Witness Name: Dona Milne
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Exhibits: 43
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UK COVID-19 INQUIRY (MODULE 6)

WITNESS STATEMENT OF DONA MILNE, DIRECTOR OF PUBLIC HEALTH

I, Dona Milne, of the Lothian NHS Board ("NHS Lothian") of Westport 102, West Port, Edinburgh, EH3 9DN. will say as follows:

1. I make this statement, about specific impacts of the pandemic on the healthcare system within NHS Lothian during the relevant period, in response to the UK Covid-19 Inquiry's Request for Evidence under Rule 9 of the Inquiry Rules 2006, dated 10 December 2024, in relation to Module 6 of the Inquiry. The facts and matters contained within this statement are based upon information held by NHS Lothian, unless otherwise stated, and I believe them to be true. Where I refer to information supplied by others, the source of the information is identified; facts and matters derived from other sources are true to the best of my knowledge and belief.

2. I make this statement on behalf of NHS Lothian and confirm that I am duly authorised to do so.

Introduction

3. I am the Director of Public Health and Health Policy at NHS Lothian. I was appointed to this role on 1 June 2021. In addition to my substantive role as a senior executive within NHS Lothian's corporate structure, I am appointed by the Scottish Ministers as an Executive Board Member on the Lothian NHS Board. This appointment is an *ex officio* one, as a direct consequence of the executive position I hold.

4. My executive portfolio within NHS Lothian is primarily specific to Public Health (incorporating the areas of Population Health, Healthcare Public Health and Health Protection). In addition, I hold senior executive responsibility for a range of strategic functions, including Community Planning, Resilience and Emergency Planning, and Equalities and Human Rights. I am also the Board's appointed Senior Information Risk Owner (SIRO). External to the NHS Lothian Board, I sit on the Scottish National Directors of Public Health Group, the membership of which includes the Director of Public Health from each Scottish NHS Board. I have been a member of this Group since 2018, including during my previous role as Director of Public Health at NHS Fife.

Overview and Background

Overview of the NHS Lothian Region as at 1 March 2020

5. NHS Lothian provides a comprehensive range of primary, community-based and acute hospital services for the populations of Edinburgh, Midlothian, East Lothian and West Lothian (around 916,000 people and covering a geography of roughly 700 square miles – as of mid-2023). The Lothian region has both the second largest and the fastest growing population in Scotland. Additionally, NHS Lothian provides selected services for patients in the Borders and Fife regions and is a national centre of expertise for various specialties provided to people from across Scotland. NHS Lothian has an annual expenditure of around £2.5bn and employs over 28,000 staff. NHS Lothian encompasses four major teaching hospitals, over 15 community and specialist hospitals, 124 GP practices and over 400 community pharmacies, dental practices and ophthalmic practices.

6. In 2020, Lothian's population was estimated to be 893,160 (of which 51.5% were female). In 2020, Lothian had a similar proportion of under 16-year-olds as the rest of Scotland (16.5%), but the population aged 16-64 was slightly larger than seen in Scotland (66.6% in Lothian versus 63.8% in Scotland), largely due to the greater proportion of people of working-age in and around Edinburgh. The proportion of the population over 64 years old was slightly smaller than seen nationally (16.9% in Lothian versus 19.7% in Scotland).

7. Using the 6-fold Data Zone Urban Rural Classification 2020, as of 2020 the majority of Lothian's population (58.2%) lived in large urban areas (settlements of 125,000 people and over), with a further 30.2% living in other urban areas (settlements of 10,000 to

124,999 people). The remaining population were split between accessible small towns (3,000 to 9,999 people, and within a 30-minute drive time of a Settlement of 10,000 or more) and accessible rural areas (less than 3,000 people, and within a 30 minute drive time of a Settlement of 10,000 or more), with 5.1% and 6.6% of Lothian's population living in these areas, respectively.

8. In comparison with the rest of Scotland, Lothian has proportionately fewer areas classified among the most deprived in the country (by Scottish Index of Multiple Deprivation, SIMD). As of 2020, around one third (32.0%) of Lothian's population lived in datazones classified as Scotland's 20% least deprived datazones, compared to 11.1% living in Scotland's 20% most deprived datazones. The distribution of deprivation was unequal across Lothian's local authority areas, with 4.9% of East Lothian's population living in Scotland's 20% most deprived areas in 2020, compared to 7.7% in Midlothian, 11.7% in Edinburgh and 14.4% in West Lothian. The total number of Lothian residents living in Scotland's 20% most deprived areas was 100,942 in 2020. This information is based on population estimates by SIMD, published by the National Records of Scotland.

9. In Lothian, as seen nationally, a wide range of health outcomes are patterned by socioeconomic status, with people living in more deprived communities consistently experiencing worse outcomes than those living in less deprived areas, for practically any conceivable health-related outcome. For example, in Lothian in 2019/20 the all-cause mortality rate was 1,534 per 100,000 for those individuals living in Scotland's 20% most deprived areas, compared to 840 per 100,000 in Scotland's 20% least deprived areas. There were particularly steep inequalities in premature mortalities, with premature deaths in those aged 15-44 being 4.5 times more likely in the 20% most deprived areas compared to the 20% least deprived. Steep inequalities in health-related outcomes were also evident from as early as infants' 27-30 month review. As of 2021, 13.5% of 27-30 month reviews conducted for children living in the 20% most deprived areas identified a speech, language or communication concern, compared to 3.4% in the 20% least deprived areas.

10. While males in Lothian in 2020 typically had lower life expectancy and higher mortality rates, females had a higher burden for many of the leading causes of ill health. This is particularly true for headache disorders and anxiety disorders, where females' rate of healthy years lost to ill health is over double that experienced by males. Males have a higher burden for relatively few of the top causes of ill-health, with the most notable

exception being for diabetes where males' rate of years lost to ill health is around 1.5 times that experienced by females. The total burden of illness increases with age, and the nature of ill health changes qualitatively throughout the life course. In Lothian in 2019, the estimated total amount of healthy years of life lost for those under 15 was a rate of 2,805 years per 100,000. This increases around ten times among those aged 85 and older (24,253 years of healthy life lost per 100,000).

11. In May 2020, the total number of registered care establishments in NHS Lothian was 188, covering provision for Older People, Children & Young People, Learning Disabilities, Physical and Sensory Impairment, Mental Health, Blood Borne Virus, Alcohol & Drug Misuse, and Respite Care and Short Breaks. Of these establishments, 109 were provided for Older People, distributed across each of the four HSCPs. Providers of these establishments included private companies (from large organisations to small family run businesses), local authorities and voluntary/not for profit organisations. References to the number of Lothian care homes in various exhibits provided alongside this statement may vary slightly, depending on whether the information is referring to all adult care homes or specifically older people care homes. Additionally, the number of care homes of each type may have fluctuated during the course of the pandemic, as homes closed, or new ones opened.

12. Validated data on delayed discharges is published by Public Health Scotland. This data reflects that, within NHS Lothian, there were 189 delayed discharges in March 2020 (a steep reduction from 291 in January 2020). This number grew and fluctuated over the relevant period, reaching a high point of 329 in January 2022 and then 261 in June 2022. The key factors influencing changes in the prevalence of delayed discharges over the relevant period were those arising from the pandemic, including: reductions in community capacity, increased need for prevention control measures, and workforce/staffing pressures. Generally, the number of delayed discharges in the system tended to reduce slightly at the beginning of each lockdown and increase when restrictions were relaxed or lifted.

Overview of the Lothian NHS Board

13. NHS Lothian is one of fourteen Territorial Health Boards in Scotland which are responsible for the provision of primary care, secondary care, tertiary care, and public health within their respective regions. The territorial boards derive their primary

functions from the National Health Service (Scotland) Act 1978 and subsequent legislation.

14. NHS Lothian exercises, on behalf of Scottish Ministers, responsibilities in relation to planning, commissioning and delivering healthcare services, and takes overall responsibility for the health and wellbeing of the population it serves. This responsibility is further underpinned by the Functions of the Health Boards (Scotland) Order 1991 (as amended). NHS Boards are discrete legal entities and legally accountable and responsible for how they carry out their functions, services, duties and responsibilities.

15. As at 1 March 2020, the Board consisted of 24 members (currently 27), all formally appointed by Scottish Ministers, including:

- a publicly appointed non-executive Chair;
- 11 (currently 14) publicly appointed non-executive members (one of whom is specifically recruited and appointed to the role of Whistleblowing Champion);
- Seven stakeholder non-executive members, nominated by relevant stakeholder bodies, including:
  i. One councillor from each of the four local authorities in Lothian;
  ii. The Chair of the Lothian Area Clinical Forum
  iii. The Chair of the Lothian Area Partnership Forum & Employee Director
  iv. A representative of the University of Edinburgh's Medical School
- Five executive members (Chief Executive; Medical Director; Nurse Director; Director of Public Health; and Director of Finance)

16. Following the earlier resignation of the Lothian Board Chair on 31 January 2020, an interim Board Chair, Esther Roberton, was appointed by the Cabinet Secretary for Health and Sport from 10 February 2020. This interim appointment was later extended, running until 30 June 2021. The current Lothian Board Chair was appointed from 1 August 2021. During the short intervening period from 1 to 31 July 2021, the Board's Vice Chair was formally invited by the Cabinet Secretary to assume the duties of Board Chair.

17. In broad terms, the responsibilities and governance arrangements of territorial NHS Boards in Scotland are determined by the Scottish Ministers through legislation and supporting guidance. They are reflected and delivered via strategic and operational plans developed and approved by the relevant NHS Board, with formal Annual Delivery Plans (ADPs) being commissioned, approved and monitored by the Scottish Government. NHS Lothian had (and has) in place a governance structure whereby assurance of delivery is provided via a number of standing committees of the Board. This structure is supported through a range of documents, including Board Standing Orders, a Scheme of Delegation and Standing Financial Instructions. Best practice in the governance of Scottish NHS Boards has been described by the Scottish Government in The Blueprint for Good Governance in NHS Scotland, first published in January 2019 and revised in November 2022. The operation of the relationship and specific responsibilities between NHS Boards and the Scottish Government is reflected in the Framework Document for NHS Boards, DL(2024)08.

18. Following the onset of the Covid-19 pandemic, NHS Lothian implemented and operated a Covid-19 Command structure, comprised of Strategic (Gold), Tactical (Silver) and Operational (Bronze) groups. This structure is represented in **Exhibit DM2/01 INQ000507161**.

Overview of Health and Social Care Partnerships and IJBs, as at 1 March 2020

19. Within Lothian, the operating model for the planning, funding and delivery of adult social care is based on the integrated authority model. This involves NHS Lothian and the four local authorities (City of Edinburgh Council, West Lothian Council, Midlothian Council, and East Lothian Council) working together through Integration Joint Boards (IJBs) and Health and Social Care Partnerships (HSCPs) to respectively plan and deliver integrated health and social care services. This model was in place during the relevant period.

20. During the initial period of the Covid-19 pandemic, from March to May 2020, NHS Lothian put a range of measures in place to provide additional support to care homes in the four HSCPs, responding to various policy and clinical guidance issued. This included the development of a Health Protection Enhanced Outbreak Response (EOR) covering a range of areas such as provision of advice on PPE and infection prevention and control, reviewing the status of care homes to admit new residents, local

responses to Test and Protect arrangements, and support and guidance on the resumption of visiting. The response during this period was largely co-ordinated by the four HSCPs, with support from NHS Lothian according to its specific responsibilities.

21. Responsibilities within NHS Lothian in relation to adult social care developed following letters from the NHS Scotland Chief Executive in April 2020 and from the Cabinet Secretary for Health and Sport on 17 May 2020. These changes led to NHS Lothian assuming new and additional responsibilities, including establishing multi-disciplinary support and oversight arrangements for care homes.

22. The response of NHS Lothian and the four HSCPs to these additional responsibilities is described further in this statement and set out in some detail through the NHS Lothian Care Home Support Framework, provided as **Exhibit DM2/02 INQ000590651**. This document presents the way in which the Board provided multi-professional oversight of all care homes, irrespective of their status (private, local authority or third sector) during the Covid-19 pandemic.

23. The scope of NHS Lothian's formal accountability throughout the relevant period remained the same and its role was to add value to existing infrastructure, systems and processes and to provide assurance. Enhanced assurance and oversight arrangements did not replace existing accountabilities for the delivery of adult social care. The arrangements put in place were developed over time in response to further communication from the Scottish Government.

Overview of the local Health Protection Team (HPT) in NHS Lothian

24. The health protection remit of Scottish NHS boards is set out in a 2007 direction from the Scottish Government's Chief Medical Officer: CMO(2007)2 - NHS boards' health protection remit, provided as **Exhibit DM2/03 INQ000147834**. The specific role and functions of Scottish NHS Boards' Health Protection Teams (HPTs), including in relation to the investigation of outbreaks of infectious diseases in care homes, are further expressed in *The Management of public health incidents: guidance on the roles and responsibilities of NHS led incident management teams*, published by the Scottish Health Protection Network (SPHN) and provided as **Exhibit DM2/04 INQ000130954.** The current Version 12.1 (interim update) of this guidance document was published in July 2020, taking account of updated legislation for the COVID-19 outbreak.

25. NHS Lothian has a long-established HPT, operating in line with both the CMO direction issued in 2007 and the SPHN guidance (first published 2017), which provides subject matter expertise on the control and follow up of infectious diseases and other health protection hazards. The HPT had a community infection control remit for care homes providing advice and guidance in the event of an outbreak of infectious disease. At the start of the Covid-19 pandemic there were 143 registered care homes with 5,000 beds in the Lothian area. The HPT supported them with outbreak management. The HPT did not have a remit for assurance of infection control practice in care homes.

26. During the relevant period, the role and functions of NHS Lothian's HPT for outbreak management did not materially change and the team continued over this time to deliver its remit of providing advice and guidance to care homes on outbreak management. However, the way that this was done and the number of staff and partners involved in this work changed over the period and in response to the developing needs of the Lothian health and care system.

27. From March 2020, the HPT developed its internal and partnership structures as necessary to support Lothian care homes during any outbreak by providing in-depth Infection & Prevention Control (IPC) advice and outbreak information, including via an out of hours Health Protection Service. The size of the HPT increased during the relevant period, in response to developing needs and directions from Scottish Government. As well as additional support sourced from internal NHS Lothian departments, such as Public Health and Analytics, the HPT utilised the Lothian Staff Bank to increase its nursing complement from March 2020, until it was able to recruit additional permanent nursing resource in December 2020. In this way, the HPT ensured the provision of safe and appropriate staffing levels throughout the relevant period.

28. A key development in March 2020 was the establishment of a Covid Testing Outreach Service, drawing upon resource from NHS Lothian's HPT, Sexual Health Service and Regional Infectious Disease Unit (RIDU). The HPT was able to refer people to this joint service for testing (after assessment) and thereafter manage the results.

29. The HPT operated a case management system (HPZone), which is used by all Health Boards in Scotland) on which all care home outbreaks were documented by staff. A new system for outbreak management notes was created to link with the national Test and Protect Case Management System (CMS) that was established. From March

2021, all care home outbreaks within Lothian were documented on the outbreak management tool of CMS. A daily Care Home Situation Report (SitRep) was established from 5 April 2020 to ensure all Lothian partners had situational awareness of outbreaks and their severity and an example is provided as **Exhibit DM2/05 INQ000590658**.

30. The composition of the Lothian HPT during the relevant period included the following roles, in summary:

- **The Director of Public Health and Health Policy (DPHHP)** – the executive board member responsible for the management and delivery of the public health function in Lothian, and for ensuring there is an adequate health protection function in place. Specifically, the Director of Public Health in a Scottish NHS territorial board is responsible for the delivery of the functions outlined in CMO(2007)2 - NHS boards' health protection remit, provided as **Exhibit DM2/03 INQ000147834**
- **Consultants in Public Health (Health Protection)** – leading investigations and incident management responses for any care home outbreak. Developing and adapting health protection guidance for Lothian care homes, based on the national position. Collating weekly care home assurance reports and issued public health exclusions when required.
- **Consultants in Public Health (non-Health Protection)** – providing an on-call and out of hours health protection response. Supporting and leading Incident Management Teams of Problem Assessment Groups established in response to specific care home outbreaks in Lothian. Assisting with care home outbreak investigations.
- **Health Protection Nurses** - the investigation and control of communicable disease in care homes, participation in incident meetings, escalation of staffing concerns and the recruitment and retention of staff to support the pandemic response. Health Protection Nurses contributed significantly to the development of infection control advice and education in the use of PPE, social isolation, environmental disinfection and implementation of control measures.
- **Public Health Registrars** – working alongside the consultants on various tasks such as setting up testing teams and creating policies, working with infectious disease consultants to support the homeless and contributing to the surveillance and data analysis requirements for care home settings.

- **Other, non-HPT staff** – this encompassed a majority of staff within the NHS Lothian Public Health Department during the early period of the pandemic and a range of staff from other NHS Lothian departments at various times during the relevant period. Areas of responsibility included staff wellbeing, staffing, resource deployment and supporting key service priorities such as the set up and running of the initial Test and Protect Service or providing business, administrative and communication support for key governance and decision-making structures.

Hospital discharges

31. Within NHS Lothian, during the relevant period, patient discharges to the adult social care (ASC) sector (e.g., residential care homes) were made for patients who were deemed medically fit with no ongoing hospital care need, and for whom temporary or long-term residential care was considered to provide the most appropriate environment and level of care.

32. The decision to discharge patients was made by the NHS Lothian clinical team in charge of each individual patient's care. It was recognised that keeping patients who did not require hospital-based care in hospitals was associated with potential risk, and the majority of NHS Lothian acute hospitals provided shared bedroom accommodation. The relevant consultant in charge of a patient's care retained overall responsibility for clinical decision making.

33. In terms of risk assessments, procedures or policies on discharge, NHS Lothian followed UK and Scottish guidance provided by Public Health Scotland, Health Protection Scotland (latterly ARHAI) and the Scottish Government. Between 1 March 2020 and 21 April 2020 there was no requirement to test asymptomatic patients who were medically fit for discharge to adult social care. Patients who displayed symptoms consistent with SARS CoV2 were not considered appropriate for discharge and met criteria for diagnostic testing (PCR). This position was not materially different to pre-pandemic clinical practice.

34. The criteria used to discharge patients from hospital to care homes remained largely unchanged in March 2020. Discharge planning and decision making, undertaken by clinical teams, was based on a range of factors, including:

(i) Patient preference and need;

(ii) Multidisciplinary review and assessment (e.g. medical staff, nursing staff, physiotherapists, occupational therapists);

(iii) Assessment of clinical condition against baseline, including any significant functional or cognitive decline;

(iv) Assessment that a patient was medically fit for discharge (e.g., acute hospital care or treatment no longer required but ongoing social care need);

(v) Assessment of progress made against active rehabilitation to establish level of ongoing care and support needs;

(vi) Absence of new acute infection (for example raised temperature, new acute respiratory symptoms);

(vii) No ongoing outbreak (suspected or confirmed) in the ward area;

(viii) The availability of a package of care which matched the person's needs (this often led to delay in discharge);

(ix) Where a patient who did not required hospital-based continuing complex care (HBCCC) but whose social care needs could not adequately be met with carer support at home, residential care could be considered; and

(x) Availability of a suitable care home place.

35. It was acknowledged by hospital staff that being in hospital during the pandemic may also be associated with an increased risk of acquiring Covid, even where all available mitigations were in place. Therefore, discharge of a patient back to their usual place of residence or new care facility that matched their ongoing needs was usually viewed as the safer option for older vulnerable patients.

36. Patients with new clinical symptoms consistent with Covid infection were not transferred or discharged from hospital to adult social care settings.

37. Asymptomatic patients in a ward with suspected or known outbreak of infection (not just Covid) were not discharged to adult social care settings.

38. If patients were identified as case contacts, in line with national guidance, patients would be isolated or cohorted with other Covid contacts for up to 14 days.

39. There was a period in late March 2020 when care home providers were aware that Scottish Government were developing a proposal to require isolation and evidence of a negative test for all patients being discharged from hospitals to care homes. This is

evidenced by **Exhibit DM2/06 INQ000590659**, which represents email correspondence in late March 2020 between staff in the Edinburgh HSCP and NHS Lothian's Western General Hospital in relation to the discharge of a medically fit and asymptomatic patient from the hospital to a care home. Based on published Covid guidance at the time, only patients who met specific clinical criteria (temperature, new cough, loss of sense of smell, etc.) would be tested for Covid. NHS Lothian complied with this guidance. The correspondence provides an example of at least one care home's reluctance to accept the discharge of an asymptomatic patient without a negative Covid test, at a time when there was emerging awareness within some parts of the social care system of a pending policy change from the Scottish Government. **Exhibit DM2/07 INQ000590661** was an attachment to the relevant email trail and represents a summary note, drafted by representatives of the independent social care sector, of a briefing provided by the then Cabinet Secretary for Health to senior staff in the social care sector on 18 March 2020.

40. Guidance was subsequently issued by Health Protection Scotland (HPS) on 11 April 2020 advising that Boards should *consider* confirmation of viral clearance (by means of laboratory testing) for COVID recovered patients being discharged to adult social care where strict isolation was expected to be challenging. See **Exhibit DM2/08 INQ000189405.**

41. The introduction of routine and mandatory testing of asymptomatic patients prior to discharge to adult social care was first mentioned in the First Minister's media briefing of 15 April 2020 and subsequently announced in the Scottish Parliament by the Cabinet Secretary for Health and Sport on 21 April 2020.

42. In March 2020, the majority of adult residential care homes in the NHS Lothian Board area offered single bedroom accommodation. All had communal social areas for residents (lounge, dining areas, activity areas) and many had some shared facilities (bathrooms, accessible toilets). All individuals discharged by NHS Lothian to adult social care settings were deemed medically fit for discharge and that their ongoing care needs could best be met in residential care. Any existing clinical needs were considered as part of matching individuals to available care. NHS Lothian is unable to comment on the ability of adult social care providers to meet new clinical care requirements associated with SARS CoV2 or other conditions. Some care homes employ registered nurses, others are predominantly staffed by care workers, but all have access to medical review through local GP services.

43. Prior to April 2020, there was no formally documented discharge policy. However, all individual discharges were discussed between the relevant hospital ward and the receiving care home. The challenges in maintaining social distancing, compliance with isolation or mask use and consent to screening in patients with dementia or other cognitive impairment/lack of capacity was recognised in the context of NHS hospital care. NHS Lothian's Infection Prevention Control service was not requested to advise on these specific issues in social care settings. However, additional guidance could be provided to care homes from the NHS Lothian Health Protection Team, as necessary (e.g., on patients unable to isolate due to medical needs, such as dementia) and care homes could escalate any specific challenges via the relevant HSCP.

44. In advance of 21 April 2020, there had been multiprofessional consultation in the development of NHS Lothian internal IPC/patient placement guidance for step down of hospitalised patients to care homes. **Exhibit DM2/09 INQ000547779** provides an email from NHS Lothian's lead Infection Control Doctor (ICD) summarising actions and stakeholder involvement up to 16 April 2020. The draft discharge pathway developed from these discussions, and attached to the ICD's email of 16 April 2020, is provided as **Exhibit DM2/10 INQ000547781**. This document was received and considered at a meeting of NHS Lothian's Acute Silver Tactical Group on 16 April 2020.

45. No additional PPE requirements were indicated by national guidance for the care of asymptomatic individuals being discharged from hospital to care home settings. Standard infection control precautions applied. Typically, this would indicate the use of disposable gloves and aprons for direct personal care where there was potential exposure to body fluids. In the absence of respiratory symptoms (e.g. cough, runny nose) a Fluid-Resistant (Type IIR) Surgical Face Mask (FRSM) was not indicated at that time for the care of people with no symptoms.

46. NHS Lothian was aware of some examples where care homes were reluctant or refused to accept patients discharged from hospital in March 2020 based on a recognition that older people were potentially more vulnerable to infection, and in part based on information available to them from Scottish Government, available as **Exhibit DM2/06 INQ000590659**. These concerns were addressed directly with providers at the time.

47. NHS Lothian did not knowingly discharge patients from hospital to care home settings if they were known to be Covid-19 positive and within 14 days of symptom onset or first positive test, if they were contacts of Covid-19 patients (for example from a ward with a suspected or confirmed outbreak of Covid-19) or had new symptoms consistent with Covid-19 infection. Evidence is provided in a document discussed further below, see **Exhibit DM2/11 INQ000590663**.

48. A total of 559 patients were discharged from NHS Lothian to adult social care homes between 1 March 2020 and 21 April 2020. 17.7% (n=99) of these patients were tested in line with extant guidance at the time (testing for those with symptoms of infection) and four of those 99 patients tested positive for Covid-19. It should also be noted that patients required capacity to consent to testing and be clinically appropriate (for example not testing due to end-of-life care or distress to the patient). Further detail is provided in a Public Health Scotland report commissioned by the Scottish Government and published on 28 October 2020: *Discharges from NHS Scotland Hospitals to Care Homes between 1 March and 31 May 2020*, provided as **Exhibit DM2/12 INQ000101020**.

49. NHS Lothian is unable to provide data on how many patients were discharged from its hospitals to care homes without two negative COVID tests after 21 April 2020. NHS Lothian undertook its own internal review of hospital discharges to care homes between 1 March 2020 and 31 May 2020 and therefore data are presented for this period only in **Exhibit DM2/11 INQ000590663**. The limitations of both the Public Health Scotland report from October 2020 and NHS Lothian's own report in December 2020 review are set out in the paragraph above. These are further highlighted in section 7 of the NHS Lothian report.

50. Whilst it would likely be technically possible to provide the Inquiry with information on the number of patients discharged to care homes with two negative tests after 21 April 2020, gathering and analysing the necessary data requires a manual and resource-intensive Case Note Review process, drawing from various sources and systems. This would represent a very significant resource ask of a small specialist team within NHS Lothian. This would be to the detriment of the ongoing delivery of clinical care and critical patient safety activity. Should the Inquiry determine that receipt of this data is necessary, we would require to first cost and risk assess the impact of the work required to provide it.

Enhanced oversight and assurance of care homes

51. On 17 April 2020, the Directors of Public Health (DPH) of Scottish NHS boards were tasked by the Scottish Government to take "immediate action" to lead, plan, initiate, and coordinate "an enhanced system of assurance" around the safety and wellbeing of care homes. To support this, DsPH were also required to prepare and provide a weekly assurance report for Scottish Government.

52. Subsequently, on 20 April 2020, all Scottish NHS Boards were instructed by the NHS Scotland Chief Executive to complete an initial assessment of every care home in their area (by phone or direct visit), use this to develop a programme of "associated visits" to each local care home, and to provide an outline of this initial programme of visits by 24 April 2020, with weekly updates thereafter. This instruction is contained in **Exhibit DM2/13 INQ000364126**.

53. Each of the four HSCPs in Lothian, under the direction of the NHS Lothian DPH, undertook immediate efforts to complete the initial assessments for their respective local authority area. By 24 April 2020, each HSCP had provided an update to the DPH of progress achieved since 17 April. At that point, three of the four HSCPs had completed initial assessments for all care homes in their area. Edinburgh HSCP (the largest local authority area in Lothian) had completed initial assessments for the majority of relevant care homes but, despite attempting contact with all care homes, had been unable to establish the necessary level of direct engagement with several at that initial stage to undertake a full assessment. The initial returns from each of the HSCPs to the DPH by 24 April 2020 are included as **Exhibit DM2/14 INQ000590665**, **Exhibit DM2/15 INQ000618526**, **Exhibit DM2/16 INQ000618527**, and **Exhibit DM2/17 INQ000618528**.

54. This position informed the initial assurance return provided from the NHS Lothian DPH to the Scottish Government on 24 April 2020, which is contained within the appendix 32 of **Exhibit DM2/02 INQ000590651**. This initial assurance incorrectly stated that assessments had been undertaken for all Lothian care homes at that time. As noted above, Edinburgh HSCP had been unable to reach the required personnel at a number of care homes, despite attempting contact with all between 17 and 23 April 2020. Those not assessed by the time of the NHS Lothian DPH's return to the Scottish Government were prioritised for urgent assessment. The weekly report required thereafter was initially prepared and submitted by the NHS Lothian HPT, but

responsibility was passed to NHS Lothian's Corporate Care Home Programme Team from 5 June 2020. An example of the weekly assurance reports compiled within NHS Lothian and provided to the Scottish Government is included as **Exhibit DM2/18 INQ000590666**.

55. The required assurance reporting process from 24 April 2020 onwards was initially supported in NHS Lothian by the introduction of a daily "care home call" between the NHS Lothian DPH and all four HSCPs (from 7 May 2020) and a weekly Tactical Meeting (from 12 May 2020).

Initial Assessments of care homes in Lothian

56. Initial Assessments were conducted by all four Lothian HSCPs between 17 and 24 April 2020. These were carried out over the telephone by a member of staff from each HSCP. In April 2020, not all HSCPs had established care home teams with Registered Nurse involvement so a range of staff were involved in contacting the care homes, such as Quality Officers and Service Managers. The Care Inspectorate was not involved in these Initial Assessments. As noted above, outcome reports from these Initial Assessments were provided to the NHS Lothian DPH, as the executive with oversight for care home assurance.

57. Standardised reporting tools were not available in this very short initial period and each of the four HSCPs utilised the approach or format most appropriate to their own situation and there was some variability in approach at this stage. Some HSCPs utilised pre-existing self-assessment Infection Prevention and Control (IPC) templates to report on IPC measures. Templates were also used to report on confirmed cases, safe staffing and PPE availability. A common assurance tool and TURAS reporting mechanism were made available later in the pandemic and were appropriately utilised by HSCP care home support teams. TURAS is a digital platform developed by NHS Education for Scotland (NES) to support health and care professionals working in the public sector in Scotland.

58. As noted above, three of the four Lothian HSCPs were able to complete Initial Assessments between 17 and 24 April. Edinburgh HSCP experienced difficulty in establishing direct contact with all care homes in the Edinburgh area during this short period. In addition, the NHS Lothian HPT contacted any Lothian care homes experiencing an outbreak of Covid-19 during this period. At the time of the initial

assurance return to the Scottish Government on 24 April 2024, the HPT was actively following up on 13 outbreak cases and the NHS Lothian DPH noted in her return that support was being offered to 50 care homes with outbreaks. During March and April 2020, the HPT had followed up by telephone in regard to outbreak cases in 73 care homes across Lothian (Edinburgh: 46; East Lothian: 8; Midlothian: 7; West Lothian: 12). The need for outbreak management was defined as a care home with two or more linked cases of Covid. The collective experience of Lothian HSCPs indicated that some care homes were resistant to direct visits at that time, due to fear of introducing Covid-19 within the care home environment.

59. Overall, the Initial Assessments were received positively and provided assurance that Lothian care homes had a good understanding of the relevant issues and had put processes in place to deal with the pandemic. Specific interventions were identified that required additional generic support to be developed for all care homes across Lothian, as well as some more targeted or specific support needs for individual care homes. The majority of care homes engaged fully and positively with the assurance process. However, some declined the offer of a direct visit and requested technology facilitated support in order to reduce the number of visits to the care home and thus reduce the risk of Covid-19 entering the care home environment.

60. Generally, Lothian care homes expressed a need for further support around using PPE, which required direct visits to those care homes. A common concern was highlighted around the availability of facemasks with reported delays of two to three weeks at that time in deliveries to care homes. Themes around IPC were also common with advice sought on the use and appropriateness of cleaning products and whether they could be used on soft furnishings. Care homes are non-clinical environments and available guidance at the time focused on clinical areas. Care home staff expressed concerns that the care homes were losing their personal touch. There were questions raised around how to ensure the maintenance of residents' human rights. Testing for both staff and residents for Covid-19 was identified as an area that required further support and guidance.

61. A key theme arising from Initial Assessments was the need to ensure sufficient levels of staffing without overreliance on bank or agency staff who may be working across different care homes. From the Initial Assessments, it was clear that care homes were keen to do the right thing but required further support and guidance in key areas.

"Associated Visits" to care homes in Lothian

62. Following the Initial Assessments, the Associated Visits were considered to be an opportunity to offer an initial response to issues identified by providing supportive assurance from NHS Lothian and HSCPs to care homes. This principle of support was later expanded and expressed via the NHS Lothian Care Home Support Framework, available as **Exhibit DM2/02 INQ000590651**. NHS Lothian's focus in this area was to ensure that care homes within Lothian were able to meet the standards required to keep residents and staff safe, and to ensure that further support was offered and provided wherever it might be indicated that standards were not being met.

63. As with Initial Assessments, the Associated Visits were undertaken by staff from within each HSCP's care home support team and involved a range of personnel with experience of adult social care. Most visits were untaken by registered nurses, although a small number of visits to City of Edinburgh Council care homes were undertaken by other social care staff. All staff involved were up to date with mandatory professional requirements for their roles. Visits were conducted through a mix of remote and in person means, with visits in the earlier phase being conducted exclusively by remote means. Engagement between individual care homes and the NHS Lothian HPT was by telephone.

64. The Associated Visits were designed according to the expressed needs and concerns of care homes and provided opportunities to work directly with care home staff on donning/doffing PPE, undertaking clinical reviews of unwell residents, anticipatory care planning support and training, end of life care and bereavement debriefing and support.

65. Each HSCP undertook discussions with care home staff during the Associated Visits, providing clarity on expectations in relation to five priority areas:

(i) knowledge and implementation of infection prevention and control measures;
(ii) knowledge and observance of social distancing measures, both for staff and residents;
(iii) staffing levels at all times and for all functions;
(iv) the availability and quality of training for all staff in particular on infection control and the safe use of PPE; and
(v) the effective use of testing.

66. Oversight for the governance and process of Associated Visits was provided by the NHS Lothian DPH between 17 April and 17 May 2020. Following this, executive responsibility was passed to the NHS Lothian Executive Nurse Director. This was in response to a direction from the Scottish Government. In the period that preceded the establishment of specific care home operational groups, regular huddles organised by the HSCP Chief Nurses were used to share experience and promote consistency in the absence of clear common guidance. Relevant structures and processes are fully reflected within **Exhibit DM2/02 INQ000590651**.

67. Key themes identified from the Associated Visits related to: the suitability of care home environments, achieving appropriate IPC standards, donning/doffing of PPE, waste management processes, laundry services, maintaining the general health and wellbeing of residents, education of care home staff, and workforce capacity.

Multi-disciplinary clinical assurance and oversight of care homes in NHS Lothian

68. Following a direction from the Scottish Government's Cabinet Secretary for Health and Sport on 17 May 2020, **Exhibit DM2/44 INQ000320162** and **Exhibit DM2/45 INQ000320169**, NHS Lothian immediately implemented a structure of strategic oversight via two key groups:

69. The **Care Home Strategic Oversight Group**, with weekly meetings chaired by the NHS Lothian Executive Nurse Director.

70. The **Pan-Lothian Operational Group**, with daily meetings (Monday-Friday) chaired either by the NHS Lothian Director of Nursing for Primary Care or a member of senior staff in the Care Home Programme Team.

71. This structure continued to develop within NHS Lothian post-May 2020 in response to the Cabinet Secretary's direction. Appropriate multi-disciplinary structures were put in place involving the DPH, Executive Nurse Director, Executive Medical Director from within NHS Lothian and the Chief Officers and Chief Social Work Officers from each of the four HSCPs. Full details of how the requirements were implemented and operated are provided via **Exhibit DM2/02 INQ000590651**.

Assurance of multi-disciplinary care home teams in NHS Lothian

72. The NHS Lothian Care Home Strategic Oversight Group provided overarching governance and professional scrutiny across care homes in Lothian. Its responsibilities

included setting metrics for weekly oversight, ensuring infection prevention and control (IPC) standards, and addressing clinical and care governance issues. The group also offered assurance to NHS Lothian's governance committees and reviewed risks escalated by operational teams.

73. The Care Home Strategic Oversight Group originally met weekly from 26 May 2020, moving to fortnightly meetings after 15 March 2021, subsequently moving to monthly meetings in March 2022. The role of the Care Home Strategic Oversight Group was to:

(i) Provide oversight and professional scrutiny in relation to infection prevention and control standards across all care homes in Lothian.
(ii) Agree a set of agreed metrics to be used for weekly oversight of care standards.
(iii) Provide oversight, professional leadership and support in relation to clinical and care governance standards.
(iv) Seek assurance through the Pan-Lothian Operational Group that met daily (Monday to Friday), and through them the individual partnership huddles, that local intelligence and data was being used to ensure that there was a clear line of sight to each care home in each HSCP area.
(v) Provide assurance to the Strategic Management Group that there was a robust system in place in relation to care homes.

74. The Care Home Strategic Oversight Group, through its Chair, provided appropriate assurance to the NHS Lothian Board and its Healthcare Governance Committee with regular briefings and formal reports. Each HSCP's Chief Officer was required to report relevant assurances via their respective Integration Joint Board (IJB).

75. A Multi-Agency Task Force was also created and convened as required, for high-risk scenarios, such as potential care home closures or severe Covid-19 outbreaks. Led by an Integrated Joint Board Chief Officer, the Task Force facilitated and co-ordinated responses by involving relevant stakeholders, including the Care Inspectorate. Its role included deciding on legislative or operational actions required to address escalating risks.

76. The Multi-Agency Task Force Group's specific role was to:

(i) Provide a point of escalation for the Strategic Oversight Group where risks and issues could not be resolved.

(ii) Convene to discuss the scenario of a care home failing.

(iii) Convene to discuss the possibility of care home owners walking away from responsibilities of the home and the consequences thereof.

(iv) Provide a platform for multiple agencies to discuss said scenarios.

(v) Agree legislation and authority of actions to address scenarios.

(vi) Provide oversight and professional leadership and support in relation to clinical and care governance standards (within the care home and care at home context).

77. The Pan-Lothian Operational Group met daily (Monday-Friday) and comprised members of the multi-disciplinary care home assurance team. This Group focused on the management of care home issues across Lothian. It was responsible for:

(i) Monitoring and managing Covid-19 outbreaks, including co-ordinating testing and specialist interventions;

(ii) Providing feedback on staffing levels, IPC concerns, and PPE availability; and

(iii) Supporting care homes through direct interventions e.g., supportive assurance visits, data collection via tools such as compliance with the TURAS Safety Huddle.

78. The Pan-Lothian Operational Group included representatives from each Lothian HSCP, who worked closely with the wider HSCPs and partners. Each of the four Lothian HSCPs had local operational meetings where issues were considered and, if necessary, escalated to the Pan-Lothian Operational Group. Any issues not resolved there were escalated to the Strategic Oversight Group.

79. Full details of the operation of these key oversight groups are set out within the Care Home Support Framework document with the governance structure illustrated via Figure 1: Lothian Care Home Governance and Escalation. See **Exhibit DM2/02 INQ000590651**.

80. The governance and escalation model described above enabled NHS Lothian to manage care home challenges effectively by integrating expertise across disciplines, maintaining clear oversight, and ensuring rapid responses to emerging issues.

81. Prior to 17 May 2020, initial local assurance assessments and arrangements had been undertaken by HSCP staff under instruction from the Scottish Government to DsPH. Each HSCP adopted their own process but all care homes were contacted, and initial assessments were undertaken with support to HSCPs assess end prioritised

dependant on the outcomes of these. The primary differences in assurance arrangements post-17 May 2020 were:

(i) A pan-Lothian approach to assurance;
(ii) Clear and transparent governance arrangements;
(iii) Clear roles and responsibilities;
(iv) Clear escalation and reporting framework;
(v) Key stakeholder engagement including care home/care at home representation;
(vi) Timely dissemination of evolving guidance and support with interpretation;
(vii) Multiagency platform to raise issues and problem solve;
(viii) A project management approach to ensure actions were documented, undertaken and timelines met;
(ix) Transparency;
(x) Shared learning; and
(xi) Supporting each other and the sector.

Operation and key themes of the Pan-Lothian Operational Group

82. The Pan-Lothian Operational Group met frequently during the relevant period with arrangements fluctuating from daily meetings (Monday-Friday) to two or three meetings per week. This frequency was determined by the specific requirements at the time. The changes in meeting frequency during the relevant period are set out below:

- 25 May 2020 – daily (Monday to Friday)
- 10 August 2020 – three times a week (Monday, Wednesday, Friday)
- 24 August 2020 – daily (Monday to Friday)
- 01 March 2021 – three times per week (Monday, Wednesday, Friday)
- 26 April 2021 – twice per week (Monday and Thursday)
- 23 July 2021 – three times per week (Monday, Wednesday, Friday)
- 29 December 2021 – daily (Monday to Friday)
- 31 January 2022 – three times a week (Monday, Wednesday, Friday)
- 21 February 2022 – twice per week (Monday and Thursday)
- From 21 April 2022 – weekly (Thursday)

83. All key stakeholders were represented at this Group and engaged in collaborative decision-making and information sharing. Representation on the Group during the relevant period included:

- Nurse Director of Primary and Community Care
- Chief Nurse from each of the four HSCPs or a deputy
- Care Home Support Team Leads from each HSCP.
- Social Work Managers
- Health Protection Team – Medical and Nursing
- Infection Prevention and Control Team Lead
- Testing team
- Staff Bank for mutual aid
- Clinical Education & Training Lead
- Lothian Unscheduled Care Service
- Care Inspectorate Area Team Leads (x2)
- Scottish Care Independent Sector Lead
- Care Home Programme Team

84. The Groups reviewed and discussed data provided via the safety huddle tool. All care homes were encouraged and supported to input data to the safety huddle tool. Intelligence from all parties regarding Covid-19 cases and outbreaks were raised and discussed at each meeting. All representatives were able to raise concerns or questions about the care of residents, with issues discussed and a plan of support agreed if required. Concerns could also be raised about the ability of care homes (either collectively or individually) to respond to the various challenges of Covid-19 and appropriate support was discussed and agreed in relation to a range of issues, including: outbreak management; "supportive visits"; testing (capacity, availability of tests, and responsibilities); staffing and workforce; PPE supply; education & training; and vaccinations.

85. Each of the four Lothian HSCPs also maintained their own local Care Home Oversight Groups, which met frequently, with information and concerns escalated from these to the Pan-Lothian assurance structure as required.

86. During the relevant period, NHS Lothian took a lead responsibility in relation to the additional assurance and oversight duties assigned to the Board's DPH and later

Executive Nurse Director. Weekly local reports were created and circulated to all key stakeholders. An example report is provided as **Exhibit DM2/19 INQ000590667**.

87. From 17 May 2020, responsibility for clinical oversight of care home assurance sat with the NHS Lothian Executive Nurse Director. Responsibilities were delegated internally to the Nurse Director of Primary and Community Care and locally to the Chief Nurses in the four Lothian HSCPs.

88. Analysis of issues, risks and the development and implementation of solutions to support care homes in Lothian was a responsibility shared between the NHS Lothian Chief Executive, Executive Nurse Director, Director of Public Health, Executive Medical Director and locally between HSCP Chief Officers and Chief Social Work Officers, who escalate matters within the established oversight and governance structures as required.

89. Each stakeholder in the multi-disciplinary structure had a responsibility for reporting and escalating issues, identifying and implementing solutions, offering support, guidance and advice, and sharing learning.

90. In terms of formal risk identification, recording and mitigation, a specific risk was escalated to and managed via the NHS Lothian Corporate Risk Register in July 2020, and subsequently revised in October 2020 and April 2021. A Care Home Risk Management Strategy was developed in June 2020. Both the risk and the supporting Strategy were set out in the NHS Lothian Care Home Support Framework at page 98 and page 100, respectively. See **Exhibit DM2/02 INQ000590651.**

Assurance visits carried out by local care home assurance teams

91. The Cabinet Secretary's letter of 17 May 2020 required the establishment of a system and process for a "supportive visit" in each older people care home in the NHS Lothian Board area.

92. In response, a "Supportive Visit Assurance Tool" was developed by the Lothian Care Home Programme Team in consultation with Care Home Managers, Chief Nurses, key stakeholders in the HSCPs, the Care Inspectorate and Scottish Care. This is included as **Exhibit DM2/20 INQ000590668**. The Tool was based on the principles of support

rather than scrutiny and focused on three key elements. There were two components to the tool and process:

(i) Self-assessment by the care home manager for each of the three elements based on open questions on what had worked well and what could be better/could have been improved.
(ii) An assurance tool with the following criteria:
    a. Infection Prevention and Control
    b. Health and Care Needs during theCovid-19 pandemic
    c. Workforce

93. There were similarities between these supportive visits and the associated visits in place prior to 17 May 2020 as the purpose remained to provide multi-disciplinary support and assurance to enable each care home to follow the range of national guidelines on Covid-19. As a minimum, the work was required to cover an assessment in respect of each care home on:

(i) knowledge and implementation of infection prevention and control measures;
(ii) knowledge and observance of social distancing measures, both for staff and residents;
(iii) staffing levels at all times and for all functions;
(iv) the availability and quality of training for all staff in particular on infection control and the safe use of PPE; and
(v) the effective use of testing.

94. The supportive visits were undertaken by the local HSCP Care Home Support Teams with involvement of a range of other HSCP staff and a small number of Registered Nurses that were seconded to the Care Home Programme Team with relevant experience of older people care. The relevant staff attended a training session on the background, assurance tool, recording and the expectations for the visit. Information given during the training sessions is reflected in **Exhibit DM2/21 INQ000590669**.

95. The Care Inspectorate were not involved with carrying out the supportive visits. However, if there were serious concerns identified at the visit these would be

discussed and escalated via the HSCP and Pan-Lothian oversight and assurance structures, which included Care Inspectorate Team Leads.

96. Supportive visits were carried out in person by two members of NHS Lothian and HSCP staff. This was a two-way process with a member of the care home staff encouraged to join a physical walk round and discuss any concerns.

97. The supportive visits conducted in Lothian were always prearranged and agreed with the relevant care home manager or their deputy. Each care home manager was asked to use the tool to undertake a self-assessment and return this to the visiting healthcare professionals that were undertaking the assurance visit prior to the actual visit.

98. NHS Lothian established a Care Home Reference Group to ensure that the work of the NHS Lothian Care Home Programme Support met the needs of care home managers and HSCP partners. This Group included key stakeholders and care home managers and developed the Supportive Visit Assurance Tool, referenced above.

99. Following the completion of the first round of assurance visits a comprehensive review was undertaken of the tool. This involved consultation with HSCP staff that had undertaken the supportive visits and the Care Home Reference Group. Feedback indicated that the underpinning principles of support as well as the existing structure had been valued by care home managers. A revised tool with several amendments was developed and approved in February 2021.

100. Each of the four local HSCPs coordinated and had local oversight of the visits for their respective area. Each HSCP reported progress to the Lead Nurse, QI and Standards as part of the Care Home Programme Team. Responsibility for final approval of the assurance tool and for the governance of the programme of visits sat with the Care Home Strategic Oversight Group.

101. During the relevant period, all adult care homes in Lothian received a formal assurance visit. The period during which these were conducted and completed in each HSCP area is set out below:

(i) East Lothian: 19 June 2020 to 31 July 2020 (19 care homes)
(ii) Edinburgh: 17 June 2020 to 18 September 2020 (65 care homes)
(iii) Midlothian: 10 June 2020 to 30 June 2020 (11 care homes)
(iv) West Lothian: 10 June 2020 to 22 July 2020 (15 care homes)

102. A second round of visits was undertaken across Lothian care homes between April and July 2021. Some HSCPs undertook further formal and regular assurance visits in collaboration with care home managers, usually at the request of the care homes themselves. Where no further formal assurance visits were undertaken, the HSCP maintained a nominated key contact to undertake a weekly supportive visit, in addition to a daily telephone call.

103. The programme of supportive visits initiated in response to the Cabinet Secretary's direction on 17 May 2020 were understood to be separate and differentiated from formal assurance visits undertaken by the Care Inspectorate and Health Improvement Scotland.

104. In June 2020, NHS Lothian supported the Care Inspectorate during formal inspections of care homes against Key Question 7 "How good is our care and support during the COVID-19 pandemic". A group of senior nurses with experience of assurance and inspection of older people services supported the Care Inspectorate inspections with HIS colleagues on elements of IPC. These Nurses were allocated to support inspections and any follow up support activity by the Lead Nurse for Care Home Quality and Standards.

105. A process for this arrangement was agreed between NHS Lothian and the Care Inspectorate with clarification of the nature and purpose of these inspections in contrast to the supportive assurance visits, which also commenced in June 2020.

106. Following discussions with the Scottish Executive Nurse Director (SEND) Group, this arrangement was discontinued in November 2020 in order to maintain a consistent approach across all Health Boards.

Advice provided to local care home assurance teams

107. All staff that undertook assurance visits were aware of the difference between the care provided in a Residential Care Home, compared to care provided in a Nursing Care Home.

108. Staff were aware they were undertaking supportive assurance visits and aware of their role, what it was, and was not and the difference between scrutiny/inspection and the Care Inspectorate's statutory assurance role. The assurance visits conducted within Lothian involved Infection Prevention and Control staff, which resulted in the challenge of the application of clinical approaches and standards to the care home environment.

National and local policies or procedures applicable to assurance visits in Lothian

109. NHS Lothian developed and delivered training and guidance, informed by an assessment of the alignment and difference between Care Inspectorate or Health Improvement Scotland inspections and supportive visits. This is reflected in pages 140-141 of the Board's Care Home Support Framework, previously referenced as **Exhibit DM2/02 INQ000590651**.

110. Relevant documents were also shared as essential pre-reading for supportive visits, including in relation to the Care Inspectorate's Quality Indicator 7 and its *COVID-19: Information and Guidance for Care Home Settings, Version 1.52 (June 2020)*. These are provided as **Exhibit DM2/22 INQ000618533** and **Exhibit DM2/23 INQ000618534**.

111. Staff undertaking or supporting visits always followed the relevant PPE guidelines in place at the time. No different approaches to IPC were applied by staff undertaking visits within care homes.

112. Lateral Flow Device testing (LFT) of all designated visitors, including visiting healthcare professionals, was introduced to care homes following publication of a letter from the Scottish Government on 25 November 2020. This came into place in early January 2021. Temperature testing was also in place.

Clarity of roles in relation to local enhanced assurance arrangements

113. The expectations, responsibilities and accountabilities around care home assurance were new and implemented immediately on issue. Measures were implemented in good faith based on the evidence and guidance available at the time, and changed rapidly as data, evidence and guidance evolved.

114. Guidance was often revised during the week and issued to Health Boards late on a Friday with immediate implementation expected. The pace and extent of change was unprecedented.

115. There was a conscious effort to support staff directly involved in assurance to deal with the extent of the changes and the trauma they witnessed and experienced in the initial period of the pandemic.

Mechanisms to ensure shared learning and good practice

116. During an assurance visit, there was verbal feedback with the care home manager followed by the issue of a written report detailing the agreed action plan. Each HSCP had their own internal governance process for review of the reports and follow up of action plans.

117. All reports following assurance visits were submitted to the Care Home Programme Review for entry into an online survey tool, supported via the Jisc (JOS) JISC Surveys, a web-based tool, that allows users to create, distribute, and analyse surveys.For confidentiality reasons a unique ID number was allocated to each care home resulting in the tool identifying the HSCP but not the individual care home. This permitted collation of findings and the identification of themes and recommendations to help prioritise ongoing support.

118. Following the first round of assurance visits, a summary table was produced and is provided as **Exhibit DM2/24 INQ000590670**. This identified what worked well, what could have been better and examples of good practice that were observed in individual care homes. The final report was widely circulated to a range of stakeholder groups with follow up presentations. There was a presentation and discussion on the process and findings at the Strategic Oversight Group on 9 November 2020. The findings from this report were influential in the workforce planning that led to the development of the substantive NHS Lothian-wide Corporate Care Home Programme Team infrastructure. A second report was produced from the second round of assurance visits in 2021, and this is provided as **Exhibit DM2/25 INQ000590671**.

119. The key themes of learning during this period related: environment of care, Infection Prevention and Control, PPE including donning and doffing, testing, waste

management, laundry services, residents' health and wellbeing, education, and workforce.

Key issues and use of emergency powers

120. Each assurance visit resulted in a written report that was shared with the care home, the HSCP and NHS Lothian. If specific improvements were required, an action plan was agreed with the care home and locally followed up by the HCSP.

121. All reports were collated and themed from both rounds of assurance visits. Themes from the assurance visits informed the focus of supporting activity undertaken by the HSCPs and NHS Lothian in the following areas:

(i) Secure email transmission
(ii) Direct referrals to specialist teams e.g., Tissue Viability Team, Dieticians, Podiatry etc.
(iii) Mutual aid
(iv) Infection Prevention and Control including standard infection control precautions and transmission-based precautions.
(v) Personal Protective Equipment including donning and doffing.
(vi) Resident and staff wellbeing
(vii) Visiting arrangements
(viii) Education and Training including the formation of the Lothian Care Academy
(ix) Quality Improvement support
(x) Cleaning, laundry, refuse/waste management

122. The NHS Lothian DPH provided a weekly report to the Scottish Government's Care Home Rapid Action Group throughout the relevant period. This included their assessment of outbreak management and care homes' ability to comply with guidance. Any issues or concerns arising about the ability of specific care homes to cope or sustain best practice were escalated via this weekly report, for awareness or action. The number of care homes for which issues were reported varied week on week, from none to a maximum of 11. Issues or concerns raised via these reports included:

(i) compliance with IPC measures
(ii) supply and application of PPE

(iii) testing (supply, compliance and delays with results)

(iv) application of other outbreak measures, including resident isolation, residents walking with purpose, and cohorting of residents and staff

(v) staffing, including the impact of staff isolation and absence due to Covid-19

(vi) the care home built environment and the challenges it created for compliance with guidance

(vii) large scale investigations

(viii) Care Inspectorate requirements and letters of serious concern

123. Routine sharing of information, escalation and implementation of support plans to address issues including "significant issues" were undertaken via the Operational, Strategic and Multiagency Taskforce groups. The Care Inspectorate were integral members of each of these groups. Escalation also happened outwith the cycle of weekly meetings if matters were considered time critical. However, no significant issues were formally escalated by the NHS Lothian leadership to the Care Inspectorate or Scottish Government, outwith these established reporting and accountability mechanisms.

124. At no time during the relevant period was there a requirement in Lothian to exercise emergency powers under sections 63A-63B of the Public Services Reform (Scotland) Act 2010 in relation to care homes.

Effectiveness and impact of the enhanced assurance arrangements

125. NHS Lothian's position is that the enhanced assurance arrangements were effective in improving outcomes as they provided focused enhanced support to care homes that required support at a very challenging time. The care homes would have been isolated without the additional support provided by the enhanced arrangements.

126. Key stakeholders including care home staff contributed to the assurance arrangements and the co-design of the assurance tool that was utilised. Initially, there were some misconceptions that the assurance visits would be similar to scrutiny rather than a supportive arrangement. There is anecdotal evidence of a small number of care homes who were reluctant to engage with the assurance visits and reluctant to allow NHS/HSCP staff to enter the care home. Discussions took place with care home providers, Scottish Care, Care Inspectorate, and other stakeholders to clearly

differentiate between the purpose of the assurance visits and Care Inspectorate inspections enabling assurance visits to progress across all care homes in Lothian.

127. During the early stages of implementation, in May 2020, some confusion between respective roles was perhaps to be expected, given the new arrangements and ways of working. However, NHS Lothian worked with the Care Inspectorate to quickly develop information detailing the differences to provide clarity to all stakeholders. Documentation, training and expectations were standardised across Lothian wherever possible, with some variation in resources and support models in the HSCPs where this was necessary to meet local needs. Evidence of this is provided via **Exhibit DM2/02 INQ000590651**.

Access to medical/health care

128. The clinical models and arrangements through which medical support continued to be provided to adult social care residents is set out here.

129. General Practice, both in and out-of-hours, continued throughout the relevant period to provide general medical services to all patients, including residents in care homes. The mode of consultation did switch rapidly to more remote assessments compared to the previous model of largely face-to-face consultations. However, home visits continued where clinically appropriate (the thresholds did change and will have varied based on professional judgement) with clinicians having appropriate PPE in place.

130. In NHS Lothian there was, and continues to be, a Local Enhanced Service to allow for a lead practice to be in place for each care home for older people. The specific Enhanced Service covering residents in care homes during 2020/21 is provided as **Exhibit DM2/26 INQ000618537**. However, all enhanced services were suspended between 1 April 2020 to 1 October 2020 to allow practices to focus on core General Medical Services (GMS) delivery. It should be noted that providing care to all patients regardless of where they are resident is part of core GMS. The enhanced services were resumed on 1 October 2020 in a phased way, with full activity returning from 1 April 2022. The impacts of the suspension of this specific Enhanced Services (and others) would have been variable across different general practices, dependent on each one's prior level of engagement with care homes.

131. Care homes did receive additional support from the HSCP Care Home Teams who were in contact with all care homes and available for telephone advice or visits, as described in more detail elsewhere in this statement. The Care Home Teams undertook clinical assessments of residents in care homes, supported the management of long-term conditions, wound care and end-of-life support, where requested by care homes.

132. Hospital at Home services remained open to referrals for care home residents, and the HSCP Care Home Teams and Hospital at Home Teams worked closely together.

133. General Practice clinicians, both in and out-of-hours, continued to visit residents in care homes where clinically required, ensuring appropriate PPE in place. However, as outlined above there will have been variation based on individual professional judgement.

134. Across the whole of NHS service delivery there was a shift to greater use of remote consultations. For most general practices, telephone consultations were used. NearMe also became more widely available and utilised as a service. Both were widely spread across NHS Lothian infrastructures including patient facing appointments.

135. This was rolled out at pace, to provide the functionality to maintain contact between clinicians and patients. A subsequent exercise was undertaken to strengthen the pathways and ensure sustainability where appropriate including training materials and Governance across NHS Lothian.

136. HSCP Care Home Support Teams undertook clinical assessment and worked to develop Anticipatory Care Plans (ACPs), Emergency Care Summaries (ECS), and DNACPRs for care home residents, where appropriate, as these were not routinely in place for care home residents at the outset of the pandemic. Care Home Teams also undertook a liaison role with GPs, Hospital at Home and other professionals to try and ensure the best possible healthcare was provided to care home residents. Further details on how HSCP Care Home Support Teams supported these areas is available in Section 4 and Appendix 15 of the NHS Lothian Care Home Support Framework, provided as **Exhibit DM2/02 INQ000590651**.

137. NHS Lothian does not hold and is therefore unable to provide the number or percentage of GP consultations with care home residents that were carried out by

remote means during the relevant period. It is possible to disaggregate GP activity by telephone or face to face, however, we are unable to break down the patients as to whether they were in receipt of adult social care. **Exhibit DM2/27 INQ000618538** illustrates trend data over time, including during the relevant period, on the number of physical versus virtual appointments undertaken by GPs in Lothian. **Exhibit DM2/28 INQ000618539** illustrates similar trend data on different consultation types (e.g., clinic, home visit, surgery consultation, telephone, and video/eConsult), also comparing GP activity against other clinicians. The overall number of NearMe consultations carried out in general practice in NHS Lothian during the relevant period (27 months) was 7,521. We cannot easily or reliably break down this data to provide patient numbers for this cohort.

138. We have no specific information about problems that recipients of adult social care in Lothian may have faced during the relevant period regarding their ability to access or utilise remote consultations. However, we note that Scottish Government funding was available that enabled the provision of devices and connectivity to care home residents and staff to support the shift to digital delivery.

139. Within NHS Lothian, face-to-face assessments continued to take place where clinically appropriate. This applied across various groups of staff including GPs, Care Home Teams, Hospital at Home and District Nursing.

140. There were no known or reported issues faced by recipients of ASC accessing medicines in Lothian during the relevant period. Community Pharmacies continued to provide pharmaceutical services throughout the pandemic.

141. Notwithstanding this, NHS Lothian took a range of actions to enhance medicines availability to patients during the pandemic, including the significant step up in stock holding at Lothian Unscheduled Care Service (LUCS) sites, enabling LUCS District Nurses (DN's) to hold within "grab bags" anticipatory care medicines for administration against a Patient Group Directions (PGD), Provision of Your To Take Out (TTO) packs from LUCS or Emergency Departments. We had, and continue to have, our on-call 24/7 palliative care network of pharmacies who can dispense medicines prescribed including Just in Case Medicines as required.

142. In response to the nationally developed guidance for Repurposing Medicines in Care Homes and Hospices for Health Board consideration, NHS Lothian's Area Drugs and

Therapeutics Committee approved this guidance for use in May 2022. However, it was considered appropriate to discontinue the use of this repurposing guidance document as well as nursing team "grab bags" within NHS Lothian, following the Scottish Government announcement that NHS Scotland would no longer remain on an emergency footing after 30 April 2022. The Lothian Area Drugs and Therapeutics Committee therefore stood down and withdrew the procedures on 10 June 2022.

143. There were some reported issues in accessing equipment, for example syringe drivers were ordered but did not arrive and so there was a reliance on utilisation of subcutaneous injections rather than continuous infusion. This did resolve after the early stages of the pandemic.

144. NHS Lothian is not aware of any formal or specific concerns about potential misinterpretations by care homes of early guidance. It is considered possible that early scenario planning and discussions, whilst national guidance was still being developed, may have resulted in misconceptions amongst staff across the health and social care system. However, once national guidance was issued and clarified, we have no indication that any such perceptions persisted. It is important to note that care homes managed multiple residents at the end of life and therefore may have experienced relatively high levels of mortality over short periods in the weeks of March and early April 2020. However, NHS Lothian does not hold data on relative mortality levels in care homes.

End of life care / DNACPR notices

145. NHS Lothian is not aware of any significant increases in the use of ACPs, DNACPR notices or the number of people choosing to die at home during the relevant period.

146. However, there had been a concerted effort in Edinburgh HSCP to promote good practice in Anticipatory Care Planning (ACP), following the 'Seven Steps to ACP' framework and this preceded the pandemic.

147. During the relevant period, the NHS Lothian Clinical Education Team provided palliative care courses in the form of webinars, which were shared with care homes, and staff were actively encouraged to attend.

148. The OSCaRS (Ongoing Supportive Conversations and Reflection Sessions) programme was piloted in 2020 and mainstreamed in 2021 to provide care home staff with structured opportunities for learning and emotional support in palliative and end-of-life care.

149. NHS Lothian finds no evidence that DNACPR national policy was applied inappropriately or in a blanket manner in relation to care homes nor that any treatments were inappropriately withheld during end-of-life care for care home residents.

150. During the relevant period, GP practices, District Nurse Teams, Palliative Care teams and Hospital at Home services in Lothian provided palliative care support for care home residents. Additionally, the LUCS service provided service to care home residents and supplied oxygen concentrators to care homes when required.

151. The four HSCP Care Home Teams provided support regarding palliative care advice, signposting and guidance when required. The same teams strived to provide this care that do so in normal circumstances and there are no reports of teams unable to or struggling to provide palliative care. Clearly there were challenges related to the situation especially during the times with significant restrictions but overall, the service continued as expected and the teams involved adapted to the different ways of working. Of particular note was the willingness of NHS Lothian District Nurse Teams who provided the vast majority of face-to-face contact for patients and families at that time. They did this with the support of palliative care and GP teams but undertook a far greater proportion of the face-to-face work.

IPC and PPE

152. NHS Lothian established a Strategic PPE group on 18 March 2020, initially called the PPE and Essential Supplies Sub-Group. This group was chaired by the NHS Lothian Executive Nurse Director who was also the Board's Healthcare Associated Infection (HAI) Executive lead. It was a subgroup of the Board's Strategic Gold Command Group. The supply and distribution of PPE to care homes in the NHS Lothian Board area was coordinated and monitored through this group.

153. NHS Lothian supported care homes and other home care on an extraordinary/emergency need basis if it was evident that their own supply chain had

failed. These chains were purchases they had made via their own purchase orders or from national stockpiles issued using the HSCP hub model, which included a hotline contact service for this sector, set up by Scottish Government and NHS National Services Scotland (NSS).

154. The NHS Lothian Associate Director of Procurement acted as Single Point of Contact (SPOC) to co-ordinate extraordinary/emergency PPE issued from the Health Board as required.

155. NHS Lothian's approach to supply and decision making in relation to PPE for care homes is summarised in the NHS Lothian Covid-19 PPE Framework 2020, provided as **Exhibit DM2/29 INQ000590672**. The Board prioritised the supply of PPE to those areas providing care for people with suspected or confirmed Covid-19 infection. During periods of supply chain uncertainty for key items of PPE, a risk-based hierarchy of control approach was adopted by the Board across all care settings and was not limited to primary care or social care services. The Board approach reflected core principles of prioritisation, redistribution and substitution.

156. The principle of mutual assistance featured very strongly in all aspects of the management of PPE, both across NHS Lothian services and in support of wider partners in social care, independent contractors in general practice, hospices, and private care homes. Greater detail on the management and distribution of PPE was provided through NHS Lothian's previous statement provided in response to the Inquiry's Module 5 (M5/NHSL/01).

157. As the primary supply chain for care homes and/or home care was via national stockpiles or their conventional supply chains, the Health Board's stocks were for Acute and Primary Care use, and extraordinary/emergency stock requests were met and issued to care homes and/or home care sector if stock was available without detriment. It is worth noting that health boards were also supplied from the NSS National Distribution Centre national stockpiles and so working stock was held in wards and departments with low volume buffer stock areas set up in hospitals to allow out-of-hours access. As the Health Board did not have any distribution networks to this sector, care home staff were requested to pick up emergency stock from Health Board sites.

158. PPE Hubs were established from October 2020, in line with a Scottish Government directive, with the resulting partnership arrangements reflected in **Exhibit DM2/30 INQ000147352** and **Exhibit DM2/31 INQ000147342**. Prior to this, a process had been established within NHS Lothian in April 2020 to ensure a daily stock take of PPE supplies, which is reflected in **Exhibit DM2/32 INQ000590674.**

159. NHS Lothian did not seek formal evidence of IPC policy implementation and assurance in care home settings. That was (and remains) the role of the Care Inspectorate as the regulator for these services. A baseline of IPC practice and processes was provided through the programme of supportive assurance reviews undertaken across each HSCP between June and September 2020. These involved appropriate clinical and social care staff but not IPC specialists. The visits were intended to identify areas for further support and advice in line with the Board responsibilities laid out by the Cabinet Secretary's letter of 17 May 2020.

160. The visits considered application of standard infection control precautions (SICPs) including the availability and use of PPE by staff. The appropriate use of PPE emerged as one of the themes from initial review. These findings were also reflected in external regulatory inspections undertaken by the Care Inspectorate and considered in information submitted to the NHS Lothian's Care Home Strategic Group in July and September 2020. Relevant examples are provided in **Exhibit DM2/33 INQ000590675** and **Exhibit DM2/34 INQ000590676**.

161. The NHS Lothian IPC team supported the development of education and training resources, including videos and posters, to support care home staff. These resources focused on aspects of standard and transmission-based precautions and any COVID specific IPC guidance. This included the safe use of PPE.

162. Where additional education or training in the use of PPE was identified as part of supportive assurance visits noted above this was facilitated or provided by NHS Lothian through the NHS Lothian Clinical Education Team, and the HSCP Care Home support team.

163. Compliance with the availability and use of PPE was noted to have improved in the second tranche of review visits that was conducted between April and July 2021, referenced above as **Exhibit DM2/25 INQ000590671**.

164. NHS Lothian is not best placed to comment on the extent to which individual care home providers or staff found PPE guidance difficult to interpret or apply. That question would best be answered by staff managing and working in those settings.

165. NHS Lothian recognised that care home staff often had limited access to the necessary provision to undertake online training, and in the context of a busy care environment even prior to the pandemic, freeing staff time to attend training was often difficult. It was also recognised that some staff did not have English as a first language. Practical face-to-face training and demonstration was used effectively in these circumstances.

166. There was initially confusion in relation to the sessional use of fluid resistant surgical face masks (FRSM) as this represented a change from pre-pandemic guidance. Staff working in both hospital and residential care home settings raised this with care home support, health protection and IPC teams in NHS Lothian.

167. Prior to the Pandemic, education, training and access to a range of online and printed IPC resources specifically designed for social care settings was available and actively promoted to care home providers through the NHS Scotland Education for Scotland (NES). This included a hard copy IPC "pocket book" (2013). These resources have been updated and are still available as an online resource via Healthcare Improvement Scotland.

168. It was evident early in 2020 that PPE, including nitrile gloves, was subject to increasing and unconventional global demand and that suppliers were unable to quickly meet increased domestic demand. Prior to the national stockpile and hub model issues to care homes and home care sector, NHS Lothian's Procurement Team did respond to enquiries from this sector as to alternative suppliers we were aware of which may help the sector should their conventional suppliers be unable to supply. In general, the increase in demand for respirator face masks and the need to face-fit test a significantly larger cohort of Health Board staff users and make available a range of masks suitable for individual face shapes, was a particular concern addressed.

169. Prior to the pandemic, IPC guidance was readily available to inform glove product selection the national infection prevention and control manual (NIPCM, NES resources). NHS Lothian is unable to comment on the extent to which care home providers procured vinyl, latex or other disposable gloves over nitrile examination

gloves on the basis of local policy, preference or cost in the period until early 2020. PPE provided through the PPE community hubs complied with NHS Scotland evidence-based IPC policy and the national procurement framework.

170. It is understood that, prior to the pandemic, residential care facilities in Scotland were expected to comply with the Infection Control Standards for Adult Care homes (2005), which include requirements to take measures to prevent the risk of infection, apply appropriate procedures for the control of infection, operate in line with best practice guidelines, and ensure clearly defined responsibility and accountability. This would incorporate the use of PPE (gloves, aprons) and hand hygiene for routine aspects of personal and clinical care, and transmission-based precautions as part of outbreak control (for example norovirus, influenza). Key parts of the Standards include page 1, paragraph 4 and page 7, standard 1, which are available in **Exhibit DM2/35 INQ000547784**. The provision of PPE to protect staff is a requirement of Health & Safety legislation as part of COSHH in response to a microbiological hazard (i.e. bacteria or virus). The provision of appropriate PPE is therefore not limited to a hospital setting.

171. Within those standards, internal compliance monitoring (audit) of the application of IPC guidance was advised as best practice. The use of fluid resistant surgical face masks and eye protection, although included in SICPs, are likely to have been infrequently used in care home settings. The infection prevention and control actions advised during the relevant period for residential social care providers fully aligned to existing IPC policy and practices defined for these settings. The IPC position reflected the understanding of the pathogen and mode of transmission at the time.

172. Formal external scrutiny of compliance and assurance of safety against national care home standards was provided by the Care Inspectorate (formerly the Care Commission) in Scotland as the regulator of these services.

173. Care home environments are encouraged to provide a home like environment. Many are provided in buildings which were not purpose built, or which do not reflect current NHS Scotland design or technical guidance for health and care facilities. The environmental condition should not preclude effective cleaning and a good standard of environmental hygiene. Some care homes were noted as needing renovation.

174. Creating a home like environment will frequently include the use of materials and soft furnishings which would not be considered appropriate in a clinical hospital environment. This was a recognised challenge for providers in relation to use of chlorine-based disinfectants advised by national IPC guidance before, and during the pandemic as these can cause staining/bleaching of surfaces. Alternative non-bleach-based disinfectants were available, but no clear guidance offered from national guidance on the selection of these.

175. IPC/PPE training was delivered directly to staff in individual care homes, and via an open weekly MS Teams channel. Written resources were shared via email and hard copy provided for local display where appropriate. If concerns regarding availability or use of PPE were identified by the NHS Lothian HPT as part of outbreak investigation and management, advice was provided in real time by the HPT and care home staff were directed to the available support and resources noted above.

176. NHS Lothian provided access to a range of resources to support PPE policy (local guidance, flowcharts, education) as well as signposting staff to the range of resources published by PHS, HPS and UKSHA. This included guidance and other resources specifically written for social care settings. A care home specific version of the national infection prevention and control manual (NIPCM) was issued as guidance in May 2021. This document was intended to provide clarity on requirements for residential settings. The Care Inspectorate also ran a series of IPC webinars for care home staff over this period.

177. The NHS Lothian HPT also provided education and training on Standard Infection Control Precautions (SICPs) and outbreak control for care home providers prior to 2020. Guidance on SICPs was available in the form of Preventing Infection in Social Care Settings, published by NHS Education for Scotland (NES). This is provided as **Exhibit DM2/36 INQ000590677**.

178. The NHS Lothian IPC team supported the development of local education and training resources including videos and posters for care home staff. These resources focused on aspects of standard and transmission-based precautions and any COVID specific IPC guidance. This included the safe use of PPE, and an example of relevant training materials is provided as **Exhibit DM2/37 INQ000590678**.

179. Many care homes identified a staff member to act as IPC champion to support their own staff with awareness and safe implementation of IPC guidance including use of PPE. These staff also carried out compliance audits to provide local assurance and feedback on compliance and improvement opportunities within the workplace. This approach was best practice and aligned to the national care standards and the community NIPCM.

Care home staff and residents

Staffing levels

180. A key principle of the supportive arrangements initiated by NHS Lothian was the provision of staffing mutual aid to care homes in order to maintain standards of care, particularly in the face of staff absence (including requirements for self-isolation). Staffing was very challenging across both health and social care during this period.

181. In NHS Lothian an agreed process was developed, and mutual aid was initiated on 9 May 2020 through the establishment of Staff Bank pools of Registered Nurses and support workers in each HSCP. Details of the Provision of Mutual Aid to Care Homes in Lothian are set out in the Care Home Support Framework at **Exhibit DM2/02 INQ000590651**.

182. From May 2020 to March 2021, 1,591 shifts were requested from Lothian care homes for both Registered Nurses and support workers with 809 shifts filled by NHS Lothian. Mutual aid was provided to the care homes in Lothian at no cost to the care home provider during this period.

183. Initial scoping work was undertaken for the potential to establish a Care Home Staff Bank run by the NHS Lothian Staff Bank. The existing NHS Lothian Staff Bank extended their scope to include the provision of Registered Nurses and support workers to the four HSCPs and local authority care homes.

184. On very rare occasions, when a care home was in extremis, NHS staff from community teams, Care Home Support Teams, District Nursing and Community Hospitals were deployed to support staff and provide care for residents.

Wellbeing of staff and residents

185. NHS Lothian had existing specialist psychology-led multidisciplinary teams in three of the four HSCPs as part of local Older People Mental Health provision in place prior to the pandemic. A core remit of these teams was to provide direct assessment and needs-led formulation interventions and case management for distressed behaviour in people with dementia; deliver a care home staff training programme, deliver the NHS Education Scotland (NES) Essentials in Psychological Care Dementia training; and offer drop-in/consultation clinics to support early and proactive strategies and support.

186. NHS Lothian's specialist care home psychology staff compiled a Wellbeing Resource Pack of original and recommended resources specifically aimed at supporting care home managers and staff. These were widely distributed across the care homes and accompanied by a visual aid/poster. Psychology Leads in each specialist care home team offered support calls to their local care home managers. The frequency and content of this was led by the needs of care homes, although a core theme was managers discussing staff and personal wellbeing.

187. The NHS Lothian "Here4U" helpline, staffed by psychology practitioners, was made available to all health and social care staff including those working in care homes, from March 2020. This offered an individual consultation, with follow-up and/or signposting for support aligned with the principles of Psychological First Aid.

188. Ongoing Supportive Conversations and Reflection Sessions (OSCaRS) are facilitated, reflective debriefing sessions, supporting staff with palliative, end of life care scenarios. As noted above, OSCaRS were piloted during this period and are currently established as an excellent resource to support staff wellbeing and learning.

189. A Reflecting Back, Looking Ahead survey was undertaken in April 2021 to capture the experiences and views of senior staff working during the preceding year within care homes across Lothian. This survey reviewed what worked well, and what could have been better and provided evidence for future focus and priorities. The survey report, compiled in May 2021, is provided as **Exhibit DM2/38 INQ000590679**.

Testing

NHS Lothian's role and responsibilities for testing in care home settings

190. During the pandemic, NHS Lothian played a critical role in coordinating and implementing testing strategies across the adult social care sector. This responsibility was in line with national guidance issued by the Scottish Government, focusing on safeguarding vulnerable populations, ensuring workforce safety, and mitigating virus transmission within care settings.

191. In March 2020, NHS Lothian provided a single point of access for staff testing through occupational health services, operating a seven-day testing service. In April 2020, NHS Lothian was tasked with ensuring effective testing use, prioritising cases such as first outbreaks, explosive outbreaks, and complex situations. Enhanced outbreak investigations were carried out by the Enhanced Outbreak Response Team involving testing ASC residents and staff, tracing contacts, and extending testing to linked care homes where staff moved between sites.

192. In June 2020, testing was expanded to care homes with prior outbreaks but no active cases, as well as those without outbreaks. Weekly operational capacity supported up to 200 tests daily, with resident testing led by trained care home staff and supported in homes lacking nursing staff. Contingency plans included mobile units, local self-testing, and exploring UK Government facilities to ensure timely testing and results. Co-ordination through daily multi-agency meetings ensured outbreaks and testing strategies were effectively managed. From June 2020, there was routine testing of care home staff.

193. Once regular asymptomatic PCR testing for staff was implemented to prevent outbreaks, NHS Lothian oversaw the distribution and processing of test kits. Staff with Covid-19 symptoms, along with symptomatic household members, were given priority access to testing.

194. On 14 December 2020, the Scottish Government issued a guidance pack on the introduction of Lateral Flow Testing (LFT) for Care Homes. Thereafter, LFT testing was introduced as a supplementary measure for faster results.

195. NHS Lothian's HPT coordinated outbreak testing in care homes throughout the pandemic. Initially, an outreach testing service for symptomatic care home residents and housebound patients in the community was set up. This progressed to the team

carrying out whole-home testing for staff and residents to contain and trace virus spread as an outbreak control measures. NHS Lothian's approach to care home testing was summarised in a letter to the Scottish Government in June 2020 and this is provided as **Exhibit DM2/39 INQ000590680**.

Testing of symptomatic care home residents

196. Throughout the relevant period, there were some instances when testing was refused by care home residents. In March 2020, there were a small number of recorded instances of individual instances of delays to testing for the reasons listed below. The specific durations of these delays are not recorded:
    (i) GP awaiting appropriate PPE;
    (ii) GP not having correct swabs;
    (iii) Care Home not having any swabs (X3);
    (iv) GP stating they did not have testing guidance;
    (v) GP 'not happy to test' but not recorded why;

Examples of good practice in testing

197. The NHS Lothian Community Outreach Testing Team was established in April 2020 to test symptomatic residents. This team conducted whole-home testing visits, coordinated and assisted with swab collection and the packaging of samples for the lab. They liaised with the HPT to prioritise testing according to need and to manage the results.

198. Prior to the establishment of testing hubs, a robust process with a Standard Operating Procedure (SOP) was implemented to deliver test kits for care home staff testing. NHS Lothian established an efficient weekly testing system, with test kits centrally ordered, prepared, and distributed alongside pre-printed labels for the labs. Care homes adhered to a set testing schedule, ensuring proper stock management and secure packaging of tests for courier collection. This well co-ordinated approach, involving care homes, NHS, HSCPs, and couriers, ensured timely and reliable testing and results.

199. Care home support teams actively liaised with care homes, providing assistance as needed and some details and actions on the process relating to testing in care homes is provided in **Exhibit DM2/40 INQ000590681**.

200. NHS Lothian faced specific challenges including data inconsistencies, limited testing capacity, and the need to adapt to rapidly evolving national guidelines. These challenges have been highlighted and evidenced in greater detail through NHS Lothian's previous statement provided in response to the Inquiry's Module 5 (M5/NHSL/01), in particular paragraphs 45-68 outlined challenges around the guidance available prior to March 2020, the rapid evolution of guidance during March and April 2020, and the challenges of interpretation, infrastructure requirements and implementation. Paragraphs 76-99 and 138-143 of that statement are also relevant. Daily operational group meetings with stakeholders across the sector were initially held, later transitioning to three times a week, with the flexibility to increase frequency as needed. These meetings provided a platform to discuss care home outbreaks, enabling the Health Protection Team, testing teams, and care home support teams to effectively coordinate outbreak responses and subsequent testing arrangements.

201. The relevant paragraphs, mentioned above, from NHS Lothian's previous statement to the Inquiry's Module 5 (M5/NHSL/01) are reproduced below for completeness.

M5/NHSL/01 – paragraphs 45-68

GUIDANCE ON IPC / PPE

45. The following part of my statement provides general comment on the experiences of the NHS Lothian Board and its staff during the relevant period in relation to the quantity and quality of guidance provided on IPC and the use of PPE. It also reflects on the impacts arising for NHS Lothian and its staff from changes to guidance and describes some of the challenges in interpretation, dissemination and implementation of such guidance.

46. The content of my statement is restricted to key policy changes which resulted in significant change or difficulties relating to IPC guidance and PPE in order to provide the Inquiry with a broad understanding of our experience of the key challenges. The total volume of information and detail which might be provided in relation to both IPC guidance and PPE over the relevant period would be excessive and may not assist the Inquiry.

47. *For context, it is important to understand the position relating to IPC guidance, staff education and training, and High Consequence Infectious Diseases (HCID) preparedness, prior to the relevant period. I have provided a brief explanation of this for consideration.*

48. *Prior to January 2020, NHS Lothian had implemented the National Infection Prevention and Control Manual (NIPCM) as extant policy and guidance. This was a mandatory requirement directed by CNO 2012 (1) in NHS Scotland since January 2012 Exhibit DM/006 [INQ000507266]. NIPCM is provided by National Services Scotland Antimicrobial Resistance and Healthcare Associated Infection Scotland (ARHAI) previously known as Health Protection Scotland (HPS). The NIPCM is underpinned by literature reviews of available evidence. It covers all aspects of standard and transmission-based precautions required to care for those with, and without a known transmissible infection, including the use of PPE.*

49. *In practical terms, this means that prior to the start of the pandemic a standardised approach to infection prevention and control, including the selection and use of PPE was well established in NHS Scotland. Induction and mandatory update training on IPC in NHS Lothian reflected the content of the NIPCM. The use of type iiR fluid resistant surgical face masks (FRSM) and face filtered piece respirators (FFP3) was advised for the care of patients with infections transmitted by droplet transmission, or airborne transmission including aerosol generating procedures, respectively.*

50. *In January 2020, any patient presenting with clinical signs of an acute respiratory infection and who met epidemiological criteria for Wuhan Coronavirus (WuCoV) (later renamed as Covid-19) had to be treated as a HCID. The management of an HCID was not (and is not) covered in any detail by NIPCM.*

51. *Published guidance on HCID at 1 January 2020 was available from HPS (when this body comprised of both IPC and Public Health national advisors), PHS (latterly UKSHA) and other organisations, including the Advisory Committee for Dangerous Pathogens (ACDP). Much of the HCID guidance available focused on responding to infections such as viral haemorrhagic fevers (e.g. Ebola) which are not primarily transmitted by an airborne route.*

52. *At this point in time, there were a number of unresolved issues relating to the*

content and consistency of HCID guidance, as well as a number of known limitations in the infrastructure, capability and capacity to implement HCID PPE guidance. These issues had been raised between Scottish NHS Boards and HPS (ARHAI) since at least 2016 through various routes, including via the HPS Respiratory Protective Equipment Expert Advisory Group (RPE EAG) a national working group.

53. *Therefore, between 1 January 2020 until early March 2020 when SARS CoV2 was classified as an HCID, there were acknowledged gaps or inconsistencies in the guidance as written at the time and significant unresolved practical issues in implementing the guidance. These points were raised by NHS Lothian representatives with HPS directly in national teleconferences in January 2020, convened in response to the emerging situation.*

54. *NHS Lothian was challenged in practical terms to implement HCID guidance (and specifically PPE guidance) more widely outside of the existing referral and admission pathway into the Regional Infectious Diseases Unit (RIDU). The RIDU pathway was and is only applicable to adult patients.*

55. *The main challenges for implementation related to which products were advised, which models of FFP3 were available in stock, which alternative products were available, the capacity to rapidly expand face fit testing, the procedures for safely donning and doffing a full HCID PPE ensemble, as well as the availability of useful educational packages or other resources to support staff on these points.*

56. *As at 5 February 2020, there were differences in the level of PPE advised in guidance documents for hospital and non-hospital-based care in response to an HCID. National guidance issued at the start of the pandemic, advised that despite classification as an HCID, staff in community health services (for example general practitioners) should wear FRSM and not FFP3 as required for management of HCID in a hospital setting.*

57. *There were multiple guidance documents and instructions issued to NHS Scotland specifically on PPE over the course of the relevant period. There were also a large number of other national policy or guidance documents issued which directly, or indirectly, influenced the selection and use of PPE over the same time.*

58. *Guidance and policy documents were issued by Health Protection Scotland (HPS) later ARHAI, Public Health England (PHE) later UKSHA, and Public Health Scotland (PHS) as a separate entity following the creation of ARHAI in 2021. Other departments within or affiliated to the UK or Scottish Governments, for example the Chief Dental Officer, Health Facilities Scotland also issued guidance. Additionally, there were joint publications issued on behalf of the United Kingdom four nations devolved health services (commonly referred to as "4 Nations" guidance).*

59. *The experience of NHS Lothian was that practical implementation of guidance was frequently challenging, and at times, simply not possible. Often, generic guidance on the provision and use of PPE was difficult to interpret and apply meaningfully in a range of real-world clinical scenarios. Different guidance documents aimed at different clinical disciplines were sometimes inconsistent. For example, guidance issued on aerosol generating procedures (AGPs) in dental practice conflicted with the guidance issued to oral/maxillofacial surgeons working in hospitals. These types of issues were largely left for staff within NHS boards to resolve.*

60. *The period between January and September 2020 was particularly intensive in regard to the frequency and nature of updates and changes being made in relation to PPE guidance.*

61. *Changes were sometimes made on a weekly basis, and it was common for PHE and "4 Nations" updates to be provided at around 1700hrs on a Friday evening. Advance release of this guidance was not provided to senior staff at NHS Board level who were responsible for the implementation and operational management of changes to guidance.*

62. *IPC Teams within NHS Boards did not have visibility of draft guidance on PPE. For the purposes of IPC, all Scottish territorial and special health Boards were represented by ARHAI at national forums where guidance was developed, discussed and approved. NHS Boards were therefore heavily reliant on discussion at the weekly HPS ICM Incident Support Group on any proposed changes but generally had no visibility of the emerging detail of those changes, and little or no ability to influence guidance prior to issue. The action log from the ICM forum of 26 March 2020 is provided for illustration see Exhibit DM/007 [INQ000507285].*

63. *Concerns about the lack of advance consultation with local IPC Teams on draft guidance were raised with ARHAI and the Scottish Government through the weekly Board IPC forum. There was some improvement in the engagement and advance notification of policy change with IPC teams and executive teams over the course of 2020 and 2021, but this could be sporadic and, where draft guidance was provided, there were often very challenging timescales in which to provide feedback. Overall, this caused operational challenges for implementation of guidance, which impacted upon staff anxiety and confidence. See Exhibit DM/008 [INQ000507298] evidence of updated changes to acute care guidance.*

64. *In general, updated IPC and PPE guidance was usually disseminated by email to a wide distribution list that included staff across the NHS and other public bodies. Sometimes updated guidance was accompanied by a formal CNO or CMO letter providing instruction on actions and timescales for implementation. Policy and guidance documents were also updated simultaneously on the publicly available websites of PHE, PHS and ARHAI. Staff who received updated guidance via their roles on external advisory or working groups also distributed these updated guidance documents within their own professional or immediate clinical teams.*

65. *This meant that, at times, the dissemination of guidance could be perceived as poorly controlled. Whilst it was understood that updated guidance and information needed to be distributed in a timely way to ensure awareness and rapid implementation, it was also important that the messaging to staff was clear and consistent and accompanied by practical advice relevant to each local context. For example, by signposting to relevant resources and training and ensuring that questions or concerns raised to local IPCTs would receive a meaningful, timely response. In practice, local IPC staff were often still trying to digest the changes made and understand their application locally. This made it challenging at times to be able to offer practical help, advice and reassurance to staff in a timely manner, thereby contributing to increased anxiety amongst staff.*

66. *The practical implementation of the changes to IPC and PPE guidance was almost always complex. It frequently required the input and expertise of a wider multidisciplinary team (e.g. procurement staff, health & safety team, communications team, clinical leads, Staff Partnership, educators).*

67. *There were specific challenges in practically applying generic PPE guidance in a meaningful way across different patient populations (e.g. neonatal units, adult critical care units, mental health wards, community), across a range of clinical care interventions (e.g. surgical procedures, speech and language assessments) and with relevance to both clinical and non-clinical staff, who may be present for some, or all of their shift in a specific location, or who worked entirely peripatetically.*

68. *There were frequently infrastructure challenges to be addressed (ordering, supply, delivery, storage), a need for consultation, communication issues (why guidance was changing and how) as well as education and training needs which had to be considered. These changes had to be delivered efficiently, effectively and at speed in the context of a rapidly evolving outbreak, high levels of clinical uncertainty (diagnosis, treatment, disease progression and outcome) and wider societal change and disruption. As a result, there was, at times, an increased level of anxiety amongst staff across the organisation.*

M5/NHSL/01 – paragraphs 76-99

PPE guidance changes between 1 March and 10 April 2020:

76. *As outlined above, until March 2020, Covid-19 was classified as an HCID, requiring hospital staff to wear a full ensemble of PPE which comprised FFP3 respirator, eye protection, coveralls, apron, double gloves, wellington boots and disposable aprons. In NHS Lothian, all suspected or confirmed adult patients would be admitted to the RIDU at the Western General Hospital, or a defined area in critical care at Royal Infirmary of Edinburgh. Guidance on HCID management and PPE had been circulated to a wide range of clinical staff within NHS Lothian.*

77. *During this time, national guidance advised that healthcare staff working outwith high-risk hospital settings, for example GPs, should wear fluid resistant surgical face masks (FRSM) if face to face consultation was unavoidable.*

78. *The New and Emerging Respiratory Threats Advisory Group (NERVTAG) declassified Covid-19 as an HCID on 19 March 2020. This meant that routine use of FFP3 and the HCID PPE ensemble was no longer required.*

79. *Boards were advised to follow published HPS policy, which aligned to pre–Pandemic National IPC policy. Staff were advised to follow droplet transmission-based precautions if providing direct care to suspected or confirmed Covid patients (unless an AGP was carried out – where FFP3 was required). Outside of that direct care activity, no PPE was advised for use by clinical or non-clinical staff. English and Scottish Guidance contained differing information on whether masks should be worn within 1 metre or 2 metres of patients detailed in Exhibit DM/011 [INQ000507186].*

80. *These changes and points required to be communicated widely amongst staff, with a clear explanation of the rationale for change, as far as NHS Lothian understood that rationale at the time. Internal staff communications in NHS Lothian, including "Covid-19 Speedreads", issued from early March 2020 stated that the Board was following national guidance on PPE and facemasks and that stocks of FFP3 respirators were therefore prioritised for use in high-risk hospital settings. See Exhibits DM/012 -[INQ000507187] and DM/013 [INQ000507189].*

81. *IPC staff within NHS Lothian were contacted directly by many staff at the time, who expressed concern about this change to guidance on the use of PPE. A number of staff were anxious and increasingly requesting to wear type iiR FRSM or FFP3 outside of defined 'Covid' care areas. However, NHS Lothian and its IPCT staff were reliant on the accuracy and quality of expert advice and guidance being provided via national advisors and fora. See Exhibits DM/014 [INQ000507189] and DM/015 [INQ000410868]*

82. *Around this time, through the ARHAI weekly ICM Incident Support Group, IPC staff in NHS Lothian were made aware that further updated national PPE guidance was to be issued by PHE. There also appeared to be a growing awareness amongst wider staff within the Board that new PPE guidance was imminent. NHS Lothian had not seen the content of revised guidance by this stage.*

83. *Following conversations with HPS on Friday 27 March 2020, NHS Lothian's subject matter lead for IPC communicated with members of the NHS Lothian PPE Strategic group and Executive Leadership Team (ELT), relaying information she had received during a call with HPS in relation to the changing policy position. She highlighted some significant and material changes to the previous policy position as well as her*

opinion as the NHS Lothian subject matter lead on perceived risks around communication and staff confidence detailed in Exhibit DM/016 [INQ000507191].

84. *PHE published this updated guidance at close of normal business on Friday 27 March 2020. This meant that by Monday 30 March, a large number of staff working within NHS Lothian had already received this through peer networks or accessed the guidance via the PHE website. The status of this guidance in Scotland was unclear at that time and the NHS Lothian IPCT subsequently received a number of questions and concerns from staff in person, by telephone and by email.*

85. *The weekly IPC support meeting with HPS scheduled for Tuesday 31 March 2020 was cancelled. It was understood that this was in order to allow HPS colleagues to focus on reviewing COVID guidance and changes made by PHE over the preceding weekend. As a result, the NHS Lothian IPCT was unable to adequately respond to local queries about the content, interpretation and application of the changes to guidance published by PHE. Likewise, the IPC subject matter lead within NHS Lothian was unable to provide immediate advice to Gold Command or the PPE Strategic Group on what steps the Board was required to take. Exhibit DM/017 [INQ000507192] is an email exchange amongst members of the ICM Incident Support Group that demonstrates the concerns about delays in confirming the status of the 27 March guidance in Scotland.*

86. *One of the difficulties in interpreting the updated PHE/4 Nations guidance of 27 March 2020 related to its instruction to adopt 'droplet precautions' in a wide range of generic scenarios. Following pre-Pandemic and extant Scottish guidance, this inferred the need for patient source isolation, enhanced cleaning with chlorine products and the use of gloves, aprons, and FRSM by staff even when not providing direct patient care. NHS Lothian duly advised its staff to follow this guidance as written.*

87. *Following further discussion with HPS over April, it became clear that national advisors were using the term 'droplet precautions' as shorthand for routine use of fluid resistant surgical face masks and that the updated guidance did not require all aspects of droplet precautions to be applied. Where FFP3 were advised, this was often referred to as "airborne" precautions, even if all of the other aspects of airborne precautions were not required.*

88. *This was one example of an often confusing and inconsistent use of accepted terminology which was not uncommon in guidance updates and discussions up to the end June 2022. In this instance, NHS Lothian acknowledged and addressed the concerns raised by staff in its internal communications Speed Read detailed in Exhibit DM/018 [INQ000507193].*

89. *NHS Lothian's Executive Nurse Director and Executive Medical Director (as chairs of their respective national peer groups) had formally escalated concerns to the Scottish Government's Chief Nursing Officer (CNO) and Chief Medical Officer (CMO) in relation to the impact of inconsistent guidance on the supply and availability of PPE, and particular FFP3 respirators, on 27 March 2020, Exhibit DM/019 [INQ000507195]. A response was issued from the CNO and CMO to all Boards on 30 March 2020, Exhibit DM/020 [INQ000480631].*

90. *On 1 April 2020, the Scottish Government issued a letter to NHS Boards advising that updated PPE guidance was expected in Scotland. It broadly indicated that there would be changes to PPE advice, but included no details of what these changes would be. See Exhibit DM/021 [INQ000507197].*

91. *On 2 April 2020, the Scottish Government issued a further letter advising the publication of the revised guidance. Key to this communication were four PPE tables in the appendices, advising the level of PPE required by different staff in different settings, or by all staff in all settings if there was "sustained community transmission of COVID-19". Individual organisations were directed to risk assess and advise their staff according to the guidance, and to ensure that "compliance with PPE is line with the updated guidance". See Exhibits DM/022 [INQ000259889], DM/023 [INQ000507199], DM/024 [INQ000507200], DM/025 [INQ000507201], and DM/026 [INQ000507202].*

92. *There followed a period of intense activity, with multiple meetings and communications internally, between NHS Boards, and between NHS Boards and HPS/Scottish Government. From NHS Lothian's perspective, this was a period of significant uncertainty which generated high levels of staff anxiety. Staff Partnership leads within NHS Lothian expressed their concerns about the perceived delay in implementing the guidance. A Holding Script was draft for change to PPE enquiries detailed in Exhibit DM/027 [INQ000507203].*

93. *The IPC network met with HPS on 2 April 2020 to discuss the revised guidance. NHS boards had already identified a number of barriers to interpretation and implementation, including a continued lack of clarity about definitions and terminology, as indicated above. There was a particular concern about how to define the threshold for "sustained community transmission" to allow Boards to understand when Table 4 would apply and when to undertake a risk assessment and advise staff on appropriate PPE, as directed by the Scottish Government's letter of 2 April 2020. No definition of "sustained transmission" was provided to determine when to increase, or step back the response in line with the published guidance. NHS boards were advised by HPS that they were responsible for undertaking local risk assessments related to this.*

94. *During the meeting with HPS on 2 April 2020, boards were made aware that the Scottish First Minister had announced the publication of the guidance via a televised public briefing at 1400hrs that day. Arguably, this contributed to a greater level of challenge for NHS Lothian and other boards with regards to the planning and implementation of the guidance and particularly in being able to provide effective and timely advice to staff. Exhibit DM/028 [INQ000507204].*

95. *Following detailed review and consideration of the updated guidance by the Associate Director IPC over the weekend (3rd-5th April) NHS Lothian held an internal meeting on 6 April 2020, to discuss and determine the steps required to implement the revised guidance from the Scottish Government. Advice provided by the NHS Lothian IPC subject matter lead to the HAI Executive Lead and the Executive Medical Director at this time was that the guidance was too complex for practical implementation and that a simplified and more consistent approach to PPE should be adopted. This alternative proposal, in line with the published guidance, included a risk stratification approach and the option to use FFP2 respirators as part of contingency arrangements. This approach accounted for potential supply and resilience issues for a number of PPE items including, but not limited to, aprons, gowns and some models of FFP3 respirators, detailed in Exhibit DM/029 [INQ000507206].*

96. *However, a number of factors ultimately prohibited agreement and adoption of this alternative approach in NHS Lothian. These factors included a lack of a consistent position between published Scottish and UK guidance on the use and suitability of*

FFP2 respirators as well as the lack of risk appetite amongst all stakeholders (already mentioned above) to deviate from nationally issued guidance.

97. *As a result, NHS Lothian did not reach an agreed position on the implementation of the revised PPE guidance instructed by Scottish Government on 2 April 2020 until 9 April 2020. This was published and communicated to NHS Lothian staff in a Speed Read on 10 April 2020. See Exhibits DM/030 [INQ000507208], DM/031 [INQ000507209] and DM/032 [INQ000507210].*

98. *A draft risk assessed proposal was developed and discussed with the HAI Executive Lead and the PPE Strategic Group. A more detailed plan to address shortages in the provision of disposable gowns was also developed. See Exhibits DM/033 [INQ000507211], DM/034 [INQ000507212], DM/035 [INQ000507213] and DM/036 [INQ000507214].*

99. *During this time, no additional evidence, guidance or tools were provided to assist NHS boards in undertaking the local risk assessments required. IPC teams and other key departments (e.g., Procurement, Health & Safety, Occupational Health, Staff Partnership) did not have direct access to the range of expert scientific advisors employed nationally, or the capacity to carry out methodological review of emerging publications. This meant that risk assessment was heavily reliant on the professional expertise, experience and opinion of the individuals working in each Board, empirical evidence or extrapolation of basic scientific principles and plausibility. This inevitably led to different approaches being adopted between Boards.*

M5/NHSL/01 – paragraphs 138-143

General examples of inconsistencies in guidance

138. *I offer here some more general comments on challenges that arose for NHS boards during the relevant period in relation to guidance on IPC and PPE and how this was developed and communicated.*

139. *The quantity of guidance issued during the pandemic was overwhelming. Guidance was issued across a large number of specific and distinct subject areas including*

diagnostic testing, patient placement, patient transport, shielding of vulnerable individuals, physical distancing, and cleaning. In almost all cases, the change to those specific documents had some impact on other aspects of IPC response including PPE in the context of health and social care delivery.

140. *During the early stages of the pandemic, there was a lack of clarity about the hierarchy of guidance and to what extent the UK or the devolved health service would lead on the development and dissemination of guidance. Following the complicated and protracted discussion about changes to the PPE guidance in early April 2020, a request to review further proposed changes to guidance was made. NHS Lothian supported the response provided on behalf of the Scottish Executive Nurse Directors group. Exhibit DM/072 [INQ000507280].*

141. *In a letter of 2 April 2020, the Scottish Government advised that only guidance issued by HPS, PHE and Scottish Government had national standing. This had limited impact at Board level as staff of all disciplines continued to refer to other sources of information. The Scottish Government issued a further joint statement through the Chief Nursing Officer, Chief Medical Officer and National Clinical Director on 20 May 2020 to clarify that guidance issued by HPS, PHE and the Scottish Government should be considered to have national standing. This was helpful to have a clear and unambiguous source which we could refer staff of all disciplines to as extant guidance.*

142. *Nonetheless, there were often inconsistencies across different guidance or policy documents issued by different bodies, perhaps due to the need to update and produce guidance quickly and limited time available to proofread or consult upon documents.*

143. *Implementation of IPC and PPE guidance developed largely on a hospital-based model of care was challenging when translating to social and residential care settings.*

Funding

202. NHS Lothian participated in a national process of cost and funding review with all other health boards in conjunction with the Scottish Government. Costs submitted for funding included costs for health and where appropriate for Adult Social Care and other services delegated to Integration Authorities (IAs), and IAs engaged in this process with health boards.

203. Submissions for funding by health boards were scrutinised as part of a peer review process to ensure consistency of approach and requirement across boards. Where variation existed, this would be followed up for understanding and validation.

204. NHS Lothian is content that it received full funding from the Scottish Government to meet Covid costs associated with non-delegated functions as well as those delegated to the IAs, and the Health Board was not limited in carrying out its functions with regard to the ASC sector by limited funding.

205. Notwithstanding the provision of additional resource and the general acceptability of the overall funding position, NHS Lothian would wish to acknowledge that, during the relevant period, the ability to carry out all functions to the required level and extent may have been experienced differently in practice by specific services, particularly those where the pandemic-related pressures were greatest e.g. in the direct delivery of care or in the management of IPC and HAI services.

206. For the purposes of this statement, we choose to highlight the example of the requirement for NHS boards to provide specialist IPC support to care homes, following the Cabinet Secretary's letter of 17 May 2020. Although additional funding was provided to facilitate this additional workload and active recruitment was pursued by NHS Lothian, the significant activity required was primarily provided from within the existing limited specialist nursing workforce. There was already an acknowledged shortage of IPC practitioners at the start of COVID, later summarised in the Scottish Government IPC workforce strategic plan (Dec 2022).

207. The timing and availability of additional funding to increase workforce capacity was essentially 'too little too late'. There is a significant time lag in the recruitment, education and training to develop specialist IPC nurses/clinicians. The additional workforce secured to provide care home support could not be considered specialist at the point of employment and it could not therefore be used effectively to provide qualified specialist IPC support to the care home sector at short notice. We are

unaware of any specific previous investment in IPC provision in this sector or of any previous directions to NHS boards to expand their IPC specialist services to cover residential care homes. It is not for NHS Lothian to reflect on or quantify any potential resulting impacts of that on the care home sector's subsequent response to the pandemic.

208. Furthermore, the funding supplied did not cover the additional non-PAYE costs associated with supporting the academic qualification required of IPC specialist nurses, or additional costs associated with travel required to support a peripatetic role across a large geographical area. Additional costs therefore needed to be absorbed within existing budget or accepted as a new cost pressure. The lack of certainty about the source of recurring funding for care home IPC has also been a factor in retaining staff to provide this role.

209. This issue and risks associated with this were highlighted in a summary report to the Board's internal Infection Control (Governance) Committee in April 2021, provided as **Exhibit DM2/41 INQ000590682**.

Lessons learned and recommendations

Lessons learned

210. The content below summarises some key lessons learned by NHS Lothian from its support of the adult social care sector's response to the Covid-19 pandemic.

211. There is a need to consider how to provide appropriately trained and qualified specialist IPC staff or teams within care homes in order to meet requirements in this sector.

212. The clarity, hierarchy and applicability of nationally issued IPC guidance should be reviewed and improved. This need has already been identified as part of the Scottish Government's HAI Strategy 2023-2025. This point was highlighted in greater detail through NHS Lothian's previous statement provided in response to the Inquiry's Module 5 (M5/NHSL/01), in particular paragraphs 140-146. With specific reference to the care home sector, Public Health Scotland was the principal body responsible for issuing guidance. This did cross reference to the ARHAI national IPC manual.

Independent care home companies based outside of Scotland may also have issued internal group guidance based on NHS England/UKSHA guidance.

213. The relevant paragraphs, mentioned above, from NHS Lothian's previous statement to the Inquiry's Module 5 (M5/NHSL/01) are reproduced below for completeness.

M5/NHSL/01 – paragraphs 140-146

140. *During the early stages of the pandemic, there was a lack of clarity about the hierarchy of guidance and to what extent the UK or the devolved health service would lead on the development and dissemination of guidance. Following the complicated and protracted discussion about changes to the PPE guidance in early April 2020, a request to review further proposed changes to guidance was made. NHS Lothian supported the response provided on behalf of the Scottish Executive Nurse Directors group. Exhibit DM/072 [INQ000507280].*

141. *In a letter of 2 April 2020, the Scottish Government advised that only guidance issued by HPS, PHE and Scottish Government had national standing. This had limited impact at Board level as staff of all disciplines continued to refer to other sources of information. The Scottish Government issued a further joint statement through the Chief Nursing Officer, Chief Medical Officer and National Clinical Director on 20 May 2020 to clarify that guidance issued by HPS, PHE and the Scottish Government should be considered to have national standing. This was helpful to have a clear and unambiguous source which we could refer staff of all disciplines to as extant guidance.*

142. *Nonetheless, there were often inconsistencies across different guidance or policy documents issued by different bodies, perhaps due to the need to update and produce guidance quickly and limited time available to proofread or consult upon documents.*

143. *Implementation of IPC and PPE guidance developed largely on a hospital-based model of care was challenging when translating to social and residential care settings.*

144. *Other organisations that had a direct interface with parts of the NHS developed their*

own PPE guidance. For example, Police Scotland had issued their staff with guidance on the use of PPE that exceeded, or was not changed in line with, NHS policy. This created challenges and professional tensions, for example when officers from Police Scotland attended NHS clinical sites.

145. *Guidance or research findings issued by other national bodies, professional membership organisations (such as Medical Royal Colleges) or staff trade unions sometimes conflicted with the guidance adopted and issued by HPA and PHE. For example:*

- *the Resuscitation Council UK's definition of chest compressions as an AGP in early 2020 conflicted with the definition of AGPs adopted by HPS and PHE guidance.*
- *There was a similar lack of national and local clinical consensus on whether the use of supraglottic airways (SGA) was considered to be an AGP. Guidance issued on this by The Royal College of Anaesthetists (RCoA) was different from HPS and PHE guidance.*
- *The Royal College of Paediatrics and Child Health (RCPCH) issued guidance in September 2020 which advised PPE selection based on a red and green pathway model which didn't align with the Remobilisation Guidance issued through by the UK 4 Nations in August to September 2020. Nonetheless, this RCPCH guidance was referred to by ARHAI in the weekly ICM forum meeting, so it was not always clear to what extent these other bodies were considered core advisors to national guidance and which documents were, or were not, considered extant guidance.*
- *At times, Trade Union bodies, whose representatives often acted as Staff Partnership leads within NHS Lothian, did not accept or endorse national policy. For example, The Royal College of Nursing published documents and reviews during the relevant period which were critical of national guidance.*

146. *Such contradictory positions created challenges for NHS Lothian's IPCT teams and senior leaders. Decision makers were frequently challenged by clinical staff who were, as a result, expressing uncertainty about the science underpinning national policy and advice, or who held a professional or personal view on the level of PPE believed they required in the context of their own area of practice.*

214. Further reducing the boundaries between health and social care through multi-disciplinary and collaborative working has proven the potential to better address common challenges and opportunities.

215. Through the enhanced arrangements adopted during the pandemic there is increased multi-disciplinary awareness of potential care home issues, with early recognition, early support, early resolution and a focus resulting in a reduction of Large Scale Investigations. We are also able to be more responsive in supporting action plans, resulting from the regulatory body, Care Inspectorate, inspections to meet requirements and areas for improvement.

216. There is greater awareness of the crucial role the HSCP Care Home Support Teams and the Corporate Care Home Programme Team play in supporting care homes across Lothian.

217. Prior to Covid-19, there was inconsistency with Registered Nurse contribution to care in Nursing Care Homes. In short, care homes in Lothian are a mix of Nursing Care Homes, which have their own Registered Nurses providing nursing care to residents and are therefore less reliant on District Nursing and Community Nursing services for nursing care, and Residential Care Homes, which are more reliant on these services. Care Home Support Teams in each of the four HSCPs in Lothian configure their Registered Nursing establishment and the inclusion of other healthcare professionals differently, according to the respective make up, types and needs of the care homes in the local authority area. The enhanced arrangements and support provided an opportunity for additional specialist support, both from Allied Health Professionals and Nurses. We have been able to implement direct referrals from care home staff to specialist services, using secure emails, enabling timely care and treatment plans.

218. The enhanced arrangements have supported and embedded a quality improvement approach to support various elements of care in care homes, including but not limited to:

(i) Education and training from Clinical Education Team, Lothian Care Academy and specialty teams.
(ii) Competency assessment and training across Health and Social Care
(iii) Improved Future Care Planning
(iv) Safe, timely discharges from hospital
(v) Urinary Tract Infection and antimicrobial stewardship

(vi) Use of technology to support care

(vii)Escalation and response arrangements

Areas of particular success:

219. Testing was a success, initial responses focused on setting up a rapid testing service which developed over the course of the pandemic. Responsibility for testing towards the end of the pandemic moved toward care homes testing residents, this was supported with education and training for care home Nursing staff with information and training videos. In addition, the care home support teams provided practical support and training in PCR testing. The systematic set up of systems to enable testing for HSCP staff and care home residents was dynamic, responsive and progressive expanding and adapting in line with continued changes in guidance during the pandemic.

220. The NHS Lothian HPT organised and led 145 care home and social care Incident Management Teams in 2020 and 2021 in response to outbreaks in the ASC sector. HPT provided expert public health advice to support and inform an evidence-based approach within an ethical framework to care homes in exceptionally difficult work circumstances.

221. At the onset we set up clear roles, responsibilities, and clear governance arrangements. We adopted a project management approach which ensured we had clear expectations timelines and records. Reporting arrangements were through initial quarterly reports and subsequently Care Home Annual Reports to NHS Lothian Healthcare Governance Committee. The Annual Reports from 2020/21 and 2021/22 are provided, respectively, as **Exhibit DM2/42 INQ000590683** and **Exhibit DM2/43 INQ000590684**.

222. The adult social care sector responded relatively well in managing outbreaks, in particular the implementation of control measures. Isolation of residents was very difficult for residents who walked with purpose or those living with dementia. The care homes implemented some innovative ways to manage and support these residents. Examples, which the NHS Lothian HPT was anecdotally aware of through its outbreak control work, included:

(i) cohorting residents who walked with purpose in the same units if they had tested positive for Covid and allocating staff to look after only those residents to restrict the spread of infection;

(ii) maintaining social distancing by encouraging residents to walk and exercise in identified areas away from other residents;

(iii) utilising activity coordinators to keep residents active in safe ways, in line with infection prevention protocols;

223. Care home staff also came well prepared to Incident Management Team meetings chaired by the HPT.

Any areas of concern

224. This was an incredibly difficult time for the adult social care sector. Generally, the support offered by NHS Lothian was gratefully received, however some care homes were initially resistant to support and/or contact for fear of scrutiny and spread of Covid-19. In some instances, it took some time to build relationships and enable an open and honest supportive culture.

Statement of Truth

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

Signed: **Personal Data**

Dated: 6 June 2025