Witness Name: David Park

Statement No. 1 - Module 6

Exhibits: 34

Dated: 09 June 2025

UK COVID-19 INQUIRY (MODULE 6)

WITNESS STATEMENT OF DAVID PARK
DEPUTY CHIEF EXECUTIVE
NHS HIGHLAND

I, David Park, will say as follows: -

PROFILE AND PERSONAL INFORMATION

1. As part of the UK Public Inquiry investigation (Module 6), which is to examine the impact of the COVID-19 pandemic on the publicly and privately funded adult social care sector in England, Scotland, Wales and Northern Ireland, I have been asked to provide a statement specifically in relation to Scotland during the specified and relevant period of 01 March 2020 to 28 June 2022.

2. I make this statement on behalf of NHS Highland based on my own knowledge and recollection as well of that of relevant colleagues who held key roles at NHS Highland during the relevant period and who are still actively employed by NHS Highland. My statement should therefore be read as representing the collective understanding.

3. I joined NHS Highland in 2017 as Director of Operations for Acute, Mental Health and Integrated Health and Social Care Sector for the south and mid areas of Highland. In 2018 I was appointed Chief Officer of Integrated Health and Social Care. I am currently the Deputy Chief Executive at NHS Highland. I took up this position on 28 March 2023 during the COVID-19 pandemic.

4. I, along with other senior leaders, led the strategic and organisational response in ensuring there was a whole system approach in managing the impact of the virus in NHS Highland.

OVERVIEW AND BACKGROUND TO NHS HIGHLAND

5. Highland Health Board is more commonly called NHS Highland and covers 41% of Scotland's landmass, making it the largest and most sparsely populated Health Board in the United Kingdom. Our diverse area includes Inverness, one of the fastest growing cities in Western Europe, as well as remote, rural and island communities.. The Scottish Government Urban Rural Classification provides a consistent way of defining urban and rural areas across Scotland. The classification is based upon two main criteria: population and accessibility. The Scottish Government Urban Rural Classification (version 2020, which updates the 2016 version) was first released in 2000 and is consistent with the Scottish Government's core definition of rurality which defines settlements of less than 3,000 people to be rural. It also classifies areas as remote based on drive times from settlements of 10,000 or more people. NHS Highland's landmass is coterminous with 2 Local Authority areas: The Highland Council and Argyll & Bute Council. Both Local Authority areas are classed as other urban; accessible small towns; remote small towns; accessible rural and remote rural [please see **DP/01 - INQ000589705** – Scottish Government's 2020 Urban Classification document]. The whole area extends to 12,500 square miles (32,500 km2) which includes 36 populated islands (23 in the Highland area and 13 in Argyll & Bute area) and a population of over 330,000 (circa 90,000 in Argyll & Bute). Gaelic is spoken in some areas. It spans a vast area, from Kintyre in the southwest to Caithness in the northeast.

6. Our population lives with some challenges; areas of deprivation and inequality. There is fuel poverty and a complex and unreliable transportation network with mobile reception and Wi-Fi infrastructure coverage issues adding further complications. Just like throughout the UK, the cost-of-living crises is affecting the general population. People living in the NHS Highland area are also, on average, older than the Scottish mean and they can have increasingly complex health, social, economic, educational, cultural, housing, food insecurity and other needs.

7. Our economy is heavily reliant on tourism, with seasonal work being commonplace. An impact of the COVID-19 pandemic has been that the levels of tourism to our area have moved from seasonal, traditionally March to October, to an all-the-year-round business. The Highlands have often been cited as having one of the best standards of living in the United Kingdom, with clean air; access to the wilderness; and vibrant and engaged communities. Our communities are proud of their areas, and we work

with them to find new and innovative ways to support delivering health and social care as close to peoples' homes as possible to provide person centred and focused care to the whole of our population. One example is the Highland and Islands Patient Travel Service. This scheme recognises that patients who are resident in the Highland and Islands may be required to travel significant distances to attend hospital appointments given the geography of the area. Under this scheme, all patients from the former Highlands and Islands Development Board areas are entitled to financial assistance with their travel costs if they live more than 30 miles from the hospital they are attending.

8. During the pandemic response, there was a significant increase in the use of digital and remote solutions including remote consultations; and a push towards digital home care and remote monitoring technologies. Whilst the COVID-19 pandemic led to an increase in the use of digital and remote technologies to help people access the "front door" of the NHS with online booking and remote consultations, NHS Highland and other public bodies recognise that digital solutions will not be the sole option moving forward.

9. Primary Care is often the first point of contact in healthcare, usually involving General Practitioners (GPs), whilst Secondary Care involves specialists and is typically hospital-based: i.e. for specialised investigations procedures or treatments. There are a number of challenges in the delivery of services: these include recruitment of Medical Consultants as well as the need to rebalance both our Primary and Secondary Care Services to meet the needs of the expanding and ageing population, as close to home as possible.

10. There is increasing health and social care complexity and need due to our ageing population; complex comorbidities; widening health inequalities; the cost-of-living crises and growing international food/fuel instability. In NHS Highland there are rural and island challenges in service delivery; lower population density but higher geographical coverage and increased distances.

11. NHS Highland directly employs circa 10,500 staff and we have 25 hospitals. Our services are delivered across 4 acute sites; 17 community hospitals; and 2 adult mental health inpatient facilities. We have Accident & Emergency (A&E) and Minor Injuries Units (MIUs). We have Care Homes and day care services managed by NHS

Highland. We have Dentists and Dental Practitioners along with General Medical Practitioners, Optometrist, Community Optometry Practices and Pharmacists.

12. Argyll & Bute Council provide a range of Care Homes and day services.

13. North Highland has 47 GMS and 15 2C or Board managed Practices; Argyll & Bute has 29 GP Practices in total with 23 being GMS and 6 being 2C. GMS refers to the General Medical Services contracts (often referred to as Independent Practices) while 2C indicates those directly managed by NHS Highland.

14. We have a number of Care Homes for adults in our jurisdiction. In March 2020 there were 68 Care Homes in North Highland; 15 of which were operated by NHS Highland and 53 operated by independent Care Home providers. This amounted to 215 registered NHS beds and 1,830 independent registered beds. During the specified period, the independent Care Home sector represented 89% of registered beds, with 11% delivered by NHS Highland on behalf of The Highland Council (THC). The average size of an independent sector Care Home in Highland is 35 beds; and in-house is 14, the latter representing delivery predominantly in smaller communities where there is no independent sector presence. In Argyll & Bute there were 17 Care Homes: - 6 were managed by Argyll & Bute Council (ABC) and 11 by the independent sector.

15. In Scotland, Public Health Scotland (PHS) is designated as a Special Health Board. NHS Highland is designated as a Territorial Health Board. One of PHS's roles is to monitor delayed discharges in NHS Scotland, reporting on the number of people delayed in hospital; the length of their delays; and the number of occupied beds due to the delays.

16. A delayed discharge occurs when a patient, aged 18 or over, who is clinically ready for discharge, cannot leave the hospital due to lack of necessary care, support or accommodation, or because funding for/availability of a Care Home is not in place.

17. NHS Highland has been submitting returns to PHS on delayed discharges since 2016 when monitoring was introduced. This focus on delayed discharges reflects broader pressures in the health and social care system including increased hospital bed occupancy, lower hospital flow which can lead to higher infection risk and strain on staff and impact on planned hospital procedures. [Please refer to **DP/02**

INQ000641735 - graphs]. This data is representative of the data lodged with PHS and covers the period from June 2016 to February 2025.

18. Ultimately, the NHS Highland Board is primarily responsible and accountable for the setting of strategic direction, holding Executives to account for delivery, managing risk, engaging with stakeholders and influencing organisational culture. To implement that obligation, we have the Core Governance Committees that consist of:-

- Clinical Governance;
- Staff Governance;
- Finance, Resources and Performance;
- Highland Health and Social Care; and
- Audit Committees.

19. The Board discharges some of its duties to these Governance Committees in line with the Board's Standing Orders. These Standing Orders, along with other documents like Standing Financial Instructions, outline procedures for meetings, decision-making, and other key aspects of the Board's business. The Governance Committees are responsible for regularly reviewing and updating relevant policies in each of their respective areas. Responsibilities for Health & Safety are reported directly to our Staff Governance Committee. The Remuneration Committee and Pharmacy Practices Committee also have direct reporting links to the NHS Highland Board and perform a more focussed assurance role. The NHS Highland Board membership includes representation from the Area Clinical Forum and Area Partnership Forum. The Board also has stakeholder representation from The Highland Council and Argyll & Bute Council. Board meetings are held every 2 months and continue to be held virtually since the instigation during the pandemic. Members of the public can attend online and subsequently the meeting papers are available on the public facing NHS Highland internet pages.

20. [Please refer to **DP/03 INQ000590702** – organisational diagram]. This structure promotes cross-service working and allows for an overview of services across the NHS Highland area, with the aim to better manage the impacts of changes across the system.

21. NHS Highland is managed by a Board of 23 Members, made up of 18 Non-Executive and 5 Executive Directors who are accountable to the Scottish Government through the Cabinet Secretary for Health and Social Care.

22. Our Executive Directors who are also Board Members are Chief Executive, Board Medical Director, Director of Finance, Board Nurse Director, and Director of Public Health. Since the beginning of the UK Inquiry's relevant and specified period, there have been changes to the Board Members as well as other key staff. During the pandemic and subsequently in preparations for this Inquiry, NHS Highland staff members have collaborated to furnish the UK Inquiry with information in relation to Module 6 – the impact of the COVID-19 pandemic on the health and social care system. This is in part because of the progression of staff either to other roles within the health and social care sector or other endeavours, such as retirement.

HEALTH AND SOCIAL CARE PARTNERSHIPS

23. NHS Highland is unique amongst Territorial Health Boards in Scotland in having a Lead Agency Model for health and social care in The Highland Council area; with NHS Highland having responsibility for delivering Adult Social Care and The Highland Council being the Lead Agency for the Integrated Health and Social Care for Children. This model of integration is overseen and governed by the Joint Monitoring Committee. The Lead Agency model does not change the statutory responsibilities of either organisation. The Highland Council retains the statutory responsibility for delivering Social Care, with professional leadership from the Chief Social Work Officer and NHS Highland retaining responsibilities for Children's Health through the Nurse Director.

24. As NHS Highland's geography covers 2 Council areas, The Highland Council and Argyll & Bute Council, each area has its own Health and Social Care Partnership (HSCP). In Scotland there are 31 HSCPs with each working towards a set of national health and wellbeing outcomes. All HSCPs are responsible for Adult Social Care (ASC), adult primary health care and unscheduled adult hospital care. Some are also responsible for Children's Services, Homelessness and Criminal Justice Social Work.

25. Highland Health and Social Care Partnership's (also known as Highland HSCP or HHSCP) unique arrangement brings together Acute, Primary Care, Community and Social Care Services. In 2012, 2 models were trialled namely; Lead Agency and Integration Joint Board models. Highland HSCP operates on a different model because North Highland were one of the pilot HSCPs for the Lead Agency model. This

model was adopted by NHS Highland and has continued to date. This means that budgets, management and clinical leadership across the whole patient pathway falls within the one HSCP, serving around 235,000 people. This arrangement in Highland HSCP went live in April 2012 in advance of the legislative changes to the Scottish wide IBJ model that was adopted in all other areas.

26. The aim of the change was to improve the way people in Highland have their health and social care needs supported by bringing Social Workers, Nurses, Allied Health Professionals and others into local teams to provide integrated care services for our communities. These teams are now predominantly co-located with single managers and single points of access to the service which benefits users of services whilst delivering improved working relationships between professionals. Highland HSCP covers the local government area of The Highland Council. In 2014 the Public Bodies (Joint Working) (Scotland) Act 2014 resulted in the development of the Integration Scheme which carried forward the arrangements in this HHSCP. The Scheme was first approved by Scottish Government on 25 June 2015 and a revised Scheme was submitted in June 2020.

27. The Argyll & Bute Health and Social Care Partnership (A&B HSCP) operates under a Corporate Body model (commonly called Integration Joint Board model or IJB model). A&B HSCP is a distinct HSCP and covers the Argyll & Bute Council area.

28. The Integrated Joint Board (IJB) is the governance board of the A&B HSCP which serves around 90,000 people across 2,600 square miles (6,700 km2). This includes contracted services from NHS Greater Glasgow and Clyde which is the next neighbouring Territorial Health Board and all Adult and Children and Families Social Work. Locally, it is served by a Rural General Hospital in Oban. This arrangement went live in April 2016. It has responsibility for planning, resourcing and overseeing the operational delivery of integrated services. The IJB membership comprises of Chair and Vice Chair; Elected Councillors and Health and Social Care Partnership Officers.

29. Key Health Board members including the Chief Officers, Senior Social Care staff, Director of Nursing, Infection Control Leads, Director of Public Health, Health Protection teams and the Medical Director all had a key role in decision making in both the HSCPs' during the pandemic.

ROLE OF HEALTH PROTECTION TEAM AND DIRECTOR OF PUBLIC HEALTH

30. NHS Highland has a local Board Health Protection Team that serves as a specialist function within Public Health responsible for the surveillance, investigation and management of communicable diseases and environmental hazards in addition to incident and outbreak management ensuring that the population's health is protected from infectious and environmental threats and major incidents. This health protection function is a key statutory responsibility of NHS Highland. The Health Protection Team at NHS Highland covers both Council areas and consequently both HSCPs.

31. NHS Highland (like all other Territorial Health Boards in Scotland) are accountable to the Scottish Government for protection and improving the health of people living within our geographic area. The Public Health (Scotland) Act 2008 provides clarity over the roles and responsibilities for NHS Health Boards and Local Authorities and provides extensive powers to protect the public's health. NHS Health Boards and Local Authorities have a duty to cooperate in exercising their functions under this Act, and to plan together to protect public health in their area(s).

32. During the pandemic, the NHS Highland Health Protection Team were responsible for infection prevention and control support and outbreak management for all Care Homes in the Argyll & Bute HSCP as well as all independent Care Homes in the Highland HSCP. The NHS Highland Infection Prevention and Control Team were responsible for the 15 NHS Highland operated Care Homes during regular/core standard business office hours - Monday to Friday 9am to 5pm - and the Health Protection Team provided 24hrs support for these Care Homes out of the usual core hours from March 2020 onwards. The Health Protection Team, along with the whole Public Health Directorate, contributed hugely to both Highland and Argyll & Bute HSCPs by providing expert advice on all aspects of outbreak management.

33. The Health Protection Team consists of Consultant(s) in Public Health Medicine; Senior Health Protection Nurse; Tuberculosis (TB) Nurse; Health Protection Nurse(s); Health Protection Secretary; and additional support was provided during the course of the pandemic from the wider Public Health Directorate and wider departments across NHS Highland.

34. The Director of Public Health (DPH) is the executive lead for public health and population health and is appointed as a full member of NHS Highland Board. The role of the DPH includes the executive lead for health protection, while the Nurse Director

is the executive lead for infection control. The DPH has line management responsibility for the Health Protection Team, and this covers both Highland and Argyll & Bute HSCPs. The DPH reports to the Board and to its sub-committees on health protection issues and in NHS Highland the DPH also takes an active role in health protection issues, where needed, including taking part in the on-call rota for public health. During the COVID-19 pandemic, the DPH was responsible for the oversight of the health protection staff and worked with colleagues such as the Nurse Director to oversee Board activity on Care Homes and made the return on Care Home status to Scottish Government.

35. Oversight and support for Care Homes was provided by the DPH, supported by the Public Protection, Infection Prevention and Control, and the Integrated Health and Social Care Teams within each of the HSCPs.

HOSPITAL DISCHARGES

36. Early in the pandemic, NHS Highland established a COVID-19 Gold, Silver and Bronze Command Governance Structure, enabling strategic, tactical and operational oversight and management. The Clinical Expert Group (also referred to as the Clinical Reference Group) was also established initially to review and translate national policy into local guidance.

37. The National Infection Prevention and Control Manual (NIPCM) was first published in January 2012, by the Chief Nursing Officer. It is evidence-based and is intended to be used by all those involved in care provision. The manual has chapters on Standard Infection Control Precautions (SICPs); Transmission Based Precautions (TBPs); Healthcare Infection incidents, outbreaks and data exceedance and infection control in the built environment and decontamination which gives guidance on how to reduce the risk of Healthcare Associated Infection (HAI) and ensure the safety of those in the care environment – those being cared for, as well as staff and visitors. The NIPCM and Care Home Infection Prevention and Control Manual (CH IPCM) are considered best practice in all health and care settings.

38. In the early stages of the pandemic, hospital discharges to Care Homes, including nursing and residential homes, without COVID-19 testing did take place across Scotland, in very limited numbers, and it has since been acknowledged that this

practice *may* have contributed to some outbreaks, the general consensus is that this is unlikely to be the dominant driver of all outbreaks. [Please see **DP/04 INQ000280639** - Scottish Government Coronavirus (COVID-19): Care Home Outbreaks - Root Cause Analysis Progress Report November 2020 to September 2022].

39. In March 2020, the Scottish Government issued guidance which stated that prior to people being admitted to a Care Home, whether from hospital or the community, clinical screening should be undertaken of patients alongside a risk assessment to ensure sufficient resources including appropriate isolation facilities were available within the Care Home to support social distancing and isolation. This guidance recommended all admissions to be isolated for 7 days and if known to have contact with COVID-19 patient for 14 days.

40. There is potentially a common misconception that there was "authorising" or "mandating" of the discharge of people from hospital. Both clinical decisions around discharge and risk assessments were undertaken locally. Clinical decisions around hospital discharge to Care Homes, both nursing and residential, were made on an individual case by case basis in accordance with local NHS Highland Policy for Discharge and Transfer and the NIPCM. Those decisions were made by the Lead Clinician responsible for the individual's care in hospital, the multidisciplinary team (both in hospital and the community) and the individuals and their family with guidance from the NHS Highland Infection Prevention and Control Team. [Please see **DP/05 INQ000641738** - NHS Highland Revised Guidance – Hospital Admission Transfer & Discharge for Adults].

41. Testing was more limited, initially, and was principally limited to symptomatic individuals and not to asymptomatic individuals, prior to discharge. On 21 April 2020 the Scottish Government Cabinet Secretary for Health and Social Care announced that all admissions to Care Homes from hospital should have a negative test for COVID-19 prior to admission to the home, regardless of symptoms unless it is in the clinical interests of the patient to be moved, and then only after a full risk assessment. Where a patient had tested positive for COVID-19; 2 negative tests were required. This policy was reflected in both Scottish Government and Health Protection Scotland guidance for Care Homes.

42. With respect to any risk assessments in relation to the discharge of patients to Care Homes, NHS Highland followed the relevant guidance for that particular time including

the "Guidance for stepdown of infection control precautions and discharging COVID-19 patients from hospital to residential settings". [Please see **DP/06 INQ000641739**]. This would involve an individual discussion and risk assessment with the Care Home. The initial discussion would involve the hospital staff and the Care Home with subsequent input to the risk assessment from a health protection perspective. If strict isolation was expected to be challenging then confirmation of viral clearance may have been sought in line with the stepdown guidance mentioned above. Our approach to mitigation measures would have been in line with the relevant PHS guidance.

43. Further to the COVID-19: Information and Guidance for Care Home Settings version 1 [please see **DP/07 INQ000347535**] states in relation to admission of COVID-19 patients from hospital that: - COVID-19 patients discharged from hospital to a Care Home should have completed the required isolation period and have given 2 negative tests at least 24hours apart before discharge. The isolation period for COVID-19 patients is 14 days. As such, the relevant guidance for the particular point in time would have been referenced as the guidance changed frequently over the specified period.

44. When testing was not possible, discharge to a Care Home could occur within the isolation period within an agreed care plan.

45. With regard to any individual care plans these would not have been held by NHS Highland but rather within the individual patient's record in the Care Home and therefore we are unable to comment on the specifics or detail of these.

46. With regard to concerns expressed regarding nosocomial transmission and challenges with isolation and PPE members of the Infection Protection and Control Team have not highlighted any specific concerns being raised at the time. National COVID guidance was being followed regarding isolation and testing prior to hospital discharge. It was recognised, due to some residents' cognitive function that isolation could be challenging. Additional plans were put in place to support residents.

47. Initially, there were concerns regarding PPE supply to some Care Homes due to the national supply chain and establishment of the hub distribution model. Assessment of available PPE formed part of the daily huddles and dealt with at operational level with stock monitoring and control. In NHS Scotland, daily huddles (also known as safety huddles or hospital huddles) are focused meetings designed to improve patient safety, communication and workflow. These huddles allow teams to discuss potential safety concerns, review relevant data and share successes in reducing harm. One of the

benefits of the lead Agency model is Highland HSCP was that they were able to redirect PPE supplies as required. This was not an option available to A&B HSCP because of their differing structure.

48. NHS Highland is not aware of concerns raised regarding the provision of clinical care following discharge from hospital or any refusals by nursing or residential homes to accommodate patients.

49. NHS Highland did not record centrally the number of patients who were discharged from hospitals who were symptomatic or asymptomatic. This data is not readily accessible and would require a systematic review of all cases/records of patients discharged from hospital to Care Homes during the relevant period.

50. Between 01 March 2020 and 21 April 2020 90 patients were discharged in North Highland and 30 patients in Argyll & Bute from hospitals to Care Homes. Of these in North Highland 11 patients were tested. In Argyll & Bute 2 patients were tested. All those that were tested were negative. Not all of these discharges were new placements as some residents were returning back home following a period in hospital.

51. Testing protocols evolved throughout the COVID-19 pandemic regarding the admission of patients from hospitals to Care Homes. A two-test rule oversimplifies admission to Care Home testing advice for recovered COVID-19 patients. The isolation period following symptom onset, the number of tests and the timing of any necessary testing before discharge all changed over the time period. It is not possible to provide accurate data about adherence to testing protocols without reviewing individual case records.

ENHANCED OVERSIGHT/ASSURANCE OF CARE HOMES

Initial Arrangements and Assessments

52. Along with our local partners, NHS Highland carried out a large amount of work to support Care Homes and much of this collaborative work stemmed from work and networking that was undertaken and in place prior to the pandemic. [Please see **DP/08 INQ000641741]** – Letter to John Connaghan at Scottish Government dated 21 April 2020].

53. In North Highland prior to COVID-19 there was:-

- Ongoing contact via contract monitoring visits by nominated Designated Managers and Area Contracts Officers, with quarterly assurance reporting to the Health and Social Care Committee;
- Improvement Lead follow up and support to Care Homes (where required) and provision of other supports as identified including nutrition and tissue viability advice;
- NHS Highland representation at Care Inspectorate feedback meetings with Care Home services;
- NHS Highland, Care Inspectorate, Police Scotland, Scottish Fire and Rescue Service multi-agency assurance arrangements to review early risk indicators, which was established following learning from a Care Home registration cancellation in October 2019;
- Link worker/professional alignment system was in place which included Social Work, District Nurse(s), Pharmacy and GPs to ensure consistency of support, advice and guidance;
- The Public Health Protection Team had an established long-term relationship with Care Homes and their Managers and staff. Regular training in Infection Prevention and Control were provided. In addition, when outbreaks of infection occurred (for example norovirus or flu) then the team are in daily contact with the Care Home to provide advice on isolation, use of PPE, visiting, transfer and admissions.

54. In the UK, March 2020 marked the beginning of the "first wave" of the COVID-19 pandemic, characterised by a rapid increase in cases. The initial spike occurred in March, leading to a national lockdown on 23 March 2020. While COVID-19 was first detected in the UK in January 2020, the surge in cases in March is what is often consisted to be the start of the "first wave". In March 2020, there were 17 Care Homes in Argyll & Bute. The A&B HSCP had identified the need for greater assurance around Care Homes and the following measures were put in place at the beginning of the pandemic:-

- A Care Home Task Force was established on 21 April 2020 with the support of the Care Home owner as Joint Lead. The Care Inspectorate has subsequently commented positively on this approach as did care providers;
- A Care Home Clinical Pathway was developed and adopted throughout Highland. The Pathway is a flowchart of clinical intervention which demonstrates person centred care

and was finalised at the Chief Executive Group (CEG) on 29 April 2020. [Please see **DP/09 INQ000590703** - Clinical Pathway].

- Support was provided from Scottish Care who called Care Homes daily and acted as the conduit for the cascade of information. Scottish Care is a charity (charity number SCO513350) and is a membership organisation representing the independent social care sector in Scotland;
- Additional assurance after the start of the pandemic was introduced in the form of the Care Home telephone round which included all Care Homes including those run privately by independent providers. From 16 March 2020, this telephone round was daily, operating 7 days a week. Weekly rounds were established from 2016 and these moved to daily rounds the purpose of which was to "check in" daily with Care Homes and establish vacancy levels, staffing levels/issues, PPE issues/status and any critical issues;
- Flagged issues were triaged daily before midday and required actions taken. Output fed into an Adult Social Care dashboard [Please see **DP/10 INQ000641743** – Example of ASC dashboard] along with other consolidated intelligence (such as closures) and reported daily to the Bronze Command and shared with wider stakeholders including Care Inspectorate;
- A comprehensive four stage Care Home Support Plan , covering both HSCP areas, was provided to Scottish Government in April 2020. This plan incorporated input from sector representatives. [Please see **DP/11 INQ000590704** - Care Home Support Plan].
- Stage 1 of this Support Plan included a number of detailed mitigating and supportive measures, of which was a 7 day per week Care Home Manager "hotline" which began operating on 3 April 2020;
- There were weekly Care Inspectorate liaison meetings on Care Home issues;
- There was sector input to draft communications to ensure clear messaging; and
- The Health Protection Team continued to provide specialist advice and support to Care Homes specifically on COVID-19 and were in daily contact with any Care Home reporting symptomatic residents or staff to provide advice, arrange testing, and implement control measures such as isolation or cohorting of residents or staff.

55. Following the directive from the Scottish Government on the 20 April 2020, that all Health Boards were tasked with completing an initial assessment of every Care Home

in their area, either by telephone or direct visit, by 24 April 2020 with weekly reporting thereafter the following was undertaken in HHSCP area: -

56. A joint NHS Highland (Public Health and Adult Social Care representatives present) and Care Inspectorate meeting took place to discuss the approach to the Care Home assurance initial assessment. The 68 North Highland Care Homes were allocated amongst Public Health, the Adult Social Care Commissioning, Contracts & Compliance Team and the Care Inspectorate, to conduct an audit. An assessment template was issued in advance to all Care Home providers, with explanatory context confirming there would be follow up to arrange telephone conversations to discuss and record responses. Those responses were collated by Public Health.

57. Subsequently notification was received on the morning of 24 April 2020 that the Care Inspectorate's Director of Scrutiny and Assurance had withdrawn from the locally agreed Care Inspectorate support for this audit after discussion between Care Inspectorate and Public Health at a national level; resulting in a short delay in completion of this audit.

58. Those providers originally allocated to the Care Inspectorate or otherwise not able to be scheduled for 24 April 2020, were followed up on 27 April 2020. As of the 24 April 2020 questionnaires had been completed on 45 of the 68 Care Homes. A review meeting took place to assess progress, complete an initial audit screening and to highlight any immediate concerns/red flags.

59. In Argyll & Bute, the national audit template produced by the Scottish Directors of Public Health Group was issued for Care Homes to complete with the assistance of local operational staff and Public Health via a telephone call. Within A&B HSCP, Scottish Care, who were contracted as support to registered services by A&B HSCP were undertaking the completion of the questionnaires. By 24 April 2020 questionnaires had been completed on 11 of the 17 Care Homes. Initial analysis was carried out on the 24 April 2020 with a plan to address immediate concerns which included a focus on contingency planning.

60. By the 28 April all Care Homes in North Highland and Argyll and Bute had completed the audit. [Please see **DP/12 INQ000641745** Care Home Audit Response Grid for more detail on how individual care homes responded during this initial assessment].

61. On the basis of the initial assessment the intended outline and initial programme of Associated Visits to each Care Home is outlined below:-

- Identify risk assessment approach/methodology, including the necessity to visit, taking into account the need to minimise footfall and also of the potential for transmission. Alternative contact methods were to be identified and agreed;
- Full triage and assessment of the initial audit by Public Health, ASC Deputy Director; ASC Commissioning Contracts and Compliance Manager; Improvement Lead for Care Homes;
- Prioritise Care Homes based on agreed methodology;
- Confirm follow up visit;
- Agree resource impact, source, roles, reporting and standard paperwork;
- Schedule prioritised visits and programme manage;
- Commence prioritised visits / contact; and
- There was weekly reporting on Care Homes to the Executive Leadership Group.

62. Associated Visits were not undertaken in NHS Highland and instead the Board moved to undertake Assurance Visits as outlined in the update from Jeanne Freeman on the 17 May 2020.

Multi-disciplinary clinical assurance/oversight of care homes

63. On 17 May 2020, Jeanne Freeman, Cabinet Secretary for Health and Sport in the Scottish Government wrote directly to the Executive Nurse Directors in each Scottish Territorial Health Board to highlight that their role now included an extended clinical and care oversight function to support Care Homes in response to COVID-19.

64. Also on that date, the Scottish Government issued a directive that multi-disciplinary teams consisting of clinical and care professionals across all HSCPs take direct responsibility for the clinical support required for each Care Home in the Board area [please see **DP/13 - INQ000320162** and **DP/14 - INQ0000320169**]. Further to this initial requirement, the Cabinet Secretary advised on the 23 March 2021 that enhanced multidisciplinary, clinical and professional oversight should remain in place until March 2022, at a minimum.

65. The NHS Highland Care Home Clinical & Care Professional Oversight/Bronze Group was established with a co-chairing arrangement between North Highland and Argyll & Bute. This had the objective of being an urgent, additional and whole system support to develop, implement and operate on an ongoing basis, the necessary processes and arrangements to provide daily clinical and care support and oversight of Care Homes operating within the whole of the NHS Highland area. [Please see **DP/15 INQ000641746** - Implementation of COVID 19 Enhanced Professional Clinical and Care Oversight; **DP/16 INQ000641747** - Care Home Oversight Arrangements and **DP/17 INQ000590705** - NHS Highland Care Home Clinical & Care Professional Oversight Action Group Plan].

66. It covered all registered independent sector and in-house adult Care Homes across both HSCP areas. There was a need for core group strategic oversight and also operational daily input; hence the daily Safety Huddles. A Care Home dashboard was created which illustrated the care needs of individual residents; infection prevention and control measures (including PPE and cleaning requirements); staff requirements (including workforce training and redeployment); and agreed supports to be deployed.

67. Membership consisted of Head of Service for Older Adults & Community Hospitals; Director Adult Social Care; Chief Officers; Interim Director of Public Health (later Director of Public Health); Strategic Adviser; Board Medical Director; Board Nurse Director; Associate Medical Director; Deputy Nurse Director; Nurse Lead; Head of Community Services; Commissioning, Contracts and Compliance Manager; Interim Head of Health Commissioning; Social Work; Project Support; Care Inspectorate; and Public Health. Any additional members could be added through the co-chairs' agreement, as and when required.

68. Escalation was via the NHS Highland COVID-19 Gold, Silver and Bronze Governance Structure, the Argyll & Bute COVID-19 Silver meeting the Clinical Expert/Reference Group and weekly reporting to Scottish Government.

69. In October 2020 as the Gold, Silver, Bronze decision making structure became integrated into the Board's standard decision making structure, the NHS Highland Care Home Oversight Group was formally convened as a sub group of the Executive Directors Group, not least because it was clear that a requirement for continued multi-professional input and oversight was now likely to be a longer term requirement. [Please see **DP/18 INQ000641749** - Care Home Oversight Board].

70. The NHS Highland Chief Officer Health & Social Care and Chief Social Worker alongside Chief Officer for Argyll & Bute, Board Nurse and Medical Directors and Director of Public Health attended these meetings and as such were sighted on the returns made to Scottish Government by the Director of Public Health.

71. These assurance meetings provided a basis that Chief Social Work Officers, Board Nurse Director and the wider colleague group could be assured that the systems in place were such as to offer a safe and robust process for the continuing delivery of Adult Social Care during the pandemic. This Group met on a fortnightly basis. [Please see **DP/19 INQ000641750** and **DP/20 INQ000641751** - Examples of Care Home Oversight Summaries for North Highland and A&B respectively].

72. This arrangement was extended to support the Care at Home agenda. The principal agenda for the Oversight Group was outlined in the Cabinet Secretary communications and included:-

- A report from the daily Bronze Huddles including any escalations;
- A report from the Director of Public Health as submitted weekly to Scottish Government; [Please see **DP/21 INQ000641752** - Example of weekly return to Scottish Government].
- Review of testing adherence and results to the latest Scottish Government policy;
- Review of Nursing support to Care Homes;
- Review and implementation of latest Scottish Government policy in relation to Care Homes; and
- Review of Care Inspectorate gradings and reports for Care Homes.

73. The Argyll & Bute HSCP Care Home Assurance Group initially met 5 days a week. The purpose of this Care Home Assurance Group was to provide oversight and support to Care Homes within the context of COVID-19. Membership consisted of:- HSCP Senior Management with Care Home responsibility; Scottish Care; Care Inspectorate; Nursing; Social Work; Older Adult planning support; Public Health; and Procurement & Contract Management. It was chaired by the Head of Service responsible for Care Homes.

74. This group covered all Care Homes within the Argyll & Bute HSCP area and this multi-agency group had responsibility to address both short term actions and to link with Older Adult Strategic Planning Groups to raise strategic issues affecting Care Homes.

This included a collective responsibility to focus on the quality of the Care Home experience for residents as well as their families.

75. This Group was supported by the Argyll & Bute HSCP and Care Homes Task Force which gathered data from all Care Homes in Argyll & Bute area to share information and problem solve. This Task Force met weekly.

76. The roles of these groups expanded and developed in line with the requirements of the Care Homes and the organisation throughout the pandemic.

77. Prior to the pandemic, in Argyll and Bute HSCP there was care home liaison already in place and therefore there were already well-established networks to communicate with Care Homes effectively and efficiently.

78. There was daily contact with all Care Homes from April 2020, in both areas utilising a mixture of different methods (telephone, MS Teams/video link, email and in person visits), which covered but was not limited to the following areas:- Service Demand; Delayed Discharge; Resident Deaths; Public Health Closures; Public Health Surveillance; Resident COVID Confirmed; Resident COVID Testing; Staff COVID Confirmed; Staff COVID Testing; Staff Absence; PPE Issues; and Critical Issues. The purpose of these meetings was to establish a status update across all services, receive any escalations and discuss and agree appropriate input, supportive actions or further escalations. The membership of these daily meetings evolved from their first commencement in April 2020 but, core membership included: Commissioning, Nursing, Operations, Public Health and Care Inspectorate and Scottish Care representatives.

79. Key issues were flagged from the daily contact with Care Homes (each Care Home submitted their information through TURAS which is a digital platform developed by NHS Education for Scotland to support health and care professionals working in the public sector) plus any other wider intelligence, and each home was RAG (Red, Amber, Green) rated. RAG rating" or "RAG status" is a traffic light system used in project management and other contexts to quickly assess the health or status of various elements, providing a quick, subjective assessment based on defined criteria. We used this RAG rating method with supporting narrative to determine areas of good practice and areas for improvement. If there was a need for specific Nursing, Infection Prevention and Control, staffing or testing support, then follow up actions and discussions with the Care Homes would take place. From a general overview of the RAG rating of Care Homes, between the start of the pandemic and 17 May 2020

common issues emerging related to PPE and staffing. These RAG ratings transitioned between Red, Amber and Green however the majority of the ratings were consistently Green or Amber. [Please see **DP/22 INQ000641753** - Bronze RAG rating dashboard].

80. As part of the Safety Huddles and Care Home assurance process, there was an inbuilt prioritisation process which developed and monitored these RAG ratings for Care Homes and was fundamentally based on local knowledge following the regular receipt of information on PPE, infection control and staffing issues.

81. Prior to the creation of Safety Huddles there were daily telephone calls to Care Homes. We used a checklist for a consistent approach which included sections for PPE, staffing and escalation.

82. NHS Highland took lead responsibility for ensuring and arranging where necessary PPE supplies on the ground and additional staffing support. The senior leaders responsible for the provision of clinical oversight included those in Adult Social Care, Infection Prevention Control, Director of Public Health, Health Protection Team and Nursing.

83. Following on from the refreshed guidance issued by the Scottish Government on 17 May 2020 [Please see **DP/13 - INQ0000320162** and **DP/14 - INQ0000320169**], plans were developed to carry out Care Home Assurance Visits as directed by Scottish Government. It was understood this new guidance from the Scottish Government superceded any plans made for Associated Visits which were not undertaken in NHS Highland.

84. These visits were to provide assurance that each Care Home had all the measures in place for their residents, to ensure that any Nursing, Social Work related, or Infection Prevention and Control issues were identified and necessary advice, support and training put in place.

85. The intended approach of these Assurance Visits in NHS Highland was one of support and joint improvement rather than inspection and scrutiny. The aim was that the visits were to be undertaken in a collaborative way that promoted partnership with Care Homes to support improvement. This is a slightly different approach by design as compared with traditional Care Inspectorate inspections or visits. The Care Inspectorate operates as the regulatory body and have investigative powers so naturally their inspections take a different approach.

86. In accordance with the agreed approach in Highland, the Care Home Assurance Visits were planned to include multi-professional representation of up to 4 staff from Nursing, Public Health or Infection Prevention and Control Team, Adult Social Care and a member of the Commissioning and Contracts Team. However, due to resource availability and COVID-19 demands, not all Care Home Assurance Visits had full multi-disciplinary representation onsite.

87. The Care Inspectorate were not routinely involved in the Care Home Assurance Visits although there were instances when the Care Inspectorate made an unannounced inspection visit to a Care Home which coincided with a pre-existing planned Care Home Assurance Visit. The Care Inspectorate was aware of the assurance process and were involved with feedback given regarding any issues found.

88. Most of the Assurance Visits were carried out face-to-face with the visiting team on site. Occasionally, due to pandemic pressures, some colleagues were present in person and filmed the visit live (using digital devices and MS TEAMS) so that a live feed was directed to another specialist multi-agency professional. This also helped to limit the number of personnel visiting the Care Home.

89. Throughout NHS Highland, the Assurance Visits were based on the model used by colleagues in NHS Forth Valley and described in the Scottish Government communication of 17 May 2020. [Please see **DP/14 - INQ 000320169**].

90. This methodology was supported by a Standard Operating Procedure [please see **DP/23 INQ000590706** - SOP item 6] and/or itinerary guidance designed to be step-by-step instructions, thus ensuring consistency, efficiency, and compliance. Care Home Managers were informed of the planned visits and were sent the Assurance Visit tool prior to the visit and were asked to self-assess their current position against the criteria. Care Homes were invited to ask any questions or raise any issues or concerns.

91. Standardised templates were used in both HHSCP and A&B HSCP areas [please see **DP/24 INQ000590707** ; DP/25 **INQ000590697** ; **DP/26 INQ000590698** – North template; A&B itinerary and A& B template repsectively] and were structured to record areas of focus for example Infection Prevention and Control including building environment, COVID-19 awareness; PPE, cleaning schedules and sharps bins; residents' well-being; communications and Anticipatory Care Planning (ACP); staffing; COVID-19 Testing and Staff well-being.

92. All visits were announced, pre-arranged and co-ordinated at a mutually convenient time with the respective Care Home Managers and, as part of this preliminary telephone call, Care Home Managers were asked about any locally implemented IPC procedures specific to their location which visiting staff needed to be aware of relevant to screening and entry to the building(s). The visiting professionals undertaking the Care Home Assurance Visit would discuss the format and arrangements for the visit with the Care Home Manager in advance.

93. Staff that undertook these visits were supported in their preparation by guidance and briefings provided by the NHS Highland Health Protection Team.

94. For the Infection Prevention and Control aspects of these visits, staff who conducted this aspect of the visits were either trained Infection Prevention and Control staff or Health Protection Team staff. Visiting staff wore dedicated uniforms or sets of clothing and would wear the requisite PPE. Staff conducted Lateral Flow Device (FLD) testing on the morning of the visit, or immediately prior to entering the home for the visit. There was no difference in approach whether the visits were to a residential Care Home or a nursing home. The same Infection Protection and Control standards were applied throughout the region irrespective of the nature of the setting or locations of the Care Homes.

95. The outputs and action plans from these Assurance Visits were developed and monitored in conjunction with the respective Care Home Managers. There was an emphasis on identifying good practice and supportive improvement.

96. Subsequent reporting and action plans were led by Operational Lead Nurses in partnership with Social Work Operational Leads, Care Home Managers and other key stakeholders including Infection Prevention and Control and Health Protection Teams.

97. Across the NHS Highland area as of 21 August 2020, 76 out of the 85 care homes had been visited. By May 2021, 86 out of 86 had been visited in the second phase of visits (in this time an additional care home had opened). On top of these Assurance Visits, some Care Homes had additional supportive visits.

98. The Assurance Visits by the multi-disciplinary team worked in conjunction with local Integrated Health and Social Care Teams, Scottish Care and the Care Inspectorate who already had established knowledge and experience in working with Care Homes.

This integrated partnership approach to support and advise Care Homes was essential as this was such a unique situation, where no one profession or organisation had supremacy in knowledge and decision making during the pandemic as all parties were working in such a rapidly evolving landscape.

99. This mutually supportive approach was well received and there are no known instances where advice was given that was in contravention to that provided by the Care Inspectorate. Advice was consistent with the recognition that these were residential care settings not clinical settings. The Care Inspectorate and the HSCPs worked together to offer consistent advice. Good and open communication with the Care Homes was crucial to these working relationships and the debriefing sessions that took place after outbreaks facilitated learning. The Care Inspectorate advised and was part of the assurance functions and we worked in partnership with them whilst maintaining clarity that our role in these visits was not regulatory.

100. However, COVID-19 also presented new opportunities for closer working and arguably a greater understanding of everyone's roles and responsibilities because of the requirement to develop integrated clinical and care oversight and support for Care Homes. Several best practice interventions and themes for improvement work emerged from the Care Home Oversight and Assurance work and this was shared via Care Homes professional leadership networks. For example, many Care Homes had put additional plans in place to support residents with cognitive impairment, recognising the potential impact of restricted visiting from relatives and carers, social isolation and other factors related to the COVID-19 pandemic. Similarly, advice about correct donning and doffing of PPE and development of specific cleaning schedules was a common theme and specific training was delivered in these areas and became available for new or returning staff.

101. The key learning from the enhanced local Care Home assurance arrangements has been used to strengthen the existing clinical support for Care Homes and develop a wider multi-disciplinary team approach to the assessment, planning, delivery and evaluation of care for residents in Care Homes across Highland which remains relevant today. In 2020, when these arrangements were established, several key areas of learning were recorded in relation to: -

- The necessity to work in partnership with Care Homes to develop relationships to ensure supportive and productive working;

- NHS Highland had to agree an approach of continuing support for Care Homes, in response to oversight huddles and any new national directions;
- The Review of training & educational requirements and development of joint training with NHS Highland staff and HSCP staff to provide essential insitu and virtual training to enable Care Home Staff to be confident and competent in caring for people at risk of and being treated for COVID-19 including refresher training on NHS Care Home Pathway and Anticipatory Care Planning; and
- Increased support for Infection Prevention and Control in Care Homes across Highland by investment in a Quality Improvement Facilitator to promote and audit best practice.

102. Many issues arising out of the Assurance Visits actions were easily addressed during the visit for example advice about the correct donning and doffing of PPE and development of specific cleaning schedules.

103. A number of key themes were identified for further improvement and educational activities to enable Care Homes to sustain services during the COVID-19 pandemic and continue to access timely clinical support when required.

104. The support visits, oversight and engagement with Care Homes represented a significant new area of work throughout the COVID-19 period and provided assurance to NHS Highland that appropriate and compliant oversight was in place to ensure support of Care Homes and that the Scottish Government requirements for enhanced professional clinical and care oversight of Care Homes had been actioned as required.

105. Summary reports for the assurance visits were produced and some of the key learning is highlighted below. [Please also see **DP/27 INQ000641758** - Themes arising from Care Home Visits 21 August 2020; **DP/28 INQ000641759** - Themes arising from Care Home Visits 4 June 2021 and **DP/29 INQ000641763** - Assurance from Care Homes undated].

    (i) On the whole, appropriate use of PPE was observed. The majority of staff were able to demonstrate correct donning and doffing procedures. Spot checks were to be utilised by allocated staff within Care Homes to ensure correct donning and doffing procedures continued;

    (ii) The awareness of COVID-19 guidance was satisfactory. Managers were aware where to access information and support as required;

(iii) There were some reported challenges with compliance with infection control and physical distancing guidelines due to the building environment and age of the buildings;

(iv) Some Care Homes were challenged with space for storage of additional waste due to the increase in PPE and other items;

(v) Social distancing, on the whole, was being achieved discretely for staff and residents. There were prompts issued to Care Homes to remove additional chairs that prevented social distancing being maintained which resulted in storage of these being challenging;

(vi) Domestic staff or those responsible for cleaning demonstrated a good knowledge of cleaning products and schedules. They had a good knowledge of products to use for decontamination although variable knowledge of dilution and contact times for products. Care Homes were advised to ensure posters with the correct information were available for all staff and "I am Clean" stickers were utilised;

(vii) There were good processes in place for staff and visitors arriving at the homes with regard to hand washing/sanitising and Lateral Flow Testing;

(viii) Many staff wore uniforms and laundry facilities were available or bags supplied to take uniforms home with in-house laundry available during an outbreak in most homes;

(ix) Mattress checks were mainly completed but some Care Homes required more robust processes to ensure staff were trained on the correct method for mattress checks;

(x) Care Homes shared their experience of caring for residents at End of Life, including expressing the challenges faced due to restricted visiting and COVID-19;

(xi) There were good systems in place for nutrition with an emphasis on food first and fortified food. There was good awareness of the referral process to dietetics. The importance of nutrition during the pandemic appeared to have been given high priority;

(xii) The zoning and cohorting of residents, if required, had been considered in many homes. Some were better able to accommodate this depending on facilities, occupancy and floor plan of the buildings;

(xiii) The requirement for targeted support was highlighted by providers or visiting teams around pressure area risk assessment and care, Nutritional Risk Screening and falls. Care Homes were utilising Pressure Area Risk Assessment and there was evidence of appropriate care planning;

(xiv) Out of Hours (OoH) teams were noted to be helpful and responsive;

(xv) Many Care Homes had weekly planned reviews with General Practice Teams which were either carried out virtually or face-to-face. This provided good support as well as providing continuity of care for residents. A number of GP Practices were utilising Advanced Nurse Practitioners for this;

(xvi) There was recognition of the challenges of implementing social distancing for those "walking with purpose" which is a term for common behaviour for people living with dementia;

(xvii) Implementation of 'bubbles' enabled residents to go into shared areas whilst maintaining social distancing for eating, drinking and socialising;

(xviii) There were daily running notes, handovers, daily huddles and flash meetings were widely utilised to update team members regarding changes to residents' wellbeing;

(xix) Personalised care plans existed, providing good insight into residents past medical and social history as well as outcome focused care plans;

(xx) Some settings utilised smaller "working files" which supported staff to find pertinent information in a timely fashion. These were also noted to be of particular value to bank, agency or COVID Response Team staff;

(xxi) Some homes introduced specific COVID-19 care plans which aimed to enhance care and mitigate against any hindering factors such as plans to ensure regular mobility when residents had to isolate and creative ways of increasing food and fluid intake as many residents required to dine in their bedrooms;

(xxii) Regular reviews from other health care professionals continued virtually via Near Me, phone or email. Face-to-face visits occurred when appropriate;

(xxiii) There were challenges around communication with masks for those with communication difficulties. Technology and flash cards were used to overcome those challenges;

(xxiv) There was very positive feedback regarding sector staff who 'stepped up' having a flexible approach to their working hours to ensure continuity of care for their residents. Many staff opted to work additional hours;

(xxv) Staff were conversant with what to do if a resident displayed symptoms of COVID-19 and what to do if they had symptoms themselves.

Key issues and use of emergency powers

106. There were no major escalations at the time of clinical visits however further escalations for one Care Home emerged following an unannounced Care Inspectorate

visit. At the time this Care Home was operated by an independent service provider. Following their inspection at the beginning of May 2020 the Care Inspectorate applied to Inverness Sheriff Court for an interim suspension order and emergency cancellation of the Care Home's registration under section 65 of the Public Services Reform (Scotland) Act 2010.

107. NHS Highland provided significant levels of input to this Care Home from the outset to improve the standards of care and cleanliness for the residents and safeguard their wellbeing. As a result, the Care Inspectorate were able to assess over subsequent months that the circumstances of care in the home were much improved. In response to this steady improvement evidenced in monitoring visits throughout July and August 2020, the Care Inspectorate ultimately took a decision to withdraw from the Emergency Cancellation application previously lodged with Inverness Sheriff Court.

108. The Scottish Government worked closely with NHS Highland and the Care Inspectorate throughout this period to deliver long-term stability for the home and to ensure the safety and wellbeing of residents. Ultimately this led to the acquisition of this Care Home by NHS Highland which took effect from November 2020, at the direction of the then Health Minister and involved the transfer of staff into the employment of NHS Highland.

109. There were no Care Homes in the NHS Highland region where emergency powers under sections 63A-63B of the Public Services Reform (Scotland) Act 20101, which came into force on 27 May 2020, were exercised.

Effectiveness and impact of the Enhanced Assurance Visits

110. It cannot be proven if the enhanced assurance arrangements were effective overall in improving outcomes for residents and staff in Care Homes as there was no straightforward way of monitoring or evaluating this. However, it is widely acknowledged that the supportive approach adopted provided the flexibility to provide additional support, at short notice, where necessary.

111. In the main, Care Home providers welcomed the opportunity for visits to take place and welcomed the clinical expert advice and additional support. However, in some instances, the Assurance Visits were seen as another layer of scrutiny and inspection being "done to the care provider". There were also some concerns about risk from

additional footfall at the Care Homes although this was mitigated and reduced using digital and remote co-visits.

112. The overall themes of the visits were largely positive, and much good practice was reported. Overall, the sector found the Assurance Visits to be supportive and informative and were proactive in completing actions suggested.

113. Although the various teams worked in conjunction it was clear the role of NHS Highland was to provide support and assurance rather than the regulatory role of the Care Inspectorate.

ACCESS TO HEALTHCARE AND MEDICINE

114. In terms of medical support, NHS Highland allocated individual Care Homes in the Inverness area, as this is the most densely populated area, to an individual General Practitioner Practice. This was to minimise footfall. All other areas remained unchanged but there was often an existing direct 1-1 relationship between GP Practices and individual Care Homes due to geography and travel constraints.

115. Hospital at Home as a standalone function was not introduced into Highland as a recognised model during the pandemic, however local Integrated Health and Social Care Teams worked closely with General Practice, Care Home Lead Nurse(s), COVID Response Teams and in some cases Secondary Care Specialist Physicians for the Elderly and Advanced Nurse Practitioners as well as other specialists to provide a bespoke and enhanced level of clinical care in the community to support Care Homes during and after COVID-19 outbreaks.

116. Ongoing clinical support continued for all residents in Care Homes provided by General Practice and local Community Health Care Teams. In addition, specialist advice was available to support Care Homes with care of individuals who required support from Tissue Viability Specialist, Continence, Respiratory, Palliative and End of Life Care Specialists. At NHS Highland we were acutely aware that elderly residents in Care Homes are and were vulnerable in terms of health. Data from population and cohort studies suggest that older people living in Care Homes have complex healthcare needs. The average Care Home resident has multiple long-term conditions, functional dependency and fraily. 75-80% of people living in Care Homes have cognitive impairment. Residents are likely to have better health outcomes if health services reflect these needs with attention to comprehensive, multidisciplinary assessment, case

management and input from appropriately trained specialists in care of complex medical problems in later life. NHS Highland wanted to ensure that Care Homes were aware of the availability of specialists to support them with the case needs of individuals in their care. A combination of face-to-face and virtual contact was used throughout the pandemic and considerations which influenced the decision to provide care face-to-face or virtually were based on the requirements to maintain supportive healthcare arrangements whilst reducing the risks associated with increased footfall in Care Homes.

117. Daily contact was initiated with all Care Homes from March 2020 as a means of providing additional support for the residents and the staff during COVID-19. Where a Care Home was concerned about individual residents, they were able to discuss these concerns and, where necessary, seek advice and review from General Practice and Community Health Care Teams. Where concern was raised about individuals presenting symptoms of COVID -19, this advice included contact with the Health Protection Team.

118. Several GP Practices provided their linked Care Homes with a GP Visiting Kit. This consisted of common diagnostic items GPs required to use when visiting. It was considered to reduce the risk to residents/patients by leaving these items for use in the Care Home. These would normally be moved between settings, carried by the GP and cleaned between uses. Some Care Homes did use this equipment to provide GP Practices with pulse oximeter (SPO2), blood pressure, temperature readings prior to the GP visiting, which did have the effect of reducing the need for face-to-face visit(s).

119. At the start of the pandemic, some Adult Social Care settings insisted on visiting GPs and/or Advanced Practitioners performing lateral flow tests and waiting for the result prior to entering.

120. The progression and rapid expansion of digital solutions are a legacy of the pandemic. NHS Highland had already begun using and promoting the use of Near Me prior to the pandemic. Near Me is a safe and secure video consulting service powered by the Attend Anywhere platform. This is a web-based system helping public sector providers offer video call access to their services as part of business-as-usual operations. All General Practitioner practices had the ability to use Near Me. The NHS Highland Primary Care Team received usage reports which showed the number of Near Me calls

by GP Practice (users and waiting rooms) but this reporting did not specifically identify calls between GPs and recipients of Adult Social Care Social Care services.

121. In terms of the rapid expansion of Near Me, volumes went from 83 outpatient waiting areas having Near Me to every GP Practice in NHS Highland within a couple of months. NHS Highland was supported by NHSS National Video Conferencing Service colleagues who set practices up on Near Me and provided training and iPads.

122. The NHS Highland Technology Enabled Care (TEC) Team worked in conjunction with the national Near Me Team to support GP practices with Near Me queries including adding new users and providing practical advice on using this new method. A video consulting checklist was developed, [Please see **DP/30 INQ000641764** - Near Me checklist] to support practitioners to plan a video consultation as well as providing step-by-step guidance for before, during, and after the consultation.

123. It is not possible to provide the percentage or number of GP consultations carried out via Near Me, other digital means or telephone specifically to recipients of Adult Social Care.

124. Whilst internet connectivity and access throughout Highland is improving, there remain still areas where a lack of connectivity is a significant barrier that may require input on a national level. Access to Wi-Fi and computers was problematic for some GP practices as well as users/patients. There was no noticeable difference between our HSCP areas. Most Care Homes did not have Wi-Fi and iPads to fully utilise remote consultation options. NHS Highland issued mobile data enabled iPads to help overcome some of the Wi-Fi and device concerns.

125. Video calls allowed continued connection with family and friends who were not able to visit. They also enabled people to join church services, weddings and funerals in a virtual manner from their Care Home. However, this depended upon strong, reliable and stable Wi-Fi or broadband connectivity, access to appropriate phones, tablets, or laptops and staff with the time to help those who needed it.

126. As we moved through the COVID-19 pandemic, the use of videoconferencing technology for consultations continued to grow. Whilst face-to-face assessments still took place, when clinically necessary, the use of photos and video-consultations allowed for quicker access to advice and treatment for some health conditions and reduced the need for unnecessary travel. This proved particularly important for people

with mobility issues, or for people with cognitive decline. Near Me is still in use for video-consultations with healthcare professionals, and so staff working in Care Homes continue to use this type of technology and be able to support people living in Care Homes to use it.

127. The uptake and use of digital technology across the Care Home sector is a source of significant variation. Reducing this variation and ensuring people living in Care Homes can benefit from digital technologies to facilitate and support healthcare is key as we move forward. This will not be without challenges as it will require investment of resource, addressing governance issues, establishing clear data sharing pathways and supporting the development of a digitally skilled workforce.

128. NHS Highland are unable to provide detail on whether the lack of access to physical assessments had any effect on recipients of Adult Social Care. We do know that there were varied approaches. Some GP Practices reduced the frequency of their visits to Care Homes whilst others increased their thresholds for face-to-face visits.

129. NHS Highland is not aware of any consistent issues faced by recipients of Adult Social Care in the region in accessing medication or medical equipment during the relevant period.

130. NHS Highland are not aware of any concerns about COVID-19 guidance being interpreted by Care Homes as imposing a blanket ban on residents who were COVID-19 positive from being transferred to hospital. Care delivered in Highland prior to; during and after the pandemic is designed to provide care as close to home as possible and where residents can be safely and appropriately supported with enhanced care in their own home, this would be the first choice but if admission to hospital was deemed necessary, then this would be part of their treatment plan. Configuration of hospital beds in response to COVID-19 in Highland, saw the development of COVID-19 admission areas where all individuals with suspected or confirmed COVID-19 were admitted if they required hospital treatment. [Please see **DP/09 INQ000590703** - Clinical Pathway].

131. NHS Highland are not aware of any issues or concerns being escalated about ambulances refusing to take Care Home residents to hospital. Ambulance services in Highland are provided by the Scottish Ambulance Service (SAS) which is a Special Health Board in Scotland and as such their policies would be standard across Scotland and not be open to local and/or regional variation.

End of Life Care and DNACPR

132. With regard to End of Life Care and DNACPR notices an anticipatory approach has been embedded in health care in Scotland and particularly in Highland since approximately 2010. In Scotland, Anticipatory Care Planning (now known as Future Care Planning) helps individuals, and their families, plan for future health changes, ensuring informed choices including where and how they wish to be cared for. An Anticipatory Care Plan (ACP) is an ongoing dynamic process which should be reviewed regularly and as circumstances change and as part of the co-ordinated approach to supporting Care Homes in Scotland. Primary Care Teams were proactive in reviewing and, where necessary, updating Anticipatory Care Plans. This included decisions about DNACPR and choices regarding end of care and treatment to ensure that, in the event of COVID-19, peoples' clinical and care needs could be planned in accordance with their wishes.

133. With regard to any perceived increase in the numbers of ACP's, DNACPR's or people choosing to die at home amongst Care Home residents there is no available data to support this. To establish if this was indeed the case would require a systematic review and comparison of pre and post pandemic records and an extrapolation that any increase was directly related to the pandemic rather than other pre-existing medical conditions that would affect the need for an ACP or DNACPR.

134. Within Scotland, Healthcare Improvement Scotland (HIS) and NHS Education Scotland (NES) have a number of learning resources which are promoted for use amongst health and social care staff to support professionals to sensitively and accurately initiate and record conversations about Anticipatory Care Planning and these were promoted through professional networks to support staff to promote best practice and avoid poor practice.

135. Across NHS Highland, there were no changes to implementation of the national DNACPR Policy and there were no known issues in relation to: -

- DNACPR notices being imposed in a blanket manner (for example in relation to whole Care Homes or in relation to people with learning disabilities and/or other complex needs);

- DNACPR notices being imposed inappropriately (for example without any, or any proper, consultation with individuals and/or their family members/guardians, or against individuals' wishes);
- CPR on recipients of Adult Social Care being attempted in a futile or inappropriate manner and/or;
- other treatment being inappropriately withheld during End of Life Care for recipients of Adult Social Care.

136. Additional efforts were co-ordinated across Highland to improve access to and support for delivery of palliative and End of Life Care in the community including Care Homes and peoples own homes and included: -

- Palliative Care Helpline, an extension of a 24-hour helpline to support all staff with advice and support with palliative care;
- Provision of Palliative Care Boxes located in Hospitals and Community bases which were available for all staff to support individuals in their own homes, including Care Homes. A Palliative Care Box is also known as an "emergency medicine box" or "just in case box" and is a pre-packed kit containing essential medications and supplies for managing pain and other distressing symptoms at home; and
- NHS Highland and Highland Hospice provided regular clinical and care updates in the form of sharing guidance and information and delivering virtual training. [Please see **DP/31 INQ000590699** and **DP/32 INQ000590700** - End of Life Care diagram and Symptom Control].

IPC and PPE

137. At the outset of the pandemic, there was a daily check-in with all Care Homes in both HSCPs areas, during which a status update on PPE was provided. Requests for PPE were made by Care Home providers, due to an inability to or concerns with access and supply. Where this was the case, the NHS Highland Commissioning, Contracts & Compliance Team sought to source PPE from elsewhere within NHS Highland and aimed to arrange same day delivery, where possible.

138. Common themes and issues that arose, during the early stages of the pandemic, included: -

- Some anxiety and frustration by Care Home providers unable to access PPE through the triage process;
- Providers required by NHS Highland to log requests through triage, resulting in a circular action by providers, wasting time and energy when they should be focusing on resident/service user care, supporting the best outcomes for these individuals and their families and also supporting and managing their staff group during the crisis;
- Some staff did not feel valued and supported to deliver care safely;
- Triage stock did not always arrive when expected;
- Volume of PPE through triage was not always sufficient;
- Providers were not always able to pick up from PPE hub due to distance or time;
- Multiple agencies asking providers for PPE updates;
- Increasing number of calls to the NHS Highland Care Home "hotline" with urgent PPE requests;

139. NHS Highland as Lead Agency model was able to provide stock to Care Homes and Care at Home from existing supplies until the social care supply chain became established.

140. Argyll & Bute organised PPE for Care Homes and providers through the social care supply route which linked to the Bronze Command structure.

141. Following the Care Home Assurance visits it was noted that there was: -

- Good access to PPE and this was readily available throughout the homes.
- Most Care Home providers had already accessed the bespoke PPE champion training offered by the Infection, Protection and Control Team.
- On the whole, appropriate use of PPE was observed.
- Most staff were able to demonstrate correct donning and doffing procedures.
- Spot checks were to be utilised by allocated staff within Care Homes to ensure correct donning and doffing procedures continued.

142. The Home Care sector originally vocalised that they considered that the needs of hospitals were prioritised over Care Homes and care at home. As above PPE was made available to direct to all Adult Social Care providers where there was available

supply within NHS Highland resources, through established supply pipelines, due to the lead agency model of integration.

143. The Health Protection Team and Infection Prevention and Control Team delivered training on Infection Prevention and Control, transmission routes and the use of PPE equipment via various methods (in-person; virtually and via the use of national eLearning modules). When notification occurred of the emergence of COVID-19 the frequency of training increased, and more on-site visits and training occurred in preparation for the management of cases and outbreaks and to ensure safe use of PPE. At the start guidance was changing frequently and being updated nationally as knowledge evolved. There was some generalised concern about ensuring changes were communicated in a timely manner but not with regard to interpreting or applying the guidance. Written guidance was available through the National Infection Control manual, and then the Care Home National Infection Prevention and Control Manual published 2021. The Independent Care providers were noted to have their own company written Infection Prevention and Control guidance; this was supplemented with guidance in line with the NIPC Manual during communications and support with the Health Protection Team.

144. During the visits to Care Homes it was evident that a lot of work had been undertaken to update staff on Infection Prevention and Control including donning and doffing of PPE. Some areas created PPE stations within the Care Homes to create extra areas to allow the safe provision and zones for donning and doffing PPE. All Care Homes were sent PPE donning and doffing educational videos when any respiratory symptoms were reported in residents. Many areas displayed the national PPE posters. All Care Homes had a system in place to allow for hand hygiene and the donning of face masks at the entrances. Care at Home staff ensured they had adequate supplies in place for visits. The availability of PPE was frequently assessed throughout this time. Another positive noted was that Care Homes has switched to using nitrile gloves as opposed to vinyl gloves.

145. Members of the Infection Protection and Control Team have not highlighted any issues regarding the application of hospital level IPC in residential settings although it was noted that anecdotally the national guidance was hospital focused at the start of the pandemic and possibly technical terms or jargon unfamiliar to the staff within the NHS Care Homes may have been used and required further explanation, at times. The Health and Social Care Sector adapted during the pandemic to the terms used and

became familiar with these. Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) Scotland also acknowledged this position and went on to publish the Care Home National Infection Prevention and Control Manual in May 2021.

CARE HOME STAFF AND RESIDENTS

Staffing Levels

146. Staffing issues and shortages were highlighted as part of the Daily Huddle. There were considerable staffing pressures across all Adult Social Care services in Highland over the pandemic including Care Homes, Care at Home and support services. The unpredictability of staff availability due to being unable to work if they were feeling unwell because of COVID-19, or recovering from it, or feeling well but unable to work as still testing positive, was difficult for all Adult Social Care providers to manage. The geography and relative employment sparsity of Highland also added to the challenge of availability of staff.

147. NHS Highland provided staff to support independent sector Care Homes. A specific COVID Response Team was established in April 2020, as part of NHS Highland's response to anticipated community-based demands to support mainly independent sector but also in-house provision. This was a highly trained and multi-skilled flexible team able to be deployed at short notice, where resources allowed.

148. There were many instances over the relevant period where Care Homes across the independent sector and in-house services had staffing difficulties due to staff being unavailable to work due to COVID-19 and being unable to access agency staff; due to extreme levels of demand. These were particularly acute during COVID-19 outbreaks in Care Homes at the start of the pandemic.

149. Later in the pandemic guidance was provided for escalation of staffing shortages. [Please see **DP/33 INQ000641767** - Care Home Escalation Protocol].

150. Many staff opted to work additional hours or took a flexible approach to their working hours to ensure continuity of care for their residents.

WELLBEING OF STAFF

151. In NHS Scotland, the National Wellbeing Hub was launched on 11 May 2020 for the whole of the health and social care workforce and unpaid carers to provide advice on

self-care and services to promote emotional and psychological wellbeing and address practical concerns. Additionally, The Highland Council and Argyll & Bute Council supported independent Care Homes accessing well-being support.

152. NHS Highland developed a single point of contact for Care Homes from 8am to 6pm, 7 days per week with access to and interfaces with specialist input from Infection Prevention and Control and Occupational Health to provide additional support for staff.

153. Care Home Managers were supported with regular "check-in" telephone calls. Common themes identified include but are not limited to:-

- The majority of Care Home providers said they felt supported and knew how to access support;
- Many Care Homes described Staff as coping well but exhausted and tired and the media spotlight on Care Homes was unsettling for Staff;
- Good leadership was observed especially in terms of communication;
- Good practice was observed included mentorship for new starts, briefings, quick catch ups, and debrief sessions;
- Use of "It's ok not to feel ok" support line; and
- Supplying food and drinks to boost morale (in some areas).

[Please see **DP/27 INQ000641758** and **DP/28 INQ000641759** for additional detail].

WELLBEING OF RESIDENTS

Common themes identified include but are not limited to:-

- Additional support was provided to those residents with cognitive impairment where the impact of COVID and isolation were well recognised by Staff;
- There was evidence of person centred care planning specifically around communication, visiting, meaningful activity, food, fluid and nutrition;
- Stress and Destress and dementia care plans were noted to be of good quality;
- Essential visits were in place throughout for End of Life Care;
- Targeted support where required regarding pressure area care, nutritional risk screening and falls prevention;
- Communal areas were adapted to ensure safe spaces for residents "walking with purpose";

- Activities continued to be facilitated on a reduced basis;
- Staff ensured regular updates to families whose relatives were unable to communicate independently and facilitated contact with families for those who could either by arranging visits, or use of technology or phone calls.
  [Please see **DP/27 INQ000641758** and **DP/28 INQ000641759** for additional detail].

TESTING

154. Processes were put in place to support testing of staff within Care Homes, care at home settings and their households. As with many aspects of the COVID-19 response, the approaches to testing did change over time and in line with guidance. The general approach involved the staff member or Line Manager submitting a referral request which would then be processed, in accordance with the approach in place at that time. The test would then be arranged at one of the local sites for testing with results followed up and acted upon accordingly. [Please see **DP/34 INQ000587787** - Testing Plan 13 June 2020].

155. The process in April 2020 involved the relevant Line Manager submitting a pro forma to a designated email account. The request for a test would be responded to within 24 hours. A referral was made to the relevant COVID Assessment Centre. There were 11 across Highland. The Assessment Centre would then contact the staff member to arrange a suitable time for testing. Over time, testing was extended to include testing of asymptomatic staff.

156. Communications were issued to all staff on 18 April 2020 confirming that staff testing was available to all health and social care staff employed by NHS Highland (including those in Argyll & Bute), as well as GPs, Dentists, Community Pharmacists, Optometrists, and NHS Highland and Independent Care Home Staff.

157. In addition, further communications were issued directly to all Care Home providers in North Highland on 23 April 2020 advising of the testing pathway for staff and/or people in their households and the single point of access.

158. At least 5 testing kits were delivered to all Care Homes so that these were on-site when required for resident testing. Staff or their family members who required testing were allocated an appointment by NHS Highland Occupational Health service to go to the

Assessment Centre nearest to their location. In addition, the Regional Testing Centre run by Deloitte and NSS was opened in Inverness on 24 April 2020 and Care Home and Care at Home staff could also access this.

159. By the 24 April 2020 the Interim Director of Public Health communicated to the Scottish Government that NHS Highland were confident that there was a robust pathway for workers, or people in their households, to testing with a single point of access; and that this had been clearly communicated to all employers in health and social care; both within the Care Home setting and employers providing care at home. [Please see **DP/08 INQ000641741** – Letter to John Connaghan at Scottish Government dated 21 April 2020].

160. This feedback is not specific to the social care sector but there were challenges identified in relation to access for more remote and rural areas including islands and challenges for those without transport. There was extremely good support from a variety of colleagues who supported testing in many Care Homes. Some Care Homes who had been initially anxious about testing embraced training options and support.

161. NHS Highland is not aware of any instances whereby testing of symptomatic residents in Care Homes was not carried out because of delays or refusal by visiting professionals to attend.

162. As a result of an emerging outbreak NHS Highland had initiated mass testing of symptomatic and asymptomatic staff and patients in a Care Home at end April 2020 ahead of national policy which came into effect the week later.

FINANCE

163. Funding was supplemented by the Scottish Government throughout the pandemic and at no stage did NHS Highland consider that funding was a barrier in responding to the needs of the Adult Social Care sector.

LESSONS LEARNED AND RECOMMENDATIONS

164. NHS Highland acknowledges that the ongoing and regular dialogue with providers (individual contacts, whole sector meetings, daily check-ins) were essential to build and maintain trust and a flow of clear information, where the policy landscape was changing frequently.

165. The provision of supplier relief payments reduced the level of financial anxiety enabling providers to focus on the delivery of care and ensuring sufficient staffing. This was particularly critical in Highland due to the number of small-scale providers, who are owners and/or Managers.

166. Care Home communication was significantly strengthened by our collaborative approach which has continued since the pandemic ended. Our huddle check-ins provided good organisational assurance and have also continued.

167. The early creation of a Care Home Support Plan, in March 2020, setting out how NHS Highland would respond to a Care Home outbreak was key in providing an essential foundation to supporting the sector.

168. Restrictions on visiting and movement had a huge impact on residents and their families and their relationship with Care Home staff and leadership.

169. Rapidly changing guidance, staffing shortages and perceptions of excessive oversight also placed strain on relationships between some Care Home staff, leadership, and HSCP/Local Authority staff.

170. Clear, consistent messaging and an equitable approach across both NHS Highland and commissioned services, with Adult Social Care services considered a more equal priority.

171. Wider appreciation of the challenges faced by commissioned services, many of whom were operating without the comfort of an extensive organisation or management team around them, and who continued to deliver front line services in prolonged and extenuating circumstances.

172. There is recognition of financial pressures and the need to provide financial resilience to enable services to continue to focus on care delivery.

173. A need for the development of mandatory joint business continuity and resilience training and support.

STATEMENT OF TRUTH

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed:

PD

David Park, Deputy Chief Executive
Dated: 09 June 2025