UK COVID-19 INQUIRY

CORPORATE STATEMENT OF NHS TAYSIDE

I, Doctor James Cotton, Executive Medical Director, will say as follows on behalf of NHS Tayside:

OVERVIEW BACKGROUND

1. NHS Tayside is one of 14 territorial Health Boards in Scotland and serves a population of approximately 414,000. The Health Board covers three local authority areas: Angus (population size 115,000), Dundee City (148,000) and Perth and Kinross (151,000).

2. The geographical area covered by NHS Tayside measures approximately 753,000 hectares, representing approximately 10% of Scotland's overall landmass. The local authority area of Dundee City is urban (1% by area of Tayside), Angus is largely rural (29% of Tayside) and Perth and Kinross (70% of Tayside) contains the city of Perth but is otherwise largely rural also.

3. Using the 6-fold definition of the Scottish urban-rural classification: approximately 1% of the Tayside area is classified as large urban; 1% other urban; 1% accessible small towns; 1% remote small towns; 44% accessible rural and 53% remote rural. 75% of the population in Tayside lives in urban areas and 25% in rural areas.

4. NHS Tayside is one of five Scottish teaching boards and employs over 14,000 staff. There are two acute hospitals (Ninewells in Dundee and Perth Royal Infirmary) plus eight community hospitals. Services in primary and community care are provided by three Health and Social Care Partnerships (HSCPs) in Angus, Dundee City, and Perth and Kinross.

5. As at 1 March 2020, there were 63 GP practices in the Tayside region, with 17 in Angus, 22 in Dundee City and 24 in Perth Kinross. Also at that time, there were 101 adult care homes in Tayside, with 30 in Angus, 28 in Dundee City and 43 in Perth and Kinross. Prior to the start of the pandemic, the daily average for delayed

discharges was 79 during the 12-month period from 1 March 2019 to 29 February 2020.

6. Approximately 21.3% Tayside residents are of a pensionable age (66+ years) compared to 19.0% nationally. The median age of people living in Tayside is 44.7 years old compared to 43.0 years across Scotland as a whole. There is, however, considerable variation within Tayside, with the median age of people living in Dundee City being 38.4 years compared to 48.5 years and 48.3 years in Angus, and Perth and Kinross respectively. The lower median age in Dundee is largely due to a significant student population in the city and also lower life expectancy.

7. Deprivation across Scotland is measured using the Scottish Index of Multiple Deprivation. The level of deprivation varies across Tayside with 37% of people who live in Dundee City living in areas of greatest deprivation compared to 7% in Angus and 6% in Perth and Kinross.

8. Socioeconomic inequality is the biggest driver of health inequality in Tayside with a male born in the most deprived areas in Dundee City currently anticipated to live on average 12.8 years fewer than a male in the least deprived areas. The socioeconomic context in which someone lives increases the risk of many health conditions, including problem substance use (drugs and alcohol) and poor mental health, which are prevalent across Tayside.

9. Other vulnerable groups across Tayside include minority ethnic groups, traveller communities, seasonal farm workers and prison residents (HMP Perth and HMP Castle Huntly).

Governance and Accountability

10. The Tayside Health Board was established on 1 April 1974, under the National health Service (Scotland) Act 1972, with responsibility for providing health care services for the residents of Angus, Dundee City and Perth and Kinross.

11. The structure of NHS Tayside comprises an Acute Division, Corporate Directorates, and a shared interest – with local authority partners – in the three Health and Social Care Partnerships which are overseen by Integration Join Boards (IJBs).

12. Services in primary and community care are provided by three Health and Social Care Partnerships (HSCPs) in Angus, Dundee City, and Perth and Kinross. The HSCPs are responsible for the delivery of adult social care (ASC) across Tayside.

Each of the HSCPs are led operationally by Chief Officers and governance of the HSCPs is provided by the Integration Joint Boards (IJBs). Membership of the IJBs comprises both local Councillors and Tayside NHS Board members.

13. At the start of the pandemic each of the HSCPs and NHS Tayside changed their operating structures and implemented an incident management approach, establishing a gold, silver and bronze command structure to enable the prompt and timely decision-making (including resource allocation) at the appropriate level.

14. In addition to enable clear decision-making and flow of information within each organisation, this structured approach also enabled the quick flow and dissemination of information between organisations at different levels.

15. Membership of Gold Command within NHS Tayside comprised the Chief Executive, Employee Director, Director of Workforce, Director of Finance, Director of Communications, Board Secretary, Director of Nursing and Midwifery, Medical Director, Director of Public Health, Chief Officer Acute Services, Health and Social Care Partnership Chief Officer representation.

Health Protection Team

16. The Health Protection Team (HPT) is hosted within the Public Health Directorate of NHS Tayside. The core function of NHS Tayside HPT as at 1 March 2020 was to undertake and ensure provision in full of the statutory responsibilities of NHS Boards as specified in the Public Health etc. (Scotland) Act 2008 and the Public Health Regulations 1988, within the Tayside area.

17. The HPT undertakes and leads on the surveillance, prevention and control of communicable diseases and health impacts of environmental hazards (including public and private water supply quality issues, and any ill-health suspected to be due to environmental factors) for the population of Tayside, and to provide specialist advice and strategic direction to the NHS Tayside organisation and partner agencies specifically in relation to these specialty areas. The HPT also has responsibility for the coordination, support and monitoring of local implementation of key national programmes with the field of Health Protection.

18. During the pandemic the HPT took overall responsibility for the control of cases, incidents and outbreaks of Covid-19 in the community, working with relevant Scottish and UK guidelines as appropriate.

19. The HPT worked closely with with other NHS services, the HSCPs, local authorities and other Tayside and national agencies as appropriate in delivering these functions and, where necessary, would convene and lead multidisciplinary, multiagency Problem Assessment Groups and/or Incident Management Teams to coordinate the overall response.

20. As of 1 March 2020, NHS Tayside's HPT responsibilities included providing leadership in the development of infection prevention and control arrangements for the wider community, including care homes as well as schools, prisons, and other closed or large group settings. This entailed working closely with infection prevention and control specialists, social care and other service providers and regulators, and with relevant national standard setting bodies. HPT professionals would also undertake informal individual care home visits, providing feedback on their adherence to best practice Infection Prevention and Control (IPC) standards and guidance.

21. As part of this responsibility, the HPT maintained close relationships with managers, operators and commissioners of social care services throughout the Tayside area, supporting proactive and prompt reporting of any confirmed or suspected individual cases, clusters or outbreaks of illness of relevance for Public Health investigation and/or actions.

22. From January 2020 onwards, the NHS Tayside Directorate of Public Health began a process of expanding and dynamically adapting its workforce capacity dedicated to the Health Protection function in response to the evolving and accelerating demands of the pandemic, enabling investigation, advice and control actions to continue to be prioritised as appropriate following notifications of suspected or confirmed Covid-19 or other infectious diseases among care home residents and staff.

23. As at 1 March 2020 the HPT comprised three Consultant in Public Health, specialising in Health Protection (2.5 whole time equivalent (WTE)), a Specialty Registrar in Public Health (0.6WTE), four nurse specialists (3.5 WTE) and three administrative assistants (2.5 WTE). However, the HPT was already being supported by an array of other members of the Directorate of Public Health workforce who provided flexible resilience cover and support for core Health Protection and Covid-19 response activities. These included Consultants, Specialty Registrars, Administrative staff, Programme Managers, Health Improvement Officers, Public Health Officers and others, who all balanced and made relative adjustments to their

usual duties, workplans and priorities in order to assist the Health Protection function, consistent with internal business continuity and resilience arrangements.

24. The Tayside HPT is an integral section of the NHS Board's Directorate of Public Health, led by the Director of Public Health (DPH).

25. The DPH is an Executive Director of the Health Board and is accountable to the Health Board for the delivery of all statutory health protection functions by the Directorate. The DPH is also the direct line manager for the most senior members of the HPT (i.e. Consultants), and is responsible for performance management, and setting appropriate strategic objectives and priorities for the HPT. The Director of Public Health in NHS Tayside is also available to provide operational resilience to the HPT and is on the on-call rota. The role of the Director of Public Health is to provide independent advocacy for the health of the population, and leadership for its protection and improvement.

HOSPITAL DISCHARGES

26. Prior to discharge to an ASC setting all individuals were reviewed and assessed by a multi-disciplinary team across the hospital/community interface and in line with the Delivering Services for Frail Older People in NHS Tayside standards [Exhibit: JC/01 **INQ000590686**].

27. Tayside has a total of 8 (eight) step-down facilities (Royal Victoria, Arbroath Infirmary, Whitehills, St Margaret's, Blairgowrie, Pitlochry, Tay Ward in PRI and Crieff Hospitals). During the pandemic these were used in various ways to cohort patients with COVID. The decision to use facilities to cohort COVID patients was based on available side rooms, medical input and cover 24/7, nurse staffing skill mix and staffing numbers to manage patient cohorting. A final important factor was the general confidence of teams to manage COVID patients. All teams and hospitals had different levels of Multi-Disciplinary Team (MDT) skill mix and experience in this domain. NHS Tayside infection control carried out risk assessments of facilities before any cohorting was introduced.

28. From 7th April 2020 NHS Tayside assessed that the side rooms in [I&S] Hospital and [I&S] and [I&S] Hospital would be the mainstay of cohorting of frail patients with COVID. We called these Amber areas [Exhibit: JC/10 **INQ000618195**] and patients would be cohorted in these areas from

day eight of acute infection until day 14. All other step-down facilities focused on non-COVID patients.

29. In terms of use of these facilities I&S had six side rooms which were usually full. I&S had 16 beds which were usually 90% occupied and I&S had up to eight side rooms at a time available which were usually used. NHS Tayside did rely on these step-down pathways to allow frail patients to be cared for in localities and ensure available capacity in acute for new admissions. Care homes and clinicians discussed cases of patients returning to care homes from hospitals and the Medicine for the Elderly team had a consultant on-call service available 24 hours a day, 7 days a week (24/7) to support Tayside care homes with admissions and discharges throughout the Covid-19 period with agreed community pathways. The decision to discharge was made by the Medicine for the Elderly (MFE) Consultant, in line with local and national pathways, supported by the multi-disciplinary team across the hospital/community interface and in consultation with the ASC setting planned for discharge.

30. Medicine for the Elderly and Public Health clinicians supported regular HSCP huddles with care home providers in order to share information, develop guidance and support a strategic response to an ever-developing picture.

31. Local guidance [Exhibit: JC/02 INQ000590687 and JC/03 INQ000590688] was implemented to supplement the national guidance available, given that the national guidance at the time did not fully describe the operational implementation of the guidance and was open to local interpretation depending on the availability of virology testing. Therefore, the development of the local supplementary guidance enabled a consistent approach to be taken, contextualised to the services that NHS Tayside was able to provide at the time (in particularly a very well-developed community-based sampling and laboratory testing function for Covid-19) that supported HSCP in all settings. Pre-16th April COVID-19 guidance senior clinicians in Tayside worked via consensus guidance that they co-produced from their COVID experience to date, and information across Scotland. This was led by MFE lead Dr Ian Logan who had communication with senior MFE clinicians managing COVID patients and general physicians to agree senior co-produced NHS Tayside guidance. This consensus guidance was updated daily as information changed and the first output was on 7th April 2020 that the team followed [Exhibit: JC/08 INQ000618193]. This was updated almost daily and circulated to the COVID MFE team daily [Exhibit:

JC/09 [INQ000618194] is a further example of the rapidly evolving consensus guidance as clinicians waited for national guidance.

32. The clinical teams of the Health Board worked very closely with colleagues and partner agencies across the whole health and care system.

33. The Health Board regularly attended Care Home Providers meetings and were very alert to the concerns that Care Home Providers had at the time with regards to the risk of nosocomial transmission of Covid-19 from hospital discharges. The Care Home Provider Meetings were led by the Independent Sector Leads (Scottish Care), with representation from each of the localities, Dundee, Perth & Kinross and Angus. The Senior Nurses of each health and social care partnership also attended these meetings. NHS Tayside has no information about their establishment and frequency of meetings. Minutes from the Care Home Providers meeting on 19 March 2020 [Exhibit: JC/04 [INQ000590689] stated that the Associate Medical Director 'stressed the importance of trust between care home providers and the hospital teams, who will strive to avoid discharging anyone to homes that they suspect has Covid-19.'

34. All discharges were discussed in advance with the care home and discharges were planned taking into account all resources available to that care home at that time. If, as part of the discharge planning, the care home was not able to accept the discharge for any reason, alternative arrangements were made. The Health Board is not aware of any refusals by nursing or residential homes to take in patients following discharge of the patient.

Testing prior to discharge

35. All patients who were symptomatic of Covid-19 were tested in hospital and managed according to pathways in place at the time to maintain rigorous IPC.

36. Between 01 March 2020 and 21 April 2020 there were 322 patients; and after 21 April 2020 to 28 June 2022 there were 3,093 patients discharged from hospitals to care homes within Tayside. There were eight people in Tayside who had been diagnosed with Covid-19 and did not have two negative swabs prior to return to care home, between March 2020 and 21 April 2020.

37. Three of these patients had been diagnosed with the infection greater than 14 days previously and had remained asymptomatic for the 48 hours preceding discharge.

38. The other five patients were all medically stable and were discharged back to care homes that already had an outbreak ongoing. In each of these five discharges, the teams liaised with the care homes impacted, confirmed that the care home had appropriate levels of staffing and availability of personal protective equipment (PPE) and were content to support the discharge of the person concerned.

39. The above was conducted in line with the local guidance agreed at the time.

40. Individuals who were 'known to have had contact with Covid-19', were managed in line with national IPC guidance at the time and the relevant care pathway in hospital was followed.

41. After 21 April 2020, one person who had been diagnosed with Covid-19 was discharged from hospital to a care home setting without two negative Covid-19 tests. This person had been in hospital for longer than 14 days following an acute admission with Covid-19.

Asymptomatic testing

42. Asymptomatic testing was first carried out on a person returning to a care home, from a Tayside hospital on 16 March 2020. From the week beginning 20 April 2020 this became routine practice across Tayside. The rationale for introducing this routine testing at this time was to confirm COVID status and support safe patient placement in community, at home and in care home.

43. The national Health Protection Scotland guidance first recommended routine testing pre-care home admission from hospitals for asymptomatic patients from 26 April 2020. Prior to 26 April, 74 of 264 people who were discharged to a care home were swabbed in hospital before transfer.

ENHANCED OVERSIGHT/ASSURANCE OF CARE HOMES

Initial arrangements and assessments

44. Following receipt of the directions from the Scottish Government on 17 and 20 April, NHS Tayside's Director of Public Health met with departmental colleagues leading on the Health Protection response to Covid-19 in care homes and agreed that a multiagency Care Homes Leadership Group should be established. A first meeting of this group was convened on 22 April 2020. Invitees were senior NHS Tayside clinicians and managers with relevant responsibilities, HPT members, senior HSCP managers and a Care Inspectorate representative.

45. The NHS Tayside Public Health team developed a questionnaire [Exhibit: JC/11 **INQ000618196**], which was administered by telephone interviews with the managers of all care homes in Tayside carried out by the Directorate of Public Health directorate and HSCP staff. The questionnaire was based on questions developed by health protection colleagues nationally and adapted following consultation with local partners. It addressed 41 subheadings under the five criteria outlined in the directive.

46. Interviews were completed for 95 of 101 care homes by 24 April 2020, with the outstanding six completed by 29 April 2020.

47. The results were captured using a structured Excel tool and reported to Scottish Government on 1 May 2020 and served to inform additional advice and support services the care homes needed from all partners involved, through the Care Homes Leadership Group.

48. A system of Red, Amber, Green (RAG) risk assessments was developed based on the survey responses, consistent with the nationally provided reporting template structure. Care homes rated as Red (denoting the highest levels of concern) were followed up via an initial telephone call and, where this provided insufficient assurance, an onsite physical visit by one or more of the partners agencies was planned. Care homes rated as Amber were also earmarked for a follow-up phone call and, where this provided insufficient assurance, a virtual and/or physical visit by one or more of the partners was considered. Following the initial assessment, four care homes were prioritised for visiting. These 'Associated visits' were conducted to provide support and assurance in relation to infection control, social distancing, staffing levels, training on infection prevention and control and the safe use of PPE and the effective use of testing.

49. Following completion of the initial interview and follow-up, the HPT took responsibility on behalf of the DPH for compiling the weekly standardised report summarising the full set of assurance information, including HSCP and Care Inspectorate data, capturing care homes assurance activity throughout the health board area. Public Health and the three HSCPs in Tayside jointly undertook the overall care home assessment, based on findings from telephone calls with all care homes, triangulated with local intelligence from the Health Protection Team, the Care Inspectorate's Risk Assessment Document, and HSCP local intelligence regarding the performance of the homes. In-depth review and discussion between Public Health and each of the

three HSCPs was used to finalise a composite RAG rating/classification for each care home.

50. As well as reporting to Scottish Government, the weekly reports compiled for the DPH (based on the standard RAG approach to overall risk assessment scoring for each care home) were received by the Health Board-led multiagency governance and oversight structure which developed from the initial Care Homes Leadership Group convened by the DPH, supporting its strategic development and implementation of support and improvement activity within the Tayside ASC sector on a continuing basis.

51. The narrative report [Exhibit: JC/12 **INQ000618197**] accompanying this initial overview assessment referenced significant amounts of time being spent both by care homes and the HSCPs in sourcing/navigating supplies of the appropriate levels of PPE for managing outbreaks, as well as issues with gaps in knowledge and practical skills in IPC and use of PPE among care home staff, and high workforce turnover, as being reasons for concerns where these were recorded, while also citing complications for care homes arising from difficulty in interpreting national PPE guidance as it evolved over time.

52. Initial reporting also highlighted examples of effective IPC practice in individual care homes, and the value of a weekly videoconference meeting covering current best practice and guidance for care home staff, led by each of the respective HSCPs in Tayside, to which Public Health actively contributed. It was noted that Tayside benefited vastly from the early and expansive implementation of a well-functioning Community Testing Team, establishment of which in the ASC setting was actively facilitated by the HPT leadership. The quick turn-around of testing and ease of access this enabled was appreciated by all services including the care home teams.

Multi-disciplinary clinical assurance/oversight of care homes

53. Each HSCP set up a Care Home Operational Group which comprised membership including: HSCP Head of Service, Associate Medical Director, Associate Nurse Director, Scottish Care representative, IPC Lead Nurse, HSCP Lead Nurse, Strategic Planning Officer, Service Lead (social work services), District Nursing Manager, Health Protection Nurse/Consultant and Medicine for the Elderly Consultant. The Care Inspectorate either received minutes of the meetings or joined virtually once Microsoft Teams had been implemented.

54. Prior to Covid-19 each HSCP already had well-established working relationships with their care homes and invaluable local knowledge which greatly improved the process for reaching out to offer support during the pandemic. The additional support provided by the Care Home Operational Group to the care homes included daily contact calls, regular supportive virtual meetings, training delivered face-to-face and virtually, ensuring appropriate processes for stocks of PPE, and where required, coordination of the most appropriate support by a wide range of professionals. Each HSCP prepared staff mobilisation plans to support any additional workforce requirements required where care homes had exhausted their own contingency plans.

55. The role of the Care Home Operational Groups was to provide leadership and support to the response to Covid-19 in care homes.

Care Home Oversight group

56. From 17 May 2020, the Executive Nurse Director and Executive Medical Director of the Health Board held direct responsibility for the clinical and management support required for each care home in Tayside, supported by the Directors of Public Health. Through the IPC team, they also took the lead on IPC guidance.

57. The Care Home Leadership Group transitioned to the Care Home Oversight group and comprised the senior leaders who were responsible for the provision of clinical oversight, the analysis of issues and provision of solutions and support to the care home. The Care Home Operational Groups provided regular updates to the Care Home Oversight Group, who had the mechanism to escalate concerns to Gold Command if required.

58. The Chief Social Work Officers remained accountable at local authority level for social work and social care governance and were expected to provide assurance to respective Local Authority Chief Executives and/or Chief Officer Groups through locally agreed reporting mechanisms.

Daily Huddles

59. The aims of the daily 'huddle' meetings were to ensure regular communication between the Health Board and the HSCPs, to identify emerging areas of concern and provide early and ongoing mutual support where needed. The daily huddles were chaired by the Executive Nurse Director and the 'RAG status' of each care home in

the HSCP were reviewed. This would then guide further discussion and decision-making with regards to any additional support required.

60. An overarching update was also given by each HSCP, detailing how many outbreaks were ongoing and their management, including visiting arrangements. Testing and PPE provision were also discussed on a daily basis. Any official frameworks and latest guidance were also highlighted at these meetings.

61. The daily huddles were attended by the Employee Director, Associate Medical Director (Primary Care), Associate Nurse Director, Chief Social Work Officer for each of the three HSCPs, Consultant Acute and Elderly Medicine, Director of Nursing and Midwifery, Medical Director, Director of Public Health, with others joining as required.

62. The 'RAG status' was informed by direct communications with the care homes, daily briefings and visits. Any concern raised at the daily meeting was discussed and followed up by the most appropriate staff member on the call. Considerations included staffing levels and resilience (including the redeployment of staff from other care homes and the health board where required), PPE delivery and advice (with redirection of PPE supplies from NHS Tayside if required), IPC guidance and education, visiting arrangements and the wellbeing of residents.

Care Assurance Support Visits

63. The purpose of the programme of visits was to:

63.1 Work together with care home staff and residents (or their representatives) to identify good practice and consider improvements that could be made to enhance residents' experience of care during Covid-19.

63.2 Act as a mechanism to ascertain the current IPC practices in relation to national guidance, including PPE and cleaning schedules.

63.3 Ascertain current practice in relation to the provision of fundamental nursing and social care

63.4 Support identification of workforce training requirements

63.5 Support the sharing of good practice

63.6 Provide structured feedback and useful information to support ongoing improvement efforts

63.7 Provide an opportunity to discuss contingency planning and safe care during an outbreak of Covid-19

64. The Care Assurance Support Visits were not a performance management tool, nor a formal audit mechanism. The approach was to encourage the early supportive sharing of information and support the workforce and management teams in times of extraordinary challenging circumstances. 287 visits to care homes were carried out by the IPC Team during June 2020 to 28 June 2022. The IPC team only commenced care home visits in June 2020.

65. The visits were conducted by members of the Infection Prevention and Control team and representation from the HSCP which included nurse, social work and/or manager. The visits were conducted in person, with telephone support being available at other times. An agreed checklist tool [Exhibit: JC/13 **INQ000618198**] (based on the National Clinical and Practice Guidance for Adult Care Homes in Scotland during the Covid-19 Pandemic) was used to inform the structure of the visits. The Care Inspectorate were not part of these visits. They carried out their own separate visits by exception and only if shared intelligence indicated a need.

66. The assurance visits involved the assessment of IPC practice and compliance against the national IPC manual and related Scottish Government directives and or guidance.

67. The level of interaction between care homes and health and care professionals working within NHS Tayside and each of the three HSCPs increased considerably as a result of the pandemic. Whilst the focus initially predominantly concerned IPC support, as relationships developed enhanced support for many other aspects of health care was developed, including the creation of the Supporting Tayside Excellence Programme (STEP) in September 2022, which aimed to promote a whole systems approach to improving health and care for residents in adult care homes in Tayside [Exhibit: JC/05 **INQ000590690**].

68. The visits were usually planned in advance with the care home. Occasionally, ad hoc visits would occur if convenient for both the team visiting and the care home, particularly given that the purpose of the visits was to be supportive and not fulfil a regulatory function.

69. Each visit was conducted with a full understanding of the operating model of the care home, including level of care provided, any particular needs of the residents, staffing

levels, and size and construct of the care home. Information was triangulated with any advice provided previously by other organisations, including the Care Inspectorate, and if concerns were identified at the time of the visit that required escalation, this was done in line with guidance.

70. All of the visits were conducted in line with the current Scottish Government and Anitmicrobial Resistance and Healthcare Associated Infection (ARHAI) Scotland guidance at the time. There was no variation in approach taken with regards to the IPC standards between care and residential homes. All care homes and residential homes received support from the IPC Team, who followed the ARHAI Scotland National Infection Prevention and Control Manual guidance.

71. Whilst there was some uncertainty as to the role and remit of staff involved in the local enhanced assurance arrangements initially (particularly for those who had not been involved to a large extent with care homes previously), the guidance issued in July 2020 clarified roles and responsibilities.

72. Learning from the assurance visits was shared locally through the governance fora established, including the Care Home Oversight Group and the bronze, silver and gold command structure of NHS Tayside and the HSCPs. At a national level, ARHAI Scotland and the IPC managers and senior nursing staff within the Scotland wide network met regularly, where learning was also shared.

73. All of the key learning from the assurance visits was assimilated and collated nationally within a document that was produced in January 2021 by the Chief Nurse for Care Homes at the time [Exhibit: JC/12 **INQ000618197**].

Key Issues and use of emergency powers

74. Face to face discussions at the visit provided an opportunity to discuss any areas of concern the care home might have and provide clinical advice, information and guidance on how best to protect their residents from contracting Covid-19 or caring for them if they tested positive. Being on site enabled the visiting staff to gain invaluable insight to understand better the practical day to day issues which care homes had to manage and collaborate over possible solutions. Where required, and in discussion with the manager, support was given to compile an action / improvement support plan and additional clinical support offered from the most appropriate professional. Home managers were given verbal feedback on the day of the visit and were given a copy of their final report and support plan.

75. The key themes emerging from the visits included: it was challenging to ensure adequate PPE supplies within the care homes consistently throughout the pandemic; a need to upskill and train staff in IPC knowledge; logistical challenges in relation to waste and laundry; and challenges to ensure isolation of residents if required along with the ability to decontaminate environment and furnishings due to it being a home environment.

76. In response to key emerging themes, Care Home Rapid Review Recommendations were formulated in an improvement plan which was monitored via the Care Home Oversight Group. [Exhibit: JC/13 **INQ000618198**, Exhibit JC/14 **INQ000280638**, Exhibit JC/15 **INQ000618200** & Exhibit JC/16 **INQ000618201**].

77. Our approach to supporting care homes with staffing levels is considered in the later section.

78. One of the care homes in Tayside experienced a significant Covid-19 outbreak in January 2021. The care home struggled to ensure the safety of their residents and staff and required considerable input and enhanced oversight from the HSCP and NHS Tayside and escalation to the Care Inspectorate.

79. No care homes required the exercising of emergency powers under sections 63A-63B of the Public Services Reform (Scotland) Act 2010.

Effectiveness and impact of the enhanced assurance arrangements

80. Feedback from the care homes was generally positive, however, there was no formal evaluation of outcomes for residents and staff. Actions were highlighted to each care home and the assurance mechanisms in place confirmed when these were completed satisfactorily.

81. Whilst the enhanced assurance arrangements led to improvements in practice, the care homes felt under considerable increased scrutiny at a time that they were grappling with unprecedented circumstances. There was an increase in staff turnover, particularly at the managerial level, during the pandemic, possibly due to the increased scrutiny, workload and associated stress.

82. There were times when the advice of the Care Inspectorate and the IPC team differed. In care home settings, differences in the interpretation and application of IPC guidance occasionally arose between the Care Inspectorate and local IPC team. An area where this was evident related to the use and disposal of personal protective

equipment (PPE). For example, defining the difference between reuse and sessional use of eye protection, along with specific cleaning protocols. Challenges may have been created due to the frequent changes to national IPC guidance. There were also practical differences in advice around the positioning of clinical waste bins. For instance, IPC teams may have advised placing clinical waste bins out with the resident rooms or en-suite bathrooms to facilitate safe disposal of used PPE. However, the Care Inspectorate may prefer bins to be located within the resident's room or en-suite bathroom to avoid potential risk to other residents. These examples highlight the importance of ongoing collaboration and dialogue between regulatory bodies and IPC professionals to ensure that guidance is both practical and proportionate to the care home environment, while maintaining high standards of infection prevention and control. However, any differences were identified quickly and resolved without issue. Inevitably colleagues whose experience was within a clinical setting took more of a hospital-based approach to IPC in particular, however, a strong effort was made to maintain the care homes as the homes of residents and therefore the Care Home Operational Groups always sought to balance clinical input with the human rights of residents.

83. There was occasional blurring of the roles and responsibilities between the IPC, HPT and Care Inspectorate teams. For example, during an outbreak in a care home, staff were unsure whether to contact the Infection Prevention and Control Team (IPCT) or the Health Protection Team (HPT) for advice on isolation procedures and testing, this could lead to delays in response.

84. This was largely a result of roles changing – for example, pre-COVID, IPCT were not actively involved in care homes as this was the role of the HPT. Traditionally, HPT would oversee outbreak management in care homes, while IPCT focused on hospital settings. However, with the emergence of COVID-19, IPCTs were asked to support care homes directly, especially in matters related to PPE, environmental decontamination, and IPC compliance with national guidance.

85. In the early days this sometimes caused confusion but to reduce the confusion a Care Home Visit NHS Tayside flowchart [Exhibit: JC/17 **INQ000618202** & JC/18 **INQ000618203**] was developed for care homes and services to refer to. This visual guide clarified which team to contact for various scenarios – such as reporting a suspected outbreak, requesting IPC specific advice – helping to streamline communication and reduce duplication of effort.

86. The guidance issued in July 2020 [Exhibits: JC/19 **INQ000618204** & JC/20 **INQ000618205**] helped to clarify roles and responsibilities.

ACCESS TO MEDICAL/HEALTH CARE

87. Medical support to care home residents was provided through a Local Enhanced Service agreement with primary care, which included key provisions such as: admission reviews for new residents; future care planning (including discussions about resuscitation preferences); a designated clinical point of contact for residents; and a first point of contact for urgent care needs.

88. As at 1 March 2020, there was no specific requirement for care homes to align with a single GP practice. In areas with only one GP practice, this was naturally implemented, while in larger towns with multiple GP practices, care homes could be supported by a number of different practices.

89. Medicine for the Elderly Consultants provide locality-based medicine services, with longstanding connections to the local areas and care home providers. Additionally each HSCP had a long-standing multi-disciplinary team model to support with adult care planning and delivery.

90. Clinical staff in Tayside continued to visit care home and other ASC settings, and provide physical assessments, throughout the pandemic where required.

91. In addition, telephone and remote consultations were conducted when appropriate, including using NHS Near Me. There is no data available around the percentage of contacts carried out by digital means. There were no known issues regarding access to medications or medical equipment by care home; and no information is held around any impact that the lack of access to physical assessments had.. NHS Tayside does not hold information regarding problems to patients accessing Broadband and Wifi, accessing devices or any other challenges in accessing remote healthcare.

92. NHS Tayside is not aware of any care home resident, who was either suspected or confirmed of having Covid-19, being prevented from being transferred by the Scottish Ambulance Service to hospital for escalation of care.

END OF LIFE CARE/DNACPR NOTICES

93. Data on the implementation of anticipatory care plans (ACPs) or DNACPR notices is not routinely collected. However, during the pandemic all care homes were supported to ensure a treatment escalation plan was in place for all residents. This included DNACPR discussions and reviews of anticipatory care plans.

94. Education, training and resources on the use and implementation of DNACPR notices were shared by the Advance Nurse Practitioner team with care home staff.

95. The DNACPR national policy continued to be implemented in line with standard medical practice throughout the pandemic, with no change to usual practice.

96. NHS Tayside is not aware of any instances where DNACPR notices were imposed in a blanket manner or inappropriately.

97. Decisions regarding resuscitation remain clinical decisions and discussions about DNACPR are part of medical training and standard medical practice. The clinical team will always endeavour to consult with individuals and/or their family members/guardians, however, there may be the rare occasion that family members are not able to be contacted and informed, either through pressures of time or being unable to reach the family member concerned.

98. Furthermore, if a DNACPR notice is in place, the patient will still receive ongoing medical and supportive care appropriate to their condition and clinical need.

99. Ensuring access to palliative care for individuals in the ASC sector, including care home residents, remained a high priority for NHS Tayside and the HSCPs throughout the pandemic. This included ensuring timely medication reviews, ongoing review of care needs and additional support to care home staff where required.

IPC AND PPE

100. As part of the Gold Command structure within NHS Tayside, a Bronze PPE group was established in March 2020. The role of this group was to assess critical supply chains and supplies, identify and maintain an overview of risk, make decisions on priority and possible rationing of available supplies and recommend any necessary measures to reduce impact.

101. Areas of responsibility included: consider and develop continuity options for distribution of PPE and other essential supplies; support the appropriate prioritisation

of Scottish Government stockpile allocations; ensure robust supply chain links between NHS Tayside and other Health and Social Care Partners; consider and implement alterations to local PPE Guidance and how changes may impact future supply and identify where new systems and processes are required to be established to support effective management of PPE.

102. In the case of supply chain disruption, the group would identify key priority areas, re-distribute essential PPE supplies, and identify mitigating actions.

103. At the start of the pandemic, the area of concern within ASC that was reported most frequently to the HPT was access to PPE. On 6 April 2020, the HPT noted that care homes were using the national PPE social care helpline and receiving small supplies as a result but these were only designed as being a short-term supply until stock could be acquired through their usual supply routes. However, there was little to no availability of PPE through care homes' usual retail/wholesale supply routes at that time. Care homes could also email NHS Tayside's essential supplies service, but this again was only for short-term supplies (12-24 hours). Services caring for people in their own homes also frequently contacted the HPT regarding problems accessing adequate PPE, and other IPC challenges such as laundering of uniforms, and management and coordination of staff including cohorting of staff dealing with suspected/confirmed Covid-19 patients and non-Covid-19 patients.

104. Care homes anticipated receiving PPE packs but were not always clear whether the items contained would meet the requirements of the contemporaneous national Infection Prevention and Control/PPE guidance, including provision of eye/face protection, which guidance advised should be used in community settings if risk assessed as necessary, but to which care homes and other community care providers reported they had very limited access. Care providers were also concerned that guidance on individually risk-assessing the most appropriate level and type of PPE to use was lacking. The issues of PPE shortages locally were escalated through Tayside's NHS/HSCP Bronze PPE subgroup, to HSCP senior managers, and nationally.

105. Training in IPC precautions was provided by both the IPC team and other NHS Tayside employees. The HPT often identified difficulties experienced by care home staff understanding and correctly applying guidance about 'sessional use' of PPE and how to don and doff correctly.

106. Educational sessions were provided through either face to face sessions or online resources. The IPC team would refer directly to the National Infection Prevention and Control Manual: Care Home Infection Prevention and Control Manual (CH IPCM) as guidance for care home staff. The manual was comprehensive and also suggested that local resource may be developed to enable adherence to IPC practices.

107. Additional education resource materials were also made available via the care home website hosted on the intranet which care home staff had access to. At the onset of the Covid-19 pandemic the level of interaction between care homes and health and care professionals working within NHS Tayside and Tayside's three Health & Care Partnership increased. This highlighted some opportunities to improve communication and the sharing of knowledge between care home staff and health and social care professionals. A website was developed to be a vehicle of bringing practical contact information, referral pathways, guidance and resources easily, quickly and efficiently to care homes and was launched in summer 2022.

108. During the pandemic the IPC team provided a proactive service and visited care homes to support safe care of residents. Positive feedback was regularly received from care homes and HSCP colleagues who commended the value of the service. Members of the IPC team participated in a variety of governance fora and were able to contribute locally and nationally to relevant IPC care home discussions.

CARE HOME STAFF AND RESIDENTS

Staffing levels

109. Staffing levels in the ASC sector were closely monitored throughout the pandemic. In general care homes were able to enact their own resilience plans to ensure sufficient staffing was available, however, on occasion (most often at a time of an outbreak) mutual aid was enacted. NHS Tayside does not have a record of directly redeploying NHS staff into care homes. However, during periods of staffing shortfall, we supported the care sector by redeploying NHS bank staff into care home settings where appropriate. Over the relevant time period, we have a record of 15 shifts being undertaken by NHS bank staff within care homes.

110. A Standard Operating Procedure [Exhibits: JC/06 **INQ000590692** and JC/07 **INQ000590695**] was developed by NHS Tayside in May 2020 to support the

provision of supplementary staffing to the local authority, third sector and private community care services within the three HSCP areas.

111. The purpose of the Standard Operating Procedure was to provide guidance and a framework for a standard approach and process to be applied to the provision of NHS Tayside substantive employees and bank workers to care providers within community settings.

Wellbeing of staff and residents

112. The need for any enhanced support for care homes was identified through the daily huddles, assurance visits and, during outbreaks, contact by the Health Protection Team. In addition to practical assistance (for example provision of PPE, training and education, and support with staffing), the teams also provided emotional and wellbeing support to the staff. All of the teams working with care home staff recognised the huge pressures and strain they were under and a significant component of their interactions with care homes was to provide reassurance and support.

113. In terms of support for residents, care homes were very creative in their approach to providing activities to help maintain the wellbeing of residents, and these approaches were shared with other care home providers via the daily huddles and at the care home oversight group.

114. To keep residents connected with their loved ones, electronic tablets were purchased to support and enable virtual communications. Newsletters were developed and shared with families and carers. Care homes were also partnered with local schools and the school children would write and email letters to residents. In addition, the HSCP enabled collaboration between care homes and local leisure providers to set up live streaming of gentle exercise classes into care homes.

115. Other initiatives included: activity coordinators providing one-to-one exercises, pampering sessions, painting, storytelling and reminiscence activities; the promotion of participation in in music, arts, crafts, sporting, line dancing within the care home; the setting up of dedicated visitor rooms with glass partitions and an intercom system; and outside music entertainment and themed meal nights.

TESTING

116. During the containment phase of the Covid-19 pandemic, Covid-19 testing was restricted to people who were experiencing symptoms of Covid-19. NHS Tayside established a community testing team to undertake Covid-19 testing for people with symptoms in the community, inclusive of all domiciliary settings in response to referral criteria and worked collaboratively with the HPT to respond to clinical need across a range of vulnerable groups. The CTT provided an outreach service which included visiting care homes to undertake COVID testing for residents, and as required for staff, in addition to the established staff testing processes in place. There was a robust referral process, with timely response, in many cases same day or following day. This service was operational week commencing 9 March 2020 and was delivered alongside the acute services response based in Ninewells Hospital to increase capacity and prioritise Scottish Ambulance and acute care facilities for people with an identified clinical need, whilst providing testing for people with milder symptoms within the community.

117. As the pandemic moved from the containment phase to the delay phase, the original community testing team function was stood down, however, in response to the changing landscape and challenges of staff resilience being experienced across health and care, the service was retained and rapidly redesigned and expanded to provide a community based Covid-19 testing service to support continued health and care provision in Tayside.

118. The High Consequence Infectious Disease Co-ordinating Group of NHS Tayside agreed on 16 March 2020 to support the provision of testing for healthcare workers who were self-isolating and where the service was experiencing challenges with business continuity arrangements. It was agreed locally that testing would be offered to healthcare workers with symptoms of Covid-19 and to symptomatic individuals who were living with a healthcare worker.

119. At the time the number of Covid-19 tests available was limited and therefore a prioritisation process for staff testing across Tayside was agreed to ensure clinical frontline services could be maintained, as well as any essential services to support the running of these organisations.

120. Due to the limited number of tests available, staff testing and testing of household contacts was prioritised for symptomatic individuals only. Individuals required to be

symptomatic for 48 hours to reduce the risk of false negatives and be in a position to return to work if the test was negative.

121. The repurposed NHS Tayside Community Testing Team was operational from 17 March 2020 to support the testing of all frontline health and social care staff (including the third and independent sector), household contacts, patients and care home residents. A drive-through testing facility from a hospital site in Dundee was established and was the main base for the Community Testing Team throughout the pandemic, with a mobile out-reach testing facility available and, later in the pandemic, an additional drive-through facility in Perth Royal Infirmary.

122. Examples of best practice across Tayside included training resource developed with in-person training support given to care home staff to undertake their own COVID testing, to ensure appropriate quality assurance. Established mobile testing to attend care homes and support staff unable to attend drive through services, when capacity allowed. Set up second testing site in Perth to improve accessibility for people in the Perth area. Supported expansion of testing capacity in labs and in staff teams to respond to clinical need.

123. The Covid-19 Testing Bronze Command was established on 27 March 2020 and was responsible for the review and oversight of the processes and practice related to Covid-19 testing in Tayside. A specific focus were the community-based testing pathways for both staff and patient and the ASC sector, across NHS Tayside and the three HSCPs. This bronze command group also provided expert advice and support to other Covid-19 testing initiatives and developments in Tayside.

124. The Covid-19 Testing Bronze Command reported into and provided advice and guidance to Silver Command and Gold Command as appropriate.

125. The volume of Covid-19 tests that NHS Tayside were able to offer increased throughout the pandemic and the availability of an NHS-based, on-site Covid-19 testing facility was invaluable to ensure the flexibility and pace of response to any emerging workforce and population health concerns across Tayside.

126. Testing of care home residents was initially carried out by the Community Testing Team but as the pandemic progressed, this was gradually taken over by care home staff following training and with support by the Community Testing Team where required.

127. However, the Community Testing Team continued to support the HPT throughout the pandemic in the management of outbreaks in the ASC sector, when required.

128. NHS Tayside has no significant concerns regarding testing within the region. NHS Tayside was well supported with COVID testing capacity through our lab services, covid testing team, and H&SCP staff as appropriate, working in collaboration with HPT and IPC. At the start of the pandemic COVD testing was very limited however testing was prioritised according to National guidance, and NHS Tayside were able to respond to testing requests as these evolved throughout the pandemic. There was effective communication to allow any concerns, requests and issues to be highlighted and addressed, either through the regular meetings supporting the COVID command structure, or regular CTT meetings.

FUNDING

129. The additional funding for IPC and domiciliary care was timely and sufficient.

LESSONS LEARNED AND RECOMMENDATIONS

130. The sector largely responded incredibly well to an environment where there was constantly changing guidance and additional scrutiny and reporting. Communities rallied and provided support and intervention without hesitation.

131. The sector, and colleagues supporting the sector, had to undertake additional roles and tasks whilst coping with a pandemic and its impact.

132. The ASC workforce had to cope with loss and bereavement in a way that other services did not. Those they lost they had often known for prolonged periods of time and had strong relations with. The care home sector experienced these issues on the greatest scale.

133. In retrospect it is easy to identify areas for improvement, but it is important to stress that the management of the response to a pandemic was a complete unknown. Many care homes would not have had clinical staff on site, but even so the rapidity of spread combined with the devastating impact of Covid-19 on frail, older people was unprecedented.

134. The more subtle, early symptoms of Covid-19, were not always easily picked up in the ASC, particularly in the elderly population and when people had significant

underlying health conditions as presentations varied. This, at times, led to delays in diagnosis, testing, and therefore early support being implemented.

135. Strong managerial oversight and leadership was crucial within care homes and associated with better outcomes for residents.

136. The ASC sector found considerable variability with the supply of PPE and the market and process for procuring PPE could be significantly improved in future. The opportunity to purchase PPE in bulk and distribute, or for providers to buy as a collective, would potentially have controlled the market and prohibited profiteering. It would also have ensured PPE was always available as and when required and reduced the administrative burden associated with distribution.

137. The early provision of NHS Tayside's Community Testing Team service, which was inclusive of adult social care, enabled improved access to Covid-19 testing and assured the quality of testing.

138. Similarly, the early provision of the NHS Tayside local laboratory testing facility allowed responsive and timely testing with validated results, to inform clinical decision making, enable timely hospital discharge to care homes, surveillance testing, and respond to ASC outbreaks management.

139. Access to the Community Testing Team for all ASC staff and household contacts helped to optimise workforce availability and reduce staff absence.

140. There were additional benefits with the Community Testing Team visiting ASC residential facilities through building professional relationships, to provide advice and support, provide a conduit for communication and support between leadership teams and services, and to support staff training in regard to Covid-19 testing.

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: **Personal Data**

Dated: 2/6/25