of testing in care homes.

515. In April 2020, care home staff and their household members with symptoms were given access to testing. This was followed by routine whole-home testing of everyone regardless of symptoms in care homes with cases of Covid-19. Further details regarding the rollout of testing follow at paragraph 692 onwards.

516. In June the Scottish Government introduced the requirement for care home staff who interact with residents to wear a medical face mask throughout their shift as part of enhanced safety for health and social care staff. Furthermore, anyone entering care homes were asked to wear a face covering throughout. Local PPE Hubs were also established to support the whole social care sector. Scottish Government also worked with its partners to obtain assurances around training on IPC measures, staffing levels and use of testing in care homes.

517. Scottish Ministers recognised the valued contribution of the workforce during the pandemic. As described earlier in the statement a range of measures were introduced to demonstrate support to the adult social care workforce. Those included

establishment of a new wellbeing hub, an uplift to the Real Living Wage, and a "Thank you" payment.

518. In conclusion, the Scottish Government recognised the importance and valuable contribution of individuals working in social care. During the pandemic, the Scottish Government acknowledged the concerns raised by workforce representatives and sought to protect and support key workers. This is demonstrated through the range of

practical, wellbeing and financial measures put in place from early in the pandemic to protect the workforce, as outlined above.

Care in the Home and workforce

519. The Scottish Government understood the range of difficulties being experienced across the social care sector including care at home services through regular engagement with people with lived experience and stakeholders. A particular concern with care at home services was the challenge in having to manage a very sudden change in support and services available during the pandemic.

520. On 26 March 2020, the Scottish Government issued Guidance for Care at Home, Housing Support and Sheltered Housing to social care providers under the cover of a letter from the Scottish Government's CMO, CNO and CSWA [CL15/162 – INQ000496478]. The guidance outlined a range of protective measures and precautions including use of face masks, provided links to further guidance such as the NIPCM Scottish Covid-19 IPC addendum and signposting to additional resources.

521. This followed the initial guidance issued by HPS, COVID-19: Information and Guidance for Social or Community Care & Residential Settings, published on the 12 and 23 March 2020 [CL15/163 – INQ000280632], and [CL15/164 – INQ000189301]. This provided advice on self-isolation, and hygiene, PPE including removal, waste, occupational exposure and referred to the NICPM. Care at Home and communitybased services were also eligible for sustainability payments. This package of financial support was provided on the basis of planned activity where this was not able to be delivered due to Covid-19. This helped with financial pressures as a result of the pandemic, including additional infection control and PPE costs.

522. Work was undertaken by the Scottish Government in March/April 2020 with NES and SSSC to consider how it could enhance the workforce to support care homes

and care at home. This involved working with COSLA, private providers and the voluntary sector to make sure that it got the right people to the right place.

523. As described earlier, CHRAG initially focused on the delivery of national polices on adult social care within the care home sector. Further detail regarding the work of CHRAG is provided above at paragraph 172 above onwards. However, these measures were also deployed in the wider social care sector as part of the Scottish Government's wider approach to supporting adult social care, for which additional policy-specific advisory groups were established to consider measures such as testing, PPE etc (see groups above). Furthermore, one of the key principles of the CHRAG, as stated in its action plan of June 2020 [CL15/165 – INQ000322942], was for all people in Scotland to have the same right to effective protection and care whether they are in hospital, care homes, at home or elsewhere, irrespective of their frailty or underlying conditions such as dementia. Its successor forum, PRASCG, also sought opportunities to enhance existing collaborative working across adult social care sector leaders.

524. In response to the challenges being faced by care at home services, additional funding was made available to increase the capacity of social care support. A national helpline was launched on 14 April 2020 to help people "at risk" access essential help if they did not have family or other support. Callers were put in touch with their local authority which could support them to access essential food and medication; links to local social work services for vulnerable children or adults; emotional support; and contact with local volunteer groups.

525. A wider package of investment by the Scottish Government to local authorities included £70 million toward a Food Fund. This was established to ensure support was put in place for people to access food, including those having to self-isolate; older people; and families entitled to free school meals.

526. As noted above, local PPE Hubs were established to ensure social care support providers had access to adequate PPE to continue providing support safely during COVID-19. 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. The enhanced Hub model created a

more stable and equitable distribution of PPE for social care support, and extended PPE to unpaid carers, Personal Assistants and non-registered social care services.

Consideration of care at home workforce

527. The Inquiry has also asked for a view on the extent to which all of the focus in April–May 2020 was on care homes and not the care at home workforce. While the Scottish Government acknowledges that care homes were considered a priority area as it was a high-risk setting, as noted above, it also introduced measures to support the Care at Home workforce, including in the early stages of the pandemic. This included:

- The 26 March 2020 'Guidance for Care at Home, Housing Support and Sheltered Housing' [CL15/106 – INQ000189302] to social care providers, which outlined a range of protective measures and precautions including use of face masks, provided links to further guidance such as the NIPCM Scottish COVID 19 IPC addendum and signposting to additional resources
- This followed the HPS - COVID-19: Information and Guidance for Social or Community Care & Residential Settings published on the 12 and 23 March 2020 which provided advice to the wider social care sector, including care at home sector, on self-isolation, and hygiene, PPE including removal, waste, occupational exposure and referred to the NICPM [CL15/163 – INQ000280632], [CL15/164 – INQ000189301].

528. On 30 March 2020 the Cabinet Secretary for Health and Sport and COSLA [CL15/135 – INQ000510003] wrote jointly 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 for people. The letter reiterated the statement of thanks from the First Minister on 29 March 2020 and the vital importance of the social care support workforce. As outlined above at paragraph 435, the letter of 30 March 2020 set out the commitment to, and the importance of, the whole social care workforce, including those providing care at home services and their status as key workers. The letter

made clear that access to appropriate PPE would be provided and provides details of how to access PPE if needed. The letter outlined the support being provided for unpaid carers and guidance available.

529. 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 as a result of the pandemic, including additional infection control and PPE costs. Care at home staff were eligible for the Social Care Staff Support Fund, which ensured that social care workers who were absent from work with illness due to coronavirus or were selfisolating received their expected income (further detail regarding this fund is provided at paragraph 475).

530. In response to concerns raised by people who could not access the local PPE hubs, including the care at home workforce, an enhanced Hub model was set up in April 2020. The enhanced Hub model created a more stable and equitable distribution of PPE for social care support, and extended PPE to unpaid carers, Personal Assistants and non-registered social care services.

531. As in the rest of the UK, regular asymptomatic testing was initially confined to high risk health and social care settings including care homes. However, it was later expanded to include the wider adult social care workforce as testing capacity, including testing labs, increased. Further details regarding testing are provided at paragraphs 772 to 785 below.

532. The challenges facing health and social care staff across all sectors were recognised and this led to the development of national and local wellbeing programmes, including the national digital wellbeing hub, which was set up on 11 May 2020 (see further, paragraph 499 above).

533. In summary, the above steps were taken to ensure social care workers, including care at home staff were supported and concerns raised by the workforce or their representatives in the early stages of the pandemic were considered.

SDS Guidance

534. SDS is a way that care and support is delivered, and about giving individuals the full opportunity to take control of their support and their lives. SDS is therefore about how a support plan is put into action so that children, adults and their guardians or carers receive the help they need to meet agreed personal outcomes. It helps supported people and carers to make informed choices – based on their unique needs and circumstances – on what their support looks like and to have choice and control over how that support is arranged, managed and delivered. SDS applies across all ages and user groups, including unpaid carers and children.

535. Recognising the challenges presented as a result of COVID-19 the SDS guidance was also reviewed in May 2020 by the Scottish Government [CL15/166 – INQ000592040]. This offered the ability for greater flexibility and was aimed at:

- Maintaining existing arrangements for care and support
- Maximising flexibility and autonomy for the supported person in meeting agreed outcomes
- Minimising bureaucracy and administrative processes surrounding SDS options 1 and 2 as far as possible
- Ensuring Fair Work principles were applied to the Personal Assistant workforce, PA employers and contracted services
- Maximising and support the capacity of the PA workforce during the pandemic period, retaining PA and provider capacity long term
- Ensuring equality of access, choice and control across all SDS Options
- Supporting efficient and sustainable use of funding.

536. Advice on the proposed revised guidance was provided to the Cabinet Secretary for Health and Sport on 30 April 2020 [CL15/167 – INQ000509956]. The draft guidance set out that supported people and unpaid carers would be able to use their budget to meet their agreed outcomes when workforce (or other resources) were affected due to shielding, self-isolation or sickness. Examples provided included; transport to take the person to appointments, shopping delivery costs, laundrette costs and house cleaning

(where PAs or providers would have supported the person with daily living tasks but were unable to do so). Other examples included the purchase of IT equipment or website memberships to facilitate social interaction whilst physical distancing applied, or gym equipment as an alternative to gym membership whilst gyms were not open. The guidance made clear that it "should remain a requirement to demonstrate a clear link between items and services purchased and the personal outcomes identified and agreed in a person's assessment/care and or support plan, adult carer support plan or young carer support plan." It was advised that, where there was pre-existing concerns regarding how budgets had been used or questions around the individual's capacity to make decisions, the professional judgment of social workers and related professionals should inform all decision making. The guidance also provided detail regarding the employment of family members during the pandemic period.

Unpaid carers

537. The Covid-19 pandemic created significant difficulties and hardships for many carers. When many support services closed or reduced capacity as part of the first lockdown in March 2020, carers stepped into the gap to support vulnerable friends and family members. 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.

538. From the beginning of the pandemic, Scottish Government engaged remotely with carer representatives. It hosted weekly meetings to better understand the issues carers and carer support organisations were facing and to keep them up to date with any changes to policy and guidance. Scottish Ministers also met remotely with unpaid carers and carer representatives during the pandemic to listen to and respond to their concerns. Together, this dialogue enabled the Scottish Government to determine the level of support required.

539. The Scottish Government hosted weekly catch-ups from the beginning of the pandemic with Scotland's National Carer Organisations (NCOs). The frequency changed from weekly to fortnightly later in the pandemic. The NCOs are the six

main charities in Scotland who focus on addressing unpaid carer issues. They are: Carers Scotland; Carers Trust Scotland; MECOPP; Coalition of Carers in Scotland (COCIS); Shared Care Scotland; and Family Fund.

540. As these catch-ups were informal and used as a way of sharing issues of common concern around carer support, no formal notes of these meetings were captured. However, updates were provided by the Scottish Government at every meeting and officials have confirmed that meetings included discussions on:

- Public information and advice for carers
- Local mobilisation plans
- Targeted funding to help local carer services adapt to working safely
- PPE for unpaid carers
- Covid testing for unpaid carers
- Prioritised vaccinations for unpaid carers
- Short breaks
- Support for young carers
- Changes to adult carer support plans and young carer statement as a result of the Coronavirus Act
- Carer's Allowance
- The Scottish Welfare Fund
- The re-establishment of respite, short break and day centre services
- Plans for moving out of lockdown
- Concerns raised by local carer organisations.

541. The Carer Leads Network was an additional informal network, which included representatives responsible for carer support from each local authority/IA in Scotland. The meetings of this network were facilitated by Scottish Government officials but the decisions around content and focus were generally led by carer leads. The meetings shared good practice and discussed issues of common concern around carer support.

Updates were provided by the Scottish Government at every meeting.

542. During the relevant period, the group met five times – 7 July 2020, 1 September 2020, 27 October 2020, 18 May 2021 and 7 September 2021. Minutes of this group are provided [CL15/043 – INQ000592021].

543. As part of these meetings Scottish Government updates and discussion points included:

- Public information and advice for carers
- Local mobilisation plans
- Targeted funding to help local carer services adapt to working safely
- PPE for unpaid carers
- Covid testing for unpaid carers
- Prioritised vaccinations for unpaid carers
- Short breaks
- Support for young carers
- Changes to adult carer support plans and young carer statement as a result of the Coronavirus Act
- Carer's Allowance
- The Scottish Welfare Fund
- The re-establishment of respite, short break and day centre services
- Plans for moving out of lockdown.

544. The Carers Act Implementation Steering Group was set-up by the Scottish Government's Carers Policy Team in 2016 to oversee the implementation of the Carers (Scotland) Act 2016. It was renamed the Carers Rights and Support Steering Group in December 2021 and given a broader remit to focus on wider carers issues across social care and broader Scottish Government policy. It included representatives from local authorities, territorial Health Boards, COSLA, third sector and carer representatives. This group has had responsibility for the implementation of the National Carers Strategy since it was published in December 2022. It is chaired by the Scottish Government. Its membership is set out below:

- Scottish Government - Adult Social Care
- Scottish Government - Unpaid Carers team
- Carers Representative
- Coalition of Carers in Scotland
- NHS NES

- HIS
- SSSC
- Shared Care Scotland
- Aberdeenshire HSCP
- Carers Trust Scotland
- The Alliance
- COSLA
- MECOPP
- CI
- North Ayrshire HSCP
- NHS Lothian
- Carers Scotland
- Glasgow HSCP
- Social Work Scotland (Adults)

545. Meetings included updates from the Scottish Government on topics such as:

- The development of legislation prioritising supporting carers looking after someone with a terminal illness
- Planning virtual Carers Parliament events
- Alternatives to a face-to-face Young Carers Festival event
- Public communications highlighting carers' rights and support
- Carers Act Implementation.

546. The group met nine times during the relevant period – on 2 March 2020, 27 July 2020, 28 October 2020, 10 February 2021, 22 June 2021, 22 September 2021, 15 December 2021, 23 March 2022 and 29 June 2022, minutes provided [CL15/044 – INQ000509913].

547. Access to information was a key issue for both unpaid carers and local carer support services. Carers needed advice on how to protect the person they were caring for, who were often people at higher risk of Covid-19 infection. They also felt an added responsibility to protect themselves from infection, both to reduce the risk of transmission to the cared for person and also so that they could continue providing the care.

548. In March 2020, Scottish Government created carer-specific pages on its website to help people and carer organisations find the most up to date information that was relevant for them and also created similar young carer friendly pages on Young Scot's Young Carer platform. The content covered a range of practical issues, including infection control; when to use and how to access PPE, testing, vaccination and wider support; and how the distancing rules applied to carers. The Scottish Government adapted these pages throughout the pandemic in response to stakeholder feedback and also as the advice and distancing rules changed. The Scottish Government National Wellbeing Hub also included a specific section for unpaid carers. It hosted information and resources to support carers to look after their mental health and wellbeing.

549. Scottish Government also provided financial support to unpaid carers. For example, 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. While in June 2020, over 84,000 eligible carers were given extra financial support through the Coronavirus Carer's Allowance Supplement in recognition of the additional financial pressures carers were facing.

550. Further support was provided by the Scottish Government in July 2020 in the form of additional funding to expand the Family Fund short break support for families looking after disabled children. This was followed in August 2020, by the SSSC and NES publishing online wellbeing resources specifically for carer support staff to provide them with information and tools to support their own emotional wellbeing and encourage them to look after themselves while supporting others.

551. An extra £300,000 was allocated to expand support for young carers. Of which, £200,000 was provided to Young Scot, in June 2020, to provide online

subscriptions and e-vouchers via its existing Young Carer Package and £100,000 funded the expansion of the Time to Live carer centre short-break micro grants scheme. On 10 April 2020, Scottish Ministers and COSLA wrote to HSCPs to ask them to prioritise additional carer support in their local mobilisation plans for responding to the pandemic. There was also an uplift of £11.6 million Carers Act funding for local carer support in the 2020–21 local government settlement.

552. Other, non-financial, support included the Scottish Government funded social media-based campaign run by Young Scot aimed at helping young people recognise if they were a young carer and directing them to support. This campaign commenced from June 2020 and was re-run from late 2020 into early 2021.

553. In December 2020, the Scottish Government undertook a national marketing campaign designed to help more people recognise when they are in a caring role and access support. This was re-run in the campaign of March 2022.

554. In January 2021, an additional amount of £750,000 was allocated to local carer centres. This support enabled them to expand support for unpaid carers in line with local priorities. Furthermore, the Scottish Government allocated an additional £28.5 million for local carer support in 2021–22 and wrote to Local Authorities and IAs to highlight the importance of expanding carer support [CL15/168 – INQ000510002].

555. In recognition of the additional financial pressures carers were facing, a second additional payment of the Coronavirus Carer's Allowance Supplement of £231.40 was made to over 85,000 carers in December 2021. Furthermore, in January 2022, the Scottish Government allocated an additional £4 million to help organisations working with unpaid carers to put expanded services in place. An additional £500,000 fund was established in April 2022 to help local carer support organisations to invest in improving their capacity.

556. The annual Young Carer Festival in 2020 and 2021 was unable to be held in the traditional way due to Covid-19. The Scottish Government recognised that more than ever young carers needed an opportunity for a break and to be able to speak

out about the most salient issues facing them. It therefore provided £100,000 in small

grants for local young carer groups to run their own Covid-safe events. It also put in place an online festival featuring workshops; activities for young carers and their families to take part in; and panel discussion involving Scottish Ministers, answering young carers' questions.

557. Unpaid carers were also represented on the PRASCG, which provided a multistakeholder focal point for work being undertaken to support the effective delivery of ASC during the pandemic (see further, paragraph 179 above).

Care in the Home and Disabled People

558. Covid-19 highlighted issues already faced by disabled people. However, the pandemic also created new discriminations and has left disabled people isolated and excluded; for example, extra barriers made shopping less accessible, leading to food insecurity. The Scottish Government heard about the experiences of disabled people including those at home, where the workforce was more diversely employed and who were more likely to move between homes, meaning that it was more complex to set up clinical support and safeguarding. Ministers were also very clear on the importance of lived experience and how to consider further how best to strengthen this going forward. The Scottish Government were made aware of the issue of disabled people having support from their personal assistants withdrawn and resultant issues listed in this question through engagement with Disabled People's Organisations (DPOs) during this period through various channels, including the sharing of DPO reports, media requests, and meetings with officials and Ministers and DPOs. These issues were also highlighted in briefings for key meetings between DPOs and officials/Ministers.

559. A paper titled "Supporting those at risk during Covid-19" [CL15/169 –

INQ000591988] was put together on 2 April 2020 by the Disability Equality team with coordinated responses from policy teams covering Adult Social Care, Carers, Maternity Care, and Learning Disabilities and Autism teams. This paper was put together to use by relevant Scottish Government policy areas to understand what needed to be done for groups of people not shielding but still at risk, including disabled people who received formal or unpaid social care. This paper noted issues with withdrawal of social care services and "continuing issues with workforce availability".

560. A copy of a press statement made by the Scottish Independent Living Coalition (SILC), a coalition consisting of DPOs in Scotland, on 21 April 2020 was sent to the Scottish Government [CL15/170 – INQ000509526]. This statement set out the impact of Covid on disabled people's lives and human rights. The Minister for Older People and Equalities, Christine McKelvie MSP, and representatives from the Disabled People's Organisations Inclusion Scotland, Glasgow Disability Alliance (GDA), and Disability Equality Scotland on 26 May 2020 [CL15/171 – INQ000591989] as part of a regular Disability Roundtable which was set up to hear from DPOs directly about issues impacting disabled people during this period.

561. The Scottish Government learned about removal or reduction of social care packages during Covid, issues accessing food and medication and difficulties of those lip reading by deaf people/BSL users due to masks. The Minister for Parliamentary Business and Veterans, Graeme Dey MSP, responded to Dr Jim Elder-Woodward regarding the SILC statement on 28 May 2020 [CL15/172 – INQ000591990]. The response outlined social care and other forms of support:

"*I recognise the impact and the pressures this pandemic has had on the social care sector, but do not expect current pressures to have a long-term effect on people's care packages. Local authorities are still expected to do as much as they can to meet people's needs, with appropriate safeguarding measures in place. We are working hard to increase social care workforce capacity, including testing more individuals to enable them to return to work. Officials are working with local authorities and NHS Boards to scale up social care services to meet the additional demands arising from Covid-19. Funding has been made available for direct payments where existing services have been withdrawn and the supported person feels that they could meet*

their outcomes in a different way. It may interest you to know that a national helpline has been set up to connect people with local helplines and access to support. This includes people who, although vulnerable, do not fall into the shielded category. Callers are put in touch with their local authority who will support them to access the service they need, including essential food and medication; links to local social work services for vulnerable children or adults; emotional support; and contact with local volunteer groups. The number is: 0800 111 4000. I recognise the importance of Personal Protective Equipment (PPE) to enable those who providing social care support to do so safely and everyone providing social care has access to PPE through local hubs. To enable these hubs have extended their provision to include all social care providers, and unpaid or family carers and personal assistants. I hope this reassures you. Furthermore, officials are in touch with SILC and will report back to the Cabinet Secretary for Health".

562. On 3 June 2020, charities representing disabled people, older people, unpaid carers and consumers (Action on Hearing Loss Scotland, Age Scotland, Carers Scotland, Guide Dogs Scotland, RNIB Scotland, Royal Blind and Scottish War Blinded and Which?) wrote to the First Minister regarding access to food for vulnerable people (including those not on the shielding list) [CL15/173 – INQ000591763]. The letter set out a range of actions which the charities considered would assist those who needed support in accessing food.

563. The First Minister responded on 13 October 2020 setting out the steps taken to support individuals to access food and other essentials, and thanking the organisations for their support in ensuring that resources reached those most in need [CL15/174 – INQ000591992]. The response also set out other measures taken, including the £350 million package of Communities funding announced on 18 March. By the end of September 2020, the Scottish Government had made £57.6 million available to support local authorities to lead a coordinated response to food insecurity and ensure that people were able to access food and essentials. The response highlighted that the national assistance helpline established on 14

April 2020 had received 107,000 calls from the shielding group and over 83,000 calls from the NonShielding at Risk group by mid-September 2020 (in conjunction with other calls made to local authority phone lines, referrals made locally and other work ongoing locally with partners in the third sector, volunteers and retailers to support individuals). The response further set out that funding of £80 million had been made available to support third sector and community efforts – with over £12 million specifically focused

on tackling food security, and that further funding was made available to support Age Scotland to increase the capacity of its national helpline.

564. The Scottish Government Winter Preparedness Plan published in October 2020 was referenced as it 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".

565. With regards to issues accessing food, a £70m Food Fund was provided by Scottish Government, as well as a contract with Bidford/Breaks for delivering food during Covid.

566. In April 2020, the SILC sent a statement on the rights of disabled people in relation to Covid-19 to ministers, local government, the NHS and "many others who have a role to play in ensuring our human rights". They said in the statement that disabled people in Scotland "are experiencing breaches to their human rights and discrimination" which "cannot be allowed to continue" [CL15/170 – INQ000509526].

567. In response to questions in Parliament regarding care packages, the Cabinet Secretary for Health and Sport stated on 28 April 2020 that, "*It is important to be clear at the outset that the majority of people who receive home care support have not been reported as losing their home care packages. However, a significant number have, and I take that matter seriously. It is a matter of considerable concern, given our commitment to people's right to live as independently as they wish to, no matter what age they are.*" [CL15/174A – INQ000329218]. The Cabinet

Secretary set out details of the range of measures in place, including the agreement with COSLA re: an uplift in

ASC contracts, workforce resilience efforts and daily contact between officials and HSCP Chief Officers [CL15/175 – INQ000509966].

568. The CI report, "Delivering Care at Home and housing support services during the Covid-19 pandemic" (September 2020) [CL15/175A – INQ000320158] presented the CI's findings. The report found that there were a number of common themes and challenges in relation to the delivery of care at home and housing support services and noted, "Almost all HSCPs experienced a reduction in overall demand for care at home and housing support services during the pandemic. People who experience care and their families reducing or cancelling their support was the most common reason for this." The report concluded that "all HSCPs prioritise support for people with critical needs, almost all made changes to packages to care to do this, but the number of people affected by this reprioritisation across HSCPs was very variable." The report noted that early in the pandemic, staffing capacity was a significant issue – however, this issue was balanced in some areas due to the reduced demand on services. The Inquiry has asked for details of the numbers/percentage of people who lost their care home packages during the pandemic and the reasons for this. The CI report "Delivering Care at Home and housing support services during the Covid-19 pandemic" (September 2020) [CL15/175A – INQ000320158] indicates that data is collected by HSCPs at a local level however this is not collated centrally. Information on total numbers of people receiving support from Local Authorities and HSCPs is published annually by PHS.

569. The report included figures of the numbers who had reduced or changed packages, "*of the 23 HSCPs that provided information, 21 had changed care packages and 19 indicated that changes had involved reductions in provision. The proportion of people experiencing care affected by these reductions ranged from as low as 0.3% to high as 71%. Nearly two thirds increased a small number of packages. The proportion of people experiencing care who received increases in support ranged from between 0.2% to 15%[...]. Despite the large numbers of people who experience care facing changes in their support in some HSCP areas, the numbers of hours of care released, by these changes was small.*" The report

set out the positive and negative impacts on those in receipt of care, care providers and HSCPs.

570. The report made recommendations to support delivery of these services (primarily aimed at HSCPs). Recommendations specifically for SG included:

- All partners, at national and local HSCP levels, should ensure new or emerging guidance on IPC measures addresses the unique challenges of providing care at home and support in people's homes
- The Scottish Government, HSCPs and service providers should review the processes for accessing SG sustainability funds for current or future Covid-19 related costs, to facilitate access for service providers, where relevant to such funding
- Partners at national and local levels should acknowledge that routine use of PPE is an ongoing necessity and ensure the associated costs are reflected in the cost of care at home and housing support
- Nationally and locally, HSC partners should build on the outcomes of the report – bringing these together with emerging information – to inform planning for the ongoing pandemic response and the agenda for ASC reform.

571. In addition to the funding directed towards social care from the 2020–21 budget, it was agreed with COSLA that Scottish Government would meet additional social care costs incurred because of the impact of the pandemic. That agreement was specifically to ensure that both existing and new demand in social care could be met. Disability Equality Scotland also shared with the Disability Equality & BSL team their weekly polls [CL15/179 – INQ000362906] with their members on issues arising with their members in the pandemic. Of relevance to this inquiry was an attachment with the results for the weekly poll for 17 August 2020 [CL15/180 – INQ000329225],which asked if members received social care support at this time and if so, had their social care support changed during the pandemic. Of the 37% (111) respondents who answered yes to the first question 111 respondents (97%)

responded yes to the second question with 306 respondents of the survey (99%) answering no to the question "is there enough support in place for carers and people receiving care during the Covid-19 pandemic". The report and the briefing highlighted "*47% [of GDA members surveyed] worried about social care support", "2000+ care packages cut in Glasgow from 20 March, many with no notice and no follow up*", and "*many left with no support to wash, eat, take medications or forced to rely on other vulnerable family, friends, neighbours".*

572. Throughout 2020 and into 2021, a wide range of organisations have been working closely with their membership and the public to understand the impact that the pandemic, and the restrictions that have been implemented, have had on disabled people.

573. The Scottish Government heard from GDA that the Covid-19 crisis was 'supercharging' inequalities for disabled people and the Covid-response risks leaving disabled people behind. The GDA wrote to provide a copy of its August 2020 publication [CL15/176 – INQ000184668].The GDA went on to state that 40% of disabled people so far were worried about food, medication or money [CL15/177 – INQ000591994]. Food insecurity had spiked. One response said, "Lack of nutritious food suitable for my diet is a worry, and the impact on my health and my condition". Over 72% were worried about becoming acutely isolated and digital exclusion was a huge factor.

574. The Scottish Government was also aware of Inclusion Scotland's Rights at Risk Report (published October 2020), which set out the results of a survey of 800 disabled people's experience during Covid-19 [CL15/178 – INQ000142277]. The report set out the range of challenges faced by disabled people during this time and highlighted issues with access to social care, with 30% of respondents reporting their social care had been stopped or reduced completely.

575. Respondents to the survey also reporting "difficulty in accessing food" and being "unable to isolate or shield as they did not have support to access food and medicine". Although there is no specific mention of difficulties accessing specialist diets, a separate GDA report mentions restricted diets, lack of social care, and due to other

barriers meant some food aid provision has not been suitable for disabled people [CL15/176 – INQ000184668].

576. The Scottish Government recognised the challenges and worked to increase social care workforce capacity, including testing more individuals to enable them to return to work. It also worked with Local Authorities and territorial Health Boards to scale up social care services to meet the additional demands arising from Covid-19. The updated Self Directed Support Guidance approved by the Cabinet Secretary for Health and Sport in April 2020 reinforced that changes were anticipated to be temporary and that all direct payment amounts would remain the same and full support provision (or alternatives) would resume as soon as is practicable [CL15/166 – INQ000592040]. Funding was made available for direct payments where existing services had been withdrawn and the supported person felt that they could meet their outcomes in a different way. For example, supported people and unpaid carers during

the pandemic should have been able to use their budgets in new ways to meet their outcomes when workforce or other resources were affected due to sickness, selfisolation or shielding. This may have included spend on transport to take the person to appointments, shopping delivery costs, laundrette costs and house cleaning where

PA's or providers would have supported the person with daily living tasks but were not able to do so. Other examples could have included the purchase of IT equipment or website memberships to facilitate social interaction while physical distancing applied, or gym equipment as an alternative to a gym membership while clubs were closed and not charging as usual. Local Authority and HSCP staff were responsible for communicating with those in receipt of SDS, the April 2020 guidance made clear that *"As advised by Scottish Government and COSLA on 24 March 2020, the Scottish Government will meet additional costs to increase support and staff capacity in social care during the pandemic, subject to alignment with local mobilisation plans."* Reasonable additional costs caused by Covid-19 were to be met and recorded through HSCP mobilisation plans – including costs for services delegated to IJBs. Additional relevant costs within non-delegated services were to be recorded on the COSLA financial template. The Scottish Government and COSLA encouraged the

expansion of carer support for unpaid carers due to the additional pressure carers were under through local mobilisation plans.

577. In recognition that disabled people have been disproportionately affected by the Covid-19 pandemic and the lockdown, in June 2020 Scottish Ministers established a Social Renewal Advisory Board (SRAB) to focus on tackling poverty and disadvantage and advancing equality. The Cabinet Secretary for Communities and Local Government and the Cabinet Secretary for Social Security and Older People presented a paper for discussion at Cabinet on 9 June 2020 which set out their proposed approach to Social Renewal in the post Covid-19 period – including the establishment of a SRAB [CL15/179 – INQ000362906]. The paper set out the steps to be taken and highlighted that engagement with social justice and equality stakeholders on these matters had been continuing since the start of the pandemic, with an initial roundtable held on 2 June 2020 to begin the social renewal work [CL15/179A – INQ000591997]. The paper set out the six principles which underpinned the approach, including a clearly articulated vision, a participative approach (informed by a wide range of stakeholders and people with lived experience), informed by data and evidence, guided by the place principle, mindful of the financial position and sustainable over the long-term.

578. The paper also highlighted the exacerbation of existing inequalities during the pandemic, including:

- Inter-generational aspects of Covid-19, and from an equality perspective, potential issues around reinforcing negative attitudes to older people
- Covid-19 played into attitudes that lead groups (particularly older people and disabled people) to be seen and referred to as vulnerable and having poorer quality of life – this led to views that they do not have full agency over decisions in their lives and/or for their lives to be seen as of less value than others
- Gendered aspects of the crisis and response have been significant given (a) the predominance of women in particularly affected sectors and (b) the disproportionate role of women in unpaid care work

- As we move into recovery, labour market impacts will be hugely important for women but also for other groups already disadvantaged in terms of employment (including disabled people and some ethnic minority communities).

579. A Parliamentary debate 'Covid-19: New steps for our Communities' was led on 9 June 2020, transcript provided [CL15/180 – INQ000329225].

580. This included specific consideration of the issues disabled people experienced over the period of the pandemic. The SRAB was jointly chaired by the Cabinet Secretaries for Communities and Local Government Social Security and Older People. With the exception of representatives from COSLA and SOLACE, members were not invited as representatives of their organisation or sector, but in recognition of the individual contribution they could make, terms of reference provided [CL15/181 – INQ000591999].

581. The SRAB's independent report, 'If Not Now? When?' was published in January 2021 [CL15/182 – INQ000366046] and included 20 Calls to Action across the three themes of (i) Money and Work, (ii) People, Rights and Advancing Equality and (iii) Communities and Collective Endeavour. The SRAB was supported by a series of nine 'policy circles' which involved people with lived experience. Summaries of this feedback are provided with the SRAB final report.

582. The Scottish Government's initial response to the report was published on 23 March 2021 [CL15/183 – INQ000592001] and set out details of the work underway to address the SRAB's recommendations and announced an additional investment of £25 million to take forward a number of actions.

583. The Scottish Government published its own research into how the Covid-19 pandemic had impacted disabled people in Scotland by considering health, social and economic harms in March 2021 [CL15/184 – INQ000182797]. This considered mortality rates including people with learning/intellectual disabilities and also summarises the wider impacts of Covid-19 on disabled people using evidence from a range of DPOs. The research concluded that the pandemic had a disproportionately negative impact on disabled people in a number of areas. Issues affecting disabled people included increased mortality, worse labour market

outcomes, access to public transport, loneliness, increased isolation, accessing food as a result of food shortages, gaps and delays in receiving shielding support and priority deliveries.

584. The pandemic highlighted equality issues to be addressed and those were to be considered as part of the SRAB and the Independent Review of Adult Social Care. While Scottish Government continued to ensure good engagement practice was maintained it was not always possible in every case to give sufficient time to consult with stakeholders, for example, due to the rapid nature of shielding policy development and implementation, and a desire to sustain a common approach at the beginning of the pandemic across the UK.

585. The Scottish Government developed a Stakeholder Matrix and Inclusion Scotland was listed as one of the relevant contacts. This list enabled the Scottish Government to reach out to stakeholders in the lead up to important milestones such as the end of the Highest Risk List in May 2022. The Scottish Government requested stakeholders' input into the content of advice, including:

- July 2020, the 'Occupational Risk Assessment Guidance'. Inclusion Scotland was one of the organisations the Scottish Government engaged with [CL15/138 – INQ000429263]
- December 2020, a booklet called 'Balancing the risks of everyday activities during coronavirus' was published [CL15/185 – INQ000510014]. This was developed through user testing with people from the Shielding List. Prior to finalisation, a draft was sent to organisations for their feedback. One of the organisations was Inclusion Scotland

586. The Scottish Government arranged meetings with the stakeholders to keep them informed and discuss issues. A meeting on 11 September 2020 included a preview of a communication to be issued by the CMO. Inclusion Scotland attended the meeting and were copied in to the subsequent correspondence.

587. In 2016 Scottish Government launched 'A Fairer Scotland for Disabled People', an action plan that was written with the direct involvement of disabled people and DPOs [CL15/186 – INQ000256770]. The action plan included five long-term ambitions and a set of 93 actions and was subject of a progress report on 22 March 2021 [CL15/187 – INQ000512657]. The progress report set out the key achievements against the ambitions, noting that the Covid-19 pandemic, *"has undoubtedly had a disproportionate impact on disabled people and has halted some of the gains made towards equality. However, it has in some situations seen positive progress made at a rapid pace and has brought about a wider public awareness of inequality."* Annex A to the progress report set out progress against each of the 93 actions, including:

- An increase in the number of people involved in choosing and controlling their support through self-directed support options
- Extension of the Support in the Right Direction Fund in April 2022 to secure independent support for people and carers using or seeking social care support
- The Independent Living Transition Fund opened on 20 December 2017 and the upper limit of the fund was extended from 21 years to 25 years in November, with a continued growth in applications. The Fund became a major provider of transition planning across Scotland, especially for those who were unable during the Covid-19 pandemic to access support from local authorities and other public bodies

- The Health and Social Care Standards – My support, my life – were published in June 2017 and took effect on 1 April 2018
- The Carers Act 2016 was implemented on 1 April 2018
- A Mental Health Strategy was published in March 2017 – work to progress the delivery of this plan was paused in March 2020 to focus on the response to the Covid-19 pandemic and a Mental Health Transition and Recovery Plan was issued in October 2020 and incorporated outstanding actions from the Strategy.

588. The Scottish Government Disability Equality & BSL team met twice (January 2022 and June 2022) with members of the SILC to begin to develop and co-design with

DPOs the next phase of "A Fairer Scotland for Disabled People 2016-2021" [CL15/186 – INQ000256770] [CL15/187 – INQ000512657]. DPOs discussed prioritising Covid recovery and considering the themes of the SRAB when drafting the plan. GDA sat on the SRAB during this period and had regular weekly engagement with officials and Ministers.

589. In the 2020–21 Programme for Government, the Scottish Government committed to actively consider the incorporation of the Convention on the Rights of Persons with Disabilities (UNCRPD), working with key stakeholders in these sectors. This resulted in a government-led National Taskforce for Human Rights Leadership which recommended incorporation of UNCRPD as part of a new and comprehensive statutory human rights framework.

590. Other meetings occurred during this period including:

- On 7 July 2020, the Cabinet Secretary for Health and Sport and Dr Sally Witcher, CEO of Inclusion Scotland, held a teleconference
- The Minister for Equalities and Older People attended and spoke at an online Access Panel held by Disability Equality Scotland on 25 February 2021
- A meeting took place between GDA, the Cabinet Secretary for Social Justice, Housing, and Local Government, Shona Robison MSP, and Minister for Mental Wellbeing and Social Care, Kevin Stewart MSP, on 25 June 2021, briefing provided [CL15/188 – INQ000592002].

- The Minister for Older People and Equalities, Christine McKelvie MSP, recorded a speech for a launch event for GDA's "triple whammy" report looking at the impact of Covid on disabled women on 8 March 2022.
- A meeting was held between the Minister for Older People and Equalities and Dr Sally Witcher, CEO of Inclusion Scotland in March 2022, minute provided [CL15/189 – INQ000323335]. The matters discussed were out with the scope of this Inquiry but in a follow up letter, the Minister mentioned the Equality and Human Rights Fund provided to third sector organisations including DPOs in relation to support during Covid.

Impact on those shielding

591. It was recognised early in the pandemic that asking people to shield would require support to be put in place to allow them to continue to access healthcare systems, prescriptions and medicines, as well as their access to supermarkets and shops.

Therefore, in the week commencing 23 March 2020, officials began working in partnership with Regional and Local Resilience Partnerships, NHS Boards, NES, PHS, NSS, wholesale food suppliers and multiple retailers to put in place a package of support to help people self-isolate. Regional Resilience Partnerships (RRPs) are statutory bodies which coordinate organisations to deal with emergencies. Local Resilience Partnerships are sub-groups to the RRPs and enable more localised responses.

592. This programme of work aimed rapidly to establish and deploy:

- A letter (consistent with letters provided across the four nations) was sent by the CMO to approximately 100,000 people asking them to self-isolate. The CMO subsequently wrote regularly to people on the highest risk list to provide updated advice, and the Scottish Government also issued regular further correspondence signposting to support services. This was done in paper form, to ensure digital poverty or lack of digital access/literacy were not barriers to accessing advice and support
- A national helpline for those who did not have family or community support
- A shielding page on the NHS Inform website
- A SMS service for shielding
- A national service to provide groceries to those at highest risk
- Priority online supermarket slots
- Access to a national food parcel delivery scheme
- A volunteer-led distribution service for people to access their prescriptions and medicines

- Later, further advice and support services were established, including access to Vitamin D supplements, access to lateral flow tests and employment risk assessment tools.

593. The SMS service that was introduced for people on the Highest Risk List, which would have included many disabled people was a deliberately 'low tech' approach taken to ensure that as many people as possible could access the service without having to rely on more sophisticated digital connectivity/skills.

594. In addition, the Scottish Government, via the Pharmacy and Medicine Division, worked with pharmacies to support the delivery of prescriptions to those who needed support, including those who were shielding and prioritising those who were not able to leave the house. Those who did not have existing support to collect prescriptions and were without support of family, neighbours or friends were able to contact the National Assistance Helpline so that local assistance centres could find someone (who was ID checked) to make a delivery. Hospital care teams made separate delivery arrangements for those receiving medicines or equipment from the hospital care team.

595. On 14 April 2020 an SMS was sent to people who had opted to receive messages, advising that Local Authorities would help with access to medications, or that people could telephone the National Assistance Helpline.

596. The Inquiry also asked about disabled people breaking shielding. As outlined above, to help prevent this the Scottish Government provided funding to support to access prescriptions, coordinating and deploying volunteers, arranging for the purchase and delivery of food alongside delivery of wider services essential to wellbeing. In December 2020 an initial £15 million flexible fund was made available followed in February 2021 by an additional £15 million. This £30 million package of support was provided to Local Authorities to ensure that the relevant support was in place to help address the issue highlighted by the Inquiry.

Learning Disabilities

597. On 1 May 2020 the Minister for Mental Health wrote to NHS Board Chairs and Chief Executives, IJB Chief Officers, Local Authority Chief Officers and Local Mental Health Services Leads to issue a set of Mental Health principles. The Annex to the principles includes specific content relating to people with learning disabilities [CL15/190 – INQ000261984]. These principles were aimed at offering safe, personcentred and effective service responses for people using NHS and local authority social care services during Covid-19 mobilisation. These operating principles were based on existing Mental Health Act principles (set out in the Mental Health (Care and Treatment) (Scotland) Act 2003) and directed Boards to Covid-related and other relevant existing guidance (such as the Health and Social Care Standards). This approach also sought to answer some specific operational queries that had arisen from Boards since the start of the pandemic.

598. The letter set out that, "*when considering decisions where there are no clear right or wrong answers, it is helpful to consider if what is being proposed is: reasonable, proportionate and justified".* The letter provided advice under each of the principles as follows:

- Responsive – advice was provided around new referrals triage and support, waiting lists (confirming that the Treatment Time Guarantee set out in the Patient Rights (Scotland) Act 2011 had not been suspended at this time). Territorial Health Boards and HSCPs were asked to provide the Scottish Government with copies of their existing policies for managing waiting lists, and to set out what they are doing during the emergency period
- Inclusive – the advice set out that the PSED apply and that treatment must be fair and equitable with no discrimination (including those people affected by Covid-19), additional care should be taken with vulnerable groups and service users with specific needs should be particularly considered (for example, those with a learning disability, neurodevelopmental disorder or dementia who may not understand/have difficulty accessing or complying with Covid-19 guidance)

- Needs led – efficient caseload management – with prioritisation based on clinical assessment of need
- Safe – minimisation of infective risk, with face to face contact to occur only where the service cannot be offered any other way and any face to face contact to follow clinical guidance.
- Collaborative – every opportunity for collaborative working should be taken, good communication, there must be an effective and robust Covid-19 escalation of concerns procedure, the Scottish Government must be advised about any critical issue that would prevent the delivery of basic safe service continuity
- Involvement – listen to and support family/carers
- Data collection – data collection of psychological therapy and CAHMS waiting times to continue
- Workforce – supporting staff wellbeing and safeguard staff wellbeing and resilience, transparency of support (if fast track pathways for staff are provided to mental health/wellbeing support, this should be articulated openly within the context of decision making about available Mental Health and wellbeing support for both the public and staff).

599. As well as other relevant resources, the operating principles linked to the Learning Disabilities and Autism Spectrum Disorder Clinical Guide [CL15/191 – INQ000592003, and asked Boards to use this to guide considerations of care and treatment where appropriate. The guidance also included workforce issues such as employers' responsibilities around optimising public mental health and safeguard the wellbeing and resilience of staff.

600. More generally, it was recognised that there were also specific groups who were more at risk as a result of Covid-19. Those include people with dementia, people with learning disabilities and autistic people. The Scottish Government engaged with organisations such as Alzheimer Scotland, the Scottish Commission for Learning Disabilities, and autism charities. At the height of the pandemic these meetings were daily to discuss emerging issues and what action was required to address them. One example of an issue that was raised was people with learning disabilities not understanding the guidance. The Scottish Government worked in partnership with the

Scottish Commission for people with Learning Disabilities and People First, to create Easy Read versions of guidance and information available on NHS Inform and gov.scot. This is a version of information that is easier to understand for people with learning disabilities. Additionally the issue of unpaid carers supporting people was raised and the Scottish Government included the carers of people with learning disabilities in the exempt list in hospital visiting guidance. Data on the vulnerability of people with learning disabilities was highlighted in these meetings, following this the Scottish Government worked with NRS and SLDO to expedite the approvals process for their data linkage proposal to research the mortality of people with learning disabilities due to Covid-19.

601. The Scottish Government acknowledged that some people were anxious or experienced emotional distress as a result of changes to routines. It provided £205,000 to support 47,000 autistic people across Scotland. This consisted of funding to increase capacity at the Scottish Autism Helpline, to provide additional support to those experiencing higher levels of anxiety and help for the National Autistic Society to keep people in touch online during lockdown. Funding of £56,000 was made available to a range of learning disability organisations to reduce social isolation over the winter period and funding of over £115,000 was made available to PAMIS and Down Syndrome Scotland to support unpaid carers. The Scottish Government worked with COSLA, autism and learning disability organisations to develop a plan for recovery and transformation.

602. On 15 January 2021 the Cabinet Secretary for Health and Sport wrote to the HSC sector to clarity that essential day service support could continue and that ASC day services [CL15/191A – INQ000240331] could continue to operate, emphasising the essential support those facilities offered. The letter reiterated alternative sources of support for those who were unable to previous support offers.

Face coverings

603. The Deafscotland "Covid-19 Emergency Survey" (published June 2020) which was shared with the Scottish Government highlighted issues and made

recommendations to the Scottish Government. Their report stated: "*The safety measures of self-isolation and social distancing as well as the wearing of face masks and visors have all made the isolation of those affected by deafness much greater than that of people who are hearing*" [CL15/192 – INQ000592004].

604. The Scottish Government's advice was for people to consider wearing face coverings in public places where physical distancing is more challenging. In doing so it was recognised this can cause difficulties for some people, including those who rely on lip reading for communication.

605. The wearing of a face covering was intended to help prevent transmission of coronavirus. In situations where face coverings must be kept in place, people could consider using paper and pens, laptops or tablets, or visuals and symbols to communicate.

606. The Scottish Government recognises the importance of an inclusive society and aims to make Scotland a fairer place for everyone. It strongly encouraged people to be mindful of the communication needs of others at all times and bear in mind that face coverings can be temporarily removed to aid communication, as long as physical distancing could be respected.

607. Scottish Ministers received frequent communications from stakeholders representing deaf people highlighting challenges faced including those which included those communicating with lip-readers. Their responses reinforced the message that one of the most effective ways of preventing transmission of Covid-19 was to maintain physical distance and clean hands frequently using soap or antibacterial gel when communicating without wearing a face covering. The benefits transparent face coverings could bring were balanced with clear information on alternative approaches to improve communications.

608. In June 2020 Scottish Enterprise awarded £50,000 of funding from their Pivotal Enterprise Resilience Fund to an Edinburgh-based company Breathe Easy to expand its production of face coverings to include reusable face coverings with transparent panes, which facilitated lip-reading.

609. The wearing of face coverings became mandatory on 14 September 2020. Everyone who could do so was legally obliged to wear a face covering where it was mandated by law. The Scottish Government acknowledged that there were some people who could not do so, due to health conditions, disabilities or other special circumstances where a face covering may cause difficulty or distress. Both the regulations and the Scottish Government Guidance provided for this.

610. In particular, the Scottish Government recognised that face coverings could pose a real challenge for people who rely on lip-reading or seeing facial expressions in order to communicate and interact with others. The Scottish Government Guidance and advice published for non-clinical settings advised multiple approaches and adjustments which could be taken in order to aid communication. For example, in situations where face coverings were mandatory, the use of paper and pens, laptops or tablets, or visuals or symbols could facilitate alternative methods of communication.

611. The use of transparent face coverings was one such approach; other options were also highlighted. On 20 October 2020, the Scottish Government launched the face covering exemption card scheme in partnership with Disability Equality Scotland to support those who are unable to wear one to feel more confident and safer when accessing public spaces and using public services. The card was developed in conjunction with a range of equality stakeholders as something which could clearly communicate to others if a person was exempt from the regulations.

612. The Scottish Government worked to ensure there was an understanding of the role that transparent face coverings could play in aiding discussions and conversations, along with other approaches permissible in guidance. This included providing organisations with information on supply/procurement and sectoral guidance. Transparent face coverings were available from a number of retailers.

613. In December 2021, through a separate workstream from "Breathe easy", a transparent face mask was approved for use in health settings in Scotland. The "Alpha

Solway" mask was developed in accordance with the transparent face mask specification originally published on 1 April 2021. This specification was produced by the NHS Transparent Face Mask Working group brought together by NHS England and NHS Improvement (NHSE/I), which included Scottish Government representation.

614. In December 2021, four nations approval was agreed for the transparent facemasks, which were then released for distribution with appropriate guidance. By February 2022, 225,500 transparent masks had been issued to social care settings and by March 2022 this had increased to 233,400. By the end of June 2022, a total of 240,250 had been distributed with stock levels indicating that there was unlikely to be an access issue with regards to social care. The SG was unaware of any specific difficulties in people being able to access these masks.

615. The mask featured a clear anti-fog front panel, positioned to prevent reflection and make lip reading easier, and could be worn in healthcare settings where a Type IIR surgical face mask would be worn. The product was introduced to make communication easier and help reduce the challenges the pandemic created for those with communication needs following feedback about the challenges which facemask use posed for a proportion of disabled people. These included people with additional support needs (speech, language and communication); craniofacial abnormalities or conditions; adults with brain injury, head and neck cancer; neurological conditions, stroke patients; elderly patients, including those with dementia; autism or Asperger's; dysphagia; hearing impairment or loss; mental health needs and those with multiple disabilities. These masks were made available by NSS to Social Care providers through the Social Care PPE triage service and Social Care PPE Hubs. They were also provided to NHSS health boards and Primary Care Independent Contractors providing NHS services.

Digital barriers

616. The Scottish Government also heard from its stakeholders that access to the internet was a barrier for some disabled people during the COVID-19 pandemic. In addition, some disabled people needed support staff to help them understand documents or

support them to give their views. More widely, the Scottish Government worked in partnership across all sectors to identify fresh opportunities to build

sustainable programs that will support even more people to gain or improve their digital skills.

617. There were wider issues of isolation, exclusion and a lack of accessible information needed to support people during periods of national lockdown where physical contact and access to services were limited. It was recognised that digital exclusion was an issue for disabled people and those without adequate digital connectivity were particularly at risk of isolation as they lacked alternative forms of interaction.

618. To help mitigate this, the Cabinet Secretary for Health and Sport announced on 7 May 2020 the Connecting Scotland programme to support 9,000 low-income individuals across Scotland that are clinically high risk to COVID-19. The programme was launched with £5 million package of funding to offer an internet connection, training and support, and a laptop or tablet to connect with friends and family during the pandemic.

619. Third sector organisations also provided support to autistic people and people with learning disabilities in response to COVID-19. As with other organisations, they had to be flexible and restructure their traditional face-to-face services online to address the lack of face-to-face connections and social connections. This has proved to be more person-centred and preferred by some clients at risk.

620. The Scottish Council for Voluntary Organisations worked with local authorities and the third sector to lead on identifying people who were digitally excluded to offer digital devices, distributing them and providing training and support. SCVO also provided training to staff and volunteers working for organisations to be able to support individuals to use the internet safely, confidently and effectively.

621. There were also challenges for people with learning/intellectual disabilities to understand Covid-19 government guidance and messaging. This was identified early on addressed by the Scottish Commission for people with Learning Disabilities providing an easy read translation service commissioned by the Scottish Government.

They provided an Easy Read translation service of key Covid-19 information, such as the infographic circulated [CL15/106 – INQ000189302], as well as easy read information in relation to Shielding, Christmas guidance and NHS Inform.

622. A range of Covid-19 resources were developed with partners on the Inclusive Communications Hub. Funding was also provided to several DPOs throughout this period to projects aimed at supporting disabled people in Scotland impacted by the pandemic. The Scottish Government provided advisory services to help people interpret information to their personal situations.

623. On 16 April 2020 it also launched a service on gov.scot to help people find available support building on the UK government's 'Find Coronavirus Support' service by highlighting Scotland-specific support services for those affected by coronavirus. It provided information on staying safe, getting food, mental health and wellbeing, paying bills and other services.

624. In addition, the Scottish Government's Equality and Human Rights Fund provided £5 million to key disability organisations between 2021-2024. This fund provided support to deliver work focused on tackling inequality and discrimination, furthering equality, improving outcomes for disabled people, and advancing the realisation of human rights in Scotland. GDA also received a grant funding from the Scottish Government's Covid-19 Immediate Priorities Fund to support members during the pandemic, including money to improve digital access through the 'no-one left behind' project.

Care at home services

625. Scottish Ministers continued to be aware of the impact on care at home services and issues and risks faced. Ministers were clear throughout the pandemic that it was critical that people's social care support was maintained to ensure their safety, dignity and human rights. The Scottish Government ASC Winter Preparedness Plan 2020-21 [CL15/142 – INQ000249502] 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.

626. Many HSCPs reported considerable challenges around putting new Care at Home care packages in place. They advised that this was due to a combination of factors, including staff absence, annual leave carry-over from 2020, recruitment challenges, and a high level of demand for larger care packages due to increased acuity of need.

627. The Scottish Government was in regular, and for a period daily, contact with HSCPs facing the greatest challenges and monitored the situation closely. Territorial Health Boards and HSCPs provided assurances that people in need of the most urgent care would continue receiving care during a challenging period.

628. CI data was used to measure Covid-19 related absence levels in care at home services, alongside a new data collection implemented in August 2021 to monitor demand for care at home services. This included the numbers of people waiting for social care assessments, waiting for packages of care to start, and the number of hours of care at home services yet to be delivered. The Scottish Government Adult Social Care GOLD Group also considered these data on a regular basis and advocated further development of the data. Care at Home national and sub-national level data was circulated in advance of each meeting as part of the GOLD Group Data Pack. For example, as of 18 July 2022 there were 13,670 people waiting for assessment or a care package (consistent with the previous week) and a 4% increase from the number waiting as at 15 November 2021 (13,153) [CL15/193 – INQ000544489]. Of this, 8,655 people (63%) were awaiting an assessment (1% decrease from the previous week) and there had been an 8% increase from 15 November 2021 (5,128, 39%). The number of people waiting for an assessment or package of care represented around 308 per 10,000 adult (18+) population – consistent with the previous week and a decrease from the peak of 315 per 100,000 adults at 24 January 2022. Around 7% of this was hospital demand, with the remaining 93% in the community (consistent with previous weeks – with the split remaining unchanged since 16 May 2022).

629. The papers also provided a summary of hours of care to be provided. As at 18 July there were 54,269 hours of care yet to be provided for those 5,015 individuals who had had an assessment, a 2% increase from the previous week and a 3% increase from 15 November 2021 (52,636). 19% of the hours of care yet to be provided came from hospital demand – 7% of people awaiting an assessment or a package of care are from a hospital setting, as on average a greater number of hours are needed for those from a hospital setting. Where data is available, those waiting in a hospital

setting need around 14 hours per person, compared to 4 hours for those in a community setting (noting that those receiving care and in need of additional hours could come from either setting). 69% of the demand for hours came from the community – and 11% of the demand for hours comes from where care has been assessed as needed and not provided for those in receipt of a care package. The data showed there were also 8,655 people who were awaiting an assessment for a package of care – if 12.5 hours of care was summed – this would account for over 108,000 additional hours, slides provided [CL15/193 – INQ000544489].

630. On 26 July 2022, it was noted that the Covid-19 related staff-absence rates peaked in January and March 2022 at 8-9% and 5-6% respectively and then decreased to 1% across all services in May 2022. The regular data showed the level of staff absences / unavailable staff for care at home/housing support services, care homes for adults and older people (including all types of absence and vacancies (including annual leave)) with all posts (vacant and filled) as a denominator). For example, on 19 July 2022 the unavailable staff rates were higher in care at home/housing support services (23%) when compared with care homes for adults (20%) and older people (18%).

631. The CI can provide further detail of the data provided on social care staff absence and its source(s).

Parliamentary engagement and scrutiny

632. As part of their scrutiny of social care in Scotland, the Health and Sport Committee in the Scottish Parliament carried out an online survey to receive views from people who provided, or received, care and support at home. The survey was created to understand the impact of Covid-19 on care at home services, and what issues the pandemic had highlighted, improved, or made worse. Their report "How has Covid-19 impacted on care and support at home in Scotland?" was published in November 2020 [CL15/194 – INQ000512604].

633. The Committee wrote to Jeane Freeman, Cabinet Secretary for Health and Sport, to provide her with a copy of the survey results and to ask for the Scottish Government to take urgent action to address the concerns raised. In her response of 14 December 2020 [CL15/195 – INQ000512628], the Cabinet Secretary for Health and Sport stated that it was critical that social care support was maintained and that the Scottish Government had been working with Local Authorities and Health and Social Care Partnerships to assure people that temporary changes to support should not be longterm. The Cabinet Secretary also referred to the ASC Winter Preparedness Plan 2020-21 the previous month, provided [CL15/142 – INQ000249502] which set out measures already in place, and those which it was considered needed to be in place to respond to the impact of Covid-19 and wider winter viruses and pressures.

CI Publication

634. As discussed above at paragraph 568, CI published, 'Delivering Care at home and housing support services during the COVID-19 pandemic', in September 2020 [CL15/175A – INQ000320158]. This report drew together the views of HSCPs and service providers about their experience of care at home and housing support services during the first phase of this pandemic including how services were prioritised. The findings and recommendations were shared with the Cabinet Secretary for Health and Sport and discussed at a meeting with the regulator.

635. The Health and Sport Committee also wrote separately to the CI about the report's findings. The CI responded that key issues and recommendations had helped

informed planning at national and local levels to support winter planning in care at home. Their report was shared with HSCPs and checks on the progress made in implementing the recommendations was undertaken by the CI.

Testing

Overall population level approach

636. Prior to the availability of Covid-19 testing, clinical assessment and/or screening were the primary methods for diagnosing Covid-19. The availability of testing provided an important additional tool for diagnosis. Limited testing capacity in the early stages of the pandemic meant testing focused on settings of highest risk, including HSC

settings. With the rise in community cases, demand outstripped supply and testing was prioritised for:

- Clinical care
- Key workers
- Vulnerable settings such as hospitals
- Outbreaks in care homes, prisons and immigration and detention centres
- Selected key studies to inform policy or clinical practice.

637. The broad principle of testing in Health protection and health care delivery was to only test if a different course of action could be taken because of the result. Building sufficient laboratory testing and contact tracing workforce to enable whole population, tracing and supported isolation was a significant undertaking. Between March 2020 and May 2020, extensive efforts were made to build testing capacity to support strategic purposes beyond surveillance, clinical care and enabling keyworkers to return to work.

638. For context, at the outset of the pandemic, Covid-19 was not thought to be infective without symptoms. Therefore, guidance required that patients were screened prior to discharge from hospital to care settings. Screening of patients prior to discharge from

hospital is routine best practice on NHS wards under normal circumstances. The 26 March 2020 guidance [CL15/069 – INQ000429281] highlighted the need to be alert to atypical symptoms in older people when considering discharge.

The guidance reinforced the need for local consideration of a patient's symptoms (and potential other causes for symptoms, such as medicines). The guidance reinforced the point that people at risk should not be transferred inappropriately. Examples of the form of clinical assessment / screening expected were also included in the 26 March guidance at point 2.1 [CL15/069 – INQ000429281].

"2.1 To support diagnosis in residents, it is important that care home staff take residents temperature and where necessary are supported to take other vital signs including blood pressure, heart rate, pulse oximetry and respiratory rate. This will enable external healthcare staff to triage and prioritise support of residents according to need. While such monitoring will be helpful for diagnosis, it is important to note that for many older people living with frailty, their presentation when unwell may be very different to younger people. They may not have a cough and a temperature but may have a decline in function, falls or increased confusion as a symptom that they are unwell. Staff and family members will often be able to provide information on changes of health, behaviour or mood. The most important thing is simply to be vigilant that someone who is frail may experience health challenges in a different way and being aware of that may provide an opportunity to flag up when someone needs medical or nursing assessment".

639. The 26 March 2020 guidance also reinforced the need for assessment to ensure sufficient resources, including appropriate and adequate PPE, IPC, staffing and isolation facilities were available within the care home, to support social distancing and isolation upon arrival.

Testing capacity

640. Testing capacity expanded throughout the pandemic. At the outset, the limited available testing capacity was prioritised for hospitalised patient diagnostic purposes and outbreak management in closed settings, utilising local public health arrangements. Two laboratories opened in Scotland on 10 February to ensure more rapid turnaround of testing. Edinburgh had capacity for 100 tests per day and Glasgow had 250 tests per day. Within 10 days, the labs had tested 202 positive cases. On 15 March 2020, surveillance testing was extended to GP practices, covering up to 1.2 million people across all Territorial Health Boards in Scotland. The surveillance testing programme was for those exhibiting symptoms (including flu-like symptoms) and those admitted to hospital with symptoms. Key workers such as NHS staff were to be tested if they showed symptoms. By 18 March 2020, Scottish daily testing capacity was at 780 PCR tests per day across three laboratories, with plans to accelerate lab expansion to reach 3,000 daily tests.

641. On 24 March 2020, as part of targeting testing capacity to maximise impact, the Scottish Government provided guidance to NHS Boards about how to use NHS Scotland testing capacity to enable key health and social care workers to return to work **CL15/250 – INQ000398888**.

642. The guidance stated that NHS Boards should continue to prioritise testing for patients requiring hospital admission and meeting the clinical criteria:

- Clinical or radiological evidence of pneumonia
- Acute respiratory distress syndrome, or
- Influenza like illness (fever greater than or equal to 37.8 degrees centigrade and at least one of the following respiratory symptoms, which must be of acute onset; persistent cough (with or without sputum), hoarseness, nasal discharge or congestion, shortness of breath, sore throat, wheezing, sneezing).

643. NHS Boards were asked to prioritise using available testing capacity to address critical pressures in HSC services. The guidance stated that testing "s*hould also be prioritised to support investigation and management of clusters of respiratory illness in residential or care settings, for example long term care facilities and prisons... In these circumstances, advice on testing will be provided by the local*

Health Protection team managing the incident." Where testing capacity remained after these priorities were met, the guidance advised that this should normally be used to enable key workers to return to work, using the principles of:

- Prioritising testing to address support service delivery
- Prioritising testing to maximise the reduction in working days lost.

644. The guidance stated that

"The Scottish Government has not decided to create a static hierarchy of key worker roles or organisations for NHS Boards to use in prioritising who should be tested. Instead, at the current time, testing prioritisation should focus on supporting critical service delivery in health and social care services (including children's services)

NHS Boards should therefore adopt a flexible and dynamic approach to identifying which health and social care services have the most serious staffing challenges, and prioritise using testing to enable staff in these services to return to work. This prioritisation is likely to change frequently, and so staff may need to be reminded of the criteria being used. In doing so, NHS Boards will need to work with partners, including Health and Social Care Partnerships, to consider pressures in the broadest sense".

645. At this juncture, capacity in the NHS was 700 tests per week. The guidance noted that work was underway to increase NHS testing capacity in Scotland to about 3,200 samples per day by the end of April – including exploration of using non-NHS resources to support testing.

646. In the First Minister's statement of 1 May 2020 [CL15/131 – INQ000509948], she described the starting position at the beginning of the pandemic of Covid-19 testing being available through NHS Lothian and NHS Greater Glasgow and Clyde laboratories at a capacity of 350 tests per day. By the end of April 2020, Covid-19 testing capacity was established in the 14 territorial Health Board laboratories and total capacity was at 4,360 tests per day through NHS Scotland routes.

647. Capacity was also being built on a four nations basis through the Four Nations Testing Programme. One of the first three Lighthouse Laboratories was established in the University of Glasgow and commenced testing in the week of 23 April 2020. It progressively increased in capacity, from processing 41 tests per day on 21 April 2020 to 1,890 tests per day by 6 May 2020, operating 24 hours a day, 7 days a week. By the end of May, it was processing an average of over 10,000 tests per day. Scotland received a population share of the Four Nations Testing Programme capabilities, forgoing Barnett consequential funding that otherwise would have been made. The UK as a whole had a total level of testing capacity (and testing supplies – tests) available – Scotland received a population share of that testing capacity/tests, rather than additional consequential funding to allow our own capacity to be created or tests to be bought separately to the Four Nations Testing Programme.

648. In addition, in these early stages additional Point of Care testing (POCT) was procured via NSS (Lumira POCT) for use by territorial Health Boards in clinical care and patients cohorting in hospitals.

649. Physical sampling infrastructure for keyworkers to access Covid-19 testing was initially set up through Regional Test Sites at airports in Edinburgh, Glasgow, Aberdeen and Inverness through the UK programme.

650. While Covid-19 testing was based on both NHS Scotland and Four Nations Testing Programme routes, contact tracing and supporting isolation was built on local public health capabilities. On 25 April 2020, advice to Scottish Ministers proposed the introduction of a contact tracing system including a national call centre and expanded territorial Health Board teams. From 28 May 2020 contact tracing began on all individuals testing positive after testing was made available to all symptomatic individuals.

651. The strategy of Test, Trace, Isolate, Support was published on 4 May 2020 by the Scottish Government and explained the intervention, the early stages of building testing capacity and how contact tracing and isolating potentially infectious contacts worked to reduce transmission.

652. Through June and July 2020 the Cabinet Secretary agreed an approach to building up to an upper threshold of 50,000 tests per day for Scotland whilst also providing additional headroom for 20% for resilience purposes. This gave a total capability to deliver 60,000 tests per day by Winter 2020 as part of Scotland's Test and Protect Strategy.

653. Scaling up Covid-19 testing capacity in Scotland during 2020 was a complex, multiphased process that required collaboration between the Scottish Government, NSS, PHS, territorial health boards, local authorities and the UK Government. The strategy evolved to meet increasing testing demand, focussing on expanding sample collection infrastructure, increasing laboratory capacity, and improving accessibility across diverse communities.

654. In addition, the DG HSC provided strategic oversight and made decisions on testing capacity on behalf of Ministers. NSS led on the associated logistics for delivering tests within Scotland, while procurement and delivery of testing supplies were secured through the UK Government as part of the four-nations approach.

655. As noted in the testing chapter of the 4 CMO's technical report on Covid-19, there was a need for rapid scaling up of capacity and wider infrastructure to enable high throughput of (particularly diagnostic) tests. While this was achieved, there was a period, most evident in March to May 2020, in which testing supply restricted the effectiveness of identifying and isolating cases, tracing contracts, or making wider informed policy decisions. This difficulty in scaling existing systems in the UK was due to several reasons, including: the limited size of the pre-existing diagnostic industry (which was not the case in all comparable countries, some of which were able to scale more quickly) pre-existing testing systems used multiple small labs with multiple platforms and space constraints although they had an expert workforce, many smaller labs faced difficulties rapidly expanding the workforce global testing supplies (particularly swabs and reagents) were extremely limited and significantly impacted due to the increasing demand and reduced production in spring 2020 as the epidemic spread more widely, including to regions producing test material insufficient laboratories with the relevant quality assurance mechanisms or data flow systems in place.

656. These pressures meant that early in the first wave, testing capacity was limited, and there was a need to prioritise those who were tested. In Scotland this prioritisation focused on: · Clinical care

- Key workers
- Vulnerable settings such as hospitals.

657. Test and Protect relied on both NHS Scotland (reference lab, diagnostic, public health, and the regional hubs that were set up) and UKG Lighthouse laboratories. The NHS Scotland National Laboratories Programme also arranged for partner laboratories that collaborated as part of the wider network to be added to the system, if required for additional capacity. These included academic, wider public sector and private labs. NSS oversaw this, and each partner node operated under NHS governance. Academic and public sector labs contributed to this effort; private lab capacity was stood up however it was not utilised. This was because results would have needed to be validated by NHS laboratories to reach the quality assurance levels required. Partner nodes were stood down from April 2021 as the NHS Scotland regional hubs that were created were fully operational.

658. Test and Protect also relied on the UK Lighthouse Laboratory network, which utilised private sector partnerships to a much greater degree, including direct contracting arrangements. The UK Government led on the development of the UK Lighthouse Laboratory network.

659. Initially PHE led on securing the PCR tests, but Health Protection Scotland (HPS) worked with partners to secure a supply and build capacity and capability in Scotland. From 10 February 2020 two NHS labs, in Glasgow and Edinburgh, began processing samples for Covid-19.

660. Over March 2020, laboratory testing capacity increased with a further laboratory commissioned in Dundee. By 18 March 2020, Scottish daily testing capacity was 780 PCR tests per day across three laboratories (Edinburgh, Glasgow, and Dundee).

661. The Glasgow Lighthouse Laboratory was operational from 21 April 2020. On 1 May 2020, NHS lab capacity was 4,350 and Glasgow Lighthouse Laboratory capacity was 4,000, giving a total capacity of 8,350. By 5 June 2020 this had increased to 8,626 and 20,000; giving a total capacity of 28,626.

662. On individual deployment decisions, the Scottish Ministers considered advice that set out the regulatory status of a specific use, whether the Medicines and Healthcare products Regulation Agency (MHRA) had approved it, in addition to the policy and clinical risks and benefits including advice from Scottish Government clinicians.

663. The Scottish Government sought military assistance from the Ministry of Defence on several occasions during the pandemic. The assistance received was in line with the support received by all home nations and fully met the requirements of the Military Aid to Civilian Authorities (MACA) principles.

664. In January 2021, 12 military planners were working in support of the national programmes for vaccination and testing, with a predominant focus on vaccine-related issues. A further 23 planners were attached to each territorial health board providing local planning support. Outside of these Military Aid to Civilian Authorities tasks, Joint Military Command Scotland provided military liaison officers to each Local Resilience Partnership and had a Joint Regional Liaison Officer and small team co-ordinating the integration of military operations with the civil authority.

665. In September 2021, Scottish Ambulance Service (SAS) faced extraordinary pressures as a result of the pandemic. To assist SAS to cope with such high demand, the Scottish Government, as part of the £1bn NHS Recovery Plan, gave SAS an additional £20m funding. This helped SAS to facilitate, as a short-term measure, the assistance over 100 military personnel, who assisted as drivers and support to the mobile testing units across Scotland, as well as allowing SAS to enlist around 100 2nd year paramedic students to assist the Service in ambulance control rooms. In addition, the number of Hospital Ambulance Liaison Officers was raised from 11 to 20.

666. In December 2021 to January 2022 a large increase in case numbers related to the C19 Omicron variant meant there was very high demand for tests. Testing availability was prioritised for those at highest risk. The approach to prioritising testing availability ensured that limited capacity was directed where it was needed most, particularly during surges in demand. This meant identifying and prioritising high-risk groups—such as essential workers, those at higher risk, and those in critical settings like care homes and hospitals—and adjusting booking systems accordingly. By guaranteeing them priority access to testing, the policy minimised transmission in the areas most susceptible to severe outcomes or staffing pressures, helping to maintain essential services and protect those at greatest clinical risk.

667. All decisions regarding testing were informed by clinical guidance and testing capacity. As with the rest of the UK, the approach to testing in Scotland was enhanced as more tests became available. By the end of April 2020, Covid-19 testing capacity was established in 14 territorial Health Board laboratories and the total capacity was 4,350 tests per day through NHS Scotland routes, in addition to the Glasgow Lighthouse Laboratory capacity. On 1 May 2020, the Scottish Government published an update on testing expansion of up to 8, 350 tests per day – made up of 4,350 NHS tests and 4,000 from the Glasgow Lighthouse Laboratory, as part of the UK-wide Lighthouse Testing Network.

668. Advice to the First Minister and Cabinet Secretary for Health and Sport was provided on 18 March 2020 which provided initial advice on the approach to Covid-19 testing and monitoring following the decision to move from containment to delay [CL15/197 – INQ000512602]. This included details of laboratory capacity (at that juncture 780 tests per day) and steps being undertaken to secure additional capacity. The advice set out work being undertaken within the Scottish Government to define critical and key workers – based on the information gathered at that point – approx. 180,000 non-NHS public sector workers were identified as critical (this figure included social care workers). The advice proposed that the Scottish Government should align with work across the UK to define frontline Health and Social Care occupations to ensure these were prioritised in any early testing programme.

669. Scottish Government Testing Strategy The Scottish Government Testing Strategy was published on 17 August 2020 [CL15/198 – INQ000147448] and its revised strategic intent as set became using testing to attempt to drive transmission, and therefore the number of cases of Covid-19, down to the lowest possible levels and to maintain that level. This strategic intent reflected the scientific and clinical advice available at the time from the available local and international evidence. At this point case number variation was evident with waves of increases and reductions having been seen in Scotland and the strategy was overt in setting out the requirement for a flexible approach to respond to these fluctuations.

670. The Strategy set out eight principles and five priorities:

Principles

1. Testing is part of our overall public health approach designed to minimise transmission of the virus, in line with our overall strategy of driving the number of cases of COVID-19 in Scotland to the lowest levels possible and maintaining that level.
2. Our priorities for testing are informed by scientific, clinical and public health advice from our expert advisory structures.
3. Our approach to testing, including prioritisation, is flexible and adaptable to the prevailing conditions of the pandemic at any time, and informed by expert advice.
4. Our approach to testing takes full recognition of the limitations of testing (particularly at low levels of disease prevalence) as well as the opportunities of testing.
5. Our overall priority at this stage of the management of the disease is rapid identification and testing of people with symptoms.
6. Asymptomatic testing will increasingly be used on a risk based approach to both minimise transmission through active case finding and to reduce harm to individuals at high risk.
7. The deliverability of any new testing priorities and pathways will be considered at an early stage to maximise successful implementation.
8. The capacity to accurately and efficiently record, report, interpret and respond to every test in a timely manner is critical.

Testing Priorities – Next Phase

1. Whole Population Testing of anyone with symptoms (Test & Protect).
2. Proactive Case Finding by testing contacts and testing in outbreaks.
3. Protecting the vulnerable and preventing outbreaks in high risk settings by routine testing.
4. Testing for direct patient care, to diagnose and to treat, and to support safe patient care as NHS services restart.
5. Surveillance to understand the disease, track prevalence, understand transmission and monitor key sectors.

671. Key to this strategy was encouraging and providing as widespread access to testing, and information and guidance about who should test and when, to as many people as possible. An information leaflet was sent to all households during the week commencing 22 June 2020, which communicated what people needed to do if they had Covid-19 symptoms.

672. As already set out capacity was created through a combination of NHS Diagnostic labs, academic partner nodes and UK Lighthouse capacity (Glasgow Lighthouse) with additional resilience capacity of 10,000 tests per day through establishment of three regional labs located in Edinburgh, Glasgow and Aberdeen, hosted by the relevant territorial Health Boards. The hubs predominantly focussed on asymptomatic PCR testing for care home and prison staff to ensure turnaround time of up to 24 hours, and where necessary provided overflow capacity for territorial Health Board diagnostic labs. 673. The Partner Node Network was a collection of public, academic and private labs that provided NHS Scotland with additional SARS-CoV2 virus PCR testing capacity which was instrumental in supporting successful national response to the Covid-19 pandemic. It was stood down in April 2021 as the Regional Hubs laboratories became fully operational and NHS Scotland had the capacity required to support surges for its testing pathways.

674. In late 2020 a review was undertaken by the CMO, CNO, NCD and Chief Scientists of the principles and priorities of the Testing Strategy and presented the clinical and scientific consensus in Scotland that prioritisation of routine testing should be expanded to those at highest risk. The publication in October 2020 set out priority strategic areas for testing which were:

- Whole population testing of anyone with symptoms
- Proactive case finding by testing contacts and testing in breakouts
- Protecting the vulnerable and preventing outbreaks in high risk settings by routine testing
- Testing for direct patient care, to diagnose and to treat, and to support safe patient care and NHS services restarted
- Surveillance to understand the disease, track prevalence, understand transmission and monitor key sectors. [CL15/199 – INQ000242098]

675. Throughout 2020 there were differing perspectives on the risk of transmission from asymptomatic individuals and, therefore, the benefits of widespread asymptomatic testing. Ultimately the evidence base and benefit of this approach was accepted. In mid2020 testing guidance advised people with symptoms to take a PCR test, but across the UK no pathway existed to test, at sufficient population levels, for asymptomatic cases. The delivery of a number of pilots including the community testing pilot in Liverpool began to make the case for wider asymptomatic testing [CL15/200 – INQ000488599]

676. In November 2020, the Cabinet Secretary for Health and Social Care announced the start of a mass asymptomatic community testing programme in areas with persistently high Covid-19 rates, in order to reduce transmission. Working with territorial Health Boards and local authorities, the programme initially deployed mobile testing units and home test kits to Glasgow, Renfrewshire, East and South Ayrshire, and Clackmannanshire, and opened an asymptomatic testing site in Johnstone, with further sites planned. This reflected the growing evidence base of higher levels of transmission in areas of higher deprivation due, potentially, to a range of factors such as the nature of lower paid employment, higher population density and larger household numbers.

677. The Scottish Government published a revised Strategic Framework for Coronavirus on 23 February 2021 [CL15/201 - **INQ000339831**] and in March 2021 a revised Testing Strategy [CL15/202 - INQ000147364] was published that set out how testing, tracing and isolation would evolve to meet the revised wider strategy taking

into account new technologies such as LFD testing becoming available at sufficient volumes to enable novel population wide approaches. It set out how testing would continue to provide a protective function for those at highest risk, and to ensure symptomatic people were tested and encouraged to isolate. It also set out the ambition for the potential of new testing technologies to allow different approaches such as asymptomatic testing.

678. From 25 April 2021, lateral flow tests were made available for whole population access to people without symptoms to participate in twice weekly testing. Access to tests was made available through home ordering or from a wide range of places such as walk-in or drive-through test sites. From 9 June 2021, the offer was rolled out to pharmacies and dispensing GPs, increasing access to over 99% of the population within a 30-minute drive and over 99% within a 30-minute walk in major urban areas such as Glasgow, Edinburgh and Dundee.

679. The Scottish Government planned the locations of walk-through local test sites in areas of high deprivation, low car ownership and high population density, and initially high student population, to increase testing uptake and access for the communities that most needed better access. By April 2021, over a third of mainland Scotland's population was within a 30-minute walk of a walk-through local test site.

680. In pursuit of achieving the strategic intent of reducing transmission to the lowest possible levels, the Scottish Government took steps to maximise ease of access to testing. In recognition of the high levels of rurality in Scotland work was undertaken in December 2020 with UK Government to extend home test kit coverage to previously excluded postcodes in NHS Highland and NHS Forth Valley.

681. To further increase access in rural areas, which existing delivery models were not suited to, the Scottish Government developed a new low-cost small-scale test site operating model in collaboration with NHS Highland and the Scottish Fire and Rescue Service. This model utilised the capacity the Fire Service had during the pandemic and required minimal additional funding, representing high value for money. By February 2021 this intervention brought test site population coverage in rural areas in line with the national average.

682. As part of minimising the risk of transmission in higher risk settings, testing for health and social care settings was expanded in phases with prioritisation based on clinical assessment of risk in different settings / cohorts. From w/c 26 November 2020, testing was significantly expanded for hospital patients, health and social care staff, and communities in Level 4 areas. This included testing for all emergency admissions, twiceweekly lateral flow testing for all patient-facing healthcare staff working in hospitals, Covid-19 Assessment Centres and the Scottish Ambulance Service; with testing for all elective admissions to hospital introduced from mid-December.

683. In the social care sector, testing was expanded in the months following for designated care home visitors, visiting professional staff (from December 2020), and care at home workers (from January 2021). Visitor testing was initially introduced in 12 early adopter care homes in December 2020 before being fully rolled out in January 2021.

684. In late 2020, Ministers considered early findings from UK pilots on serial testing, a testing regime intended to support a 'test to release' approach. The decision at this stage, supported by the clinical view, was not to progress this type of testing until the evidence base had developed further on the potential risks. This pilot activity continued through 2021 however because of the relatively new use of PCR and LFD testing for coronavirus, the evidence base on risks did not develop sufficiently to give clinical confidence in the risk of 'releasing' a person from isolation and the potential for onward transmission.

685. The emergence of the Delta variant in mid-2021 required additional responses to support action to reduce community transmission. In June 2021, to respond to the increased transmissibility of the Delta variant, the Scottish Government worked with Glasgow City Council and NHSGGC to implement enhanced testing measures locally – including lateral flow testing collection points, increased mobile testing unit deployments for asymptomatic testing, home test kit postcode pushes and home test kit drop-off points, along with local communications.

686. Throughout the Covid-19 response, whenever planning indicated that testing demand risked exceeding capacity, measures were introduced to prioritise booking

slots for essential workers and individuals considered at highest risk under the definition agreed by clinicians. This approach was designed to safeguard capacity whenever case numbers suggested it might be reached. These measures were implemented at various points, including in early 2020 (prior to the launch of Test and Protect), in early 2021 (due to the emergence of the Alpha variant), and during the 2021/22 winter Covid-19 peaks (due to the emergence of the Omicron variant).

687. By February 2022, towards the end of population-wide testing, over half the population was within a 30 minute walk of a walk-through, small-scale or mobile test site; and over 99% of the population was within a 30 minute drive of a test site (these figures are over a two week period, taking into account mobile testing unit rotation cycles).

688. On 21 February 2022 the UK Government announced the intention to end population wide access to testing in England from 1 April 2022. On 15 March 2022 the Scottish Government published its Transition Plan (for more detail, see paragraphs 430-446), setting out the revised strategic intent in light of widespread vaccination and the evidence that the efficacy of vaccination and the risk of harm from the virus were much reduced across the population [CL15/203 - INQ000235186].

689. This plan saw the majority of asymptomatic testing no longer advised from 18 April 2022. From 30 April as part of the transition, population symptomatic testing would end with the ongoing focus of symptomatic testing being for people as part of clinical care and for surveillance and outbreak response.

690. From May 2022 ongoing consideration was given to the appropriateness of continuing with the remaining instances of testing including asymptomatic staff testing.

691. On 28 September 2022, asymptomatic staff testing in health and social care and hospitals was paused, following four nations CMO advice that it was safe to pause weekly staff testing, visitor and carer testing, and hospital admission testing [CL15/204INQ000147373]. This coincided with a change to the Covid-19 alert level and the evidence that widespread vaccination was protecting people from hospitalisation and death as set out in, for instance, UKHSA's Weekly vaccine

surveillance data. In January 2023, Ministers confirmed that they were content to pause routine asymptomatic testing of prison admissions and transfers.

Testing – Social Care

692. In March 2020, the PHS advice on discharge from hospital to care homes reflected the advice discussed and agreed at the Scottish NHS Clinical Cell – the group responsible for formulating the clinical cell guidance required to allow professionals within the system to respond effectively and appropriately to Covid-19.

693. The guidance issued on 13 March 2020 [CL15/013A – INQ000280689] stated that prior to transfer from hospitals to residential care settings, "steps should be taken to ensure that patients are screened clinically to ensure that people at risk are not transferred inappropriately", but did not mention a specific form of risk assessment. This guidance was then updated and expanded in the 26 March 2020 iteration [CL15/069 – INQ000429281] to set out that, although testing was still not required prior to discharge at this point, a documented clinical risk assessment should be undertaken prior to discharge. A new admissions/ transfer form template was provided in the annex with the stated aim of providing "a means for safely admitting a new resident and identifying that where possible they have been deemed safe for transfer." However, risk assessments were undertaken locally by HSC professionals and were not required to follow a specific format.

694. In statements to the press and Parliament on 17 March 2020 [CL15/099 – INQ000280668], the First Minister and Cabinet Secretary for Health and Sport committed to testing critical frontline NHS staff and those others who are essential to maintaining critical infrastructure – including social care workers (as set out in the guidance described at paragraphs 625 to 627 above). These decisions were based on clinical advice and details regarding testing capacity available at the time.

695. This message was reiterated in the Cabinet Secretary for Health and Sport's statement to Parliament on 24 March 2020, in which she said: "we must continue to prioritise testing in hospitals. All remaining capacity must be used to ensure that

critical staff can return to work as soon as possible. Today, I am publishing guidance for the NHS to support use of the testing capacity in our laboratories, in so far as it is not needed for essential care, in order to enable health and social care staff to be back at work when that is safe. NHS Boards will prioritise testing, based on where the pressure is felt most in their workforce and in social care" [CL15/205 – INQ000389191]. The First Minister advised that a further statement on work to rapidly scale up testing in Scotland would be issued shortly.

696. The submission to the Cabinet Secretary of Health and Sport dated 18 March 2020, provided delay [CL15/206 – INQ000512602] set out the priorities for testing during the containment phase of any outbreak the monitoring and testing regime is intended to:

- Ensure our testing capacity is directed in the most effective way to protect the most vulnerable and to save lives
- Ensure that the most critical staff in the public sector workforce can be at work
- Monitor and report on the prevalence of the virus in the population.

697. The submission set out laboratory capacity and exercises underway to secure additional capacity. At this date, it was advised that HPS were modelling demand. It was stated that: "*What we know is that there are 35,989 residents in 1,142 care homes. Testing a significant proportion of all of these residents would significantly exceed the available capacity in laboratories.".* The submission provides advice regarding the proposed switch to a statistically driven testing in occupational groups and the Sentinel general practice scheme and proposed alignment "*with the work already in hand with colleagues across the UK to define the frontline health and social care occupations to ensure these were prioritised in any early testing programme."* Sentinel general practice schemes involve the reporting of clinical data from GP surgeries on a weekly basis.

698. On 29 March 2020, advice was provided by the CMO to Ministers [CL15/207 – INQ000250464], which recommended that a Scottish Covid-19 Testing Strategy be developed, along with an accompanying Oversight Group. The Oversight Group was established on 2 April 2020 and chaired by Professor David Crossman. The advice

proposed that the Scottish Covid-19 Testing Strategy should include the following six priority themes:

- Strengthening laboratory testing capacity
- Developing antibody testing
- Supporting surveillance, epidemiology and prioritisation
- Managing Data and maximising quality of data management
- Access to testing
- Supportive effective Communication about testing.

699. On 9 April 2020 the Cabinet Secretary for Health and Sport wrote to NHS Boards, Local Authority Chief Executives and IJB Chief Officers to ask them to review the arrangements in place, and to enable all critical staff in HSC to access testing (where there was capacity). NHS Boards consequentially put in place local pathways with HSCPs to enable social care staff to access testing, including pipelines for the private sector social care workforce.

700. A Deep Dive on Care Homes was held on 14 April 2020, which included consideration of testing for Covid-19 in care homes. A number of issues were raised by representative organisations such as Scottish Care [CL15/076 – INQ000509954] and clinicians, including increased testing due to workforce issues (including loss of skills due to self-isolation). Scottish Care expressed an expansion in testing would help to reduce the level of barrier nursing, thus reducing demand on staff and supporting the management of distress in individuals with dementia (particularly those with advanced stage dementia). At this stage, symptomatic patients in hospital were tested but care home residents were not as it is harder to trace routes of transmission within a hospital setting, and therefore testing provided a useful way to track possible routes of transmission.

701. Further advice was provided to the First Minister regarding the approach to testing care home residents on 15 April 2020 (associated email chain provided [CL15/208 – INQ000510049]) as follows:

"The testing regime followed the same principles developed during flu outbreaks – i.e. an outbreak is suspected due to two or more people coming down with similar symptoms, then it is important to know the cause. The purpose therefore is to identify whether there is an outbreak of Covid-19. This means that the first few cases are tested, this allows those caring for residents to know what they are dealing with and further cases with a similar pattern of symptoms can reasonably be presumed to be the same cause if linked in time, place and person. Further new cases would be designated within that care home as presumptive cases, testing every individual would not alter the treatment or care of the individual, or management of the outbreak.

We are aware that England has announced it will test all Care Home residents – our initial assessment is, that from a health protection policy perspective, testing every care home resident with symptoms would have a marginal, if any, impact on outbreak control. The current approach would avoid the discomfort of swabbing all symptomatic elderly residents in circumstances where it will not impact on their care or on outbreak control. This also avoids the risk of a false negative result from a symptomatic resident (e.g. because a swab is taken incorrectly) leading to IPC measures being relaxed, and consequently the continuation of the outbreak."

702. Further discussion took place between the First Minister, Cabinet Secretary for Health and Sport and the CMO and it was agreed that, whilst testing may not be clinically required, it would be expanded to include symptomatic patients in care homes for reasons of public confidence [CL15/209 – INQ000250464].

703. On 15 April 2020, the First Minister announced that all symptomatic patients in care homes would be clinically assessed and, where appropriate, offered testing for Covid-19. The CNO wrote to all NHS Territorial Board Chief Executives and SDsPH on 16 April 2020 explaining the change from the existing infection management procedures [CL15/210 – INQ000147357]. The CNO's letter stated, *"we are making this change in acknowledgement of the unprecedented pressures on our care homes, in order to offer this additional level of reassurance during what will be a deeply unsettling time for both our vulnerable elderly population and their families*." CNO advised that HPS would be updating their guidance accordingly. The CNO's letter

further advised that the Scottish Government was continuing to work closely with NHS NSS and PHS to rapidly increase testing capacity across Scotland and that testing capacity had already increased to over 2,000 tests per day and was on track to increase to 3,500 by the end of April 2020.

704. Additional guidance was issued on 17 April 2020 by HPS to for those working in social or community care and residential settings [CL15/077 – INQ000509955]. This guidance provided contact details for local health protection teams. If it was believed that a care resident or residents were displaying symptoms consistent with Covid-19, individuals were asked to contact the local HPT who would provide support in putting place arrangements for testing. Social care staff who had symptoms consistent with Covid-19 (or where a member of their household displayed symptoms) were told to self-isolate and discuss testing with their employer is appropriate. The employer was then responsible for referring to local arrangements for the testing of health and social care staff.

705. On 18 April 2020, further explanation of the clinical cell's advice on the testing of patients prior to discharge to care homes (where those patients had previously tested positive) was provided to Ministers [CL15/211 – INQ000510042]. The Clinical Cell considered that discharge advice balanced the risks of onward community transmission against the harms of delayed discharge (which include risk of hospitalacquired infection). It was advised that "extra caution is required when discharge is to a closed community setting such as care or nursing home which is reflected in differing advice for this group". The advice stated:

"viable infectious virus was difficult to find after 7 days, and that the best scientific advice available at this date supported the view that 14 days after symptom onset and 48 hours free of symptoms (except for cough, which persists for some time), the patient is no longer considered infectious. The approved discharge advice acknowledges that an individualised risk assessment of each patient should be carried out, and when strict isolation is not possible for a 14 day continuous period after symptom onset, then testing may be sought to verify viral clearance prior to hospital discharge.

The PCR test is sensitive and that at the end of illness tests can be negative one day and positive the next. Furthermore, the test shows the presence of any virus – active or inactive (i.e. not infectious). Therefore it is not in itself a measure of viral infectivity.

Discharge is only possible when each patients care need can be met in their care facility and their respiratory symptoms (other than cough) have resolved. There is no intention to transfer symptomatic patients (other than cough) back to care homes until their symptoms have resolved and they are fit for discharge – this is a separate issue from testing."

706. On 19 April 2020 the Cabinet Secretary for Health and Social Care wrote to care homes via the CI and Scottish Care, outlining that care home staff and residents were priorities for testing [CL15/212 – INQ000261560].

707. On 20 April 2020 the CEO for NHS Scotland wrote to all territorial Health Board Chief Executives, 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 specifically reminded recipients that they were 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."* [CL15/078 – INQ000363375]

708. On 20 April 2020 a submission was provided to the Cabinet Secretary for Health and Sport on "testing policy and application in a care home setting" [CL15/127 – INQ000249330], to which was annexed clinical advice. In that submission was CMO advice that "given the current PCR test may give false reassurances, and a positive

test may well not impact upon how residents would be treated, blanket testing of all admissions to care homes prior to their admission is not advised at this stage."

709. More detailed clinical advice, developed by the DCMO, CNOD and HPS, was attached to that submission including the rationale that:

"…a… patient may have been exposed to COVID-19 in the hospital or community, and therefore could be incubating infection. There is some debated evidence that people can be infectious prior to onset of symptoms and so isolating only at the onset of symptoms may result in transmission within the care home during the presymptomatic phase. Symptoms can be atypical in older frail people, so may miss onset if based on typical respiratory type illness. Testing is unhelpful in guiding decisions as a test taken during the incubation period and prior to onset of symptoms may be negative and does not rule out developing infection."

710. This combined clinical advice drew on relevant evidence to recommend an isolation period of 14 days in combination with robust IPC policies and appropriate numbers of staff. The advice also recognised, and took into account, that in a small number of Covid-recovered patients PCR testing could remain positive for a prolonged period of time due to the presence of (non-infectious) viral RNA fragments.

711. The submission to the Cabinet Secretary for Health and Sport further outlined that the CMO had established a new short-life clinical working group to consider the development of an 'admissions package' for all entrants to care homes (from either hospital or community settings).

712. On 21 April 2020 the Cabinet Secretary for Health and Sport announced that Covid19 patients discharged from hospital to a care home should be given two negative tests before discharge; and that other new admissions from care homes should be testing and isolated for 14 days in addition to the clear social distancing measures set out in the HPS guidance [CL15/128 – INQ000292544]. The policy decision to introduce the requirement for two negative tests prior to discharge for Covid recovered patients was made by Ministers, following their consideration of all the information available at the time regarding testing and the nature of Covid-19, and the risks posed to care home residents and staff.

713. The Cabinet Secretary for Health and Sport wrote to all Scottish Care Homes on 22 April 2020, reminding them of the developments of 9 April, 15 April and 17 April 2020 [CL15/213 – INQ000147428]. It was advised in this letter that, *"the testing of staff working in locations where there have been multiple cases of Covid-19 is being kept under review and further advice will be issued on this in due course."*

714. Further advice was provided to the First Minister and Cabinet Secretary for Health and Sport on 30 April 2020 re: testing [CL15/167 – INQ000509956]. The advice provided a summary of testing capacity and the core priorities for testing, in line with

WHO guidance. The advice stated that the focus areas for future testing should be:

- Care homes and care at home – given the 5% per day increase in infection in the care home sector and the steep mortality rate in this well-defined population. It was stated that at this juncture, the impact on those cared for at home was not yet known, but that the population was assumed to be potentially high-risk
- Other care settings, although not yet presenting an issue, were assumed to be high risk.
- Hospital acquired infection continued to be a growing concern
- The advice noted that key workers would be a priority given the "boundaries between these settings, and more generally in the community, are porous" – and will have the most impact on transmission (assumes they are most mobile under the current and future restrictions).
- Community control – particularly as some social distancing measures are released. This may also include additional work at ports and borders
- Vulnerable groups in the community – including symptomatic or asymptomatic over 70s who pose a greater mortality risk. Also included were those without stable accommodation arrangements. It was advised that consideration may also want to be given to some volunteer groups supporting the shielded in communities, as well as individuals providing caring responsibilities.

715. On 1 May 2020, the First Minister announced enhanced outbreak investigations in care homes due to the expansion in PCR testing capacity (which had exceeded

its target of 3,500 tests per day). The First Minister also stated that 40% of care homes had reported cases of Covid-19. All residents and staff were to be offered testing, whether they were symptomatic or not, in homes where there had been a confirmed case. The enhanced outbreak investigations also included other homes, if that facility was part of a group or chain. Sample testing in care homes where had been no cases was also announced [CL15/132 – INQ000509948].

716. This enhanced outbreak approach to care homes was identified to minimise the risks faced by patients and residents of care homes, alongside other measures, such as testing of over 70s on admission to hospital and testing arrangements for those being admitted to care homes. The NHS Scotland CEO wrote to all territorial Health Boards informing them of these changes on 1 May 2020, requesting that that the policy be implemented from 4 May 2020 onwards. Advice provided on 11 May 2020 gave further detail regarding the objectives which informed the testing approach in special settings

(i.e. "health facilities and nursing homes" - as defined in the WHO advice set out in the submission of 30 April 2020). These objectives are:-

- Reduce the risk of nosocomial transmission to/from between staff – to identify cases so that steps can be taken to avoid transmission in HSC settings
- Reduce the risk of nosocomial transmission to and from patients and care home residents – to identify cases so that steps can be taken to avoid transmission in HSC settings
- Reduce the risk that HSC workers transmit Covid-19 in the community in which they live (as opposed to HSC settings)

717. The advice of 11 May noted emerging evidence regarding rates of asymptomatic positive swab tests (on the case for healthcare worker screening) and the frequency of testing. The advice stated that "Given the relatively static nature of care home and care/hospital at home residents, we propose to focus more closely on the staff as they are more likely to pose a transmission risk – including consideration of testing of all asymptomatic care home workers in homes where

they are no known cases of Covid19". Discussion of asymptomatic testing follows below at paragraph 680 onwards.

718. Advice was subsequently provided to Ministers on 21 May 2021 [CL15/214 – INQ000592039] seeking approval to update the policy of testing and discharging of Covid-19 recovered patients from hospitals to care home settings which proposed that the guidance be updated to reflect that "*COVID recovered care home residents in hospital can be safely discharged home after 14 days from symptom onset or first positive test without further testing. If they are to be discharged before that time they should have two negative tests as before*". The recommendation was based on the scientific body of evidence, including the recommendations of the SAGE Social Care Working Group. The submission set out the situations which has arisen as a result of the two test discharge policy (introduced in April 2020) , including.

"*As a consequence of this policy of requiring two tests for COVID recovered patients and, given the considerable interest and political heat around care home discharges from hospital, several situations have arisen:*

- *Firstly although in the original guidance allowances were made for ethical reasons for someone who was unable to tolerate a test that on clinical judgement and after discussion they could return to the care home; in practice hospitals and care homes have been insisting on two negative tests. For some patients with dementia this has led to distress or them being kept in hospital for prolonged periods.*

- *Secondly as we now know some patients remain PCR positive for prolonged periods after an infection. This is because fragments of inactive virus can be persistently detected by PCR in respiratory tract samples following infection – long after a person has completed their isolation period and is no longer infectious. This phenomenon is slightly more common in older adults, and in some cases these tests may persistently remain positive for some months. This has changed advice across the UK on retesting up to 90 days: patients should be exempted from routine re-testing by PCR or LFD antigen tests within a period of 90 days from their initial illness onset or test unless they develop new COVID19 symptoms. However due to the policy of two tests for COVID*

recovered patients before discharge to a care home, some care home residents who have remained persistently positive have been unable to get the required two negative tests that would enable them to return to their own care home or to enter one for the first time. This has led to some frail nursing home patients being kept in hospital for weeks and in some cases months having repeat testing in the hope that they will test negative.

Remaining in a hospital environment can exacerbate isolation or create delirium. It is a higher risk environment from the perspective of healthcare acquired infections, falls, delirium or persistent functional decline. Over time increased numbers of such patients have accumulated in hospitals leading to challenges around where to safely house them whilst awaiting a return home and leading to delayed discharges. It has prevented vulnerable individuals returning to their own homes.

Although individual risk assessment is recommended for a case by case attempt to move individuals with the support for the patient, family and care home, homes now say that liability insurers will not cover them if they accept a resident home with a positive test. In the current climate with a crown prosecution office investigation of deaths in care homes this is a very difficult situation for individual care home managers."

719. Further discussion took place with stakeholders, including AIB, CCPS and Scottish Care and HSCP representatives regarding the proposed change in policy, as outlined in the provided submission [CL15/147 – INQ000510055] and as outlined above at paragraph 470. Updated PHS Guidance "Covid-19 Information and Guidance for Care Home Settings (Adults and Older People) (Version 2.2) was issued on 24 June 2021 which reflected the advice above.

Testing in care homes throughout the pandemic

720. The Health Performance & Delivery business area was responsible for monitoring the uptake of staff testing in care homes in each territorial Health Board area. This

involved working with territorial Health Boards and Chief Executives to understand any barriers to testing and offer support where necessary to help the Board overcome these. For example, on 1 July 2020, officials wrote to all territorial Health Boards to offer additional resource to help tackle the increased administrative burden associated with the weekly testing. This included the offer to backfill existing administrative posts in each territorial Health Board for a minimum period of three months with up to £50,000 available per post.

721. Weekly calls were scheduled with the Chief Executives and the nominated territorial Health Board Testing SPOCs (Single Points of Contact) to discuss the performance of their Board. This included identifying data quality issues to territorial Health Boards and seeking assurance that the issue had been highlighted to the relevant care homes and that the cause of the error was rectified. While the commitment was to test all care home staff on a weekly basis, in reality, 100% of staff would not be available at work each week for various reasons, including annual leave, sick leave, maternity leave, rota pattern and bank / agency staff not on shift on a regular weekly basis. On that basis, it was assumed that 70% was a more accurate performance target and therefore, weekly performance monitoring was based on the expectation that circa 37,000 staff tests should be carried out on a weekly basis across Scotland. The 70% benchmark figure was developed through discussions by the CEO of NHS Scotland and a sample of care homes across the country. This performance benchmark was communicated regularly to territorial Health Boards through the weekly calls.

722. The data captured through staff testing in care homes was provided on a weekly basis to the Health Performance and Delivery business area by the Scottish Government Health and Social Care Analysis team. In the initial stages of this collection, data quality was a concern principally around the need to have an accurate baseline figure for the number of staff across the circa 1,080 care homes across Scotland i.e. the number of staff eligible to be tested. Scottish Government first published weekly staff testing data in adult care homes by territorial Health Boards on 15 June 2020 [CL15/128 – INQ000292544], and this continued on a weekly basis until 10 January 2021, after which the data were collected and published by PHS. Data held for the week, 22-28 June 2020, shows that around

23,350 care home staff tests were carried out. This represented around 63% uptake compared to the 37,000 performance target (after weekly testing had been introduced on 25 May 2020). It took until the week of 21-27 August 2020, until the 37,000 performance target was reached with around 37,010 staff tests recorded that week. Various measures were taken, as set out below, to increase uptake and ensure arrangements were in place to support care homes and staff to participate in testing.

723. The CNO met with Directors of Public Health, Nurse Directors, Medical Directors, Chief Executives and Chief Officers on 27 May 2020 to seek assurance that they had put in place;

- Arrangements for testing throughout NHS Board areas and that they had sufficient staff in place to provide testing for care home residents and staff to oversee the process (where care homes undertake their own testing)
- Plans to oversee training for care home staff to build capacity and capability to undertake their own testing.

724. Uptake of care home staff testing was discussed at the CHRAG on 28 May 2020 [CL15/028 - INQ000544457], where "*SG expressed unease around the rate at which testing was being implemented. This position was supported by Scottish Care who called for more strategic planning. SG advised that Ministers would be writing out again to Chief Executives for details of their testing plans, looking for assurance that these plans are robust, deliverable and consistent, and match ministerial expectations on capacity. The Group was advised about the ongoing work of chairs of directors and chief executives to inform testing policy and work being done to make it easier to access tests for staff.*"

725. Performance discussions continued with territorial Health Boards to focus on reducing variation between territorial Health Board testing levels. For example, working with territorial Health Boards where a proportion of care homes reported

more than 50% of their staff not tested or where there were a high number of staffing declining to be involved in testing. By January 2021, 45,500 tests were recorded

(week of 11–17 January 2021) [CL15/215 – INQ000324889]. This high level of coverage continued throughout 2021 with typically 40,000 tests being recorded on a weekly basis. It should be noted that testing could only be conducted where staff members consented. In order to explore issues around testing of staff, the Scottish Government established a short life working group (including union and care home management representatives). This helped to address practical barriers – including the introduction of four weekly ordering of test kits and bulk upload of tests once completed, to reduce the administrative burden.

726. On 4 June 2020, the Cabinet Secretary for Health and Sport wrote to all territorial Health Board Chief Executives regarding testing in care homes [CL15/216 – INQ000358283]. The Cabinet Secretary thanked Chief Executives for providing, as requested, their plans for the delivery of Scottish Government testing policy but stated that "*the plans do not set out the level of detail required to give assurance to me and the public that commitments on testing will be fulfilled.*" The Cabinet Secretary directed that Chief Executives should provide additional details, including a detailed weekly delivery trajectory which specified deployment of testing capacity into care homes on a daily basis (and an accompanying weekly template was provided for completion and return). These returns were collated and further discussions took place with relevant Boards.

727. On 24 June 2020, the Cabinet Secretary for Health and Sport and Councillor Stuart Currie, COSLA jointly wrote to staff of care homes in Scotland [CL15/152A – INQ000260096], thanking staff for their hard work and dedication, and reiterating the importance of weekly testing, recognising the additional burden this placed on staff. The letter also set out,

"*Recently we were made aware that receiving statutory sick pay when isolating was causing financial hardship for social care workers including those in the care home sector. This week we are introducing the Social Care Staff Support Fund. This Fund will ensure that social care workers receive their normal pay when, due to the nature*

of their work or work environment, they self-isolate as part of infection, prevention and control measures. The Fund is open to staff who meet the Fund criteria set out in guidance and is intended to remain operational in line with the duration of the Coronavirus No.2 Scotland Act 2020 (2020 Act), currently September 2020. If you do need to self-isolate as a result of COVID-19, you will be able to access this support.

Information on how to access the fund will be published shortly".

728. The Adult Social Care Winter Plan 2020/21 referenced the critical role of testing in limiting transmission. The Covid-19 Review of Testing Strategy produced by the CMO,

CNO, NCD, Chief Scientist and Chief Scientist (Health) published in October 2020 [CL15/199 – INQ000242098] set out the approach to expanding routine testing – priority groups for additional testing capacity were identified as health and care staff who visit care homes, as well as other residential settings (as appropriate), designated visitors to those who live in care homes; and care at home staff.

Testing for unpaid and domiciliary carers

729. The introduction of testing for unpaid and domiciliary carers followed after testing was available for care home staff and residents. This included permanent and visiting staff to a person's home, residential settings, sheltered housing and day care. Anyone experiencing symptoms, however, could access testing via a test site or requesting a home test kit.

730. Decisions regarding the expansion of routine testing were guided by the clinical and scientific evidence – as set out in the Testing Strategy – and testing capacity. The Testing Strategy made clear that available capacity should be directed to protecting the vulnerable and preventing outbreaks in high risk settings – including those provided care at home for the most vulnerable.

731. On 25 November 2020 the Director, Mental Health and Social Care Directorate, wrote to registered care at home providers (adults), Directors of Public Health, Chief

Social Work Officers, Chief Officers, Chief Executives of territorial Health Boards and Local Authorities, NHS Board Nurse and Medical Directors regarding the testing expansion plan for care at home, providing further information regarding the Testing Expansion Plan announced by the Cabinet Secretary on the same date. The letter stated that,

"*The Plan will significantly expand testing, including to the care at home workforce. All permanent and visiting staff and personal assistants to both a person's own home and where a person's home is within a residential setting/sheltered housing complex, plus staff who work in adult day care centres are included in the expanded testing arrangements. Staff will be included regardless of role, if they undertake two or more visits to any setting per week and come within 1 metre of social care recipients.*"

732. The letter also made clear that, "*This expansion is only possible because of increases in our testing capacity – for adult social care the expansion has been enabled by new testing options, particularly lateral flow devices.*"

733. The Plan was rolled out from 11 January 2021 for sheltered housing and residential settings, and to care at home services from 18 January 2021, in areas of highest viral prevalence first. It was expected that roll out would conclude by the end of March 2021.

734. Logistical challenges in the testing of care at home staff were factored in the wider rollout. For example, due to the nature of their roles, care at home staff often do not gather in a single place prior to commencing their shift, and are likely to visit multiple homes/locations in a single day, which presented a challenge to administering testing. It was also necessary to ensure that there was training in residential and day care settings on lateral flow testing and local partners were able to provide relevant support before testing could be expanded. The final logistic designs for this rollout were reliant on confirmation from the Medicines and Healthcare Products Regulatory Agency that individuals can self-test with lateral flow tests

Testing for visitors to care homes

735. The Scottish Government's letter to care homes of 25 November 2020 [CL15/217 – INQ000571315] and the Cabinet Secretary's statement to Parliament on the same day [CL15/218 – INQ000240872], set out the arrangements for the expansion of testing to visitors to care homes. This included both health professionals and family/friend visitors to care homes. The rationale was set out in both the letter and the statement,

"This additional testing will enhance the existing layers of protection in place for our social care sector, for the people it serves, and for our communities. This expansion is only possible because of increases in our testing capacity and new testing options, particularly lateral flow devices which return a rapid result."

736. In summary, with the increase in testing capacity (lab and type of test), the Scottish Government, alongside other UK nations, was able to significantly expand testing beyond people with symptoms and people living and working in vulnerable settings. As a result care home visitors were included, both and family/friends and health professionals.

737. LFD tests allowed family members to test on the day of the visit so that if the test were positive, they could take immediate action to isolate and avoid visiting.

738. Testing for family/friend visitors was piloted within 12 early adopter care homes November across four local authority areas in December 2020, with full roll-out across all homes completed over January and early February 2021. As set out in the letter of 25 November 2020 [CL15/217 - INQ000571315], the purpose of the pilot was to:

"….ensure we get the pathway, logistical, training and local support measures for care homes right."

739. Learning from these pilots was used to inform the wider rollout. It was advised that not all care homes would be able to start LFD testing pre-Christmas, so PCR

testing was made available during the festive period. LFD kits were delivered to care homes across Scotland during week commencing 14 December 2020.

740. For visiting professionals, this included "public sector, independent contractors or statutory body staff who attend care homes or provide care at home at least twice per week and have to be within one metre of residents, clients or patients". Rollout began mid-December but priority was initially given areas of higher prevalence, as set out in the letter of 25 November 2020:

"The introduction of testing for all visiting professionals, including public sector, independent contractors or statutory body staff who attend care homes or provide care at home at least twice per week and have to be within one metre of residents, clients or patients will begin in mid-December. The priority will be to roll out testing in areas of higher prevalence in the first instance. This will again be supported by lateral flow testing which will be undertaken by the professionals twice weekly. The responsibility for distribution, testing and recording of results will sit with the professional and their direct employer, but care homes will be able to ask for confirmation of compliance from visiting professionals from late January 2021."

741. The letter acknowledged that:

"No test is 100% accurate, and testing will not replace the other layers of protection needed, including appropriate PPE and strict hand hygiene. However, it is an important additional layer of prevention and assurance to support the safe resumption of visiting."

742. On 18 December 2020, further restrictions to visiting to care homes were announced by the FM, which led to an urgent review of the care home Covid-19 testing strategy. Letters were issued to Registered Care Homes, Chief Executives of territorial Health Boards and Local Authorities, CO HSCP, Chief Social Work Officers, DPH, Nurse and Medical Directors and the Chief Executive of CI of 22 and 24

December 2020 [CL15/219 – INQ000496549] [CL15/220 – INQ000147360], regarding care home visiting and testing (for visitors).

743. The letter of 22 December 2020 set out that testing kits already held by care homes should be offered to essential visitors from 26 December 2020 onwards [CL15/221 – INQ000496549].

744. The letter of 24 December 2020 stated that from 4 January 2021, care homes would be given access to twice-weekly LFD testing for staff members, to be utilised alongside the existing weekly PCR test (in line with SAGE recommendations) [CL15/220 – INQ000147360].

745. Arrangements were made to distribute additional LFD kits to all care homes from 29 December 2020 onwards. It was advised that the decision had been made to accelerate LFD testing of professional visitors to care homes by one week to further protect residents and staff. MHRA advice at the time meant that the CI distributed tests for their visiting professionals, whilst stock for social care professionals was to be delivered by PPE hubs. For NHS professionals, LFD testing was to be provided on the basis of existing healthcare worker LFD supply and guidance delivered by the NHS.

746. This letter confirmed the expansion in LFD testing for the following groups:

- Designated family/friend visitors to care homes (in Level 3 areas where indoor visiting is supported)
- Care home staff, twice weekly alongside PCR testing at work (enhanced testing) (from 4 January 2021)
- Outbreak management staff testing at work if advised by health protection (from 4 January 2021)
- A small number of professional visitors to care homes which were not covered by the arrangements in place through the NHS/their employer (i.e. dentists, optometrists, podiatrists and essential maintenance staff).

747. The expanded healthcare worker testing pathway was put in place from midFebruary 2021 to cover these visiting professionals, to enable them to test twice weekly outwith the care home setting.

Consideration of 'false positive' or 'false negative' test results

748. The potential for 'false positive' or 'false negative' test results was considered in clinical and scientific advice and evidence provided to Ministers and by scientific and clinical advisers as our approach to testing developed.

749. For example, in clinical advice of 20 April 2020, it was noted that that there was the potential for positive results to persist well beyond the period of infectivity. These considerations informed the decision isolate residents discharged to care homes until

14 days after the onset of symptoms (if the individual had previously tested positive for Covid-19) [CL15/127 – INQ000249330]. It was considered that this was a more precautionary approach, to minimise the potential risks of community transmission, rather than relying solely on test results. New admissions which had never tested positive for Covid-19 were required to isolate for only 7 days and were not tested.

750. The CMO advice outlined in a submission provided to the Cabinet Secretary for Health and Sport and the FM on 20 April 2020, summarised as such, "*given the current PCR test may give false reassurance, and a positive test may well not impact upon how residents would be treated, blanket testing admissions to care homes prior to admission is not advised at this stage.*" [CL15/127 – INQ000249330].

751. SAGE discussed the matter of false positive results at its meeting of 23 April 2020 and advised that behaviour studies demonstrated that people who thought they had already contracted Covid-19 were less likely to adhere to social distancing measures. Note exhibited [CL15/222 – INQ000217547]. SAGE advised that any testing strategies in development should factor in these behavioural insights (as produced by the SPI-B sub-group, which was attended by Scottish Government analysts).

752. The risks of false negative test results for PCR tests was reflected in the

Coronavirus Covid-19 Scotland Testing Strategy published 17 August 2020 [CL15/198 – INQ000147448], which stated, "if we assume tests are perfect, and that results are always accurate, we put others at risk."

753. As set out in the Scottish Government's Covid-19 Framework for Decision Making (April 2020) [CL15/223 – INQ000369689] testing formed part of the Scottish Government's overall approach to responding to the pandemic, in conjunction with other measures.

Developing understanding of asymptomatic transmission

754. The Scottish Government's understanding of asymptomatic transmission, and the potential risks to those in receipt of adult social care, was informed by the available clinical and scientific advice. Initially, owing to testing capacity constraints, testing was restricted to those who were symptomatic. As set out below, as capacity and

knowledge expanded, testing was extended to include those who may be asymptomatic (including health and social care workforce and those in receipt of adult social care). Physical distancing was a key strategy for reducing transmission.

755. On 25 January 2020, the Scottish Government's Health Protection Policy team's fourth daily briefing on WN Co-V included reference to further information being sought about potential for asymptomatic transmission in response to a query on this point from the First Minister. An update provided later that day to the First Minister, Cabinet Secretary for Health and Sport and the Minister for Public Health and Sport set out that Professor Jim McMenamin (of HPS) had approached Professor Nick Phin (then of Public Health England (PHE)) for a view in relation to this query. Professor Phin in turn had sought input from the PHE Clinical Lead, Dr Jake Dunning, who had advised that "*We know very little about this virus currently, but it is likely that person to person transmission, when it does occur, mostly involves transmission of virus from people with symptoms.*" [CL15/224 – INQ000292534].

756. It was noted at the SAGE meeting on 28 January 2020 that there was limited evidence of asymptomatic transmission, but that early indications implied that some asymptomatic transmission may be occurring. Testing of asymptomatic individuals was also discussed, and it was advised that "*currently if would not be useful to test asymptomatic individuals, as a negative test result could not be interpreted with certainty.*" [CL15/225 – INQ000057492]

757. A paper regarding asymptomatic transmission was published by the Public Health England virology cell on 28 January 2020, which concluded there was not yet sufficient data and that further detailed epidemiological information was required regarding possible transmission on a significant scale from asymptomatic individuals or during the incubation period [CL15/226 – INQ000074909].

758. As knowledge increased, the views of experts and advisory groups developed. SAGE discussed asymptomatic transmission again at its meeting on 16 March 2020 [CL15/227 – INQ000075664] and noted that antibody testing would be vital to addressing unknown questions around the ratio of symptomatic to asymptomatic cases.

759. On 24 March 2020, CMO provided an update to Cabinet regarding the number of cases and deaths. The CMO stated, "Overall, there is likely to be a significant underestimate in the number of reported cases, particularly where people were currently asymptomatic or had only mild symptoms. The programme of testing was being stepped up in order to improve accuracy of community surveillance" [CL15/228 – INQ000362735].

760. The WHO's daily Covid report on 2 April 2020 noted that "there are few reports of laboratory-confirmed cases who are truly asymptomatic, and to date, there has been no documented asymptomatic transmission. This does not exclude the possibility that it may occur." On 3 April 2020, Dr Michael Ryan (WHO) stated that "we have to look at what's driving this epidemic" and "we still believe the main driver of this pandemic is symptomatic individuals coughing or sneezing or contaminating surfaces or contaminating other individuals."

761. On 2 April 2020, the Scottish Government, Department of Health and Social Care,

HPS, Public Health Wales, Public Health Agency Northern Ireland, Public Health England and NHS England jointly issued revised PPE guidance [CL15/229 – INQ000259889]. The guidance recommended that a risk assessment was undertaken for all health and social care staff for their use of PPE, including masks, regardless of whether they were caring for patients who were suspected of having Covid-19, "given the recognised sustained community transmission of COVID-19".. The guidance also stated that asymptomatic staff living in the same household as a possible case of Covid-19 should follow 'stay-at home: household isolation' guidance.

762. As stated above at paragraph 327, on 8 April 2020, the European Centre for Disease Prevention and Control updated its Technical Report to make clear that, "testing of symptomatic patients should have priority over the testing of asymptomatic patients before release from isolation" [CL15/230 – INQ000509962].

763. Issues regarding the potential asymptomatic transmission of Covid-19 by healthcare workers were discussed at the Clinical Cell on 18 March 2020 [CL15/231 – INQ000509958]. The Clinical Cell were asked to consider whether the exemption of asymptomatic healthcare workers (and whole public sector) from household quarantine (where a household member was unwell) would be reasonable. The Cell

view was that there was a need to balance adequate staffing with the potential risk of nosocomial transmission by asymptomatic individuals. It was considered that healthcare workers who tested negative 48 hours post onset of symptoms could return to work. It was advised that there was "No option without risk" and that further data was needed on virological infections in children, which would help to free up those with a child at home, given uncertainty around their status as amplifiers of transmission.

764. Advice provided to the Cabinet Secretary for Health and Sport on 20 April 2020 from HPS, CMO and CNO re: testing policy and care home settings [CL15/127 – INQ000249330] referenced that symptoms can be atypical in older, frail, individuals – which may lead to failure to recognise the onset of symptoms. The advice stated that

"some patients may essentially have an asymptomatic episode of Covid-19 infection" and therefore should be isolated on admission to a care home setting. The approach to testing care home residents is discussed further above in conjunction with concerns regarding the sensitivity of PCR tests, and the decision was taken to isolate patients on discharge, in order to mitigate the potential risks of asymptomatic transmission.

765. On 23 April 2020, the CMO Advisory Group discussed a paper on asymptomatic cases, which identified studies which found asymptomatic infection rates ranging from 13 to 51%. The paper noted that asymptomatic cases were as likely as symptomatic cases to transmit infection and that more research was required [CL15/232 – INQ000217539].

766. Further HPS guidance for care homes was issued on 26 April 2020 [CL15/129 – INQ000189405] which again reiterated that the messages set out in the NIPCM should be followed regardless of the infectious nature of that individual.

767. On 30 April 2020, SAGE noted a recent NHS study which suggested a positive test rate amongst asymptomatic healthcare workers of 5-6%.

768. Advice provided to the Cabinet Secretary for Health and Sport on 30 April 2020 [CL15/167 – INQ000509956] noted that current surveillance testing provided information on those presenting with Covid-19 like symptoms. However, "*given the uncertainty on the virology, there is evidence to suggest that around 20% of people with the virus are asymptomatic. Surveillance of an asymptomatic sample through forthcoming blood testing (for antibodies) will provide better understanding of this. This information is bolstered by the results of all tests through NHS labs which are shared with the HPS surveillance team.*"

769. On 7 May 2020, SAGE advised that there should be extensive testing of healthcare workers, including asymptomatic workers.

770. Further advice was provided to the Cabinet Secretary for Health and Sport on 19 May 2020 [CL15/233 – INQ000509959] regarding the approach to testing staff in care homes. The submission proposed that, in order to support reduction of risks for residents in care settings, testing should be provided to all care home workers

on a weekly basis. This would be in addition to the testing requirements for those being discharged from hospitals and the enhanced outbreak approach (where all residents and staff to be tested if there is one infected resident). This reflected the growing understanding and knowledge of asymptomatic transmission. Weekly testing was recommended for healthcare settings by the Scottish Nosocomial Group. Actual testing volume remained at around 3,000 per day as at 19 May, with colleagues in territorial Health Boards working to increase capacity for testing for existing priority groups (such as the over 70s and people who are asymptomatic in care homes where there is an existing case). The advice stated that it was estimated that 7,358 tests per day would be required to facilitate weekly testing (based on a staffing group of 46,430 staff working in care homes for the elderly and 6,740 in other care homes for adults). On 18 May 2020, the Scottish Government announced that testing would be offered to all care home staff on a weekly basis from 25 May 2020.

771. On 23 June 2020, further advice was provided to the CMO by the Scientific Advisory Group on Testing and the Scottish Government Covid-19 Advisory Group regarding "Who and when to test for Covid-19" [CL15/234 – INQ000217709]. The advice stated that "*policies on testing HCW and care home staff and residents should follow consistent principles of protecting the most vulnerable from infection. Where there is evidence of active Covid-19 in hospitals and care homes there is a strong case of systemic testing of staff and residents/patients because of the high level of asymptomatic infections/carriage. Where Covid-19 free environments are the aim, routine testing will be needed to maintain confidence in this disease-free status.*"

Summer 2020 onwards

772. Routine asymptomatic PCR testing of care home staff, which began from 8 July 2020, remained a critical tool for detecting COVID-19 in high-risk settings, including care homes, for the remainder of the pandemic. The introduction of Lateral Flow Devices (LFDs) in late 2020 further supported the expansion of asymptomatic testing in care settings. The purpose of LFDs was to enable individuals to immediately assess their likelihood of infectiousness on a

day-to-day basis and be removed from the workplace thereby reducing the risk of spread of Covid-19. LFD tests to care settings were provided by NHS NSS through either direct supply to workplaces or via the PPE Hubs. NSS also set up and ran a dedicated support call service for social care services using testing.

773. The Coronavirus (Covid-19): Review of Testing Strategy [CL15/199 – INQ000242098] published in October 2020 considered priorities for further testing in light of emerging scientific and clinical evidence. The review stated that it considered that the five priorities set out in the 17 August edition remained valid, and that "*it is the unanimous view of clinical and scientific advisers that the overriding priorities for testing capacity in Scotland are symptomatic demand and clinical care of patients.*" This also reflected the latest guidance issued by SPI-M-O on 11 September 2020 (population case detection).

774. The review considered the emerging data on infection rates in older people and noted that there had been a recent increase in cases associated with care homes (as at 21 October 2020, 11% of care homes had a suspected case of Covid-19), with the consensus view of scientific and clinical advisers being that additional testing capacity should be prioritised to those most vulnerable to severe harm, stratified by risk,

"focussing first, for example, on those delivering close contact care to care home residents – to designated care home visitors, and to staff who provide care at home for those most vulnerable to harm." CNO, CMO, NCD, Chief Scientist and Chief Scientist (Health) also recommended that testing should be expanded for healthcare workers, with a focus on those caring for the most vulnerable patient groups and testing for surveillance. At this juncture, other priorities would include extending asymptomatic testing to more groups of close contacts of confirmed cases, when recommended by local health protection teams, and more intensive use of asymptomatic testing in outbreaks (to shut down outbreaks as quickly as possible, reducing their contribution to overall community transmission).

775. In response to the development of a new Covid-19 Delta variant, the then Cabinet Secretary for Health and Sport announced on 25 November 2020 that there would be enhanced testing in care homes and the rollout including permanent and

visiting staff and personal assistants to a person's home and covering residential settings, sheltered housing and day care [CL15/218 – INQ000240872]. Care home staff were required to undertake twice weekly LFD asymptomatic testing as well as weekly PCR tests. This commenced on 4 January 2021. As part of this, testing was further expanded in care homes with visiting professionals and family/friends prior to entering a care home. This commenced with a pilot of LFD testing undertaken in 14 care homes across five HSCPs. Some of these homes commenced from 7 December while others followed later in December using the learning from the initial pilots. A full roll out across all homes was completed over January and early February 2021.

776. To support Christmas visiting, Scottish Government provided access to PCR testing for visitors in the weeks beginning 21, 28 December and 4 January. The winter plan 2020/21 was also published which outlined the Scottish Government Covid-19 testing commitments for social care.

777. The 25 November 2020 statement [CL15/218 – INQ000240872] also announced expansion of asymptomatic testing during January–March 2021 beyond care homes to the wider adult social care workforce, including care at home, adult day centres, housing support and CI staff through either weekly PCR testing or twice weekly LFD testing. This expansion was made possible through increases in testing capacity with 3 new NHS regional hub laboratories, and from new testing options (due to arrival of LFDs). Asymptomatic testing was further expanded during April–May 2021 to staff working in children's residential care, children and young people community settings, social workers, addiction, learning disability, mental health and women's shelters. Again, this was either weekly PCR testing or twice weekly LFD testing. The phased approach to testing was based on clinical advice from SG clinicians and the risk associated with Covid-19 to those who were being supported and cared for by staff. Care home residents were viewed as most at risk due to vulnerability, often underlying long term conditions and the closed nature of the setting. Expansion was also informed by those local authority areas with the highest virus prevalence at the time and expanding out from there to cover the whole sector from April–May 2021.

778. To support rapid roll-out, SG ran a series of education workshops on testing which had widespread participation from across the social care sector including staff from care home and care at home services, health professionals supporting care homes, national bodies supporting social care providers. The workshops provided important information on how and when tests should be undertaken within care settings.

779. Sixteen workshops on testing care home visitors were run between 9 December 2020 and 27 January 2021. The workshops drew on material and video demonstrations developed by NHS NES on the Health and Social Care Learning Platform. Copies of the workshop presentation and materials are provided [CL15/235 – INQ000592010], [CL15/236 – INQ000592011]. The workshop presentations covered:

- Care home visitor testing process – the pathway
- Logistics (e.g. delivery of test kits)
- Preparing the visitor
- Doing the test
- Results and follow-up
- Key points
- Q&A
- Feedback to inform roll out.

780. Materials were provided to care homes to support the introduction of visitor testing, including a letter template and consent form. An information leaflet on visitor testing ('Coronavirus (COVID-19) testing for visitors – Information for people visiting care homes in Scotland') was developed with NHS NES to help visitors prepare for their visit, and what to expect when visiting.

781. For care home family/friend visitors it was envisaged that visitors would test on-site

(at the care home) in advance of seeing the resident. They would then wait for the result before visiting, and the result would be recorded. For visiting professionals, it was envisaged that they would undertake LFD tests twice weekly. The responsibility

for the distribution, testing and recording of results stay with the professional and their direct employer. The letter of the 25 November 2020 [CL15/217 – INQ000571315] indicated that care homes could ask visiting professionals for confirmation of testing from late January 2021 onwards.

782. As noted at paragraph 195 above, the Scottish Government established the ASCTB, an internal Short Life Working Group, in January 2021 to support oversight of the delivery of the expansion of asymptomatic testing in social care settings. The Scottish Government worked with NSS and territorial Health Boards to resolve issues raised through the Group. For example, to reduce waits at peak demand times for processing PCR tests at UKG labs, NSS led on setting up three regional labs that would primarily be used for care home staff PCR testing. The first of these opened in December 2020 in Glasgow, with sites in Aberdeen and Edinburgh opening in early 2021.

783. The ASCTB held ten meetings between January 2021 and July 2021. By July 2021, the main rollout of asymptomatic testing was complete with pathways for distribution and testing firmly established. As noted at paragraph 195 above, any further changes to arrangements were overseen by the ASC Pandemic Response Unit and considered in PRASCG. These arrangements and progress made, were summarised in a report developed in October 2021 for the AASCTB, provided [CL15/035 – INQ000147405].

784. In December 2021 concern around the Omicron variant led the Scottish Government to introduce daily asymptomatic LFD testing, in addition to baseline testing for social care staff. This further expansion of asymptomatic daily testing built on the existing pathways developed by the ASCTB and so the ASCTBrd did not need to be stood up again. Instead, the arrangements were overseen by the ASC Directorate and PRASCG, clinical and professional advisers within the Scottish Government, and with NHS NSS responsible for delivery. The Scottish Government worked at pace with NSS colleagues to facilitate expansion across the sector. For services that were not already accessing NSS testing supplies, the Scottish

Government collaborated with colleagues in UK Government to obtain details of those services that were accessing PCR and LFDs from the UK route. NSS supplemented supplies to the whole sector to allow daily testing.

785. In March 2022, Scottish Ministers agreed to a pause in asymptomatic testing in social care with the exception of care homes, primarily due to the success of the vaccination programme in reducing severity of illness. All remaining routine testing of health, social care and prison settings staff was paused from 30 August 2023, reverting to COVID-19 testing 'as appropriate' to support clinical diagnosis and outbreak management as per the NIPCM. Routine asymptomatic testing for admissions to care homes from hospitals remained until 3 June 2024.

Infection Prevention Control (IPC) and Personal Protective Equipment (PPE)

786. As set out above at paragraph 280 onwards, the Scottish Government published clinical guidance to support the care home sector that supplemented HPS advice. From June 2020 onwards, Covid-19 guidance for social care, including care homes, was published by PHS, with the Scottish Government publishing standalone detailed guidance for the sector on specific areas, particularly in relation to care home visiting and the use of face masks. Scottish Government also developed specific guidance around addressing elements of care home life that were not covered in PHS guidance, for example management of care homes at Christmas time. These guidance documents continued to be co-developed with stakeholder representatives through the CPAG and PAC process was introduced (see further, paragraph 311) to ensure there was a formal review of changes to guidance.

787. There was a collaborative process for guidance and policy changes affecting the care sector. When issues came to the attention of officials, there was consultation with clinical advisors and stakeholders, including:

- Public health officials
- Care provider representatives
- Chief Social Worker Officers

- Chief Officers
- Nurse Directors
- Trade unions
- Local care home oversight teams
- Through meetings of the CPAG

788. This collaborative process, illustrated in more detail below, helped ensure that published guidance was tailored to the needs of the sector.

Face mask guidance

789. The NIPCM provides guidance for IPC within HSC settings [CL15/064 – INQ000339585]. During the COVID-19 pandemic, Scottish Government developed guidance in relation to face mask/covering use within HSC settings, which supplemented but did not replace the NIPCM guidance.

790. Scottish Government had first issued guidance on the use of face coverings on 28 April 2020 [CL15/237 – INQ000302502]. This was a recommendation to the general public that they consider wearing a face covering in addition to social distancing in enclosed public spaces. This guidance was updated multiple times throughout the pandemic. In June 2020, as a result of new and emerging evidence, including from the WHO, the COVID-19 Nosocomial Review Group (CNRG) recommended that face masks should be worn at all times by staff within hospitals and care homes. The role of Scottish Government was to respond to emerging evidence and scientific advice and to issue guidance which sought to prevent transmission of the virus.

791. Scottish Government's guidance on face mask use within health and social care settings adapted over the course of the pandemic in response to recommendations from the WHO, CNRG, PHS or ARHAI Scotland. These recommendations evolved with greater knowledge about the transmission of the Covid-19 virus and the differing risk/benefit profile as infection-derived and vaccine-derived immunity increased along with the availability of effective treatments for Covid-19, amongst other factors.

792. In common with other guidance issued by Scottish Government to the ASC sector, guidance on the use of face masks was informed by advice from PHS, ARHAI Scotland, CNRG and Scottish Government's professional advisors – including professional advisors in IPC, CNO and CMO – and was developed in collaboration with stakeholder groups such as CPAG.

793. The Scottish Government regularly published updated face mask guidance for health and social care settings, with the final version being withdrawn on 16 May 2023. Guidance was published:

- 23 June 2020 – 'Covid-19: Interim Guidance on the Wider Use of Face Masks and Face Coverings in Health and Social Care' published [CL15/238 – INQ000343816]. This guidance recommended that staff providing direct care and working in a clinical area of an acute adult (including mental health), community hospital or in a care home for the elderly should wear a Fluid Resistant Surgical Mask (FRSM)

throughout their shift. Professional judgment allowed for removal for a short time, when necessary and safe to do so. For example, during times of distress or if communication issues arose when providing care

- 17 July 2020 – A FAQ document was published to support the 23 June 2020 guidance. This provided further clarity on who should wear a mask, when a face mask should be worn, and other practical matters [CL15/239 – INQ000343820]

- 18 September 2020 – 'Covid-19: Interim Guidance on the Extended Use of Face Masks and Face Coverings in Hospitals, Primary Care, Wider Community Care and Adult Care Homes' was published. This extended the scope of the guidance to cover primary care and wider community care (including adult social or community care, adult residential settings, adult care home settings and domiciliary care), in addition to acute hospitals. The guidance recommended that individuals receiving care should wear a mask/covering if tolerated, when on a medium or high-risk pathway within a hospital or older adult care home [CL15/240 – INQ000619781].

- 2 October 2020 – A clarification to the FAQ was published

- 20 October 2020 - A further clarification to the FAQ (regarding wearing a face mask during meal times when not seated) was published

- 7 June 2021 – 'Coronavirus Covid-19: guidance on the extended use of face masks and face coverings in hospitals, primary care, wider community care and adult care homes' was published [CL15/241 – INQ000525332]. The guidance was updated across all settings within its scope and the document was written to highlight the guidance specific to each setting. For ASC, the guidance recommended that a FRSM should be available for adult care home residents when receiving direct care, and FRSM should be worn, unless exempt, within communal spaces. Residents were not expected to wear FRSM within their own living spaces (such as bedrooms or personal toilets) unless they are receiving direct care or were unable to maintain 2 metre distancing. The guidance stated residents should wear FRSM when being transferred or transported to hospital

- 23 June 2021 – 'Coronavirus Covid-19: use of face coverings in social care settings, including adult care homes', was published [CL15/242 – INQ000429260].

ASC guidance was separated from acute and primary care settings at this point. The guidance clarified that residents of adult care homes were not required to wear a FRSM/face covering within the care home but could chose to do so if they wished

- 27 August 2021 – 'Coronavirus Covid-19: use of face coverings in social care settings including adult care homes' guidance was published to reflect changes in physical distancing. A letter to the sector setting out the changes was issued on 1 September 2021 [CL15/243 – INQ000509953]

- 20 December 2021 - 'Coronavirus Covid-19: use of face coverings in social care settings including adult care homes' guidance was updated to add in references and links to face mask regulations [CL15/244 – INQ000510036]

- 24 March 2022 - 'Coronavirus Covid-19: use of face coverings in social care settings including adult care homes' guidance, in recognition of the impact of the wearing of face masks on relationships, wellbeing and communication, was updated to remove the recommendation they be worn at all times [CL15/196 – INQ000222889]. The guidance recommended that family/friend visitors to adult care homes could choose not to wear a FRSM/face covering in a resident's own room. The guidance recommended that, in end-of-life situations with essential visiting, FRSM/coverings need not be worn. A FRSM/face covering was still recommended for visitors in communal areas/when moving around the care home

- 7 September 2022 - 'Coronavirus Covid-19: use of face coverings in social care settings including care homes' published [CL15/245 – INQ000510037]. This guidance removed the recommendation that staff wear a face mask at all times when in social care settings. Visitors to care homes were no longer recommended to wear a face covering in communal areas. Face masks were still required in particular scenarios, such as known or suspected outbreaks

- 12 October 2022 – a minor clarification was made to the face mask poster accompanying the 7 September 2022 to state that the NIPCM remained in place

- 9 May 2023 – Withdrawal of the Coronavirus Covid-19: Extended Use of Face Masks and Face Coverings Guidance across HSC with effect from 16 May 2023 [CL15/246
  – INQ000496524]. HSC settings were advised to continue to follow IPC guidance (including for face masks) as per the NIPCM.

794. On 18 June 2020, the Covid-19 Advisory Group met to discuss whether there was a need to revisit the IPC measures introduced to care homes in the Spring 2020 [CL15/247 – INQ000217696]. This discussion included consideration of the RAPID datasets (datasets used for administrative purposes). This data showed that the majority of those who had tested positive within 14 days of discharge had been discharged to their own homes or other hospitals rather than care homes. Group members acknowledged that positive tests 14 days post discharge could mean infections were acquired in the community and the Nosocomial Group were asked to consider further.

Adult Social Care Winter Preparedness Plan

795. In November 2020, the Scottish Government published the first ASC Winter Preparedness Plan 2020–21 to provide further guidance and support to the sector on managing winter pressures, in addition to the challenges of managing Covid-19 [CL15/142 – INQ000249502].

796. The ASC Winter Preparedness Plan [CL15/142 – INQ000249502] was drafted following consultation with a wide range of organisations across the social care sector, including those represented on the PRASCG: local government, the NHS, HSCPs, regulators, the third sector, trade unions and professional bodies. It set out the range of measures introduced to support the sector from the outset of the pandemic and the further enhancements that would take effect in preparation for winter pressures, including in relation to:

- IPC

- Testing and vaccinations
- Admissions from hospitals
- Mental health and wellbeing
- Workplace safety and support (incl. PPE)
- Oversight arrangements
- Use of the safety huddle tool

797. A range of new measures were also introduced by the ASC Winter Preparedness Plan [CL15/142 – INQ000249502] including in relation to staff movement, fair work, increased testing and outbreak management. Territorial Health Boards and Local Authorities, including through the multi-disciplinary oversight teams, were asked to: build in mutual aid between social care providers and across IAs; provide local level planning and co-ordination to support workforce capacity required and to manage and limit the impact on individual members of the workforce; and provide professional advice where required. Workforce planning and deployment practice was monitored by the local multi-disciplinary care home oversight teams and through CI support and inspections of care homes. The ASC Winter Preparedness Plan was supported by additional funding of up to £112 million, which was allocated broadly as follows:

- £50 million to support the additional costs of restricting staff movement across care settings
- £50 million for the SCSSF and winter sustainability funding through to the end of March 2021
- £7 million for territorial Health Boards to invest in Nurse Director teams to support increased infection protection and control measures in care settings
- Up to £5 million for additional oversight and administration costs associated with responding to the pandemic and outbreak management.

798. The enhanced winter measures also provided access to the social care/NES recruitment portal to secure additional staff in the short/medium term if needed.

799. The ASC Winter Preparedness Plan for 2021-22 [CL15/158 – INQ000147362] similarly provided updated guidance to the sector on the issues identified above, but with an increased focus on:

- Supporting the needs and wellbeing of the social care workforce and unpaid carers
- Maintaining high quality integrated health and social care services throughout the autumn/winter period
- Protecting those who use social care support from the direct impact of COVID-19 and wider winter viruses.
- Working in partnership across health and social care to deliver the Plan.

Personal Protective Equipment (PPE) provision

800. 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.

801. Pre-pandemic, in line with planning assumptions across the four UK nations, the Scottish Government held stockpiles of PPE based on the assumed needs of the health and social care sectors in Scotland - and the assumed 'Reasonable Worst Case' influenza pandemic scenario. That included specific assumptions regarding the needs of adult social care and so included facemasks, aprons and gloves for the sector, both residential and non-residential, as well as for children's services.

802. During the pandemic, social care providers received PPE support from the Scottish Government 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 [CL15/168 – INQ000510002]. 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) as discussed at paragraphs 460 and 461 above.

803. 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:

- 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

- 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.

804. SG records indicate that an agreement was reached between SG officials and NSS on 16 March 2020 in relation to using PPE from the NSS stockpile to supply the ASC sector [CL15/248 – INQ000496482]. Formal authority was subsequently provided by DGHSC, Malcolm Wright, with the Director for Community Health and Social Care, Elinor Mitchell, writing to the sector on 16 March to confirm the new arrangements.

805. 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. The following groups – including within the public, voluntary or private sectors – were eligible to access PPE from the Local and National Hubs over the course of the pandemic:

- Staff in care homes
- Care home visitors

- Care at home providers
- Unpaid carers
- Personal assistants
- Day services
- Sheltered housing services
- Supported housing and housing support
- Children's homes
- Hospices.

806. The PPE Hubs were supplied by NSS with governance arrangements set out in a Memorandum of Understanding (MoU) which was co-signed by: Scottish Government, COSLA, NSS, HSCPs, CCPS, Scottish Care and National Carer Organisations. Copy of MOU provided [CL15/033 – INQ000147351]. The MoU set out in detail how the PPE Hubs and National Support Centre would operate in practice, in addition to a set of principles to which all parties to the MoU agreed. The May 2020 MoU set out these principles as follows:

- Business as usual is that care providers source their own stock of PPE
- Where this fails, the PPE Hubs will provide PPE to the whole social care sector, including personal assistants and unpaid carers
- Supplies will be used in line with Hub supply guidance and distributed equitably according to need, regardless of employer
- NHS NSS will supply stock to the Hubs to meet need based on actual consumption/reasonable planned usage data – recognising that actual consumption may rise as business as usual sources of supply dry up and as Hubs expand their provision
- PPE Hubs will receive stock on a pre-determined day of the week, and will know what deliveries will include. They will be expected to provide a regular stock return to

NSS

- NSS will provide training for Hubs and providers on Hub operations and expectations
- All parties recognise the global scarcity of PPE
- The Social Care PPE Support Centre will revert to being for emergency use only · Distribution and supply arrangements will be analysed using evidence gathered from the ongoing operations, and kept under review for changes and improvements where necessary. This process will include all parties.

807. These organisations also formed the Adult Social Care PPE Steering Group which met to monitor the use of the PPE Hubs and levels of supply and demand, in addition to addressing any issues of concern raised by Steering Group members (see further, paragraph 193).

808. The PPE Hubs, and the MOU underpinning them, were initially established for a period of six months. However, the MOU was frequently extended so that the PPE Hubs remained in operation throughout the pandemic with the final extension agreed to September 2022.

809. The Inquiry has asked about whether concerns were raised regarding access to PPE by the ASC sector prior to March 2020. Scottish Government records do not provide evidence of concerns relating to access to PPE being raised by the ASC sector. However, as noted above, records indicate that SG engagement with the ASC sector during February 2020 was primarily in relation to wider operational resilience planning for the sector.

810. As the pandemic progressed, the provision of PPE broadly stabilised and systems remained in place to manage the operational aspects of continuing good supply for the remainder of the relevant period. The Adult Social Care Steering Group continued to meet frequently both to monitor PPE requirements within the sector and to ensure that the PPE local Hubs and national helpline were meeting the needs of social care providers. The Steering Group also provided a useful forum for stakeholders to raise issues relating to PPE more widely, including seeking advice and clarification from PHS/ARHAI on the correct use of PPE such as face masks and gloves. SG records indicate that 651 million items of PPE were delivered to the social care and community

care sectors in Scotland in the period up to 1 May 2023. The Inquiry may wish to contact NSS directly for confirmation of how much PPE was transferred to the ASC sector over the relevant period.

Visiting in Care Homes

811. As noted elsewhere in this statement, the Scottish Government considered that care homes were a substantially higher risk setting for Covid-19 and therefore there was a need to be vigilant. The Scottish Government's role within the context of visiting was to provide direction, leadership, oversight and guidance around the approach,

taking account of scientific and clinical advice and the dynamic and rapidly changing situation. This involved considering advice from UK-wide bodies such as SAGE, WHO as well as the UK IPC cell, discussions with other UK nations and advice from PHS, DPH and other organisations. Scottish Government also worked with stakeholders including care home provider representatives to develop guidance, monitor its implementation and support national and local bodies to help care homes in adopting guidance.

812. As documented in Chapter 8.2 of the UK CMOs' Technical Report on the COVID19 Pandemic in the UK [CL15/249 – INQ000203933] the challenge posed by Covid-19 was significant despite the best efforts to prevent, manage and mitigate its impact. Changes happened rapidly; staying ahead of the threat remained complex and difficult. Policy, health and social care teams therefore needed to be flexible, dynamic and responsive to changes in community attack rates, symptoms, protective measures and emerging evidence that came to light. That ability to rapidly escalate and deescalate, adapt and deploy was critical to successful oversight.

813. In the early stages of the pandemic, the Scottish Government's priority with respect to care homes was to ensure measures were in place to prevent ingress of infection and minimise transmission. At this time, there were no pharmaceutical

interventions available, no vaccines and limited availability of testing. As a result, the initial Scottish

Government Covid-19 guidance for care homes published on 13 March 2020 [CL15/013A – INQ000280689] took a cautionary approach through seeking to minimise the number of people, including family visitors, entering a home; reducing the use of communal spaces; and isolation within rooms as much as was practical. It was recommended to cut visiting by 75%, with the suspension of 'routine' visiting, but supporting essential visits for those experiencing distress and for end-of-life care and allowing visits from essential healthcare staff.

814. It was recognised that this was at a time when such restrictions were hard to comprehend and there was no ideal solution for the sector. However, the competing priorities of the risks to the right to life against the risks to loss of rights to family life for vulnerable people approaching the end of their lives required weighing up. The risk balance was not a binary one, so it was not a case of high risk versus no risk. The aim was always trying to minimise risk, but risk was dynamic and differed from week to week, and so it was important to constantly adapt to what was the safest option.

815. Such considerations around the complexity surrounding decisions on visiting and associated risks, and other decisions are reflected in the findings of the UK CMO Technical report [CL15/249 – INQ000203933], which states that:

"*… 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.*"

816. Such a cautious approach early on was also promoted by Scottish Care who, in a letter to members on 11 March 2020, endorsed an early protective approach

around measures including visiting restrictions but urged members to support contact in endof life-care situations [CL15/250 – INQ000326477]. It also encouraged care homes to maintain resident contact with family and others (using social media, camera, phones, electronic messaging) with particular sensitivity required to support residents living with dementia (particularly those in advanced stages) and palliative care.

817. As more became known about the virus and protections were put in place to support care homes including testing, there was general agreement that there was a need to facilitate the gradual opening of care homes to support wellbeing, which was reflected in discussions of the CPAG and CHRAG.

818. In particular, there was agreement during the CPAG meeting of 14 May 2020 to the establishment of a CPAG sub-group to develop stand-alone visiting guidance, outlining a four-stage approach to the safe reintroduction of indoor visits to care homes [CL15/251 – INQ000323029]. This group, which comprised Scottish Care, territorial Health Boards, CI, care home providers and clinical and nursing advisers, co-wrote the first stand-alone visiting guidance which was published on 25 June 2020 [CL15/113 – INQ000147431]. The paper discussed at the CPAG meeting on 3 June 2020 [CL15/252 – INQ000323334] included consideration of the needs of the resident, impact on visitors and the circumstances of the particular care home. The guidance attempted to balance the risks associated with visiting with the harms associated with loss of visiting. It was stated that a blanket policy applicable to all care homes, or all residents with particular characteristics, should be avoided and it should be assumed that all residents will wish to see visitors. The guidance also reflected that visitors may be distressed and how staff may need to support the visitor and resident during these times. The guidance outlines the IPC precautions which need to be followed.

819. To inform the development of this approach, the Scottish Government's Senior Medical Officer sought advice from the CMO Covid-19 Advisory Group in May 2020 on whether it would be possible for care homes to open to visitors beyond essential visiting. In the advice provided by the Advisory Group on 1 June 2020

[CL15/253 – INQ000217662] it was noted that the position was to "*proceed with extreme caution.*

The group consensus is that it is not the time to relax restrictions in care homes.". The group noted that "*once the outbreak situation is managed, and effective measures established for monitoring, there may be an opportunity to consider a risk based and proportionate way to reintroduce some limited visiting."* The advice recognised the need to balance the risks and potential harms from relaxing measures in this vulnerable population, with the ongoing risks and harms resulting from social isolation and consequent deterioration in care home residents' health and wellbeing. The advice also reflected the heterogeneous nature of care homes (in terms of both their physical setup and the characteristics of their residents) and therefore stated that decisions to relax measures may need to be taken on a case-by-case basis.

820. Outbreaks in care homes were closely correlated with community prevalence; care homes situated in higher transmission areas were more at risk due to the close links with staff and visitors and their local communities. However, recognising the need to balance the risks and potential harms from relaxing isolation measures in this vulnerable population, with the ongoing risks and harms from social isolation, the Advisory Group recommended the reintroduction of some limited visiting, taking account of the needs and characteristics of residents, the measures in place and understanding of local community transmission.

821. In view of this advice, the Scottish Government worked with stakeholders including the CPAG sub-group to develop a four-staged approach to the return of indoor visiting. On 25 June 2020 the first stand-alone Visiting Guidance for Adult Care Homes in Scotland was published [CL15/113 – INQ000147431]. 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.

822. To support local decision making, the guidance recommended that SDsPH provide a regular professional assessment of whether visiting was likely to be appropriate within their area, taking into account the wider risk environment. Alongside this an individual risk assessment was recommended to determine a care home's

progression through the stages with support from the local Health Protection team and the Care Home Clinical and Care Professional Oversight Team (these teams, comprising NHS and Local Authority staff, were set up early on in the pandemic to provide multidisciplinary support to care homes).

823. The Inquiry has asked specifically about the extent to which 'blanket' guidance was provided in respect of visiting. For the reasons highlighted above around the significant risks posed to a vulnerable population and the lack of pharmaceutical interventions, it was important to take a cautious approach in all adult care homes in the early stages of the pandemic. Thus, guidance initially recommended a national and consistent approach to the pausing of routine visiting. However, support for essential visiting for end of life and distress was recommended taking account of the needs of residents.

824. As understanding of the virus developed and pharmaceutical interventions became available, guidance was adapted and recommended risk-based decision making to adopting routine visiting. For example, as noted above the first standalone visiting guidance provided a framework to support national and local decision making around the movement through the four stages of visiting. Visiting decisions locally were therefore informed by local public health considerations with the involvement of the DPH of wider risk environment alongside an individual risk assessment of a care home's ability to manage risks.

825. Such an approach had the advantage of ensuring some care homes were able to open sooner than others based on the advice from the DPH and therefore avoided a blanket approach. This would have included care homes with younger populations with a lower risk profile including those with learning disabilities, although some care homes had a mix of younger and older adults which made it challenging to balance the risks. The disadvantage of the approach was that homes in areas where there was higher prevalence were slower to progress though the visiting stages. In such instances it was important to ensure that essential visits were always supported.

826. Scottish Government (and PHS) Covid-19 guidance, from the outset, always emphasised the importance of supporting essential visiting. The 13 March 2020 Scottish Government guidance envisaged essential visits as those from health and care staff and also that consideration would need to be given to named relatives as essential visitors (and that there should also be flexibility for end-of-life situations) [CL15/013A – INQ000280689]. The relevant extracts from the various iterations of the Scottish Government Guidance from March to May 2020 are set out below:

827. On 13 March 2020 Scottish Government guidance [CL15/013A – INQ000280689] stated:

"Reducing visitors to the home apart from essential visits. This should seek to reduce external visitors by 75% as with other guidance. This might need to consider visits from appropriate health and care staff as essential. Thought should be given to having a named relative as contact. There may need to be consideration given to a named relative as an essential visitor, but the frequency and duration of visiting will need to be reduced. Obviously there needs to be flexibility where appropriate such as in end-of-life settings."

828. Prior to the issue of updated care home guidance on 26 March 2020 [CL15/069 – INQ000429281], it was noted that most European countries had banned visits to care homes. It was queried whether the guidance, which stated essential visits only, named family contact, consideration in end of life situations and importance of risk assessment should be amended considering this information. The CNO advised on 25

March 2020 that it was her preference that visiting should be restricted to end of life as per the guidance for hospital settings (other than those individuals with dementia who are distressed), advice provided [CL15/254 – INQ000429273].

829. Following wider consideration, on 26 March 2020 Scottish Government guidance 2020 [CL15/069 – INQ000429281] stated:

"Routine visiting should be suspended – Only essential visitors permitted in line with HPS guidance. Local risk assessment and practical management should be considered, ensuring a pragmatic and proportionate response. Visits from appropriate health and care staff would be classed as essential. For family and friends, visits should be restricted to end-of-life care situations or people with dementia who are distressed. In such instances there should be a named contact for visiting, and ideally visits should involve one person at a time; no children should be permitted. These visitors must not visit any other care areas or facilities."

830. In addition, the guidance stated that "Consideration should be given to alternative measures of communication including phoning or face-time. Visiting may be suspended if considered appropriate."

831. On 15 May 2020, Scottish Government guidance [CL15/070 – INQ000383486] further expanded on essential visits and stated:

"Visiting policy – As per HPS guidance, 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, it may be helpful to make clear the purpose of the visit so that precious time is used well and to ask the visitor to relay messages to or from family. These guiding principles produced by the Royal College of Physicians Edinburgh, the Scottish Academy of Medical Royal Colleges, Marie Curie & Scottish Care on visiting at end of life are considered particularly helpful.

832. The first standalone visiting guidance published on 25 June 2020 [CL15/113 – INQ000147431], outlined a four-stage approach to support the return of indoor visiting, continued to emphasise the importance of essential visits and provided a definition of an "essential visit" as "where it is imperative that a friend or relative is

allowed to see their loved one in the circumstances where their loved one may be dying or where they may help to ease significant personal distress."

833. The Scottish Government position has always been that 'essential' and 'end of life' visits should be supported, and a flexible needs-based approach should be taken. However, a small number of care homes did not always provide for this, which was a serious concern and required Scottish Government alongside partners such as the CI and local Health Protection teams to intervene to ensure that essential visits were always supported.

834. To avoid whole-home blanket closures in the event of an outbreak within a care home, local Health Protection teams would often recommend that units within the home which were not affected by the outbreak could remain open as long as a number of measures were followed including restrictions on staff movement between units.

835. In recognition of the role of family and loved ones providing wellbeing support to people living in care homes, the Scottish Government worked with members of CPAG to develop a proposal for enabling people who live in adult care homes to nominate a

'wellbeing supporter' who was able to visit in their room during a controlled COVID outbreak. This was because of concerns about the impact of isolation for prolonged periods when care homes closed following a COVID outbreak (which sometimes involved continuous COVID-19 outbreaks in a care home) or if someone was selfisolating as a precaution. Following the presentation of paper considered at CPAG on 9 September 2021 [CL15/255 – INQ000509973], members endorsed the approach. They recommended using the term 'named visitor' rather than 'wellbeing supporter' or 'essential care giver' to avoid the assumption that it was only for those families that provided care.

836. Following the discussion at CPAG, the Scottish Government published guidance on 15 September 2021 to support named visitors during controlled COVID-19

outbreaks which ensured that people could remain connected even in an outbreak situation [CL15/256 – INQ000509972].

837. The Inquiry has also asked specifically for detail on the steps taken by the Scottish Government to ameliorate the impact of visiting restrictions. A range of steps were taken by the Scottish Government to mitigate the impact of reduced visiting on people living in care homes and their families. This involved developing more detailed advice in guidance around specific strategies for supporting people, particularly the 15 May

2020 Scottish Government Clinical Guidance for Care Homes [CL15/070 – INQ000383486], which provided more detailed considerations for supporting people.

838. Advice on the use of technology to enable people to remain connected was also provided. Many care homes facilitated family connections through alternative means including technology. While this was not appropriate for everyone, it enabled many people to remain connected. To support care homes in using and accessing technology to facilitate family connection, a range of actions were undertaken as part of the Digital Approaches in Care Homes programme (this is discussed in more detail separately).

839. While some care home providers took individual decisions to construct screens (i.e. partitions separating visitors from the residents) there were concerns raised around the negative impact of use of screens on residents and their families. At the time when screens were being considered by care providers, the Scottish Government was developing guidance to support a return to indoor and routine visiting. It was for these reasons the Scottish Government did not promote screens. However, it provided adult social care providers with sustainability funding for a range of COVID-19 associated costs incurred including those associated with supporting safe visiting.

840. Recognising the impact on families, the Scottish Government provided funding to Alzheimer Scotland's Action on Rights team to operate a helpline to provide advice and support to families of people who were resident in care homes during the pandemic. The helpline provided emotional and practical support for families and carers of care home residents regardless of a link to a dementia diagnosis, offered advice on care home visiting guidance to empower families and carers to have informed discussions with care home staff and, where necessary and appropriate,

liaised directly with care home staff responsible for visiting arrangements to facilitate visits and essential visits. The team also signposted families and carers to link them with other sources of support including Alzheimer Scotland services or other relevant agencies or organisations.

841. The Scottish Government also funded Alzheimer Scotland to establish a national counselling service in response to the trauma experienced by people living with dementia and their carers throughout the pandemic. This involved a team of trained counsellors to support families to deal with the impact of the pandemic and lockdown restrictions on their mental health with a focus on those who experienced the loss of a loved one due to COVID-19. The counsellors routinely informed carers of their rights under the Carers (Scotland) Act 2016 and signposted them to local services.

842. The Inquiry has asked specifically about the 13 March 2020 guidance [CL15/013A – INQ000280689] stating that the more marked adverse effects of implementing measures including social distancing on residents with dementia "*may be best addressed using volunteers or third sector charitable organisations to support the work of activity coordinators adapting to engaging with individuals and to be seen as part of essential contacts".*

843. The 13 March 2020 guidance [CL15/013A – INQ000280689] advocated that visitor numbers or visits were reduced by 75%. It was not a complete 'lockdown', and the nationwide 'lockdown' was not yet in force. Residents were to isolate in their rooms for around 75% of the time. The intention was to reduce footfall and contact as much as possible to reduce the likelihood of virus ingress into care homes. The guidance indicated that management of people in their own rooms would be challenging for many socially and cognitively, recognising that this may be more marked for residents with dementia. Therefore, some potential measures were outlined to mitigate the potential effects, such as the use of care home activity coordinators (some of whom are directly employed and some may be third sector volunteers for resident wellbeing) and other staff that are often involved in care homes in the social and wellbeing space. At the time this approach was considered appropriate given that there was no national 'lockdown' and that the

majority of such people, typically activity coordinators, would already be employed by the care home.

844. In view of the escalating threat of COVID, which required more stringent measures, the guidance changed on 26 March 2020 [CL15/069 – INQ000429281] to the effect that, while a section on mitigating impacts was included, it did not recommend consideration of utilising such staff.

845. Following the publication of the first standalone visiting guidance, further iterations of guidance, informed by clinical advice, were published to encourage progress through the stages to supporting indoor visiting and visits out of care homes. Concerns nevertheless remained that opportunities for visiting were being restricted by some care homes and those advising homes at a time when more formal measures were being relaxed for the wider population. Many homes were fearful of opening due to the high number of deaths seen across the sector. There were also challenges in the journey of adopting a full return to routine indoor visiting with the arrival of new variants (e.g. Delta), about which the presentation and impact were initially unknown.

846. To support a full return to indoor visiting SG published, 'Open with Care – Supporting Meaningful Contact in Adult Care Homes' in February 2021 [CL15/015 – INQ000147437]. The guidance drew on recent advice from the WHO ad hoc COVID19 IPC Guidance Development Group which published a paper unanimously agreeing that visiting should be supported, as long as a range of IPC measures were in place. The Open with Care guidance was supported by dedicated communication with promotion of messaging by national and local stakeholders to encourage adoption and SG direct engagement with care providers through dedicated workshops.

847. The guidance was updated in September 2021 [CL15/256 – INQ000509972] to support named visitors during COVID-19 outbreaks. This ensured that people including essential carers could remain connected even in an outbreak situation.

848. Advice was also issued on 3 September 2021 around recommendations for the safe resumption of communal activities within care homes and of visiting people, professionals, and organisations into homes. it provided advice about residents

leaving the care home for day/overnight visits and residential respite [CL15/257 – INQ000496539].

849. The Scottish Government worked with stakeholders and the CPAG to closely monitor progress on the adoption of visiting guidance within the sector through analysis of data contained in the Safety Huddle Tool (outlined below) in addition to receiving feedback from care homes, stakeholders and families. Concerns were raised with Ministers and officials as well as other organisations that some care homes were not adopting the guidance and that different approaches were being taken by local public health teams based on a different risk appetite in advising care homes on the approach.

850. To support this a subgroup of CPAG – the National Open with Care Oversight Group – was established in March 2021 to monitor and promote national Open with Care visiting guidance [CL15/015 – INQ000147437] to ensure people's rights were being supported. Further detail regarding this group is provided at paragraph 156 above. The group continues to meet in order to support the development and implementation of 'Anne's Law'.

851. Stakeholders played an important oversight and monitoring role, alongside Scottish Government, in promoting the national guidance through their role as representative organisations or through their oversight of and support to the care home sector locally. For example, the CI operated an accelerated policy of investigation of visiting complaints where concerns about visiting in care homes were raised. Also, local care home oversight teams, which were set up to support care homes during the pandemic and comprised NHS and Local Authority leads, were asked to support adoption of the guidance locally. Scottish Care also played an important liaison role with care homes to ensure consistent adoption of guidance. Scottish Government liaised with PHS where concerns were raised around the lack of consistency between local HPTs.

852. To support monitoring of visiting guidance, the Scottish Government added visiting questions to the TURAS care home Safety Huddle Tool (SHT). This data collection allowed the Scottish Government and other stakeholders to act locally where visiting was not being supported.

853. Using the data from the SHT, from 23 December 2020 the Scottish Government published Care home visiting data – example publication from 1 June 2022 provided [CL15/258 – INQ000512568]. These statistics were published for the final time by the Scottish Government on 18 May 2022, with PHS taking responsibility thereafter.

854. On 25 June 2021, the Scottish Government published a progress report on 'Open with Care – supporting people in adult care homes to have meaningful contact with others' [CL15/256 – INQ000509972]. The report summarises progress with the implementation of Open with Care since publication. It highlighted where there was excellent progress and identified key actions to improve and embed good quality, meaningful contact as the norm.

855. In August 2021 the Scottish Government also undertook an on-line survey of care home managers' experiences of implementing the Open with Care visiting guidance. The aim was to gather experiences and insights from managers to inform future planning and guidance to support the sector. The report was published [CL15/257 – INQ000496539].

856. Throughout the pandemic, Scottish Government policy, clinical and social work officials liaised with their counterparts across the UK to support decision making and the development of appropriate guidance. For example, CMO, CNO and CSWA liaised with their UK counterparts on a range of matters including the developing situation and support for care homes. Similarly Scottish Government social care policy officials convened and attended an informal four-nations care home visiting group which met fortnightly during the height of the pandemic then monthly. This was a forum to highlight issues and concerns and share approaches to the development of appropriate visiting guidance for the sector.

Digital initiatives

857. The Digital Approaches in Care Homes Action Plan was launched in November 2020 following a £1.5 million announcement by the First Minister to provide all of

Scotland's care homes with digital devices to enable their residents to communicate with their loved ones during the COVID-19 pandemic and support being able to access public services e.g. a video consultation with a health professional [CL15/259 – INQ000323331] [CL15/260 – INQ000243258].

858. Over three-quarters of Scotland's 1400 registered care homes took up the offer of iPads and MiFi devices which accounts for over 90% of residents in Scotland and feedback has been extremely positive. The initiative known as Connecting Residents

in Scotland's Care Homes' (CRSCH) was taken forward in collaboration with Connecting Scotland and included digital skills support offered by SCVO. The Digital Health and Care Directorate wrote to all care home managers on 16 November 2020 to make them aware of the initiative and the application process [CL15/261 – INQ000323329].

859. The CRSCH initiative played an important role in supporting residents of care homes to maintain contact with family members during Covid-19 lockdowns. iPads were used to support regular video calls between residents and family members, with the technology also found to provide further benefits including physical activity and entertainment. An evaluation is provided [CL15/262 – INQ000510057]. This formed part of an overall Digital Approaches in Care Homes Action Plan led by Digital Health and Care Directorate [CL15/259 – INQ000323331]. It also contributed toward the aims of the previous recently published Digital Health and Care Strategy, as well as the ASC Winter Preparedness Plan 2020-2021.

860. Following engagement with care home staff via surveys, support forums and training sessions, a need was identified for increased training and support to be offered to staff who support residents in the use of the digital devices.

861. The programme was then offered digital skills training by Barclays Digital Eagles, Barclays Bank's community interest arm. Its offer was a free bespoke training package tailored to meet the requirements of Scotland's care home staff, based on learning from their work with care homes in England. This offer applied to all care homes in Scotland.

862. The Digital Health and Care Directorate's TEC programme had also established a dedicated programme of work for social care. The Digital Social Care programme evolved out of an initial Covid-response to support Care Homes with digital solutions, support and skills development. The programme had a number of demonstration projects under way to measure the impact of embedding new technology solutions in home care, such as:

- The trial of a Care Technologist role which works with people receiving support to identify, try, and embed technology that fits with their needs and wants, and helps meet their outcomes
- Video medication prompt service, which supports people to take their medications while also reducing the need for very frequent in-person support and may help people to be discharged from hospital quicker
- The use of SEM (Subepidermal Moisture) scanners by care providers in a home setting to reduce the risk of pressure ulcers and unavoidable admission to hospital
- Shared digital care planning systems to provide transparency of care arrangements and empower citizens and their families to co-manage care provision
- Digital support planning grids to enable people to have better control and oversight of their SDS budget, and their care and support.

863. All Care Homes were also contacted and made aware that they can utilise Near Me appointments to prevent the spread of infection or the need to visit a healthcare setting. As of 2022, this programme has provided support to care homes covering more than 90% of residents across Scotland.

Care Home residents' access to healthcare

864. The Inquiry has asked about the impact of the pandemic on care homes residents' access to healthcare and the extent to which the Scottish Government was aware of the impact and what it did to address concerns.

865. Although the Scottish Government was clear throughout the pandemic that those requiring medical treatment should continue to seek it, there were nevertheless concerns that broader communications, such as the 'Stay at Home' messaging, were resulting in people across wider society not seeking medical attention. The Scottish Government took a number of steps to address the impact this would have on care homes, outlined below.

866. The Scottish Government's clinical guidance for care homes indicated that essential visits, including healthcare visits, should be supported. Although the 13 March 2020 guidance stated only that care homes *"might need to consider visits from appropriate health and care staff as essential"* [CL15/013A – INQ000280689], this was reinforced more strongly in the 26 March 2020 and 15 May 2020 guidance [CL15/069 – INQ000429281] [CL15/070 – INQ000383486], which made clear that visits from healthcare teams should be classed as essential.

867. On 17 April 2020, the CMO wrote to GP practices to emphasise the importance of GP support to care homes. The letter added, "It is important to remember that even at this time decisions on the care of patients should always be made on an individual basis. If it is in the best interests of an individual that they be admitted to hospital, then this should be arranged" [CL15/263 – INQ000259882].

868. On 20 May 2020, the CMO, with the support of the Royal Colleges, wrote to territorial Health Board Chief Executives, Medical Directors and DPH highlighting the significant impact of Covid-19 in the care home sector and encouraging the recipients to consider ways to provide support to the sector, including involving geriatricians in supporting older people in care homes [CL15/264 – INQ000343843]. The letter also highlighted the likely atypical presentations of Covid-19 in older people and the importance of visiting in cases of distress or at

end of life. It reinforced that admission to hospital should be considered where there is clear benefit to the individual.

869. Both the Scottish Government clinical guidance and the CMO letter also promoted the use of NHS Near Me technology to provide access to GPs and community teams.

The CMO letter stated: "*The way we provide patient care has changed during the pandemic, with increased use of telephone and Near Me assessments where possible to minimise potential transmission of infection through face-to-face contact. However, there are still times when a face-to-face consultation is clinically necessary, and an expectation that health and care professionals will continue to enter care settings such as care homes to provide ongoing care and support when required, with appropriate safety measures such as PPE in place"* [CL15/264 – INQ000343843].

870. The Scottish Government continued to engage with stakeholders, including through the CPAG, to monitor and address concerns relating to access to healthcare throughout the pandemic.

871. In collaboration with stakeholders, clinical and professional advisors, SG continually revised and updated guidance to reinforce messaging on the importance of face-to-face contact - 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 [CL15/257 – INQ000496539]. This guidance proposed a staged approach to the return of people and organisations to care homes, with healthcare professionals able to offer face to face routine care including preventative and rehabilitation visits (with appropriate mitigating actions) from 7 September 2020.

872. The Open for Care - Visiting health, social care and other services in care homes and communal activity', guidance of 14 April 2021 [CL15/265 – INQ000496554] emphasised the importance of involving a wide range of professionals and people in the life of the care home and the impact this would have on the wellbeing of residents. It set out principles to support the staged return of visiting professionals to care homes, recognising the importance of the provision of equitable,

person-centred and holistic healthcare alongside wider services to improve the wellbeing and overall health of people living in care homes..

873. 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. All Care Homes were also contacted (between 17 April 2020 – 8 June 2020) and made aware that they can utilise Near Me appointments to prevent the spread of infection or the need to visit a healthcare setting. See the above section on Digital Initiatives for more information.

Changes to regulatory inspection regimes

Changes to Care Inspectorate practice

874. The CI continued to operate and embed its risk based and intelligence led inspection approach while providing support to care services working in partnership with the Scottish Government and others. It prioritised work on adult social care and worked closely, and at pace, with the Scottish Government across a raft of emerging issues, including provision of data, on its approach to inspections, contributions to briefings, guidance and engagement with Scottish Ministers and the care sector. They also contributed in the response to the pandemic via participation in a variety of working and advisory groups.

875. Scottish Ministers met regularly with the CI to share information and receive updates on actions, including enforcement activity, and to address findings from their scrutiny of care homes. Scottish Ministers also recognised that this was a particularly difficult and stressful time for staff and expressed appreciation for their contribution and commitment throughout the pandemic.

876. As the national agency responsible for regulating care services in Scotland, the early stages of the pandemic saw a rapid transformation of the CI's work from a 'business as usual position' to an emergency response, with associated changes to its assurance and scrutiny activity. Scottish Ministers sought information and intelligence

from the CI to better understand the effect the pandemic was having across the sector and risks to individual care services and to aid decision making. The CI's knowledge of the care home sector and interplay with other agencies were relied upon to identify emerging issues and threats.

877. 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 where approval was then sought and obtained on 13 March 2020, submission provided [CL15/266 – INQ000261292]. This saw a move from a 'business as usual position'.

878. Therefore, Ministers were aware that the CI intended to scale down its inspections of care homes and strategic scrutiny. The rationale was clear and aimed at minimising the risk that CI staff would spread infection of Covid-19, and that their inspectors might too be at risk.

879. The CI developed a decision making tool and framework as part which set out how decisions would be made about how to carry out scrutiny as guided by the following principles:

- Focus strategic scrutiny activities on supporting local authorities and health and care partnerships to ensure people receive safe care. Prioritise activity according to where we believe risk is highest and where we can make a difference
- Support local authorities, health and social care partnerships and other key services throughout this challenging time by reducing the asks of them wherever CI can without compromising people's safety, and by ensuring CI are not contributing to the risk of spread of infection
- Prioritise the health, safety and wellbeing of CI staff and reduce the risk they are exposed to. Following HPS/PHS guidance, CI may restrict service visits, travel, attendance at events and so on.

880. The Scottish Government's understanding of this decision making process was that it consisted of three different scenarios i.e. continue with current inspections, an intermediate position and cessation of scrutiny. In adopting the intermediate response the CI cancelled all non-essential inspections based on assessment of risk, grading at last inspection and intelligence. The answers to key questions such as: what would the likely impact be on people using services, what would the likely impact be on providers and what would the likely impact be on CI (now and in future) all featured in their risk assessment.

881. The CI also moved to use of remote monitoring and telephone contact with care home services. It introduced a new RAG assessment for notifications from care homes on staff levels on 3 April 2020 and this ran until 17 June 2020. This enabled the CI (and other local partners) to identify and provide coordinated support where and when required to support

882. The CI developed a new Covid-19 Scrutiny Assessment Tool (SAT) in August 2020 as part of its planning process during the pandemic. It replaced the Risk Assessment Rating (RAD) for all Care Homes (Adults, Older People, Children and Young People). This was used to identify areas of potential concerns in care homes. Those included: Covid-19 outbreaks, experiences of people, leadership, concerns raised and notifications from services. An assessment was then made using the intelligence gathered about the service including complaints, from oversight groups and DPHs to categorise it as high, medium or low risk. This informed the next steps on scrutiny. This might include a range of measures such as an onsite visit, a phone call to the service or improvement support. The risk rating was not routinely shared with the Scottish Government but with HSCPs and public health partners.

883. On 17 March 2020, the Chief Executive of the CI wrote to the care sector to provide an update on how the CI was responding through its contingency planning to the Covid-19 situation [CL15/267 – INQ000509994]. This explained the decision to scale down the regulator's inspections and put in place arrangements which involved gathering information, assessing the level of risk in care services and establishing assurances about the quality of care people experienced.

884. The First Minister led a Scottish Government Resilience Room (SGoRR) 'Deep

Dive' on 14 April 2020 on care homes [CL15/268 – INQ000510018], [CL15/269 – INQ000510019], [CL15/270 – INQ000510021, [CL15/271 – INQ000510022], [CL15/272 – INQ000233414] [CL15/076 – INQ000509954]. 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 reinstitute some inspections to follow up their current telephone approach for greater assurance and support.

885. Furthermore, the Scottish Government's DG HSC wrote to Chief Executives of NHS Boards on 17 April 2020 with a request, from the FM and Cabinet Secretary for Health and Sport, that SDsPH take immediate action to deliver an enhanced system of assurance around the safety and wellbeing of care home residents and staff [CL15/273 – INQ000364126].

886. This included SDsPH and health protection teams working with local Infection and Protection Control Teams, the CI, primary care teams and others to oversee the provision of local support and assurance to all care homes. It also requested contact with every care home and an assessment around care home adoption of and training on IPC measures, staffing levels, use of testing and weekly reporting to Scottish

Government around these areas. A follow-up letter on 20 April provided more details around direct contact with care homes and visits on a risk prioritised basis as well as testing arrangements for workers [CL15/078 – INQ000363375].

887. The Cabinet Secretary for Health and Sport also wrote directly and separately to Scottish Executive Nurse Directors (SEND) about their roles and responsibilities during Covid-19 and in relation to multi professional oversight of care homes and being accountable for the provision of nursing leadership, support and guidance within the care home and care at home sector. Executive Nurse Directors worked closely with other NHS and Local Authority professional leads such as Chief Social Work Officers, IA Chief Officers, SDsPH and medical directors to provide wrap-around support for care home providers including assurance and support for IPC implementation

888. The Cabinet Secretary for Health and Sport's Ministerial Statement on 21 April 2020 set out a tailored series of additional steps to support staff and residents of care homes [CL15/128 – INQ000292544]. This included the CI being equipped to have an enhanced role of assurance across the country, including greater powers to require reporting. This related to enhanced reporting activity taking place through the CI's RAG system mentioned above, capturing more data and working with DPHs locally in their leadership role to support care homes.

889. Following the 'Deep Dive' on 14 April 2020, the Cabinet Secretary for Health and Sport wrote to the CI on 29 April 2020 requesting a timeframe for resumption of its inspection programme, as this was an agreed action [CL15/076 - INQ000509954]. In the CI's response of 1 May 2020 they expressed concerns regarding the action on visits to care homes and recommencing any inspections [CL15/274 – INQ000320168]. This centred around the risk visits would pose to residents and staff in all care homes, in terms of the transmission and spread of Covid-19. However, following meetings with NHS Highland about the Covid-19 situation at the Home Farm care home, the CI decided that the most appropriate course of action was a for a visit to take place on the 4 May 2020. This reflected the level of concern of health professionals locally and the nature and seriousness of the information shared. CI were in place to support the care home and consider any regulatory enforcement action which may be needed. As a result of these event, CI resumed unannounced on-site inspection visits to care homes from 4 May 2020 onwards.

Clinical oversight and joint inspections

890. 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 [CL15/275 – INQ000320169]. This letter summarised the Scottish Government's support for care homes and what still needed to be put in place. These were to be introduced in every area in the week beginning 18 May. This additional support was to be provided by Scottish Government, Local Authorities, territorial Health Boards, and the regulatory and improvement support bodies.

Local oversight teams were required to ensure, amongst other duties, that "*Joint inspection visits (of care homes) are undertaken as required by the Care Inspectorate and Healthcare Improvement Scotland, working together, to respond to priorities and concerns".*

891. The CI and HIS worked together under a statutory duty of co-operation, as outlined in section 114 of the Public Services Reform (Scotland) Act 2010 in responding to the Covid-19 pandemic. These arrangements were as a means to enhance the existing expertise and provide additional capacity to the CI during the pandemic in the inspections of adult care homes. It also supported the assessment of the quality and access to care and support for people experiencing care. The joint inspections were set up without recourse to introducing new regulatory powers and managed via a Memorandum of Understanding between the two regulators.

892. These inspections were done 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 they provided, provided additional assurance around 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. In planning their scrutiny activity both agencies sought to minimise the disruption. More widely the Scottish Government relied on the CI's judgement along with its key partners to coordinate its scrutiny of services where possible to minimise the burden of the inspection process on the sector.

893. The CI introduced a learning and support programme for inspectors who were responsible for on-site inspections in care services. This was provided for both CI and HIS colleagues. NHS NES, HPS and the SSSC supported this training. Precautions for inspection activity were undertaken for the safety and protection of residents and staff including:

- IPC training that included minimising the risk of contact and the safe use of PPE
- Guidance on appropriate practice to inspect safely
- Physical distancing
- Spending less time in the service
- Completion of activities remotely where possible
- Hand washing and sanitising
- Limiting the items inspectors brought into the service and use of tablets to record and photograph information rather than taking paper copies.

894. In May 2020, the CI added a new key question specific to its quality frameworks in order to assess services. Key question 7 asked 'How good is our care and support during the Covid-19 pandemic?'. This was done in consultation with HPS/PHS and HIS in response to the pandemic and in recognition that services had to adapt and operate differently. It was introduced to ensure that services implemented relevant practice in line with Health Protection. Wellbeing was also included as part of the inspection methodology used by the CI from May 2020.

895. The Coronavirus (Scotland) (No.2) Act 2020 (the "2020 (No.2) Act") also contained provisions around care homes. A package of measures were introduced to provide assurance to those involved in the care home sector, including staff and particularly those using these services and their families. In the event of a material risk to the health of persons at a care home, heath boards had the power to intervene. In addition, Ministers could apply to a court for an Emergency Intervention Order (EIO) to nominate a person to act as a nominated officer to enter and occupy accommodation where there was serious risk to life, health or wellbeing. The 2020 (No.2) Act also included powers for local authorities to purchase care home or care at home services providers and territorial Health Boards to purchase care at home service providers under certain circumstances.

896. The 2020 (No.2) Act also placed new duties of the CI in relation to reporting to the Scottish Parliament on its inspection activities and findings and care home deaths. The provisions required care homes to report on the number of deaths in the service. This was seen as an extension of existing reporting practice. In providing this information the Scottish Government was also responding to calls for increased openness and transparency from politicians, the public and media rather than wishing to place an unnecessary burden on the sector.

897. Furthermore, the inspection reports produced by the CI now featured:

- Indicative grades based on existing quality themes
- Summary of observations relating specifically to Covid-19 including, for example IPC, staff awareness and training, availability of PPE.
- Other observations that highlight quality of care or safety concerns, good working practice, or other information the inspector deems relevant.

898. The first tranche of reporting to the Scottish Parliament following the introduction of the Coronavirus (Scotland) (No. 2) Act 2020 commenced on Wednesday 10 June 2020 and continued every two weeks thereafter. The Scottish Government received advanced sight of each fortnightly report during the period and this was shared with the Cabinet Secretary for Health and Sport. The Act specified that the Care

Inspectorate must lay a report before the Parliament every two weeks, setting out (a) which care home services it had inspected during those two weeks, and (b) the findings of those inspections. The Scottish Government does not hold a summary of these reports, and the Inquiry may wish to contact the Care Inspectorate directly for any summary.

899. On 12 August 2020, the CI produced a document setting out its Role, Purpose and Learning during the Covid-19 Pandemic [CL15/276 – INQ000280642] which

provides further detail regarding the changes made, data analysis and next steps, which the Inquiry may wish to consider.

900. On 8 October 2020, the CI wrote to the sector to outline areas for improvement, identified through scrutiny and assurance activity and provided good practice documents to support services [CL15/276 – INQ000280642]. The CI also developed and implemented two winter plans, which included lessons learned, and used webinars to guide and support the sector.

901. The Scottish Government worked with the CI on the clinical aspects of care in care homes and their inspectors being fully up to date with current nursing care standards so that they were able to discharge their role and responsibilities regarding the

Nursing and Midwifery Council's code of professional practice as it interacts with the scrutiny process. Scottish Ministers also sought assurances around the ongoing activity by the CI to strengthen its expertise on IPC and nursing matters should the agreement with HIS cease.

902. Discussions on these issues continued during 2021 and the Scottish Government obtained sufficient assurances from the CI on nursing aspects of inspections and continued to offer support as those were fully embedded. On the basis of the enhancements undertaken by the CI including appointment of a Chief Nurse, Scottish Ministers agreed to formally end the joint working arrangements with HIS in-care homes in June 2021.

Multi-Agency, Multi Professional Oversight Guidance for scrutiny and assurance partners

903. Guidance for multi-agency scrutiny assurance partners, including the CI, was introduced on 1 October 2020 [CL15/277 – INQ000429273]. This was developed by the CHRAG and sought to build on good practice in enhanced monitoring and professional support for care homes that had emerged in response to the Covid-19 pandemic. The key areas of concern raised by the care home sector included:

- Visiting: concerns around Covid-19 transmission risks and a perception of an imbalance between the ability of health professionals being able to go into care homes, but not family members. In addition, the need for professional and assurance visits could mean multiple external visitors in care homes
- Risks of the medicalisation of care homes
- Potential for significant unintended consequences on residents' physical health and emotional wellbeing, if a perceived lack of focus on rights, choices and their social and emotional needs
- Care homes seen as 'green', for example on IPC or staffing challenges, may also require support, even if they were not self-reporting that they did
- Different protocols for professionals visiting including the range of PPE

904. Key areas of agreement across partners included: scrutiny, assurance and improvement action – evaluation of issues and risks, and determining the support needed to ensure compliance with the national Health and Social Care Standards.

    There was recognition of the importance of IPC and effective assessment of issues and risks in the context that care homes are not hospital settings, but are people's homes.

905. The guidance set out the background and context for current partnership working in responding to the support needs and associated challenges in care homes. It set out the areas of concerns from the care home sector and key areas of agreement across partners. The CI attended related meetings to inform discussion. Additionally, information from support and assurance visits was used by the CI to inform decision making regarding the need for future scrutiny activity.

906. The guidance also stated that where appropriate visits to care homes should be planned and scheduled with the care home, although the use of unannounced

assurance visits were to be undertaken where this was deemed to be the most appropriate approach.

Changes to regulatory practice of social care professionals by SSSC during the pandemic

907. During the pandemic, the SSSC undertook changes to the regulatory practice of social care professionals to provide flexibility within the social care workforce and to address workforce capacity challenges. The Scottish Government understands that there were concerns raised with the SSSC regarding the care sector's capacity to release staff to meet qualification requirements. The SSSC anticipated this issue and mitigated risks by providing automatic extensions of time to anyone who was unable to meet their qualification condition(s) during the pandemic, pausing the removal of these individuals from the Register. It is understood that this measure was intended to provide individuals extra time to meet these conditions whilst continuing their role.

908. The Inquiry has noted the changes SSSC undertook to the regulatory practice of social care professionals to provide flexibility within the social care workforce and to address workforce capacity challenges, such as allowing SSSC to pause removing individuals from the Register who did not meet qualification deadlines, which meant those individuals were able to continue to work. It has asked about the extent to which the Scottish Government was aware of any concerns raised by the sector relating to qualifications or training of social care staff who provided adult social care services during the pandemic following the changes to the regulatory regime. There were no concerns raised about these aspects with the Scottish Government. It is the Scottish Government's understanding that such changes were received positively by the sector. The sector welcomed the flexibility the SSSC measures in these areas afforded during a challenging time. No concerns regarding these changes by the SSSC were raised with Scottish Government by the ASC sector. The SSSC may be able to provide the Inquiry with further information on these matters.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

909. The Inquiry has asked about the Scottish Government's role, activities and response in the development of policy and guidance relating to DNACPR decisions. The Scottish Government does not have any role in individual decision making around DNACPR. It is an individualised treatment decision based on a discussion (where possible) between a doctor and their patient or where appropriate their power of attorney. This can sometimes be a difficult and sensitive discussion for all involved.

910. In 2016 the Scottish Government produced updated guidance for health and social care professionals on Cardiopulmonary Resuscitation (CPR) decisions [CL15/278 – INQ000429278]. This guidance is grounded in the principles set out in the Human Rights Act 1998, the Adults with Incapacity (Scotland) Act 2000 and the UN Convention on the Rights of Persons with Disabilities (CRPD) and is supported by the UK Resuscitation Council, BMA and Royal College of General Practitioners (RCGPs) among other professional organisations. 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. Further guidance to support individual decision making is provided by bodies such as the General Medical Council (GMC) around good medical practice as well as from other professional bodies (e.g. the Royal Colleges).

911. The Scottish Government 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. These Anticipatory Care Planning discussions are a useful tool to help understand what matters to an individual and are suitable for anyone regardless of their health status. Pre-pandemic, Anticipatory Care Plans (ACPs) were widely promoted by Scottish Government and HIS within the health and social care sectors including care homes.

912. Sometimes as part of an anticipatory care planning discussion, it is necessary for clinicians to raise difficult matters in conversation with people and their loved ones about their care wishes should there be a risk of them becoming seriously unwell. In some cases of overwhelming illness, particularly in individuals with significant or multiple pre-existing conditions, CPR may not be an effective treatment. In such instances, medical professionals are expected to discuss this sensitively with the

individual and address any concerns that they have. Ideally, these discussions take place before an emergency occurs to help ensure that the individual has ample time and space to consider what care would be right for them and discuss this with their family.

913. Guidance did not change in light of the Covid-19 pandemic; however, the Scottish Government played a key role, alongside other organisations, in supporting the communication of guidance around the importance of ACPs and good DNACPR practice. This involved clinical and policy officials working with stakeholders to understand concerns raised and developing further communications and guidance to support consistent adoption of best practice.

914. On 3 April 2020, the Scottish Government published its Covid-19 Guidance; Ethical Advice and Support Framework, outlining the key principles to underpin the approach to ethical decision-making during pandemic. It was updated regularly to take account of feedback and concerns and support good practice around decision making in challenging circumstances [CL15/279 – INQ000363462].

915. The Scottish Government worked closely and extensively with a wide range of stakeholders including Inclusion Scotland, Scottish Care, Scottish Commission for Learning Disabilities, Equality and Human Rights Commission, Scottish Human Rights Commission, the Scottish Academy of Medical Royal Colleges, and many others, to consider the impact of the guidance. They provided constructive advice and support in developing the EQIA that accompanied the guidance [CL15/280 – INQ000343738].

916. Within the care home context, the specific advice regarding residents was contained in the Scottish Government's clinical COVID guidance for adult care homes dated 13 March, 26 March and 15 May 2020 [CL15/013A – INQ000280689], [CL15/069 – INQ000429281] [CL15/070 – INQ000383486]. This was updated with additional material including links to further advice and tools on ACPs and emphasised the importance of working closely with people living in care homes and their families to discuss what matters most when making plans for care in the future. The guidance therefore recommended that ACPs should be in place so the needs and wishes of residents and families were considered in the event of changing circumstances. The care home guidance also provided considerations around person-centred discussions

for those nearing end of life and reinforced the point that a blanket approach should never be taken with regard to DNACPR decisions.

917. The Inquiry has asked about whether concerns in relation to potential blanket use or misuse of DNACPRs came to the Scottish Government's attention, the response to such concerns and any action taken. During the first wave of the pandemic in spring 2020, there were concerns raised by third sector stakeholders including Age Scotland, the public, and reports in the media about the use of DNACPR forms. Concerns related to a perceived blanket use of DNACPR forms and a misperception that DNACPR forms indicated that a person should receive no treatment should they contract Covid-19. Many of the concerns appeared to relate to individual anticipatory care planning discussions, particularly those that encompassed the use of DNACPR forms early in the pandemic, which could have been handled in a more sensitive manner.

918. In response to such concerns, the Scottish Government's CMO, the BMA and the RCGP issued a joint letter to GP practices on 10 April 2020 [CL15/281 – INQ000429276] to provide advice and support on ACP conversations. This made it clear that, in line with guidance on CPR, the Scottish Government expected everyone supported by health and social care services to be treated with sensitivity, dignity and respect at all times, including during conversations around ACPs with individuals and their loved ones, and that no one should ever feel pressured to agree to a specific care plan or agreeing 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 it was necessary to raise in conversation for the patient's wellbeing. They stressed that a 'blanket' approach to DNACPR conversations should not be taken, with discussions undertaken based on individual clinical circumstances.

919. Additionally, on 17 April 2020, a further joint letter from the Scottish Government's Chief Medical Officer, BMA and RCGP was sent to GPs to reinforce this message and set out how they could effectively support care homes during this difficult time [CL15/273 – INQ000364126]. A Q&A was provided as a supplement to the letter issued 17 April letter which also covered advice on care home access to GP support

and considerations around admitting care home residents to hospital [CL15/263 – INQ000259882]

920. In addition on 5 May 2020, the Scottish Government wrote to Chief Executives and Medical Directors of territorial Health Boards for distribution to all clinical teams regarding the use of DNACPR with younger patients, those with a stable long term physical need, learning disability or autism. The letter made it clear that treatment decisions should never be based on the presence of a learning disability and/or autism, rather they should be made on an individual basis and in consultation with their family and/or paid carers [CL15/282 – INQ000471396].

921. Additionally, the NMC and GMC issued a joint UK wide statement on 15 April 2020 to highlight the continuing importance of advance care planning for individuals during these unprecedented times and to emphasise that medical professionals should not be taking a 'blanket' approach to ACP and DNACPR decisions. They also emphasised the importance of adhering to professional and clinical guidance at this time.

922. The Scottish Government worked with HIS to produce a range of tools and resources to support clinicians having these conversations in a more person-centred, sensitive and holistic way, based on our experiences early in the pandemic. These resources were available on the HIS website. A Video Blog was also produced by HIS in April 2020 to support anticipatory care planning conversations [CL15/283 – INQ000509988].

923. In its 23 June 2020 response to the Equalities and Human Rights Committee's review of the impact of the COVID-19 pandemic on equalities and human rights, the Scottish Government acknowledged the concerns raised by stakeholders and the public and outlined the steps it was taking to ensure that guidance was being followed. [CL15/284 – INQ000182819].

924. The Scottish Government continued to address concerns around DNACPR later in the pandemic. In November 2020, Age Scotland communicated concerns they had been receiving via their helpline which suggested that DNACPR decisions during the pandemic had been made or communicated in ways that fell short of good practice. Following a meeting with Age Scotland at the end of November 2020, the Scottish

Government provided materials on DNACPR and ACP to Age Scotland to assist them in responding to any queries and enable people to get the right advice and support. [CL15/285 – INQ000510067].

925. In February 2021, there were some media reports regarding the charity Mencap's (UK learning disability charity) concerns that people with learning disabilities were having DNACPR forms placed in their medical records inappropriately. This was expressed in a press release from Mencap where they responded to a Care Quality Commission (CQC) report in England into the application of DNACPR decisions during the COVID-19 pandemic.

926. Scottish Government guidance on DNACPR [CL15/278 – INQ000429278] has always been clear that a stable long-term physical need, learning disabilities or autism should never be the sole reason for considering whether a person would benefit from CPR. The Scottish Government's ethical advice and support Framework had been 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 be a part of clinicians' decision-making regarding accessing treatment.

927. Given the concerns raised by Mencap, a submission was sent to Ministers in February 2021. This provided details of the CQC report, concerns raised, DNACPR policy in Scotland and what steps had and were being taken to support good practice. The submission indicated that no concerns had been raised with officials regarding the use of DNACPR forms for those who have learning disabilities [CL15/286 – INQ000510068].

928. Following the publication of Mencap's concerns in February 2021, further reassurance was provided to Scottish stakeholders that social care needs, health conditions or disabilities that are unrelated to a person's chance of benefiting from treatment must not be a part of clinicians' decision making regarding accessing CPR treatment. This involved issuing key messaging to learning disability stakeholders to provide reassurance around the expectations of Scottish Government in relation to DNACPR [CL15/287 – INQ000509978].

Deaths and Data

929. As outlined above, at paragraph 117, a Covid-19 Health and Social Care Analysis Hub (HSCA) Hub was established in March 2020 to support the process of developing, collecting, reporting and briefing on Covid-19 data on a daily basis, example Situational Report from 28 April 2020 provided [CL15/288 – INQ000509938].

930. Working with partner agencies, HSCA worked at pace to collect, report and brief on Covid-19 data on a daily and weekly basis to track and inform the response to the pandemic. The mainstay of this tracking was a suite of national level measures, including social care data such as:

- Data on confirmed cases of Covid-19 amongst care home residents and staff
- The number of adult care homes with a current suspected case of Covid-19
- Covid-19 related staff absences in care homes
- Covid-19 related deaths in care homes
- Visiting status of care homes
- Covid-19 vaccinations for care home residents and social care workers.

931. Key data sources used to provide briefing to Scottish Ministers and officials on the latest Covid-19 daily data included: data from PHS on Covid-19 in care homes, on cases, tests and vaccinations; data from NRS on deaths where Covid-19 was mentioned on the death certificate (with breakdowns for numbers in care homes) alongside CI care home deaths data; data from care homes on confirmed cases of Covid-19 amongst care home residents and staff, and the visiting and outbreak status of care homes; data from the CI on care home staff reporting absent due to Covid-19.

932. In addition, in August 2020, the Scottish Government, in collaboration with care homes and NES, developed the SHT for the care home sector, hosted on the "TURAS" platform. The SHT was designed to collect pertinent data such as IPC measures, occupancy, staffing and outbreak levels, and information on care home visiting to enable situational awareness and risk assessment for care homes. This daily data supported oversight teams to identify care home risks earlier and the need for early intervention and enabled ongoing monitoring of Covid-19 across HSCP areas.

933. Further information was collected by the CI, including a new survey to collect Covid-19 related absence levels in care homes and also in housing support and care at home services. The data collection evolved across the pandemic to provide new breakdowns and data items, for example on absence due to self-isolation, confirmed Covid-19 and long Covid-19. These were reported each week to the SG Adult Social Care GOLD Group from January 2021 until December 2022, along with a range of other care home related data sources. The CI also provided information on the number of positive Covid-19 cases in housing support and care at home services.

934. The Scottish Government's CAD closely monitored and updated colleagues across the Scottish Government on the progression of Covid-19 in other nations, regularly monitoring the international epidemiological picture (case numbers, hospital admission/occupancy and deaths), including for emerging variants. This data was included within a weekly slide pack that was presented internally to key SG colleagues.

935. From March 2020, material generated from the CAD provided Scotland level monitoring data, seven days a week. This covered cases, deaths, situation in care homes, hospitals, supply of goods, workforce, attitudes, other public services, economy and media and communications. In May 2020, work on providing information on the vulnerable population in Scotland was taken forward by Communities Analysis Division, to provide a better understanding of the most at risk, non-shielded groups.

936. In addition, modelling work was conducted to create a daily Scotland Reasonable Worst-Case Scenario (RWC) impact assessment which included total number of infections, estimates of hospitalisations, estimates of those needing ICU; numbers of people recovered and fatalities. The model was extended to help understand how the virus was spreading in different parts of Scotland (identifying likely future hotspots), and how the impact would be felt by different levels of community deprivation. The data fed into other mobilisation planning across social care, primary care, and secondary care, as well as wider public service impact. It was shared with technical experts working in other hubs on issues such as the economy, transport, and vulnerable communities.

937. Data collections were developed alongside and shared with other nations. For example, throughout the pandemic, each weekday, a series of indicators were shared with the UK Cabinet Office covering a number of themes including cases, deaths, testing, healthcare staff absences, ventilator stock, hospitalisations, social care, shielding, school attendance, other staff absences, prisons, and vaccinations. Social care data, including the number of confirmed Covid-19 cases in care homes, live outbreaks in care homes, care home size, deaths in care homes and staff absences in care homes was provided on a weekly basis. The indicators were included in the return as requested by the UK Cabinet Office in response to their requirements, and key headline measures were included in a published UK covid dashboard. HSCA met weekly with analysts in the UK Cabinet Office to discuss Scottish Covid-19 daily data to feed into the Cabinet Office internal dashboard. The full UK Cabinet office dashboard was shared back to Scottish officials for review.

938. The UK Government distributed Covid-19 Situational Awareness Briefs to devolved administrations for awareness, which included Care Home Covid-19 cases data for England, and further detail on the progression of the pandemic in care settings in

England was available within information packs provided for Cross Whitehall meetings, including number of cases, outbreaks, notifications of suspected cases and deaths by sub-national regions and local authority.

939. The pre-existing Adult Social Care (four nations) statistics group met regularly to share knowledge and discuss ways to improve coherency in social care data and

statistics across the 4 nations for a number of years. A matrix of indicators produced by the group in the latter stages of the pandemic, highlighting sources of data and comparability, was expanded to include a section on Covid-19, provided [CL15/289 – INQ000592041]. This acted as a signposting mechanism for sources of Covid-19 data across social care and is publicly available on the PHS website.

940. Social care data and analysis were widely and regularly communicated to Scottish Government officials and Ministers to aid decision making and used in a wide range of briefings and papers. This included providing daily Covid-19 briefings (seven days per week) from 2020 to 2022 on key Covid-19 statistics to Ministers, senior clinicians and policy leads, with a key focus and emphasis on weekly social care data and evidence used to inform statements made by the First Minister in the Scottish Parliament and media interviews.

941. The Covid-19 daily data webpage on the gov.scot website was also used extensively by external users, including the media and public to understand the latest position on the pandemic, for the four harms assessments and as input data for the state of the epidemic and modelling the epidemic reports.

942. Scottish Government Social Care analysts also supported the Scottish Government Clinical Care Homes Professional Advisor at the SAGE Social Care Working Group, updating at the meeting each week on the latest Covid-19 position and trends in Scottish care homes. This was then reported to CPAG and Scottish Government colleagues on emerging trends and research in other parts of the UK and internationally. A range of clinical advice, analysis and academic assessment were considered during these meetings, for example on transmission in closed settings, which was used to inform advice back to clinical and policy leads in Scotland. Further information and analyses were also collated from published data, management information and external sources where useful. This included, for example, a Covid-19 modelling hotspot prediction analysis from Imperial College.

943. Scottish Government analysts also regularly updated other groups including the SG Adult Social Care GOLD Group with the latest data and trends on the transmission of Covid-19 in adult social care settings and in the wider general population, providing analytical readouts following meetings of the Scottish

Government led DAR CPAG sub-group – a group of care homes-focused policy leads, social care clinicians, academic experts and Scottish Government analysts.

Challenges, gaps and limitations

944. In early 2020, it quickly became clear that there were significant gaps in the data available within social care which would help monitor the pandemic amongst vulnerable population. Most of the data available pre-pandemic is on an annual basis, and data set up to specifically to monitor the pandemic in the social care sector begins several weeks or months after the start of the first wave.

945. Scottish Government analysts worked closely with PHS, CI and other analysts from across the social care sector to quickly understand data available on social care and to develop new collections to understand the rapidly emerging situation. The pace of change and focus on social care required careful consideration, across a short time period and collaboration across a number of organisations. As the pandemic progressed this included work to develop new reporting for the Covid-19 cases, deaths, outbreaks, and vaccinations. Explanatory notes, caveats and limitations were regularly supplied with this new data, where required.

946. Over the course of the pandemic data sharing was used to produce new statistics and reduce duplication. While some duplication did exist, progress has been made through the subsequent review of care home data to rationalise care home data. In addition, changes to TURAS Care Management (SHT) resulted in duplicate collections, such as reporting on Covid status and pressures in local areas to Scottish Government Care Home Support Teams, being stopped.

947. In the early part of the pandemic until July 2020, and in advance of widespread roll out of testing, data on the number of suspected cases in adult care homes were provided by the CI and collated within a Scottish Government database. Following this, the number of adult care homes with a current suspected case of Covid-19 was also provided. This definition was revised in July 2020 when data on routine testing of care

home residents and staff also became available, after which new information received from PHS on care home cases replaced the CI data.

948. Coverage of data across the country was generally comprehensive and consistent definitions were used across most social care data sources, with breakdowns of social care data provided where possible – for example, for care home staff and residents. However, much of the social care information collected was at an aggregated level with little information separated on inequalities and protected characteristics. This is a recognised data gap and was identified in the Care Home Data Review (see further discussion at paragraph 949). Few of the social care data sources have information on protected characteristics; however, information on age, gender and ethnicity of care home residents is captured by the Care Home Census for Adults in Scotland – published by PHS.

949. There was and remains no register of care home residents across the country to extract these sort of protected characteristics data (or other data) from, to allow simple identification of who is in a care home, and had Covid-19, by their characteristics, in real time. However, a care home data review was prioritised and reported in May 2024 with a range of recommendations for improvements, report provided [CL15/290 – INQ000509993]. Those included data quality, sharing, comprehensiveness and reducing duplication, to be taken forward by a new working group. This, and the associated formation of the Social Care Data Intelligence Programme, now provides the forum for partners to focus and collaborate on agreed priorities, although prioritising and resourcing this work will need to be considered within the current budgetary framework for both the Scottish Government and PHS. The data on care home residents from the annual care home census is a snapshot in time of people living in a care home as at 31 March each year. This is completed by care home managers and not all of the information requested will be available for all residents. There is no register of care home residents which would allow access to total numbers of people or their demographic information, at any other time of the year. The information available on residents is therefore limited to snapshot information obtained from the census, on sex, age and ethnicity.

950. In addition, improvements to data on social care equalities and protected characteristics is under consideration in Scotland's Equality Evidence Strategy 2023–

2025 [CL15/291 – INQ000182805], although much of the work around social care data is still in the early stages.

951. Management information from the SHT was self-reported by care homes and unvalidated. Not all care homes submitted information daily and there were care homes where no information was available on a certain day, and this varied considerably, each day and each week, and so impacted on reported trends in data nationally and by territorial Health Boards.

952. The SHT and other data sources were collected as management information and markings were applied to briefing materials to distinguish them from published statistics, to confirm which would be suitable for public statements. From early 2021, statistics on visiting status were routinely published, with supporting explanatory material and further developed to provide additional information on the type of visiting permitted. These statistics were published for the final time by Scottish Government on 18 May 2022, with PHS taking responsibility thereafter.

953. Other information gaps were regularly identified and action taken. For example, a gap was identified around qualitative intelligence on care home visiting. A survey was undertaken by the Scottish Government in July/August 2021 and reported in November 2021, with information to understand the barriers and enablers to the implementation of the Open with Care visiting guidance (published in February 2021 [CL15/015 – INQ000147437]) from the perspective of care home managers. Specific questions were included on the broad set up of current visiting (for example length and location of visits) and the extent to which care homes were able to meet visiting preference, the full list of questions asked is provided in the survey report [CL15/292 – INQ000512581]. The survey was also an opportunity for care home managers to provide feedback to the Scottish Government on their experiences of implementing Open with Care to inform future planning and guidance to support the sector.

954. Much of the data was timely and regular with little lag in the data. However, for example, information on the provision of and demand for services for those receiving care at home was published only annually by PHS and did not provide up to date evidence to monitor the pandemic. This resulted in new data collections being established, including on the numbers of people waiting for social care assessments,

waiting for packages of care to start, and the number of hours of care at home services yet to be delivered. This data was collected initially as management information from August 2021 by Scottish Government analysts, before responsibility for data collection and management was passed to PHS. Monthly publication of this data by PHS began in November 2022.

955. The Office for Statistics Regulation (OSR) recognised that, "The pandemic reinforced the vital role that data and statistics play in our society and their ability to serve the public good. Data and statistics enhanced public understanding on important issues and supported individuals to reach informed decisions and hold their governments to account" [CL15/293 – INQ000092810]. However, an OSR November 2022 report, provided [CL15/294 – "INQ000092810"] has also helped us to consider how to continue to improve data and statistics. It outlined, for example, a number of lessons for health and social care statistics from the pandemic, including understanding user needs, making statistics accessible, enhanced collaboration and communicating with clarity. In Scotland, our current care home data review is leading work to improve key data sources on social care, although prioritisation of this work will need to be considered within the current budgetary framework.

Overview of impact of the Covid-19 pandemic on ASC (recipients & providers of care) on risk of infection, adverse outcomes, morbidity and mortality due to Covid-19 infection and more generally, health inequalities and the number of excess dates (inc. differentiated impacts).

956. In December 2022, the Four Nation Chief Medical Officers (CMOs) published a technical report on the Covid-19 pandemic ("the Technical Report") (which was then updated in January 2023 [CL15/249 – INQ000203933]. Chapter 8 of the report covers care homes. The report was drafted by a range of authors who supported the SAGE

Social Care Working Group, including representatives from Scotland. The Technical Report assesses the pandemic and its impacts within social care settings across the UK, rather than within Scotland or other UK nations specifically. At section 8.2, the Technical Report [CL15/249 – INQ000203933] states,

"The COVID-19 pandemic had significant impacts on residents, staff and carers across care homes. In this pandemic, care homes were a substantially higher risk setting for COVID-19 as so much of the risk was in older people, in particular the most vulnerable older people, and spread occurred most readily in indoor environments. This was not always the case in previous pandemics and epidemics and could look different in a future pandemic. Experience from COVID-19 will be most relevant in pandemics where the elderly are particularly at risk, and where respiratory infection and close contact are important routes of transmission."

957. The pandemic in care homes and wider social care settings in Scotland was monitored using a wide range of data sources as set out above at paragraphs 929 to 943. Information was communicated to Ministers, Covid-19 policy leads, clinicians and others. The progression of the pandemic in social care settings in Scotland followed wider Covid-19 trends. For example, Covid-19 outbreaks and cases in care homes and care at home cases coincided with waves of the pandemic seen in the wider population.

958. Weekly monitoring of Covid-19 in care homes across Scotland demonstrated these patterns geographically, with information on care home outbreaks and cases charted and regularly assessed against pandemic case numbers in the wider population, both nationally and across HSCPs.

959. The PHS report on discharges from NHS Scotland hospitals to care homes between 1 March and 31 May 2020 (published in April 2021, provided [CL15/116 – INQ000147514]) notably found that care home size is much more strongly associated with the risk of an outbreak than all other care home characteristics, including hospital discharge. In addition, the Technical Report noted that larger care homes were more badly affected, which likely reflects their greater number of points of ingress as well as greater risk of resident and staff movement, and that:

"*epidemiological and genetic evidence from across the UK suggests that for COVID-19 while some care home outbreaks were introduced or intensified by discharges from hospital, hospital discharge does not appear to have been the dominant way in which COVID-19 entered most care homes."*

960. Less data on those in social care settings was available to monitor pandemic impacts and trends by factors such as protected characteristics, social economic background, occupation, immigration status, or on morbidity and health inequalities.

961. Data shows that older age groups receive relatively more social care provision than younger aged groups, and that Covid-19 had a significant, intense and profound impact in social care settings.

962. The November 2023 Scottish Care Home Census shows that on 31 March 2023 [CL15/061 – INQ000507842], the mean age of care home residents at admission was 79, and that residents in care homes for older people accounted for 92% of residents in all care homes for adults.

Data on care home deaths

963. The Scottish Government carefully monitored official statistics on deaths in Scotland, including Covid-19 deaths, collated and published by National Records of Scotland (NRS). These statistics included the location of death, with a breakdown on the number of deaths in care homes.

964. NRS was the official source of information on Covid-19 deaths in care homes. The data came from death registrations, where causes of death were certified by a doctor. Deaths involving Covid-19 were deaths where Covid-19 had been identified as being involved in the death by a doctor, either as the underlying cause of death or as a contributory cause of death. The figures were based on location of death and may not have included all care home residents. For example, if a resident became unwell, went to hospital and died, they were counted as a hospital death as opposed to a care

home deaths. Care home deaths published by NRS also include a number of deaths which occurred in hospice settings.

965. Between 3 June 2020 and 5 April 2022, the Scottish Government also published CI information on Covid-19 care home deaths. The figures were collected and published on a weekly basis from the CI, at a Scotland level and included:

- The number of confirmed Covid-19 related deaths in care homes
- The number of suspected Covid-19 related deaths in care homes
- The number of deaths (other causes) in care homes
- The number of deaths (all causes) in care homes.

966. The figures included all care home deaths for adults in Scotland notified to CI during that week. Care homes were required to notify whether Covid-19 was noted as confirmed or suspected on the death certificate. These statistics were published for the final time by Scottish Government on 6 April 2022. Thereafter, the CI took responsibility for continuing to regularly publish the data on the same basis. This was alongside their data on care home staff absence and care homes with suspected cases. CI continues to publish this summary data.

967. Although NRS data on deaths in care homes and CI data on deaths of care home residents are similar, they differ mainly for the following reasons:

- NRS data was based on location of death, so care home residents who died in hospital were included in the deaths in hospital figures, while 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 it was registered or the date it was notified to CI. Occasionally a service may have notified a death that occurred several weeks earlier. These were attributed to the week in which the CI was notified.

968. From April 2020, Covid-19 daily data were updated on the SG website at 2pm each day. From 21 May 2020, this included HSC staff deaths, as notified to SG by

territorial Health Boards and CI respectively, which were included in the published daily data updates until that process ceased on 31 March 2022.

969. On 19 April 2021 in response to a Freedom of Information (FOISA) request, the Crown Office and Procurator Fiscal Service (COPFS) published care home level data in respect of the number of deaths linked to Covid-19 in care homes to date, as per records held by their Covid Deaths Investigation Team, provided [CL15/295 – INQ000509982].

970. On 26 May 2021, the NRS and CI released data under FOISA on the numbers of deaths of care home residents, at care home level. The CI released a short report, provided [CL15/296 – INQ000507855] alongside their data to help users better understand the data, and the differences between CI, NRS and COPFS data.

971. It is also possible to look at excess deaths; however the Scottish Government has not calculated an accurate and robust excess death rate for care home residents during the Covid-19 pandemic. The reason for this is that the number of long stay care home residents fluctuates over time and is estimated once each year i.e. on a census day within the Care Home Census. There were an estimated 33,637 long stay care home residents on 31 March 2019 and there was no census collection in March 2020, therefore we do not have the total number of people who were long stay care home residents between set dates.

972. Excess deaths are also affected by a range of factors relating to changing care home resident cohorts over time. This means that excess deaths for all locations are more reliable than excess deaths in care homes specifically. The risk of severe outcomes varied over time, with a decline in deaths as vaccines were rolled out and immunity increased, as Covid-19 mitigation measures and non-pharmaceutical interventions were implemented and also likely reflecting the impact of high levels of mortality amongst the most vulnerable residents during the earlier phases of the pandemic.

Lessons Learned and Recommendations

973. There was an ongoing process of learning and improvement through consultation and discussion with a range of adult social care stakeholders throughout the pandemic. Lessons learned were considered and best practice shared through feedback from individual stakeholders on polices and approaches, established formal groups and Scottish Government commissioned work. The key pieces of work relating to adult social care are described below in chronological order of commissioning:

Lessons Learned from Reducing Delayed Discharges and Hospital Admissions

974. The report, Lessons Learned from Reducing Delayed Discharges and Hospitals Admissions, was published by Health and Social Care Scotland and Scottish Government on 29 July 2020 [CL15/297 – INQ000280635]. Scottish Government officials, alongside Health and Social Care Scotland (a collaboration of health and social care leaders and managers from across health and social care partnerships), carried out an extensive lessons learned exercise on delayed discharge and hospital admissions. This looked at how delayed discharges, A&E attendances and hospital admissions all reduced significantly during March and April as the COVID-19 outbreak hit (a drop from over 1600 delays to under 600 in only six weeks and A&E attendances dropped from around 23,000 per week to about 11,000, with admissions by over 60%). The report explored what had worked well and what could have been done differently. There were no recommendations but the report included seven next steps:

- Sharing the report widely to inform other local and national lessons learned exercises
- Working with HSCPs to create a record of good practice
- Using the findings of the report to inform the refresh of the Framework for Community Health and Social Care
- The formation of a small expert group (comprising Chief Officers, providers, HSC practitioners) to chart key activities by August to ensure progress is sustainable in the long-term, using the findings to inform parallel national work

on social care, primary care and unscheduled care ad linking to the Short Life Working Group on complex delays (due to report in August 2020)

- Working with Chief Officers, along with LAs and territorial Health Boards, to establish methods for ensuring learning is spread at all levels across HSC.

975. The report was shared widely with all IA Chief Officers and the good practice recommendation was taken forward via the Discharge without Delay (DwD) programme. A range of support materials and a good practice library were developed in relation to good discharge planning. A self-assessment tool was also introduced to benchmark service improvements. This commenced in March 2023, and continues to be utilised across local systems to assess progress against a whole system approach to discharge planning, planned date of discharge and community assessment/discharge as well as the ethos of Home First and Discharge to Assess.

PHS Report on Discharges from NHS Scotland Hospitals to Care Homes

976. On 18 August 2020 the Cabinet Secretary for Health and Sport, commissioned PHS to carry out work to identify and report on discharges from NHS Hospitals to care homes during the first wave of the COVID-19 Pandemic. Both the University of Edinburgh and the University of Glasgow were partners in the production of this report. PHS analysed discharges from NHS Scotland hospitals to care homes between 1 March and 31 May 2020.

977. The report was first published on 28 October 2020, with a revised report published in April 2021 [CL15/116 – INQ000147514]. The report looked specifically at whether there was a link between hospital discharges and Covid outbreaks and concluded: "*In conclusion…we do not find any statistically significant association between hospital discharge and the occurrence of a care home outbreak but cannot rule out a small effect. Care home size is much more strongly associated with the risk of an outbreak than all other care home characteristics, including hospital discharge.*"

978. The revised report also highlighted major issues surrounding the availability of data about people in care homes and made recommendations to improve the systematic

recording of information on hospital records to identify when a person is either admitted from or discharged to a care home. It further recommended that priority should be given to the development of an individual level national dataset collected by care homes themselves which records information on all people resident in a care home including temporary stays.

979. PHS is working alongside its partners to take forward these recommendations, within the Care Home Data Review [CL15/290 – INQ000509993], with a working group established in Autumn 2024 to prioritise work to take forward recommendations.

Independent Review of Adult Social Care

980. The First Minister announced on 1 September 2020 that there would be an Independent Review of Adult Social Care in Scotland. The Independent Review was led by Derek Feeley, a former Scottish Government Director General for Health and Social Care and Chief Executive of NHS Scotland. The Review was in relation to the long-term reform of the whole Adult Social Care Sector. The report was published on 3 February 2021 and included 53 recommendations [CL15/004 – INQ000280640]. The review led to work to establish a National Care Service (NCS).

981. Recommendations were split across the following themes:

- A human rights based approach to social care - this would see human rights, equality and equity mainstreamed and embedded in social care. This could be further enabled by the incorporation of human rights conventions.
- Support for unpaid carers – offer support along with better representation in local planning, more involvement and transparency regarding decision making – and that carers must be represented as full partners on the Integration Joint Boards and on the Board of the NCS
- The case for a NCS and how it should work – including placing the NCS on a statutory footing.

- A new approach to improving outcomes – closing the implementation gap, a new system for managing quality – including the introduction of a National Improvement Programme for social care
- Models of care, including investment in alternative social care support models

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Commissioning for public good – this would see a radical overhaul of commissioning and procurement, with a shift from a competition based approach to more collaborative approaches.

Fair Work – including rapid delivery of all Fair Work Convention recommendations, a national job evaluation exercise and minimum national terms and conditions for commissioning and procurement by IJBs

- Finance – prioritising investment in social care as a key feature of Scotland's economic plans for recovery from the Covid-19 pandemic.

Progress in implementing the findings of the Independent Review

982. Work to implement the recommendations of the IRASC is continuing. The Care Reform (Scotland) Bill (previously the National Care Service (Scotland) Bill) is currently at Stage two of its passage through the Scottish Parliament. The Minister for Social Care recently announced changes to the Bill to the effect that Part One of the Bill, which contained sections on structural reform and accountability, will be removed. SG will instead set up a non-statutory Advisory Board instead of a National Board, to provide advice to Ministers. It is expected to meet for the first time in the spring.

983. Parts two and three of the Bill will remain, subject to Parliament's agreement, and cover some of SGs original NCS proposals and include:

- Anne's Law
- Improved information sharing and information standards
- A new right to breaks for unpaid carers
- Independent advocacy: SG will consider how to ensure this is available to those who need it.

984. SG is also investing £88.4 million per year in local carer support and will deliver £125 million to enable the funding of the real living wage for children's and adult social care workers. Planned improvements also include:

In line with a commitment to improve regulation of services, SG will review the current health and social care standards and improve access to information for those seeking social care.

Co-develop and implement a framework which builds learning, improvement and quality management into the system.

- Establish a national partnership approach to social work
- Take forward an updated programme to improve complaints processes
- Publish a Charter of Rights and develop a NCS workforce charter.
- Consider where changes to legislation, including procurement regulations, may strengthen the implementation of ethical commissioning. Work is already underway on improvements that do not need legislation.

985. SG is also working on several national programmes:

- Getting it Right for Everyone (GIRFE). This is a multi-agency approach to support and services from young adulthood to end of life care.
- Self-Directed Support improvement plan 2023 to 2027.
- Dementia strategy for Scotland

Coronavirus – Care Home Outbreaks: Root Cause Analysis

986. The Scottish Government commissioned an independent review into the circumstances surrounding the occurrence and transmission of COVID-19 infection within four care homes in Scotland, the Coronavirus – Care Home Outbreaks: Root Cause Analysis (RCA) on 12 October 2020. The report was

published in October 2020 [CL15/298 – INQ000280638]. This revealed certain factors that contributed to the increased vulnerability, in the care homes included in the review, to the spread of Covid-19. These factors are collectively summarised as:

- High community prevalence of Covid-19 in the region the care home is based in
- Care home size and occupancy

  Staff members who worked and who were asymptomatic but SARS-CoV-2 positive (unknowingly due to errors and delays to reporting screening results to care homes)

  Staff members who worked in more than one place intra- and inter-organisations (staff, inclusive of nurses, carers and kitchen staff) not cohorted to floors/units, and continuing to work across these until outbreaks were confirmed (agency use, wider care home group staff use was high in some homes)
- Missed opportunities to identify early warning signs in safety huddle data and DPH reports (indicators included staffing data, single positive cases and self-reporting of these not sufficient to identify risk (e.g. 100% compliance with IPC and PPE reported, but this was discovered not to be the case when inspected)
- Inadequate familiarity and adherence to IPC measures which may contribute to risk of transmission, delayed to introducing additional transmission-based precautions when a known case was suspected or identified
- Challenges to implementing IPC practices, including keeping up to date with latest guidance, specific care home built environment aspects and lack of expert advice of guidance in context (e.g. cleaning products)

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- Inadequate staff IPC measures to minimise staff to staff transmission. Situational awareness risk in changing rooms, break rooms, smoking shelters, car sharing and socialising outside work with respect to social distancing
- Delayed recognition of cases in residents because of a low index of suspicious (not familiar with broader syndrome of Covid-19 in older people)
- Delayed identification of cases, related to limited testing availability at the right time and turnaround time of the test, and difficulty identifying persons with Covid-19 based on signs and symptoms alone, asymptomatic or pre-symptomatic residents
- Underlying health conditions and advanced age of many long-term care facility residents and the shared location of residents in one facility places these persons at risk of severe morbidity and death. These homes had high levels of residents with dementia and receiving end of life care
- System relationships to support staffing in crisis. Larger care home groups did not have well-established relationships with territorial Health Boards, and tended not to use identified capacity and support available. There were indicators that there was

a high staff absence and fewer staff than the establishment identified as required at homes, which warrants further investigation.

987. A report outlining progress against the recommendations made 2020 report '*Coronavirus - Care Home Outbreaks: Root Cause Analysis' (RCA)*' was published in June 2023 [CL15/299 – INQ000280639]. The report examined progress on taking forward 40 recommendations, as at the end of September 2022. It demonstrated that there had been progress in many areas and recommendations had been implemented. However, there were areas where further work was required. These included comments for the SG on the following themes: need for clarity on commissioning IPC guidance, timely updating of guidance, ensuring the purpose and role of the Safety Huddle Tool, ensuring the consistency of messaging on IPC in care home context. investment in leadership, Anne's Law, and advice on ventilation for social care settings. These are provided at Annex 1 of the report:

Short Life Delayed Discharge Expert Working Group

988. A Short Life Delayed Discharge Expert Working Group, established in February 2021, was led and sponsored by the Scottish Government's Unscheduled Care Programme and 'Home First' Teams. This produced a Best Practice Discussion Paper on "Transforming Urgent and Unscheduled Care – Optimising Flow – Discharge without Delay" (August 2021) [CL15/300 – INQ000280636]. The findings are the outcome of engagement with experts from across the whole system, to find out what worked well and puts patients at the heart of planning and preparing for discharge.

989. The Best Practice Discussion Paper identified a number of key actions including for Social Work and Social Care. These included that multi-disciplinary working and close collaboration should be encouraged at all times. It was also recommended that the key actions in the guidance were adopted nationally by territorial Health Boards and HSCPs across Scotland, to ensure consistency of approach. The Scottish Government continue to work with its partners to support implementation.

Coronavirus Covid-19 Initial Health and Social Care Response – Lessons Identified

990. The Scottish Government published the Coronavirus (COVID-19) initial health and social care response: lessons identified on 6 August 2021 [CL15/301 – INQ000147847]. The purpose of this report was to provide insight from the Covid-19 response including lessons identified from Health and Social Care organisations within Scotland, supplemented by global case studies where appropriate. This considered what had worked well and conversely what improvements could be made so that Scottish organisations were better equipped going forward for any future waves of Covid-19 response, on-going recovery and remobilisation plans as well as future incident preparedness. The report highlighted examples of good practice and also cross cutting themes for further improvement.

991. The review stated that to return organisations to sustainable operations with high levels of preparedness for future potential waves of Covid-19, international insights suggest that there were eight key actions for health and care leaders to focus their resources on as the pandemic response continued and remobilisation plans were refined. The key actions included continued acceleration of digitally-enabled care transformation, prevention of staff attrition and burnout and improved support for remote and flexible working, increasing virtual care, support care at home or in residential settings.

Progress in implementing key actions

992. Progress toward implementing the key actions relevant to social care (care homes) is described in the following paragraphs.

Workforce Planning

993. There will be scope for the NCS Advisory Board to advise Ministers about improving support for the workforce and advance Fair Work. Furthermore, a priority for the NCS as it takes shape will be to ensure social care and community health services have a high standard of workforce planning and staff learning,

development and leadership support. The SG is also developing an NCS workforce charter. It will aim to bring together social care, social work and community health as a more integrated workforce.

Agile Workforce

994. Learning from Covid-19 on digital in care homes was subsequently taken forward through the My Health, My Care, My Home - National Healthcare Framework for adults living in care homes (published June 2022) [CL15/023 – INQ000323023] and the Digital Health and Care Strategy launched in October 2021 [CL15/302 – INQ000592028].

995. Key developments have included prioritisation of the shift to digital telecare. SG is currently rolling out a shared Alarm Receiving Centre for Telecare nationally to address this. It is also exploring the use of digital technology across new areas including telecare in care homes and for cohorts of the population who have previously not been identified for this to have a benefit. Digital skills in social care are being taken forward as part of the national digital skills and leadership programme led by NHS NES and partners.

Governance for a future pandemic response

996. A whole system approach to health and social care is more embedded, with senior leaders collaborating via the Whole System Oversight and Improvement groups. This is underpinned by a national oversight function with a whole system assurance group, a co-chaired group with the Cabinet Secretary and CoSLA spokesperson. There is regular engagement between SG officials and chief officers as well as NHS Chief Executive Officers (CEOs) and LA CEOs.

997. In response to the review's points relating to the lack of consistent data, the Scottish Government can confirm that it has taken forward the Care Home Data Review (CHDR). The full CHDR report was published on 18 December 2024 [CL15/309 – INQ000510073].

PPE

998. The Scottish Government also worked to identify the successes, challenges, and lessons to be learned relating to PPE supply during the Covid-19 pandemic. Several reviews and exercises have been carried out. The main themes identified within these reviews were communication, collaboration, and the fundamental inadequacy of the traditional just-in-time PPE supply system in the context of the COVID-19 pandemic. In addition, a series of independent, official audit reports (the Audit Scotland brief; published June 2021, and the KPMG report; published August 2021) highlighted specific points for action [CL15/303 – INQ000108737], [CL15/304 – INQ000470067]. The key issues highlighted in these reports were:

- The Scottish Government could have been better prepared and should have acted fully on recommendations of preparedness exercises
- New approaches to stockpiling and supply chain resilience are required
- Longer terms solutions for PPE supply to primary and social care should be implemented.

999. From December 2021 work to consider lessons learned and incorporate them into future PPE preparedness policy continued as part of the PPE Futures Programme. The Programme's Future Supply workstream used this work to develop and propose new pandemic supply arrangements for the future, which the Cabinet Secretary agreed to take forward in December 2021. Implementation of arrangements are being taken forward by NSS and relevant Scottish Government policy teams.

Four CMO Technical Report (updated 2023)

1000. As noted above at paragraph 956, the Four Nation Chief Medical Officers (CMOs) published a technical report on the Covid-19 pandemic ("the Technical Report") (which was then updated in January 2023, [CL15/249 – INQ000203933]. At section 8.2, the

Technical Report states,

"outbreaks in care homes were closely correlated with community prevalence throughout the pandemic, and there is genetic evidence that the majority of outbreaks were introduced unintentionally by staff members living in the wider community. Care homes were, at this point, largely closed to visitors, but ingress of infection through staff living in the wider community and moving between care homes was readily amplified by the close contact networks required in the provision of care. high care home transmission followed around 2 weeks after high community transmission.

1001. The Technical Report [CL15/249 – INQ000203933] provides six points for future CMOs or GCSA to consider in relation to care home settings:

- Point one; residents of care homes for older adults are very likely to be at high risk of serious disease in any respiratory disease epidemic (measures to reduce ingress to care facilities via staff or visitors and minimise transmission whilst maintaining quality of care will be a high priority)
- Point two: NPIs that reduce personal contacts, particularly isolation from family and loved ones will have a considerable impact on residents' (and families') quality of life
- Point three: The control of transmission in care homes also depended on alignment with wider public health, social care and healthcare systems
- Point four: The value of reliable and comprehensive routine population and health data describing the population living and working in residential care to inform policy decisions and evaluate the impact of interventions cannot be overstated
- Point five: Advice from behavioural and social science was essential in informing good practice in the support and management of care staff and in protecting residents
- Point six: Research and innovation to improve care homes' resilience to respiratory and other infections is needed and could inform, among other things, building regulation and best practice.

1002. Many of the key observations and conclusions from this Technical Report were based on the collective experience during the pandemic and as such informed the approach to supporting care homes at the time. However they continue to inform future work in care homes. For example as mentioned earlier, building on the guidance in the pandemic which supported people to remain connected in the in outbreak situations, the Scottish Government has developed legislative provisions on visiting (known as Anne's Law) within the Care Reform (Scotland) Bill. Similarly, building on work to improve care home during the pandemic, a care home data review was prioritised and reported in May 2024, with a working group established in Autumn 2024 to prioritise work to take forward recommendations. The report published on 18 December 2024 is provided [CL15/290 - INQ000509993].

ONS Report

1003. In March 2023, a report was published by the Office of National Statistics (ONS), [CL15/305 – INQ000503374], which brought together work from across the four nations to consider a UK measure of deaths in care homes. The report established that a direct comparison of care home deaths between the four nations to produce a UK statistic was not possible. This was because of definitional differences in the care types provided in care homes (such as care homes with nursing or respite care) and the care needs provided for (such as care for learning disabilities, dementia or those who are terminally ill).

1004. The ONS report noted that Scotland registered a higher proportion of care home deaths across all age groups compared with the rest of the UK between 2015 and 2020, and the difference was more pronounced in those aged 0 to 64 and 65 to 74. However, the ONS noted that this the likely explanation was the inclusion of some hospices in Scotland's care home definition. The paper also noted that overall trends in care home deaths followed a similar pattern across the UK, peaking in 2020 before reaching their lowest level since 2021. Since 2015, dementia and Alzheimer disease have been the leading cause of death in care homes every year in all four nations. In

2020, coronavirus (COVID-19) was the second leading cause of death in care homes for males and females in England, Wales, Scotland, and Northern Ireland.

Lessons learned for health and social care statistics from the Covid-19 pandemic: 2022 update

1005. As outlined above at paragraph 955, OSR published a report outlining a range of learning for statistics producers following the pandemic [CL15/294 – INQ000509975].

1006. Other reviews relevant to the adult social care sector include:

- Information relating to lessons learned with respect to vaccines and therapeutics were submitted to the Inquiry in the Scottish Government's response to Module 4 [pages 65–68 of [INQ000147422] & pages 43–47 [INQ0003703633].
- The CI's report, regarding its 'Role, Purpose and Learning During the Covid-19 Pandemic' was issued on 12 August 2020 [CL15/276 – INQ000280642]. The report included consideration of CI Staff Training & Wellbeing, 'Near Me', Complaints, changes to the scrutiny and assurance and lessons learned.

1007. Other CI publications include:

- A review undertaken by the CI in its "Delivering Care at home and housing support services during the COVID-19 pandemic", published September 2020 [CL15/175A – INQ000320158] (see above at paragraphs 568 and 634)
- Scrutiny and Support of ASC during the Covid-19 pandemic, published March 2021 [CL15/072B – INQ000510070]
- There was a revision in 2022 to the 'Building Better Care Homes' guidance 'Care Homes for Adults – The Design Guide' guidance taking into account information learned from outbreaks and learning environments [CL15/306 – INQ000510071]

- The key themes from CI work completed in registered care home services for adults and older people between 1 April 2020 and 31 December 2022 were published in 2023 [CL15/307 – INQ000320180].

Future pandemic preparedness

1008. At national level, the Scottish Government has established governance structures to deliver a cross-government programme of work to improve pandemic preparedness, including for adult social care. This includes a Ministerial Oversight Group, jointly chaired by the Cabinet Secretary for Health and Social Care and the Cabinet Secretary for Justice and Home Affairs. The structure also includes a Programme Board of senior officials which has now been established and which oversees the strategic planning, coordination and delivery of work to enhance the organisation's readiness for future pandemics, terms of reference provided [CL15/308 – INQ000592027]. The first meeting of this Programme Board took place in August 2024.

1009. In addition, the Scottish Government is contributing to work led by the UK Government to refresh the Pandemic Flu Plan and produce a Respiratory Response plan and a Pandemic Strategic Framework. The UK Government has already reconstituted the Pandemic Flu Board to be a Pandemic Disease Capabilities Board, looking beyond flu as the sole pathogenic challenge.

1010. The Scottish Government is working with the UK Government and other devolved administrations to keep under review the countermeasures and capabilities required to respond to future pandemics, including retaining stockpiles of PPE, which can be deployed as required during the supply chain pressures likely to occur during a pandemic.

1011. In March 2024, Scottish Government officials undertook an internal scoping exercise to consider the lessons identified from the pandemic, drawing on the reports outlined above, and to provide an overview of work underway to support future pandemic preparedness in social care. It provided an assessment of lessons identified, with associated risk ratings and actions underway or required. This work is

ongoing and informing the cross-government programme for work to improve pandemic preparedness across the Scottish Government, including for ASC. The initial conclusions and recommendations of this work are summarised in the paper provided [CL15/309 – INQ000510073].

1012. In April 2022, Scottish Ministers agreed that the Scottish Government should commission PHS to create a new national vaccination and immunisation programme, the Scottish Vaccination and Immunisation Programme (SVIP). This programme builds on previous initiatives like the Vaccine Transformation Programme, the Scottish Immunisation Programme, and the Flu Vaccine COVID-19 Vaccine Programme. The SVIP aims to provide a comprehensive vaccination service for Scotland, including future pandemic preparedness. It reflects Scotland's vision for a world-class, personcentred, and public-health-led vaccination programme, essential for a sustainable and resilient healthcare system. The SVIP officially started in December 2024, with a transition date of 8 January 2024. The Scottish Government is working with the UK Government and other devolved administrations to keep under review the countermeasures and capabilities required to respond to future pandemics, including retaining stockpiles of PPE and the purchase of vaccines and medicines.

Whole system approach

1013. Within the ASC sector in Scotland, a whole system approach to health and social care is now much more embedded , with senior leaders collaborating via the Whole System Oversight and Improvement groups, drawing heavily from the Whole System Dashboards that provide insight into pressures and variability in performance both locally and nationally which was previously not possible. Improved data collection, analysis and synthesis make strategic leadership more effective and would give senior system leaders more information which would inform decision making in any future pandemic. This is underpinned by a national oversight function with a whole system assurance group, a co-chaired group with the Cabinet Secretary for Health and Sport and COSLA spokesperson and regular engagement between SG officials and chief officers as well as NHS and Local Authority Chief Executive Officers.

1014. With regard to workforce preparedness, Scottish Ministers have committed to implement Fair Work principles now and embed them at the heart of the NCS. This is intended to address the variability of terms and conditions for social care staff and therefore improve recruitment and retention, and therefore staff turnover. In addition, Ministerial decisions to establish the Social Care Staff Support Fund (to provide financial support to staff absent from work due to Covid or because of the need to selfisolate) and the Death in Service payment for social care staff are considered to have been successful policy interventions. The general improvements across the sector under the banner of the NCS are intended to ensure that the sector is likely to be more resilient. In the event of another pandemic, the experiences of the successful policies would mean that similar schemes would be considered again.

1015. On visiting, 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, in April 2022, utilising powers conferred by Section 50 of the Public Services Reform (Scotland) Act 2010 to introduce two new statutory Health and Social Care Standards to incorporate 'Anne's Law'. 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 a Covid-19 outbreak, and be able to name a person or persons who can directly participate in meeting their care needs.

1016. The Care Reform (Scotland) Bill (previously the National Care Service (Scotland) Billcontains provisions to implement 'Anne's Law' and the Scottish Government continues to engage with CHRS and other stakeholders, including care providers, to support the development and implementation of these legislative provisions.

1017. On IPC, guidance and training materials that are appropriate to social care settings and are available free of charge to social care providers and staff are now improving knowledge and the adoption of effective IPC principles in care homes. A lessons learned exercise was undertaken into PPE future supply. Scottish Government identified the successes, challenges and lessons to be learned relating to PPE supply during the pandemic. Through SG investment there is now integrated collaborative clinical support to care homes from each territorial Health Board.

1018. Beyond pandemic planning, the Scottish Government has been considering ways to enhance resilience and business continuity management within Government and how we support improved business continuity/contingency/resilience planning arrangements in social care for a range of events. This is looking at the risks around our current level of preparedness for a range of threats, as well as the maturity of our planning and exercising function. The work will include measures to ensure that we

are reinforcing resilience in the here and now but also looking to the future implementation of the NCS and how this can support improved resilience in the social care sector.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: PD _____

Dated: _____09 May 2025_____