Witness Name: Sarah Horan

Statement No:

Exhibits: SH/01 - SH/43

Dated: 10 June 2025

UK COVID-19 INQUIRY

WITNESS STATEMENT OF SARAH HORAN, DIRECTOR OF NURSING, MIDWIFERY & ALLIED HEALTH PROFESSIONALS

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1. As Director of Nursing, Midwifery & Allied Health Professionals I make this statement in response to the UK Covid-19's Inquiry's Request for Evidence under Rule 9 of the Inquiry Rules, dated 10 December 2024, in relation to Module 6 of the Inquiry. The facts and matters contained within this statement are within my own knowledge unless otherwise stated, and I believe them to be true. Where I refer to information supplied by others, the source of the information is identified; facts and matters derived from other sources are true to the best of my knowledge and belief.
2. I make this statement on behalf of NHS Borders and confirm that I am duly authorised to do so. During the Covid-19 pandemic I held the role of Associate Director of Nursing for Acute Services reporting to the Director of Nursing, Midwifery, AHPs and Acute Services. I became Director of Nursing, Midwifery & Allied Health Professions on the 10 June 2021.

Overview/Background

3. NHS Borders and its partner organisations manage a mix of remote, rural and urban health and social care services within the Scottish Borders. The Scottish Borders is covered by a single council, Scottish Borders Council. NHS Borders is responsible for providing health care services to protect and improve the health of the people of the Scottish Borders and plan services for the local population. Other roles include to:

- focus clearly on health outcomes and people's experience of their local NHS system.
- promote integrated health and community planning by working closely with other local organisations.
- provide a single focus of accountability for the performance of the local NHS system.

4. Throughout its work, NHS Borders is committed to forging effective links with all its partners in care, such as patients, staff, local communities and disadvantaged groups, so that their needs and views are placed at the heart of the design and delivery of local health services. Attached are copies of NHS Border's Board Structure as at 1 February 2020 and as at 05 April 2021 (SH/01 INQ000590588 Attach 4 NHS Borders Board 01.02.20.pdf and SH/02 INQ000590589 Attach 6 NHS Borders Board 05.04.2021.pdf) and Organisational Structure as at 1 August 2021 (SH/03 INQ000590590 Attach 5 NHS Borders Board Map 010821.pdf).
5. NHS Borders is one of the larger mainland health boards in terms of land mass (1,827 square mile (4,732 km^2)), but one of the smallest in terms of population size and annual budget. Information on Health Records Scotland gives an estimated population of 116380 in mid-2020 (116490 in mid-2019) (SH/28 INQ000618160 mid-year-pop-est-revised-2011-2022-data-tab). There is a single council, Scottish Borders Council, covering the same area as NHS Borders, both organisations work closely to serve the population of the Scottish Borders. NHS Borders has a workforce of approximately 3,450 directly employed staff.
6. NHS Borders has 1 District General Hospital, 4 Community Hospitals, 4 Mental Health inpatient units and 22 GP Practices. Within the Scottish Borders there are 23 registered care homes for adults and 3 Learning Disabilities Care Home providers. 17 provided by external providers and 6 by Scottish Borders Council.
7. The Scottish Borders Health and Social Care Partnership is the sole Health and Social Care Partnership in the Scottish Borders. Attached are the memberships for the Integrated Joint Board for 2020 & 2021 (SH/04 INQ000590591 Attach 8 Membership 2020 IJB.docx and SH/05 INQ000590592 Attach 9 Membership 2021 IJB.docx). NHS Borders does not have any responsibility for Adult Social

Care and Adult Social Work within the Scottish Borders. This is the responsibility of Scottish Borders Council and their commissioned providers.

8. In 2021 NHS Borders's proportion of the population over 65 was the highest in Scotland.

   - 45 – 59 years 20.84% (19.29% Scottish average)
   - 60 – 74 years 15.83% (13.98% Scottish average)
   - 75+ years 8.86% (7.09% Scottish average)

   Public Health Scotland mid year calendar 2020 population projection:

   - 40 – 64 years 35.9% (33.9% Scottish average)
   - 65 - 74 years 14.1% (10.9% Scottish average)

   75+ years 11.4% (8.7% Scottish average)

9. The Scottish Index of Multiple Deprivation (SIMD) is better applied to more densely populated towns and cities so, whilst we are able to demonstrate many stark inequalities, we know that some of the challenges are also hidden. The following link details the Scottish Index of Multiple Deprivation - (SH/29 INQ000618161 SIMD+2020v2+-+datazone+lookup+-+updated+2025). Within the Scottish Borders region:

   - 21.7% of people earn less than the living wage, compared to 14.4% across Scotland. The average income in the Scottish Borders is lower than across Scotland. The average residence-based weekly wage in the Scottish Borders was 89% of the Scottish average and, in 2022, the gross weekly workplace-based wage in the Borders was £69 less per week than the average for Scotland.
   - Children living in low-income households in the Scottish Borders has increased from 14.6% in 2021 to 19.7% in 2022.
   - 19% of households with children under 16 years were considered workless in the Borders compared to 11% across Scotland. The ratio of total jobs to the working age population in Borders is lower than that of Scotland (0.79 vs 0.81) meaning that individuals may have to travel for work or have fewer opportunities locally than other areas of the country.

10. Below are the weekly delayed discharge numbers from 24 June 2019 to 24 February 2020. Pre-pandemic NHS Borders and the Health & Social Care Partnership had between 30 and 40 delayed discharges. Most of these related to availability of care packages or care home placements in particular parts of

the Scottish Borders. Reflective of an ageing demographic and growing need for social care provision in the region. Delays have continued to grow during and since the pandemic.

2019

Week Commencing	**24/06**	**01/07**	**08/07**	**15/07**	**22/07**	**29/07**
Total Delays	36	34	35	38	33	36

2019

Week Commencing	**05/08**	**12/08**	**19/08**	**26/08**	**02/09**	**09/09**
Total Delays	36	45	34	46	40	39

2019

Week Commencing	**16/09**	**23/09**	**30/09**	**07/10**	**14/10**	**21/10**
Total Delays	37	27	28	21	29	24

2019

Week Commencing	**28/10**	**04/11**	**11/11**	**18/11**	**25/11**	**02/12**
Total Delays	25	23	22	24	34	18

2019

Week Commencing	**09/12**	**16/12**	**23/12**	**30/12**
Total Delays	27	20	20	30

2020

Week Commencing	**06/01**	**13/01**	**20/01**	**27/01**	**03/02**	**10/02**
Total Delays	37	37	33	35	42	38

2020

Week Commencing	**17/02**	**24/02**
Total Delays	40	36

11. Prior to the pandemic NHS Borders Health Protection Team would respond and co-ordinate the response to any infectious disease outbreak in the Scottish Borders, including in Care Homes. In early 2020 NHS Borders Health Protection Team (HPT) comprised of:
    - Health Protection Nurse Consultant 1.0 WTE
    - Health Protection Nurse Specialist 1.0 WTE
12. The Director of Public Health and Associate Director of Public Health both contributed to the on-call rota and provided resilience in times of surge capacity.

Operationally, support to care homes was provided by a Community Infection Control Nurse embedded within the NHS Borders Infection Prevention Control team. Strategic and operational oversight was provided by the HPT with an on-call availability 24/7, 365 days per year. This had always included surveillance, investigation and control of communicable disease and non-infectious environmental hazards and provision of personnel to exercise the powers conferred by the Public Health (Scotland) Act 2008 in keeping with requirements of 'Designation of Competent Persons Regulations 2009'. The Director of Public Health was the overall executive clinical lead for the NHS Borders Health Protection Team.

13. In the early stages of the pandemic the support structure for care homes quickly strengthened. A single case of Covid-19 infection in a care home constituted an 'incident'(see following link section 3.2.19 which details the circumstances in which a public health incident may arise – SH/30 INQ000130954 1_shpn-12-management-public-health-incidents) and prompted contact with NHS Borders HPT to advise on the need for testing of residents and staff as well as assessment of resident cases, including symptomatic cases who have either been transferred from the facility to hospital as a result of infection or a suspected Covid-19 individual who has died within the same time period.
14. For resident(s) displaying symptoms of Covid -19 (low threshold of suspicion) care home management were advised to contact the General Practitioner (GP) for clinical advice or for an emergency to call an ambulance, arrange testing of resident(s) through NHS Borders (7-day service) and inform a newly constituted (from beginning April 2020) Community Infection Control Advisory Service (CICAS) Mon-Fri.
15. Any staff (or household member) reporting symptoms of Covid -19 were advised to call NHS 111 if needing medical advice and contact line manager to arrange Covid -19 testing.
16. A Problem Assessment Group (PAG) was convened for all positive cases within a care home involving representatives from public health; Scottish Borders Council; Primary and Community Services, and local GP practice. The CICAS team contacted the Care Home Manager for advice and to explain the requirements for an Outbreak Monitoring Tool daily return. The Community Infection Control Nurse provided direct advice to Care Homes (Mon - Fri) as

required throughout an outbreak and provided updates to key individuals. The 'Test & Protect' team worked with the HPT to establish contact tracing interviews as appropriate.

17. From May 2020 a daily Care Home Operational Group (further details of CHOG set out under Oversight of care home section below) reviewed the Outbreak Monitoring Tool and kept a full audit trail of the group's response, considered the submitted metrics and intelligence gathered about the outbreak and conducted a RAG assessment (tool that uses traffic light system Red, Amber, Green to indicate status of an action/item). The RAG assessment would be decided by the Chair of the Operational Group in consultation with other key stakeholders. All with a 'Red' status (as a result of Covid attributed deaths, loss of control measures and/or significant staffing concerns) triggered the establishment of an Incident Management Team (IMT) to provide strategic advice for the operational partners and brief the Executive Oversight Group. The IMT would be led by Public Health and include senior representatives from Scottish Borders Council, Primary and Community Services, local GP practice and the communication team.

Hospital Discharges

18. NHS Borders followed previous process for discharging patients from hospital with the clinician who was overseeing the patient's care making the decision whether the patient was medically fit for discharge, taking into account national guidance around testing of individuals and the management of infection control. However, we note this was changed frequently at a national level. NHS Borders adhered to national guidance as the pandemic progressed, for example as attached letter from the Cabinet Secretary for Health and Sport dated 13 March 2020 (SH/06 INQ000280689 2020_03_13 Letter from Cabinet Secretary for Health and Sport - Social care guidance.pdf).
19. Within Borders General Hospital measures were taken to reduce the risk of nosocomial transmission of Covid-19 by segregating patients according to risk. These measures would also have reduced the risk of transmission of Covid-19 into care homes. There is an Emergency Department (ED) Covid-19 assessment process (SH/07 INQ000590594 created 11/03/2020 - ED PT FLOW COVID 19.docx attached) to reduce risk of nosocomial transmission from the initial arrival of a patient in the ED.

20. There is also an Acute Services High Level (Covid-19) Pandemic Plan dated 13 March 2020 (SH/08 INQ000590595 Acute Services Pandemic (Covid 19) Plan 2020_v1_ 12 03 20.pptx attached). This describes an escalation process to expand the number of beds allocated to Covid-19 and maintain separation of Covid-19 patients from other patients. Attached is a flow diagram created on 19 March 2020 which describes the patient admission process including Covid-19 assessment. An updated version created on 31 March 2020 (SH/09 INQ000590596 COVID patient flow.docx & SH/10 INQ000590597 FLOWCHART Emergency admissions meeting screening criteria for COVID-19 V1.1 .docx attached) classified each hospital admission into one of three groups to inform segregation and reduce the risk of nosocomial transmission:
    - Group 1 – Patients with positive test
    - Group 2 – Patients with negative test but who are thought likely to have Covid-19 on basis of clinical presentation
    - Group 3 – Patients with negative test who are thought unlikely to have Covid-19 on basis of clinical presentation
21. A Covid-19 clinical risk assessment tool dated 07 April 2020 (SH/11 INQ000590598 COVID Clinical Score 070420.docx attached) and accompanying SBAR communication document (SH/12 INQ000590599 SBAR for cohorting potential COVID patients awaiting swab results into 6 bedded bays.docx attached) was provided to clinical staff to support decisions on patient placement. An SBAR is a regularly used format for communicating in NHS Borders and describes the report structure - Situation, Background, Assessment, Recommendation. This was provided for use in the context of bed pressures and process delays in receiving laboratory Covid-19 test results (prior to the establishment of on-site Covid-19 testing capability).
22. A Standard Operating Procedure (SOP) for Acute discharge to care homes and community hospitals was developed (attached is a draft version of this dated 09 April 2020 (SH/13 INQ000590600 SOP Acute pre discharge to Nursing Residential homes & Community Hospitals v3.docx) and a final version dated 17 April 2020 (SH/14 INQ000590601 SOP Acute pre discharge to Nursing Residential homes & Community Hospitals v5 FINAL.pdf). The SOP references the previously established classification of Covid-19 risk and required all

planned moves of Group 1 and 2 patients to be discussed with and approved by the Infection Prevention and Control Team. For patients in Group 1 or 2, infection control precautions (including self-isolation) would continue for 14 days following their positive test and until they had no symptoms apart from cough for 48 hours, including being apyrexial without receiving antipyretic medication. The SOP also required completion of the following Covid-19 status for each discharge to a care home:

- Symptoms
- Temperature
- Pulse
- Oxygen Saturations
- BP
- Respiratory rate (with appropriate clinical adjustments for underlying respiratory disease)
- Information on Covid-19 status must be shared with receiving care facility before progression of discharge.

23. NHS Borders was made aware of anecdotal issues being raised relating to being unable to isolate residents where their level of mobility enabled them to walk with purpose within the care home setting. There was a need to balance the risk between people remaining in a hospital setting and being returned to a care home or their own homes.
24. The statements below are based on information provided by the Infection Control Manager following review of records held by the Infection Prevention and Control Team relating to the period of interest spanning 1 March 2020 to 28 June 2022 (It is possible that additional information may have been recorded in individual patient records, but it has not been possible to undertake a search of records of that magnitude):
    - There is only one instance recorded relating a care facility seeking advice in relation to the risk of nosocomial transmission of Covid-19 from a hospital discharge. On 13 July 2021, a residential facility for people with learning difficulties sought advice about a discharge from hospital who was a known contact of a Covid-19 patient.

- Five instances where concern was expressed about the ability to isolate residents following discharge from hospital. There was also an instance where a number of care homes were unwilling to accept a hospital discharge due to the individual being unable to isolate.

25. Beyond the concerns detailed above NHS Borders is not aware of any other instances of care homes expressing concern about their ability to provide clinical care for residents following discharge from hospital. There is information to indicate that there was one instance of a care home refusing to take a discharge from hospital. There were also generic concerns relating to adequate staffing in particular care homes at specific periods of heightened sickness absence akin to the staffing pressures being experienced in NHS services.
26. Care homes who made enquires with NHS Borders about infection control and Personal Protective Equipment (PPE) were provided with support from CICAS, however the information held on HP Zone indicates that these enquiries were not specific to discharges from hospital. There only one documented instance relating to a refusal by care homes to take patients being discharged from hospital. There is information recorded in HP Zone of District Nursing Teams providing clinical support to care homes where there was a need for support with clinical care. GP Practices were also contacted by care homes to seek clinical advice with symptomatic cases.
27. Within the period, the HPT detailed eight enquiries relating to access to PPE.
28. The Health Secretary announced on 21st April 2020: *"Covid-19 patients discharged from hospital to a care home should have been given two negative tests before discharge. I now expect other new admissions to care homes to be tested and isolated for 14 days in addition to the clear social distancing measures the guidance sets out".* Formal guidance was issued on 26 April 2020 (SH/15 INQ000189331 attach 1_covid-19-information-and-guidance-for-care-homes.pdf) requiring all transfers to care homes to have two negative tests prior to transfer. Within NHS Borders a review was undertaken in June 2020 of discharges to care homes, the outcome of that review is detailed in a document dated 23 June 2020 (SH/16 INQ000590603 attach Review of Covid status of people transferred from hospitals to care homes Final rev.docx). The review found that between 28 February 2020 and 4 June 2020 there were 142 discharges from NHS Borders hospitals to care homes. There did not appear to

be any cases where patients were transferred with Covid-19 or were transferred without testing and subsequently became Covid-19 positive except for:

- 2 patients admitted from a care home as known Covid positive patients and subsequently transferred back to the same care home.
- 4 patients who became Covid-positive greater than 2 weeks after transfer – so would not have been infected when leaving hospital.

29. Therefore, during the period (March 2020 and 21 April 2020) there would appear to be no transmission of Covid-19 from NHS Borders hospital discharges to care homes. The analysis was split between the period up to 21 April 2020, the date of the Ministerial announcement and the period following 21 April 2020.

30. Between 28 February 2020 and 21 April 2020, there were 79 patients transferred from hospital to care homes. This includes 3 patients transferred before the first known Covid-19 case in Scotland and 9 patients transferred before the first known Covid-19 case in the Scottish Borders. The data indicates that:

- 63 patients (80%) had not been tested for Covid prior to transfer.
- 14 patients (18%) had at least one negative test.
- 2 patients (2%) tested positive for Covid. However, both patients were transferred well beyond the 14-day assumed infectious period (21 days and 22 days) so would not have been infectious at this point.

31. Between 22 April 2020 and 4 June 2020 NHS Borders transferred 63 patients to care homes, out of these:

- 61 patients were tested prior to transfer. 2 (3%) patients were not tested for Covid prior to transfer. Their discharge dates were 22nd and 23rd April (i.e. before revised guidance was issued). Neither of these patients was transferred from a Covid ward and neither subsequently tested positive for Covid.
- All but 2 tested patients were negative. 2 patients were admitted from a care home with known Covid and were subsequently transferred back to the same care home without further testing. These transfers were made following careful clinical guidance and in the best interests of the patient.

- 6 patients have previously tested positive for Covid either on or during their hospital admission. They were transferred to care homes after between 2 and 4 negative tests.

32. To review all transfers after those reported to the 4 June 2020 would require a manual review of individual cases which has not been completed for the purpose of preparation of this statement due to the time committed.

Enhanced Oversight/Assurance of Care Homes

Initial arrangements and assessments

33. CICAS provided infection control support to care homes and in addition District Nurses continued to visit as normal to provide clinical care. Assessment calls with each care home took place led by a Clinical Nurse Manager. Additionally, the Care Home Operational Group received weekly updates which were shared with Scottish Government (as described in more detail in the following section around oversight of care homes).

34. Prior to the 24 April 2020 a self-assessment questionnaire and framework for action document (example included for one care home) was initiated for all care homes as part of the initial assessment process as summarised in the attached email (SH/39 INQ000618174 Care Home Business Continuity Plans), which includes the example for one care home and an overview spreadsheet, on 23 April 2020 highlighting what care homes did or did not have in place at that point.

35. The initial assessments were followed by a programme of associated assessment visits commissioned by the Director of Public Health, , Director of Nursing, Midwifery, Allied Health Professionals and Acute Services, the Chief Officer of Scottish Borders Council Social Care and Adult Social Work and other members of the Care Home Executive Oversight Group. Care Homes were assured that the primary focus of the visits was of a quality/supportive nature and while the visiting team would be undertaking an assessment the intent was to undertake this collaboratively and to develop a shared understanding of care and improvement support requirements during the Covid-19 pandemic. During these visits discussions took place between respective care home managers. A team of 6 senior health and social care workers was put in place to support this. All had considerable experience of adult and older people's care in care

settings. The team received additional training in infection control, PPE and were tested for Covid-19 on a weekly basis.

36. A comprehensive assessment tool was developed for the associated assessment visits (SH/17 INQ000590604 care home assessment tool April 2020.docx) around 6 key areas:
    - Communal areas, entrance and corridors
    - Laundry and waste management
    - Infection Control and PPE
    - Residents' health, care and well-being
    - Anticipatory Care and communication with other services
    - Staff safety and engagement.
37. The initial assessment was to be completed by 24 April 2020 (as described in 34 above). The associated assessment visits were then initiated, visits for 20 care homes were completed in person and were announced. Three care homes were outstanding as at July 2020. Due to the resident group of these care homes, they had requested virtual visits, and these were scheduled for 27 and 29 July 2020. For these three independent care homes it was specifically requested by the care home manager or owner that in order to minimise people physically attending the care home posing a greater risk to residents that the visits be carried out virtually. With the exception of the three outstanding care homes, all homes were evaluated as green i.e. as good in their individual performance. Some improvements were identified in certain areas which were required to maximise wellbeing and ensure that going forward residents consistently have experiences and outcomes that are as positive as possible. Individual reports with actions and areas for improvement were produced and shared with the respective homes and with the Care Home Operational Group (one example provided SH/34 INQ000618169 Safety Inspection and Walkround **I&S** . We have been unable to obtain the write up of these virtual visits within the timescale for submission due to absence of a key member of personnel. A summary report was prepared in June 2020 (SH/18 INQ000590605 attach supportive visits summary June 2020.docx). These visits were repeated in February 2021 and a summary report for April 2021 and April 2022 is included (SH/33 INQ000618165 Assurance visit report April 21 Final +

SH/40 INQ000618178 Assurance Report April 2022) as well subsequent reports to the Clinical Governance Committee in March, May, June and August 2021(SH/35 INQ000618170 CGC Appendix 2021-18 Care Home Clinical Governance June21.docx, SH/36 INQ000618171 CGC Appendix 2020-94 Care Home Clinical Governance Mar 21.docx, SH/37 INQ000618172 CGC Appendix 2021-04 Care Home Clinical Governance May 21 Final.docx, SH/38 INQ000618173 CGC Appendix 2021-33 PCS Report August 2021.docx). From August 2021 reporting was included in the Primary & Community Services Report to the Clinical Governance Committee. The Summary report June 2020 provides details of the actions taken in preparation for the visits. The report states - In preparation for the visits the team received additional training in infection control, PPE and were tested for COVID-19 on a weekly basis. Prior to the visits the team undertook extensive training and learning on the use of the assessment tool, agreeing collective measures for observation, documentation and interpretation. The purpose of this was to ensure consistency and reduce subjectivity. The team also met on a weekly basis to discuss observations and findings and agree consensus. Arranged visits were arranged with each of the care homes during June and July 2020 and visits were undertaken by two members comprising both a health and social care representative.

38. The associated assessment visits identified the following recommendation areas:
    - Identification and care for deteriorating residents
    - Areas for nursing support
    - Support from other services
    - ACP/DNACPR
    - Daily safety Huddles
    - Training and Education
    - Workforce Planning
39. Recommendations made in relation to the above areas:
    - Undertake a programme of training across all homes in early recognition, response and clinical escalation planning using National Early Warning Scoring System (NEWS) and RESTORE2 (a physical deterioration and escalation tool for care/nursing homes based on

nationally recognised methodologies including early recognition) ensuring that this skill exists within the home.

- Undertake a review of the current community nursing model and workforce skill set against effective evidence-based models elsewhere e.g. District Nurses /ANPs, Virtual Wards for both in and out of hours care.
- In collaboration with Primary Care undertake a review of the current Local Enhanced Service. Share examples of exemplar approaches identified during visits and agree outcomes focused approach to support as part of the wider primary care improvement plan.
- The input and support from Allied Health Professionals and enablement type services was identified by homes as an area where further support or in-reach would be beneficial in relation to outcomes. Older people were at significant risk and more likely to experience falls and challenges in relation to in reach support which could reduce risk and enable residents were described, Historically these services have not been available to homes. Explore further an in-reach model of enablement and rehabilitation/falls prevention for homes.
- There is a need for comprehensive review and programme to revisit a shared and consistent approach to Anticipatory Care Planning.
- Develop best practice guidance for daily safety huddle process for sharing across all homes.
- Develop a training and education programme in collaboration with care homes that can be provided using a variety of methods.

Multi-disciplinary clinical assurance/oversight of care homes

40. Within NHS Borders oversight of care homes was undertaken by the Chief Nurse, Health & Social Care Partnership and clinical managers along with Scottish Borders Council's existing Care Home Commissioning and Review Team (CCRT) and was then taken up by the Care Home Support Team when this team came into post. The model of care in care homes was acknowledged and understood by the Care Home Support Team in order to tailor the education/support/guidance that was offered. A daily safety report was provided from each Care Home to inform the support required. Daily information provided

by Care Homes is provided in the attached example from 26 May 2020 (SH/43 INQ000618186 26 5 20 Daily Care Home Returns Summary Sheet) which gave an overall RAG status and details of staff who were self-isolating with symptoms or who had tested positive for Covid, whether there was adequate PPE, whether there were confirmed or suspected Covid 19 cases in service users or any deaths from Covid 19 and lastly whether the Care Homes was open to new admissions and beds available as well as any other comments or escalations. This information was used to deploy any necessary support to Care Homes and was fed into the CHOG. An example of the report to the CHOG of 11 February 2021 is attached (SH/42 INQ000618185 11 2 21 CHOG Daily Report to Strategic Group). This daily process for sharing information was initially started by Scottish Borders Council, with involvement from the Director of Social Care, the Director of Nursing Midwifery and Acute Services, the Care Home sector and health and social care. When the care homes had Care Inspectorate notes to improve and based upon the grade given the Care Home Support Team would ensure that this was part of the tailored response and suite of education/support that was offered to homes.

41. The attached Scottish Borders Care Home Governance Framework describes the governance arrangements put in place (SH/19 INQ000590607 attach Scottish Borders Care Home Governance Framework.pdf). NHS Borders established an Executive Group for Clinical and Care Oversight of Care Homes (CCOCH). Previously the Scottish Borders Council's CCRT provided care home oversight and support with no NHS input other than community teams attending as need for clinical care delivery. The membership of the Executive Group CCOCH was Director of Nursing, Midwifery, AHPs & Acute Services (Chair), Chief Operating Officer Adult Social Work and Social Care (Vice Chair), Chief Officer Health & Social Care, Chief Social Work & Public Protection Officer, Medical Director, and Joint Director of Public Health.
42. The role of the Executive Group for CCOCH was to:
    - Be responsible and accountable for the provision of professional oversight, analysis of issues, development and implementation of solutions required to ensure care homes remain able to sustain services.

- Ensure care homes have access to expert advice on, and implementation of, infection prevention and control.
- Secure/provide responsive appropriate expert clinical support to care homes and their residents when needed.
- Ensure granular scrutiny and support to Health& Social Care Partnership Mobilisation Plans.

43. The Executive Group for CCOCH's objectives were to:

- Hold a daily discussion covering each care home and decisions on any additional direct clinical or IPC support needed.
- Ensure testing guidance is clarified urgently, and maintained as a priority, with clear routes and responsibilities set out to ensure:
    - staff are tested in accordance with the guidance and regardless of impact on staff rotas.
    - patients and service users are also tested in accordance with the guidance in relation particularly to admissions to care homes.

44. The Executive Group for CCOCH was responsible for fulfilling the following:

- NHS Borders takes direct responsibility to ensure all care home staff are offered tests as per the national care home testing policy.
- NHS Borders ensure contact tracing is undertaken where required in line with national Test and Protect policy.
- NHS Borders ensure linked home testing is offered as per national care home testing policy.
- NHS Borders and Scottish Borders Council ensure clinical, and care resource is provided to care homes to ensure staff rotas are maintained to deliver safe and effective care.
- NHS Borders and Scottish Borders Council ensure care homes have access to expert advice on, and implementation of, infection prevention and control.
- Joint inspection visits are undertaken as required by the Care Inspectorate and Healthcare Improvement Scotland (HIS), working together, to respond to priorities and concerns. The Care Inspectorate contributed to intelligence sharing and what specific support Care Homes had required as part of their active registration as well as information

about homes out with NHS Borders locality owned by the same business group. The rationale was to ensure that the CCOH had a full view of all parties involved in Care Home work. The CCOH had little involvement other than being made aware of visits planned by the Care Inspectorate and or HIS. The difference was one of regulation and inspection purposes by the Care Inspectorate/HIS rather than one of support/education by the CHT and CICAS.

45. Underneath the Executive Group the Scottish Borders Health and Social Care Partnership established an Operational Group for Clinical and Care Oversight of Care Homes. The Operational Group for CCOCH was a multi-disciplinary team comprised of senior operational service managers, professional leads and health care infection control across Scottish Borders Council (SBC) and NHS Borders (NHSB) formed in response to the Coronavirus (Covid-19) pandemic. Their intent is to undertake assessment, analyse and identify risk, implement and escalate operational support mechanisms and provide overall assurance to the Executive Group for CCOCH regarding the quality of care and support requirements in all care homes. Membership includes the:

- Associate Director of Nursing/Chief Nurse (Chair)
- Operational Manager Scottish Borders Council (SBC) Social Care (Co-Chair)
- Associate Director of Human Resources
- Associate Medical Director Primary and Community Services
- Social Work Team Lead
- Infection Control Nurse
- Community Infection Control Advisory Service Lead
- NHS Testing Services Coordinator

46. The role of the Operational Group for CCOCH is to:-

- Be responsible for the analysis of issues and development of support solutions to sustain services.
- Ensure care homes have 24 hour access to expert advice infection prevention and control. Outline, develop and implement clear escalation routes for urgent operational clinical matters.

- Establish operational delivery models through support from General Practice, Primary and Community Services SBC and other services which will deliver responsive appropriate expert clinical support to care homes and their residents when needed.
- Communicate escalation routes for urgent clinical matters. Establish models through support from General Practice, Primary and Community Services SBC and other services which will deliver responsive appropriate expert clinical support to care homes and their residents when needed.

47. The responsibility of the Operational Group for CCOCH is to fulfil the following:
    - Operationally support and ensure the testing of all staff.
    - Ensure care homes have access to the Test and Protect service.
    - Implement models ensuring clinical and care resource is provided to care homes to ensure staff rotas are maintained to deliver safe and effective care.
    - Joint inspection visits are undertaken as required by Social Work and Health working together, to respond to priorities and concerns through implementation of a robust proforma and visit schedule for all care homes. Assess risk and provide assurance on all the above to the Executive Group.
48. Within NHS Borders the understanding of the purpose of the associated assurance visits carried out by our local teams was to:
    - Identify where specific nursing support may be required and to develop and implement solutions where required. This included clinical input to ensure that there are effective community nursing arrangements in place to support increasingly complex nursing care requirements.
    - Identify where specific infection prevention and control support may be required; this included recommendations and review regarding cleaning to prevent transmission and appropriate use of PPE.
    - Support the development and implementation of testing approaches for care home and care at home settings - Identify and support sourcing of staffing as required by the care home and care at home settings as

defined by the requirements set out in DL (2020) 10 and DL (2020) 13 from Scottish Government.

49. These associated assurance visits were carried out by the Care Home Support Team and CICAS First visits took place between May and July 2020 as detailed in 34 – 37 above with a second set of visits in February 2021.

50. In NHS Borders we benefitted from an existing team in the local authority, the Care Home Commissioning and Review Team (CCRT) who had established good working relationships with both local authority and privately owned, commissioned care homes. This enabled a cohesive way to introduce a health developed service for enhanced assurance. It would be fair to say that even with this introduction it took time for the care home team to establish a supportive way of working rather than the perception of inspection and scrutiny held by some providers. Also, for health who had limited experience of working with the Care Inspectorate especially from an acute perspective this took time to understand and deliver clear roles and responsibility. As the pandemic progressed the roles and responsibilities in the enhanced arrangements became clearer and were appreciated by the care providers.

51. The Care Home Operational Group (CHOG) developed a system of sharing best practice and learning across the region. All care home managers attended a weekly call which was chaired by the Chief Nurse for the Health and Social Care Partnership. This learning was fed up through the Executive Care Home Oversight Group into national discussion and learning was also cascaded down through this system to the Care Home Operational Group.

52. The Care Home Operational Group met weekly and provided a regular forum for key stakeholders with responsibility for services across the Scottish Borders. This forum enabled rapid sharing of issues and concerns as well as learning and successes. The Terms of Reference for CHOG include collating information for a weekly Public Health Director report for the Scottish Government. This report used a standard template and included a section to highlight examples of good practice. The weekly report dated 1 July 2020 which captures the following examples of good practice. A second example is attached from the 24 March 2021 (SH/41 INQ000618184 Weekly Return 24th March 2021_Final.docx):

- Many homes are now carrying out daily safety huddles/flash meetings. These daily meetings feed into a weekly report and then into the care home governance infrastructure. There are excellent examples of where bundles of care are being utilised. We are currently working with two homes to develop a safety huddle bundle and best practice guidance which can then be shared and implemented across all homes.
- Development of dashboard- we are currently finalising a dashboard proposal which will enable the homes to complete their safety huddle information but also pull this directly from their own electronic system and their weekly care inspectorate returns. The majority of care homes now have to complete various daily and weekly returns which is placing excessive demands on their time. We are working to streamline this.
- Development of the innovative CICAS (Community Infection Control Advisory Service), supporting and advising Care Homes/Residential Homes/Care at Home during the pandemic, establishing excellent relationships with Care Home Managers, external agencies and Health and Social Care Partnership colleagues, while contributing to the low incidence of outbreaks in the Borders region.
- Reassurance from onsite clinical support – for service users, staff and relatives.
- Nurses communicating with fellow health professional sped up decision making in relation to the language they speak. The nurses knew what questions would be asked and were able to give a much more detailed description of what was going on with individuals clinically.
- With the service users who were unwell and dying the nursing support provided more continuous care from a medical perspective in terms of reacting to changes and being able to monitor and interpret the situation and use the sliding scale for medication that the GP has written up.
- Much needed medication was given more swiftly whereas we would have had to wait on a visit from Borders Emergency Care Service.

53. A summary of the recommendations from associated assurance visits has been provided at para 39 above. This was also reported to the NHS Borders Clinical Governance Committee at their meeting on 29 July 2020 (SH/20

INQ000590608 attach CGC Appendix 2020 57 Care Home Clinical Governance.docx)

54. NHS Borders cannot comment on advice provided by the Care Inspectorate or other organisations. However, we note that the Care Inspectorate website references the same national IPC guidance used by NHS Borders.
55. NHS Borders Infection Prevention and Control (IPC) advice to care homes was consistent with national guidance published by Antimicrobial Resistance & Healthcare Associated Infection (ARHAI) Scotland and the Scottish Government and this was referenced during IPC visits and in written feedback. In May 2021, a national infection control manual was launched for older people and adult care homes which provided sector specific guidance. This was then regularly referenced in advice provided to care homes. (SH/31 INQ000510054 National-Infection-Prevention-and-Control-Manual-for-Older-People-and-Adult-Care-Homes)
56. Any NHS staff visiting care homes were expected to comply with the current standards at the time of the visit including use of PPE and testing. The same approach and advice was provided in relation to IPC standards regardless of whether the home was a residential care home or a home with nursing.

Key issues and use of emergency powers

57. There were no issues escalated by NHS Borders to the Scottish Government relating to emergency powers.
58. NHS Borders is not aware of any care homes where the emergency powers under sections 63A-63B of the Public Services Reform (Scotland) Act 2010 were exercised. Scottish Borders Council would be the appropriate organisation to provide comment around the use of emergency powers.
59. It is recorded that in August 2021 three care homes went into voluntary moratorium, one with Care Inspectorate involvement.
60. I have provided detail of the recommendations made following the initial assurance visits within NHS Borders in para 39 above.

Effectiveness and impact of the enhanced assurance arrangements

61. Once the ways of working for both the existing local authority CCRT and the NHS Care Home Support Team were established it provided the care home managers with clinical advice and infection prevention and control advice that

was timely and accessible. This improved communication and articulation of need and rapid response for Care Homes.

62. The negative impacts, of the enhanced assurance arrangements on care homes, in the early days were about the volume of information and the flow of this to relatively isolated care home managers. The initial feelings of some, but not all care homes were that this was an additional layer of scrutiny and was added due to Scottish Government and/or local concerns. Building effective relationships and communicating the roles and aims of the newer services was key in addressing these initial feelings. The Care Inspectorate remained the scrutiny and legislative power. In the Borders the existence of CCRT was pivotal in this.
63. Our Care Home Support Team and CICAS both provided additional professional support and advice to nursing teams once they were established.

Access to Medical/Health Care

64. The attached documents outline Locally Enhanced Service (LES) agreements with general practitioners in the Borders to support ongoing medical care for adults in social care settings from March 2020 (SH/21 INQ000590609 Care Homes LES 2020-21.docx). A range of guidance was issued to support GPs to carry out their role as attached (SH/22 INQ000590611 GP Practices and Care Homes.docx; SH/23 INQ000590624 Guidance for GP Practices and Care Homes Regarding the Supply and Administration Of Anticipatory Care Medicines during COVID-19 Pandemic). The Associate Medical Director for Primary and Community Services (a General Practitioner) was a member of the CHOG operational group where issues and concerns could be escalated for support beyond the usual locality based arrangements for medical support directly into care homes. The CICAS and HPT provided infection control and outbreak management advice and were supported with medical advice to each of these teams.
65. NHS Borders as a small organisation supported secondary and primary care clinicians at all times. There were various collaborations that took place in specific outbreaks; however, there was no specific time allocated in job plans for this.
66. GPs across the Scottish Borders moved to significant levels of telephone consultations but also provided a reduced level of service in their Practices

under enhanced infection prevention controls in line with national guidance from Public Health Scotland and the Scottish Government Primary Care Directorate. GPs continued to visit care homes to provide support where required in line with national guidance. A number of health services moved to a model of deploying virtual 'Near Me' consultations where relevant, in line with national guidance. In addition, where health needs were flagged by the health or social care teams to GPs they would respond as per normal clinical practice.

67. Regarding the provision of remote healthcare services to recipients of Adult Social Care (ASC) NHS Borders does not directly hold information on GP consultations and how these take place (in person, telephone or Near Me). This information is available on the Public Health Scotland website and a copy is attached. (SH/32 INQ000618164 24-12-03-general-practice-activity-statistical-summary_final)
68. NHS Borders is aware of anecdotal reports of challenges related to internet access and the availability of suitable computing devices, primarily due to the rural nature of the Borders region and the demographic composition of our population. However, we are not aware of any specific, documented challenges that have significantly impacted access to remote healthcare during the relevant period. Furthermore, we have no evidence to suggest that these issues were widespread or disproportionately affected particular geographical areas within our Health Board region.
69. There is no evidence to indicate that early guidance was being interpreted by Care Homes within NHS Borders area as imposing a blanket ban on residents who were Covid-19 positive from being transferred to hospital. Information from HP Zone (a digital data recording/resource) indicates that if a resident was clinically unwell and required hospital treatment they were being admitted to hospital. Within NHS Borders area we are not aware of any instances of ambulances refusing to take care home residents to hospital.
70. Within NHS Borders area the Hospital at Home service commenced in April 2023 and therefore was not available between 1 March 2020 and 28 June 2022. Hospital at Home provides urgent short-term hospital level care at home. This may range from 1 day to several weeks which would otherwise be spent in hospital.

End of Life Care/DNACPR Notices

71. As per attached letter dated 25 May 2020 (SH/24 INQ000590626 2020_05_25 Community resus letter (2).docx) from NHS Borders Medical Director and the Chief Officer Borders Integrated Joint Board Health and Social Care advice was given to health and social partnership staff regarding resuscitation in context of the infection risk. This advised that clinicians should not administer rescue breaths or chest compressions due to the Infection control to staff but should wait for the paramedics to arrive in level 3 PPE. In addition to this, all clinicians were advised that patient centred compassionate conversations took place in relation to anticipatory care planning.
72. In relation to secondary care, national guidance was followed regarding level of required PPE prior to resuscitation attempts. Please see attached Adult CPR Guidance for Acute Hospital if a patient has a confirmed or suspected Covid-19 (SH/25 INQ000590627 NHSB Covid arrest - Copy.pptx)
73. The assurance visits to care homes highlighted that there was no standard approach to Anticipatory Care Plans (ACPs) and that these varied in quality, length and in some instances had not been reviewed for some time. The statement in the Scottish Borders HSCP Care Home Assessment and Support Visit Summary Report dated July 2020 'some homes used a blanket approach with 3 short questions' refers to some homes using 3 key questions to guide their approach to ACPs for residents. These questions were 'If you had a sudden illness (such as a stroke or a heart condition), how do you think you would like to be cared for?'; 'If you had a serious infection that was not improving with treatments we can give like antibiotic tablets or syrup, how you think you would like to be cared for?' and 'If you were not eating or drinking because you were now very unwell, how do you think you would like to be cared for?'. As described at para 39 above recommendations were made to give a shared and consistent approach to ACPs. We did not record the numbers of ACPs or DNACPRs in place before or during the pandemic as these were paper based documents, so we are unable to advise on whether there was an increase in use.
74. NHS Borders advised all clinical teams providing care across the organisation to focus on patient centred conversations around declining health. No advice was issued imposing DNACPR discussions in a blanket manner.

75. We are unable to comment from an independent contractor perspective but from an NHS Borders value based healthcare perspective we are clear that we would not have supported DNACPR notices being imposed without proper consultation with individuals and/their family members.
76. NHS Borders is unaware of treatments being withheld at end-of-life care or of any futile attempts of CPR of individuals in adult social care.
77. NHS Borders was aware of the advice within the letter Cabinet Secretary for Health and Sport dated 13 March 2020 (attached see para 18) regarding the avoidance of admission of patients from care home settings. NHS Borders assessed each situation on an individual basis and did not follow this guidance. Palliative care was provided either at home, including a care home where that is the person's place of residence, or in a hospital setting depending on the individual situation.

IPC and PPE

78. In relation to the distribution of PPE to care homes/home care within the Scottish Borders, NHS Borders did not formally supply directly to care homes. This was done through National Services Scotland National Procurement and Logistics. NHS Borders is not able to comment on whether National Procurement prioritised the needs of hospitals over the adult social care sector. During the period 1 March 2020 and 28 June 2022 NHS Borders had to manage its stock of PPE across teams to ensure adequate availability. There was a need for health care staff to reuse and decontaminate single use items. Accessibility to PPE was managed by National Procurement and Logistics with an extremely robust process in place for ordering and distribution of all PPE.
79. PPE for care homes and adult social care was distributed through a hub led by the local Health and Social Care Partnership. There were 3 instances documented where the CICAS team provided PPE from the hospital stock to care homes who contacted the team where supplies were needed.
80. Early in the pandemic the changing guidance on when and where to wear PPE and visors led to some confusion, particularly around when staff were on breaks and issues were identified with social distancing and use of face masks. As clearer guidance emerged this was communicated to care homes.
81. The following concerns relating to PPE have been identified:

- PPE Committee minutes dated 21 May highlight confusion across health and social care on the "sessional use" of PPE which was introduced in the national guidance.
- Minutes of the CICAS Partners Weekly Huddle dated 27 May 2020 raise concerns about differing interpretation and execution of PPE guidance in care homes which highlighted the need to deliver training to care home staff.
- Escalations to the Executive Care Home Oversight Group dated 16 June 2020 and 05 February 2021 noting concerns around PPE practice in a care homes. There is also a Director of Public Health report dated 16 December 2020 which highlights poor PPE practice in a care home.
- CICAS activity logs dated 20 November 2020 and 06 January 2021 from care homes raising confusion about the correct PPE process and seeking advice.
- CICAS telephone call log dated 26 February 2021 from a home care manager raising poor PPE practice and seeking guidance.
- Spreadsheet of enquires received by CICAS covering the period 31 March 2020 to 03 November 2020. There are 89 entries where PPE was discussed. In a number of instances, the enquiry was specifically seeking advice about PPE. In other instances, the advice reassured that existing PPE practice should be continued.

82. A Covid-19 PPE briefing document prepared by Audit Scotland dated June 2021 states that on 19 March 2020, NHS National Services Scotland (NHS NSS) established a social care helpline to triage urgent requests for PPE. On 27 April 2020, local PPE hubs were established to supply social care providers with PPE where normal supply routes have failed. The hubs are run by local Health and Social Care Partnerships.
83. During the pandemic, the Scottish Government introduced the TURAS Safety Huddle Tool, requiring care homes to complete a daily status report which included access to PPE. NHS Borders Infection Prevention and Control Team has reviewed available saved documents from the Turas system and daily summary reports based on the Turas data. The documents related to the period April 2020 to October 2020. On 69 days, at least 1 care home declared that

they did not have adequate access to PPE. The majority of instances were in April 2020 and May 2020.

84. The following highlight concerns regarding the availability and access to PPE:

- One care home advised the Testing Team of having homemade masks which were to be washed, reused, and struggling to get supplies of PPE.
- Minutes dated 07 May 2020 of the 'CICAS Partners Weekly Huddle', the representative from SB Cares stated that the triage centre was not distributing the amount of stock of PPE to meet current government guidance. The minutes state that this was escalated to the Chief Officer Health and Social Care and Chief Executive of Scottish Borders Council.
- Minutes dated 18 May 2020 of NHS Borders PPE Committee. The representative for SB Cares stated that high quantities of PPE (particularly eyewear) are not given by supplies to social care. The minutes for the following meeting of NHS Borders PPE Committee dated 21 May 2020 record SB Cares being in a strong position in terms of PPE stock and supply.
- A daily report from the Care Home Operational Group (CHOG) to the Executive Group dated 04 June 2020. The report confirms that each of the care homes that had reported on Turas that day as not having adequate supply of PPE was contacted by CICAS. The care homes informed CICAS that they did have adequate PPE.
- Minutes dated 01 July 2020 and 15 July 2020 of the 'CICAS Partners Weekly Huddle'. The minutes reference a care home which repeatedly reports on Turas daily returns as not having adequate PPE but each time when contacted about this, the care home verbally confirms that they do have enough PPE. The reason provided by the care home for reporting on Turas as not having enough PPE is due to not holding a large stockpile within the home.
- A spreadsheet of enquires received by CICAS 31 March 2020 to 09 November 2020. The spreadsheet records 101 instances where PPE was discussed. On 33 occasions, it was recorded that advice was

provided on how to access PPE through either the local hub or national triage helpline.

- A spreadsheet listing activity initiated by CICAS 16 April 2020 to 23 October 2020. Of the 544 phone calls/emails logged on 399 occasions, the providers were specifically asked if they had sufficient PPE. On 368 of those occasions, providers confirmed that they had sufficient PPE. On 24 occasions they indicated that they did not have sufficient PPE but had plans to address this – generally by accessing from the local hub or national triage helpline. On 7 occasions, the provider indicated that they did not have sufficient PPE but no action to address this was recorded in the spreadsheet.
- A CICAS telephone log dated 06 June 2021 to a care home to provide advice on accessing PPE from a community hub.

85. Concerns highlighted within NHS Borders relating to the application of hospital-level IPC in residential settings were as follows:
    - Email from a District Nurse Team Lead escalating IPC concerns which prompted a care home visit. A care home visit and improvement support which was initiated by the Care Home Operational Group following an inspection by the Care Inspectorate.
    - Escalation from the Care Home Operational Group to the Executive Group dated 18 August 2021 highlighting infection control concerns identified by the Care Inspectorate.
    - Director of Public Health reports dated 13 January 2021, 19 October 2021 and 18 January 2022 which note concern about IPC measures.
    - Daily RAG (Red Amber Green Report) report dated 21 January 2022 produced for the Care Home Executive Group highlighting PPE and IPC issues in 2 care homes.
86. CICAS and the HPT provided support and training for care homes on the use of PPE and links for the care home PPE donning and doffing video was shared with care homes. In person training, which the Infection Control Manager has confirmed focussed on correct PPE use, was delivered by NHS Borders staff to care home staff during May and June 2020. This training was delivered to a total of 99 care home staff working across 21 care homes in the Scottish

Borders. In person training was undertaken in one care home on 29 and 30 March 2022 promoting the use of National Infection Prevention and Control Manal and covered the following topics.

- Resident Placement/Assessment for Infection Risk
- Hand Hygiene/Bare Below the Elbow
- Respiratory & Cough Hygiene
- PPE
- Safe maintenance of equipment
- Safe maintenance of environment
- Blood & Body fluids
- Safe disposal of waste
- Occupational safety: prevention and exposure management (including sharps)

87. A review of NHS Borders records includes details that indicate that on-line training (Infection Prevention and Control/Covid-19 Webinars) was sent to all care homes within NHS Borders Area. In August 2021 PPE guidance posts and information about the Infection Prevention and Control Manual for older adults and care homes was issued to care homes. CICAS and infection control provided support visits to care homes around the use of PPE and infection control. In addition, the HPT provided advise when supporting outbreak management.
88. In relation to the application of hospital level IPC in residential settings, in care home organisations, where they have more than one care home, there were concerns about the movement of staff between care homes. This was raised with the care home managers and assurance was given that staff remained consistently in only one care home.
89. The CHST came into place in October 2021. Clinical Educators supported the care homes within the Scottish Borders with IPC training supported by the Infection Prevention Control team. Training was carried out across the all the care homes and was checked during outbreaks within the home by both the CHST and the team who carried out all the PCRs on care home residents. During the Problem Assessment Group (PAG) meetings IPC and Donning/Doffing was included. Simulations were run by the Clinical and

Professional Development team for NHS Borders staff around correct PPE positioning and timing to ensure a slick process into preventing further delay in commencing CPR.

90. Below are examples of good/best IPC/PPE practice that was adopted within NHS Borders:

- A distribution process was set up internally whereby NHS Borders staff managed all issues of PPE (in particular gowns and FFP3 masks). Stock was held centrally and distribution managed from one location. Stock counts were undertaken regularly. A specific temporary role was created to provide a PPE top up and distribution services across NHS Borders main areas. This approach worked well for health facilities and could have supported adult social care as a model in future.
- Dedicated CICAS to support and advise care homes. During any outbreak the HPT also provide IPC advice using the ARHAI Care Home guidance and the testing team were also given IPC advice so they could provide additional support to care homes when they visited for testing purposes.
- Coordinated support provided to care homes to improve staff practice and confidence to the benefit of residents.
- PPE training delivered in care homes by NHS Borders staff as well as training on Covid-19 testing.
- NHS Borders PPE Committee (05 May 2021, 20 April 2022) which were attended by representatives for SB Cares. There was coordinated planning to implement changes in staff PPE guidance at the same time across health and social care. This was to avoid confusion between different staff groups across health and social care who work together.
- The Directors of Public Health weekly questionnaire on Care Homes dated 01 July 2020 (SH/26 INQ000590630 attached Dir of Pub Health_SG Weekly Return 1st July 2020.docx) describes the positive development of the innovative CICAS (Community Infection Control Advisory Service). This service supported and advised Care Homes/Residential Homes/ Care at Home during the pandemic,

establishing excellent relationships with Care Home Managers, external agencies and Health and Social Care Partnership colleagues.

Care Home Staff and Residents

Staffing Levels

91. Concerns around care home staffing were noted when a care home was experiencing an outbreak as staff affected were required to isolate.

92. NHS Borders deployed staff to support care homes as follows:

- Both substantive and bank staff supported one care home for a period of 4 weeks maximum.
- NHS staff were redeployed under secondment agreement under a Memo of Understanding to reopen a decommissioned care home facility. This included providing Registered Nurses and Health Care Support Workers (total of 15.2 WTE).

93. The care home rapid response bank became operational in Autumn 2020. Staff were employed on 4-hour contracts to undertake basic orientation and training with Scottish Borders Council to enable them to be job ready. Participants were offered appointments from 1 October 2020, with 2 bank workers being deployed during the relevant period. A medical student bank was operational in Summer/Autumn 2020. 6 bank workers being deployed during the relevant period, one of whom was deployed temporarily to a care home before being recalled to full time education.

Wellbeing of staff and residents

94. NHS Borders provided wraparound care in terms of the CICAS team and the CHST who offered support and advice, otherwise the wider support for staff and residents came from the care home owners which includes Scottish Borders Council and social care providers.

Testing

95. NHS Borders is not aware of any healthcare professionals refusing to carry out testing during the pandemic. Refusals were made by resident's/family's and as staff required consent to carry out testing the resident's/family's wishes were respected. Where it was not possible to carry out testing this was documented and if the resident was symptomatic the resident was assumed to be positive.

96. All adult social care staff in Borders were able to refer into NHS Borders testing services, this included household members. In addition, these staff where able to attend any Mobile Testing Unit (MTU) or community testing sights. NHS Borders encouraged staff who work in adult social care or members of their household to be referred to NHS Borders drive through site for PCR testing during the period.
97. Examples of good/best testing practice that were adopted within NHS Borders:
    - Training was delivered to care home staff onsite in care homes and competency checked and signed off by the trainers in the testing team. A register was available to all care home staff trained on an on-going basis. Support was offered to those staff who needed to increase competency.
    - Reference guides relating to testing process and PPE best practice was provided to care home staff.
    - When regular staff testing with LFT was introduced NHS Borders testing team provided support for implementing testing across care home staff and ensuring suitable onsite location was established. Testing Team provided support to care homes to set up appropriate staff testing areas for self-testing or to have tests carried out by a colleague.
    - PPE training provided to every care home in the Scottish Borders from 17 May 2020 by two members of the Covid Testing Team. The training initially covered the correct use of PPE as well as safe disposal but was further developed to include how to carry out effective Covid-19 oral and nasal swabbing for care home residents, labelling swabs and returning these to the Labs for analysis.

Funding

98. Additional Covid-19 funding was made available by the Scottish Government and deployed to relevant areas. With regard to the Adult Social Care sector, there is no indication that limited funding/resources affected NHS Borders in carrying out its functions.

Lessons Learned and Recommendations

99. NHS Borders undertook an overall lessons learned project called Collecting Your Voices Programme which included some staff who had been seconded to care homes (SH/27 INQ000590631 attach Collecting Your Voices Summary Aug 2020.pdf).

100. From November 2021 new member of staff within Health Protection took more ownership of outbreaks as by this time CICAS had disbanded. This included initial outbreak forms, outbreak management and checklist and continuing with the final outbreak forms introduced by CICAS. The HPT would have regular contact, usually daily with care homes and reinforce PPE/IPC information. When any concerns were identified the HPT would seek support from the IPCT to carry out a supportive visit to the home. There was a good relationship between Health & Social Care Partnership/HPT and Care Homes. This enabled care homes to feel listened to, supported and not afraid to contact HPT for advice and support. Co-ordinating implementation of key changes such as PPE guidance across health and social care avoided mixed messages to staff from different agencies who work closely together. Regular attendance of a Scottish Borders Council PPE lead at NHS Borders PPE Committee was particularly helpful in strengthening relationships and improving co-ordination and response across health and social care.

101. There was an existing Care Home Review Team (CCRT) in place in adult social care prior to the pandemic which provided a head start on linking into well established relationships with both the Scottish Borders Council and independent care providers. This supported early conversations and access to care homes which was and is led by a registered nurse. The rapid set up and deployment of CICAS supported the increased ask of the IPCT and secured good working relationships and understanding.

102. Initially the contract tracing team were carrying out contact tracing on individual positive residents and staff. This was onerous for care home staff and therefore this was adapted so that all positive residents were reported to the HPT and instead of individual contact tracing the Care Home Manager completed a daily outbreak record.

103. In the event of a future pandemic NHS Borders would like the following recommendations to be considered as it feels they would help improve the response of both the health and adult social care sector:

- Support both financial and in legislation for enhanced professional oversight and support to care homes regardless of funding source.

- In addition to frequently changing national guidance, at various times through the pandemic, there were key differences between national guidance for hospitals and national guidance for care homes. This increased complexity for staff responsible for providing advice on local implementation as well as being confusing for staff across health and social care. These factors also undermined staff confidence in both the national guidance and local advice. Given the close working relationships of staff across health and social care, in future harmonisation of national guidance across health and social care is critical.

Statement of Truth

104. 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: 10.06.2025