Witness Name: Humza Yousaf
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UK COVID-19 INQUIRY
MODULE 6

WITNESS STATEMENT OF HUMZA YOUSAF

In relation to the issues raised by the Rule 9 request dated 15 November 2024 in connection with Module 6, I, Humza Yousaf, will say as follows: -

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Background

Positions I have held

1. I am Humza Yousaf of the Scottish Parliament, Edinburgh, EH99 1SP.

2. I have been asked to provide a written statement in response of Module 6 of the UK Covid-19 Inquiry ("the Inquiry") in response to a Rule 9 Request dated 15 November 2024.

3. While this Module 6 written statement is self-standing, the reader my wish to refer to my previous statements provided to the Inquiry in respect of Modules 1 (2 November 2023) [INQ000273956], Module 2A (16 November 2023) [INQ000273973], 3 (16 August 2024) [INQ000480774], 4 (23 October 2024) [INQ000474454] and 7 (4 March 2025) [INQ000475071].

4. In the preparation of this statement, I have referred to records and material provided to me by the Scottish Government. I have also received assistance from the Scottish Government Covid Inquiry Response Directorate. Due to the significant volume of questions and material that the Inquiry has asked me to consider, I was also assisted in identifying documents and factual information relevant to the questions being asked to assist in the preparation of my statement. However, any views or opinions expressed in this statement are my own. The structure and headings of this statement accords, as requested by the Inquiry, with those set out in its Rule 9 Request.

5. Unless stated otherwise, the facts in this witness statement are within my own knowledge and are true. Where they are not within my own knowledge, they are derived from sources to which I refer and are true to the best of my knowledge and belief.

Current and Previous Roles

6. My current role is serving as the Member of the Scottish Parliament for the Glasgow Pollok constituency. Between 28 March 2023 and 7 May 2024, I was the First Minister of Scotland. I was the Leader of the Scottish National Party between 27 March 2023 and 6 May 2024. Following my resignation as First Minister and as Leader of the Scottish National Party, I am not currently serving in the Scottish Government.

7. Between 19 May 2021 and 28 March 2023, I served in the Scottish Government as Cabinet Secretary for Health and Social Care. I held primary responsibility for the Health and Social Care Directorates and NHS Scotland. This included, but was not limited to, primary care, allied healthcare services, healthcare and social integration, carers and adult care, and child and maternal mental health. I also had lead responsibility for a number of public bodies including NHS Scotland, the Care Inspectorate, the Mental Welfare Commission for Scotland, the Scottish Social Services Council, and Sport Scotland.

8. Between 28 June 2018 and 19 May 2021, I served as Cabinet Secretary for Justice. Prior to this I served as Minister for Transport and the Islands from 18 May 2016 to 28 June 2018. I served as Minister for Europe and International Development from 21 November 2014 to 18 May 2016 and from 5 September 2012 to 21 November 2014 as Minister for External Affairs and International Development.

Pre-pandemic Knowledge of the Adult Social Care ("ASC") system

9. I had regular engagement with the ASC system as a local MSP, and a more high-level overview, as a Minister within the government. As a local MSP, my knowledge of the ASC system was informed by visits to local adult social care facilities in my constituency, of which there are a number.

10. Although I did not have any ministerial responsibility for ASC until I became Health Secretary, ASC was an issue that was discussed regularly at Cabinet and across government. At Cabinet, it was often raised in relation to some of the ongoing challenges that we faced regarding delayed discharge and the importance of ensuring the ASC system was adequately funded.

Role of Cabinet Secretary for Health and Social Care and working relationships

11. As I have set out in at paragraphs 10 to 13 of my previous statement for Module 4 (submitted 23 October 2024) [INQ000474454], in my role as Cabinet Secretary for Health and Social Care, health boards across Scotland were ultimately accountable to me. My responsibilities covered the areas of both health and social care and involved doing everything possible to improve the health of the country. A lot of responsibility, and day-to-day operations, was in practice devolved to Scottish local authorities and to territorial heath boards. However, I worked closely with health boards and local authorities to improve public health in Scotland, and of course to respond as effectively as possible to the Covid-19 pandemic, as well as recover our healthcare systems in Scotland from the effects of the global pandemic.

12. My responsibilities included:

- Acute services
- Allied healthcare services
- Centre of excellence for rural and remote medicine and social care
- Community care
- EHealth
- Health and social care integration
- Health improvement and protection
- NHS estate
- NHS performance
- Patient services and patient safety
- Person-centred care
- Primary care and GPs

- Quality and improvement
- Unscheduled care
- Workforce, training, planning, and pay.

13. During my time as Cabinet Secretary for Health and Social Care, my responsibility for decision-making in the NHS in Scotland and across the ASC sector was strategic rather than operational: operational decision-making was primarily the responsibility of health boards in the case of the NHS, and Local Authorities and Health and Social Care Partnerships when it came to the ASC sector. Where I had concerns, or needed further information, I would seek to query or interrogate why a particular operational decision had been reached. I ultimately was accountable to the public and Scottish Parliament for decisions made by healthcare and social care systems in Scotland during the pandemic, so it was not unusual for me as Cabinet Secretary, and for Government, to question operational decisions made by health boards or local authorities. That was particularly the case during the pandemic, when decisions were made at a quicker pace, given the urgency of the situation we were all facing. Throughout the pandemic, issues around the capacity of social care, and the recruitment and retention of staff were raised with me on a regular basis by parliamentarians.

14. The National Health Service (Scotland) Act 1978 confers upon Scottish Ministers a general power of direction in relation to the carrying out of functions by health boards, which I could have used if required. I could also use the NHS Scotland support and intervention framework, also known as the "escalation framework", when issues arose [HY6/001 - INQ000480775]. The framework is a tool that is used in monitoring performance and managing risk across the territorial health boards in Scotland, and is overseen by the National Planning and Performance Oversight Group (NPPOG) – a sub-group of Scottish Government's Health and Social Care Management Board. It has five stages, ranging from stage one ("steady state", which is applied to health boards that are delivering in line with agreed plans) to stage five ("statutory intervention", which is applied to health boards within which the level of risk and organisational dysfunction is so significant that direct intervention using statutory powers of direction is required).

15. I was pleased to be supported in my role as Cabinet Secretary for Health and Social Care by Kevin Stewart MSP and Maree Todd MSP. Kevin Stewart was my Junior Minister and had responsibility for Mental Wellbeing and Social Care. While I retained a strategic overview of social care, and was involved in strategic discussions about the challenges facing the sector, it would be fair to say that the day-to-day responsibility for social care, from a Ministerial perspective, fell to Kevin Stewart, who, in my view, discharged that function very well.

Overview of how I worked with various roles to support the response of the ASC system to the pandemic

16. I think it's worth noting the context around why ASC is so vital. With virtually all the individuals and bodies listed there was some level of discussion in relation to ASC. The ASC system was central to our thinking when it came to our response to the COVID-19 pandemic for a number of reasons.

17. First and foremost, when it came to an assessment of the Four Harms [HY6/002 - INQ000131028] (and primarily Harm 1), in order to protect people from the most dangerous direct harms of COVID, those in ASC were high priority due to their vulnerability - both residents and, of course, the staff. There was barely a discussion at Cabinet level that took place around Covid-19 that did not involve consideration of ASC.

18. The other reason why it was so important was in relation to dealing with the significant pressures the health service was under during the pandemic, and, to a large extent, is still under. One of the main issues was trying to increase capacity in ASC by reducing delays in discharge from hospital, where possible. Better access to ASC care can help with both the “front door pressure” and the “back door pressure” in a hospital. A good ASC system should prevent more people from having to access the front door of a hospital because their needs are attended to in an ASC environment and should also meet the needs of those that do not need to be in a clinical setting but are unable to cope at home (and require care packages to be put in place). ASC can help us to alleviate the significant pressure that hospitals are under. If you do not alleviate that pressure,

then the entire system becomes blocked and the flow within any hospital is completely disrupted.

19. My discussions with the First Minister, Deputy First Minister, Minister for Public Health, Minister for Mental Wellbeing and Social Care and the Finance Secretary were key and they were imperative. The First Minister at the time, Nicola Sturgeon, and the deputy First Minister, took a significant interest in developments around ASC. I found them to be engaged in the issues, and helpful when their input was required. The First Minister , who herself was previous a Health Minister, understood the issues well given her previous ministerial experience.

20. By the time I was Cabinet Secretary for Health and Social Care, the testing regime within ASC was well established, so there was little change, or very few changes, to the testing system within ASC. Most of the conversations that I would have in regard to ASC were when there were surges or waves of the virus, or an emerging new variant such as Omicron. Our priority was to protect the most vulnerable in our society, which included those people living and working in the ASC system. We also had to respond to the needs of families that had relatives within a care home and met with stakeholders such as Care Home Relatives Scotland (CHRS), Scottish Care and the Coalition of Care and Support Providers in Scotland (CCPS).

21. There were some changes to the testing regime made during my tenure. A full chronology of all changes to the testing regime is set out at paragraph 127 of my Module 7 statement (submitted on 4 March) [INQ000475071] and is provided here [HY6/003 - INQ000605490] and set out below is a list of all changes made between 19 May 2021 to 28 June 2022 that impacted the ASC sector during my tenure as Cabinet Secretary for Health and Social Care:-

Date	Title	Exhibit/INQ Reference Number	Category: - Key Guidance - Core decision - Key policy / strategy
22 June 2021	Strategic Framework	HY6/004 - INQ000235137	Key policy/strategy
21 June 2021	Coronavirus (Covid-19): social care and community based testing overview	HY6/005 - INQ000571294	Key guidance
22 July 2021	Coronavirus (Covid-19): living with dementia in care homes	HY6/006 - INQ000571297	Key guidance
11 August 2021	Testing access expansion	HY6/007 - INQ000571261	Key policy/strategy
16 August 2021	Guidance on twice weekly asymptomatic testing of Healthcare workers	HY6/008 - INQ000571324	Key guidance
16 November 2021	Strategic Framework	HY6/009 - INQ000353777	Key policy/strategy

Date	Title	Exhibit/INQ Reference Number	Category: - Key Guidance - Core decision - Key policy / strategy
29 November 2021	Essential workers priority for PCR test site slots	N/A	Core Decision
29 December 2021	Prioritising test and protect for those at highest risk	HY6/010 – INQ000571301	Key policy/strategy
5 January 2022	Changes to self-isolation and testing regarding LFD and PCR requirements	HY6/011 - INQ000571375	Core Decision
15 March 2022	Test and Protect Transition Plan	HY6/012 – INQ000235186	Key policy/strategy
30 March 2022	Changes to testing. People with symptoms no longer required to take tests. Test sites to close on 30 April 2022	N/A	Core Decision
29 April 2022	Managing Health and Social Care	HY6/013 - INQ000571325	Key guidance

Date	Title	Exhibit/INQ Reference Number	Category: - Key Guidance - Core decision - Key policy / strategy
	Staff with symptoms of a respiratory infection, or a positive Covid-19 test, as part of the Test and Protect transition plan		
01 May 2022	Ceasing of routine contact tracing in health and social care settings and cessation of population wide contact tracing	HY6/014 - INQ000571303	Key policy/strategy

22. I would say that a significant amount of my time discussing ASC with my ministerial colleagues was in regard to trying to free up additional capacity within the ASC sector. Given the extreme pressure our acute sites were under, particularly during the emergency phase of the pandemic, we were frankly desperate to ensure that we could find any spare staffed bed in social care across the country and ensure it was being used. As indicated in the letter of 4 November 2021 [HY6/015 - INQ000587187] – setting out funding allocations for 2021-22 (discussed further at paragraphs 25 and 26 below) - delayed discharges were rising to "unacceptable levels due to care, primarily care at home, being unavailable." The intended outcome for the funding was that more appropriate

care and support should be found for those who are unnecessarily delayed in hospital – including the use of interim solutions "*until the optimum care and support is available (noting that remaining in hospital cannot be one of the options).*" Funding was made available to expand care at home noting the pressures on social care caused by increased need and acuity. The pressures on unpaid carers were also flagged.

23. What became abundantly clear in my time as Cabinet Secretary for Health and Social Care was that there was staffed capacity within the ASC system, but that the connections between the NHS, the Local Authorities and the private providers of social care were often fragmented and therefore we were in the unacceptable position of having staffed capacity but it not being used, at a time of extreme pressure on our acute sites. In addition, there was simply not the level of data available in relation to the ASC sector. For example, I was aware there was staffed beds in social care in various Health and Social Care Partnerships (HSCPs) across the country, but there wasn't the data on how many beds were available, broken down by HSCP area, and why those beds were not being used. Sometimes that was down to the fact that a care home wasn't somebody's first choice, or a family's first choice, which to me was not an acceptable reason not to fill the bed, or it could be down to the specific needs of the individual, for example, where they required a care home with a dementia unit which was, of course, an understandable reason. But for the most part, it did not feel like the synergy and the engagement between those partners was not nearly as good as it should be.

24. Many of the discussions I had with the First Minister, Deputy First Minister, the Finance Secretary, the Minister for Social Care were focussed on the question of how we created more capacity. The Finance Secretary was helpful because we had to increase the funding and investment within ASC, which we did.

25. In 2020-21, £1.7 billion of additional funding was provided to support the HSC sector – a total of £561 million was allocated to Integration Authorities in 2020-21 (including funding for sustainability payments – discussed later at paragraph 258 of this statement). This included the £112 million allocated to Integration

Authorities as additional funding committed through the ASC Winter Preparedness Plan.

26. On 4 November 2021, Scottish Government officials wrote to Local Health Authorities, HSCPs, COSLA, Chief Social Work Officers and NHS Boards regarding the key components of the additional winter funding for 2021 to 2022 agreed in response to the system pressures faced [HY6/015 - INQ000587187]. Funding was made available from 1 October 2021 to 31 March 2022 as follows:

    - Stand up interim care provision to support significant reductions in the number of people delayed in their discharge from hospital - £40 million
    - Enhance multi-disciplinary working (including strengthening multi-disciplinary teams and recruiting 1,000 Band 3s and 4s) - £20 million
    - Expanding care at home capacity – £62 million
    - Social care staff hourly pay increases – Up to £48 million

27. An additional £20 million was planned to be made available for 2022-23 for the provision of interim care, whilst support for expansion of care at home capacity was made available on a recurring basis to support permanent recruitment and longer-term planning. The Schedules set out in the letter set out the stated outcomes for each funding allocation.

28. I asked the Deputy First Minister for his assistance in engaging with Local Authorities and social care partners. He agreed to do so and joined a number of meetings in that regard.

29. The First Minister took a regular interest in the progress that was being made in regard to freeing up capacity in relation to ASC and the impact that it was having on our hospitals in terms of Accident and Emergency (A&E) performance and the need to resume elective procedures.

30. Kevin Stewart, Minister for Mental Wellbeing and Social Care, spent a significant portion of his time working tirelessly on the issue of ASC. He was often tasked by me to engage vigorously with those Local Authorities where there was not nearly enough progress. There was some quite robust engagement with Edinburgh City

Council, as just one example, where the progress was not nearly as good as it should have been with unacceptably high levels of delayed discharges, which resulted in equally unacceptable performances in Edinburgh hospitals.

31. In terms of my engagement with clinical advisors and civil servants, including the Chief Medical Officer (CMO), Chief Nursing Officer (CNO), Chief Operating Officer (COO), Chief Social Work Officer (CSWO) and the National Clinical Director (NCD), these officials, at various different times, were incredibly useful and helpful.

32. The most frequent and regular engagement in terms of ASC was with John Burns as the COO of the NHS Scotland. We would often have Caroline Lamb, the Director General for Health and Social Care and the Chief Social Work Officer for Scotland on the calls. John Burns and I would speak multiple times a week with Caroline Lamb also joining calls frequently. ASC would have been a regular feature of those conversations.

33. Government officials within the Social Care Directorate were also involved in meetings. I dealt with those key government officials on a much more frequent basis than any others, with the possible exception of John Burns. The Minister with the appropriate responsibility for Local Authorities would on occasion join conversations and calls as well. I met regularly with officials such as the then Director for Mental Health and Social Care and the Director of Health Finance and Governance, as well as relevant officials across the Directorate General for Health and Social Care.

34. When it came to the CMO, CNO and NCD, calls with those clinical advisors would have been less frequent in relation to the issue of ASC. I dealt more so with Professor Alex McMahon (CNO at the time) and our discussions largely centred around the issue of infection prevention and control (IPC). Again, many of those processes were largely well established by the time I became Cabinet Secretary for Health and Social Care.

35. There was an issue at one point during one of the vaccine programmes where we were beginning to notice that the level of uptake from social care workers

was far lower than it had been in previous iterations of the vaccine programme. We discussed that issue with colleagues - the CNO, from my recollection the CSWO was also involved in the conversations, as well as the NCD, who did a lot of media outreach. I also visited a care home to promote the importance of taking up the offer of the vaccine. For example, on 5 September 2022, I attended the I&S in Edinburgh to promote vaccination uptake as residents and staff received their vaccinations – a 93 year old resident there was one of the first to receive the winter booster.

36. I also met with Chief Executives and Chairs of Scottish Health Boards regularly. As set out at paragraphs 20 and 52 of my Module 3 statement (16 August 2024) [INQ000480774], I had regular calls and meetings with the Chief Executives and Chairs of Scotland's health boards. These would often be a mixture of bilateral meetings, me visiting healthcare settings in a local health board area, or as part of our weekly catch-up with all health boards. Given the scale and size of larger health boards, such as NHS Greater Glasgow and Clyde, NHS Lothian and NHS Lanarkshire, I would speak to the senior management in these health boards more regularly. The DGSHC and the COO would also have very regular engagement with health board Chief Executives and Chairs if they felt an issue needed my attention they would flag it to me, either directly or via my private office.

37. Most of the discussions with NHS boards were in relation to pressures our acute sites were facing, and discussion on solutions to alleviate such pressure. In regards to potential solutions, we would discuss how to collaboratively work with those delivering ASC to reduce the high numbers of delayed discharge in our hospitals.

38. At one point I instructed a weekly call with all health board Chief Executives and Chairs, and that was in addition to the bi-lateral engagement with health boards that would be either as virtual calls or in person visits that I undertook. Representatives from COSLA and SOLACE (Society of Local Authority Chief Executives) would also regularly join these calls. The discussions focused on the need to support the ASC sector. The need to ensure that we worked with the

ASC system to use any capacity they had to alleviate the pressure on the health service more generally.

39. Engagement with Local Authority partners was also carried out on a regular basis. Again, there was one point when I was having weekly calls with those Local Authorities where I felt they were not making significant enough progress on issues such as delayed discharge and using their staffed capacity. Those calls would also include HSCP colleagues.

40. The Local Authority and HSCP areas we were engaging with most regularly , as a result of not making the progress we required, included Edinburgh, Fife, Glasgow, Highland, North & South Lanarkshire and South Ayrshire. Regular updates were provided to me as Cabinet Secretary for Health and Social Care and also copied in to the First Minister who continued to maintain a strong interest in matters related to ASC.

41. I did not have much engagement with PHS (Public Health Scotland) on the issue of ASC. If there was advice that was required in relation to testing or vaccination or outbreaks in a care home then PHS would make themselves available when required. But again, by the time I became Cabinet Secretary for Health and Social Care there were fairly good protocols in place. This was also the case with the Care Inspectorate, who resumed routine inspections in care homes fairly early on in the pandemic (4 May 2020), which was well before the time I was appointed as Cabinet Secretary for Health and Social Care.

42. As regards engagement with UK Government Ministers and my counterparts across the four nations, ASC is devolved and therefore there was not a direct need to engage on the issues, particularly in regard to the pressure on the health system. However, I did raise the matter and mentioned it to my counterparts, particularly my colleague, the then Welsh Health Secretary, Eluned Morgan. She and I would discuss the pressure we were both facing in our respective nations in relation to ASC, just to see if there was anything innovative that either nation was doing that the other could potentially learn from. Unfortunately, there was no silver bullet to alleviate the pressures we were facing and each nation was trying

similar solutions such as increasing step-down care, investing more in Hospital at Home and funding additional social care capacity.

43. In addition to the above, I should also mention engagement with the social care sector itself. As well as the Local Authorities there was a need to speak to the private providers and with representative bodies such as Scottish Care, who were able to bring those partners together. That was very important and was done on a frequent basis primarily by my Junior Minister responsible for social care, Kevin Stewart, but also by me as the Cabinet Secretary for Health and Social Care.

Challenges in working relationship with individuals and entities

44. I found that colleagues within the Scottish Government - particularly from those I engaged with on the issues of the social care sector, including the Finance Secretary, FM, DFM and my own junior ministerial colleagues - everybody understood the challenges that we were facing in the social care sector. The Finance Secretary was helpful in regard to providing additional funding. During internal budget negotiations, I would prioritise my request for additional funding for social care. Obviously there was a limit to any additional funding received, given the financial constraints we were operating under, but I found Kate Forbes (and John Swinney, when Kate Forbes was on maternity leave) as well as and the FM to be understanding, helpful and supportive given the scale of the challenge the ASC sector was facing.

45. I did not feel we were making enough progress in getting those across the social care landscape moving together at a quick enough pace in order to resolve the challenges the sector faced. In that regard, I asked the DFM at the time, John Swinney, to use the weight of his office to try to help us to get some movement, and he duly made himself available. The First Minister did the same when required. From my recollections, the First Minister joined some calls particularly in relation to freeing up additional capacity and increasing step-down care. In my view, there was very little, if any, internal challenges in terms of government. I would say the same for those in government including Ministers, clinical advisors

and civil servants. We all understood the scale of the challenge, and what had to be done.

46. However, where I do think we encountered challenges, and to be frank tensions, was probably in the engagement between Government, Local Authorities and HSCPs. A crucial relationship which was, at times strained, due to the ASC challenges we collectively faced. There was a frustration from me, that I communicated often, that I did not feel Local Authority and HSCPs colleagues were moving at a pace required given the scale of the pressures our acute sites were facing. There was a real concern coming from Health Board Chairs and Chief Executives that Local Authorities were content to allow those clinically safe to be discharged to remain in hospital, as opposed to finding the appropriate care home placement for them. This was wholeheartedly and robustly rejected, of course, by Local Authority colleagues. However, it is fair to say that those tensions between Health Boards and Local Authorities existed and at times were quite pronounced.

47. My personal frustrations came as a result of the lack of data available to all partners in regards to the ASC sector. In particular, I was perplexed and, frankly astonished, that we did not have the levels of spare, staffed capacity across the ASC sector, broken down by HSCP region. This basic level of data was crucial if we wanted to ensure every spare staffed bed in social care was being used. It was very evident to me when investigating this issue, as soon as I assumed the role of Cabinet Secretary for Health and Social Care on 19 May 2021 that there was not the level of data that we would have expected there to be, nor that was required to help free up ASC capacity.

48. I immediately tasked officials to work with those HSPCs and Local Authorities to gather the numbers of staffed beds per HSCP that were unoccupied. It became evident, relatively early into this process, that there was spare, unused capacity, but it was not clear why it was not being used. I could not fathom why every single spare staffed bed was not being occupied, and therefore weekly calls were set up so that I could personally push officials, COSLA, Local Authority and HSCPs colleagues where necessary to ensure every spare bed that was staffed was being used.

49. There was, on occasion, good reason why bed capacity was not being filled, for example the type of beds that were available did not match the needs of individuals that needed discharge or people might have specific needs around dementia care.

50. In particular, we were keen to ensure that the Choice Guidance was clearly understood – advice provided to me on 17 December 2021 [HY6/016 - INQ000378670 regarding system flow and reducing delayed discharge included advice on emphasising the flexibility to Health Boards in the Choice Guidance to free up further bed capacity where a patient was clinically able to be discharged. In essence, this meant that where necessary, we would have to emphasise to individuals, and their families, that they may not receive a place in their first care home of choice, but possibly another one that has capacity in the HSCP region.

51. There were times when the representatives of social care expressed to me that they felt like they were not being supported enough and this was usually in relation to pay increases we were making available for social care staff. We would make funding available for an increase in wages for ASC workers - which was the right thing to do - but private providers would then have to meet that wage demand from their pockets, and they felt that was a difficult burden at the time given other pressures. The burden on private providers was considered when assessing uplifts. Issues were raised by the Coalition of Care and Support Providers Scotland (CCPS) when considering the weighting for national uplifts, particularly for third sector providers, given differences in workforce costs (e.g. providers delivering sleepover services also often have higher workforce costs due to specific contracts – and therefore had less flexibility in funding). The Scottish Government asked providers to come forward for an 'open book review' if insufficient funding was provided to deliver the policy intent of the uplift. No policy providers came forward to advise this was the case for the uplifts to £10.02 or £10.50 per hour (From 1 April 2022), as outlined in the submission provided [HY6/017 - INQ000587188].

Decisions at UK level impacting ASC in Scotland

52. The issue of the Scottish Government only learning of UK Government decisions at the last minute, or through the media, was less pronounced in the ASC sector because it was fully devolved, with the funding for ASC coming from the Scottish Government block grant. This was very different to, say, testing where virtually all of the funding for testing during the Covid pandemic came from the UK Government. Therefore, when the UK Government made a decision to unilaterally withdraw that funding, it had serious impacts on our ability to continue the universal offer for testing.

53. Where ASC could be affected by decisions made by the UK Government would first and foremost be in relation to funding. If funding for the Scottish Government's block grant was cut, that would inevitably have an impact on our budget and it would be my job as Cabinet Secretary for Health and Social Care to ensure that there was support for the health and social care sector.

54. The other decisions that were made by the UK Government, often without any consultation with the Scottish Government, or Scottish care providers, that would adversely affect ASC in Scotland, were decisions in relation to immigration. There were occasions when changes were either briefed publicly or made to immigration rules in regards to social care workers entering the country, such as changes to wage thresholds that would have more of an impact in Scotland, as the ASC wage tended to be lower than in comparison to a London social care wage for example.

Decision-making or expert advisory committees, groups and fora

55. I attended a range of decision making and expert advisory committees, groups and fora in my capacity as Cabinet Secretary for Health and Social Care.

56. The Scottish Government established the Clinical and Professional Advisory Group for Social Care (CPAG) in April 2020, it provided clinical and professional advice along with guidance for protecting the care home sector during Covid-19. I attended the Scottish Cabinet, Gold Command, Scottish Covid 19 Advisory Group (C19AG) and Joint Biosecurity Centre (JBC) Ministerial Board meetings

as detailed in my Module 2A statement (submitted 2 November 2023 [INQ000273956] at paragraphs 13, 16, 17, 100, 121 and 123.

57. The primary decision-making structure for core decision-making in Scotland during the pandemic was Scottish Cabinet. If a decision was to be made urgently, Scottish Cabinet would be called to make this decision. On occasion during the pandemic, due to the large membership of Cabinet, a smaller group of core Cabinet members would meet to consider more rapid advice. For example, if there was an update domestically on the evolution of the virus or if there was information about a new and emerging variant. These meetings were informally referred to as 'Gold Command' and attendance would depend on the issue in question. The Scottish Government Resilience Room (SGORR) was also regularly convened to provide situational updates, and were attended by appropriate Cabinet Secretaries and Ministers, and where necessary decisions were also taken and recorded. I regularly attended SGORR meetings, where the strategic direction for the Scottish Government's response to the pandemic would be set. My dates of attendance are listed below:

2020	2021	2022
17 February	29 September	05 January
25 February	06 October	26 January
02 March	21 October	
09 March	27 October	
16 March	31 October	
19 March	10 November	
23 March	17 November	
06 April	10 December	
09 April	15 December	
31 July	22 December	
1 September	30 December	
21 December		
23 December		

58. I did not attend any COBR(M) meetings during the pandemic as invitations to these were generally only extended to the First Minister or the Cabinet Secretary for Health and Sport, a position held by Ms. Freeman when these meetings occurred in 2020.

59. I attended the Scottish Government Covid-19 Advisory Group on one occasion, in my role as Cabinet Secretary for Health and Social Care, on 5 August 2021, where I discussed a number of issues including the balance of easing restrictions whilst supporting the continued compliance with Non Pharmaceutical Intervention (NPIs) where recommended and the uncertain trajectory of the pandemic [HY6/018 - INQ000218188].

60. In May 2020, the JBC was established to provide independent and evidence based analysis to inform decision making in response the pandemic. Despite

health being a devolved matter, the JBC worked collaboratively with Scotland and the other Devolved Administrations and Health Ministers attended the JBC Ministerial Board. When making decisions in both my roles as Cabinet Secretary for Justice and Cabinet Secretary for Health and Social Care, I found the JBC to be effective in being an additional source of analysis and advice on Covid-19 policy and in identifying lessons learned which informed core decision making in Scotland.

61. I separately met with members of the Care Home Relatives Group due to my portfolio as did my predecessor. I do not believe that there was a risk of information overload or repetition for key decision makers

62. In addition, I held regular meetings with the CMO, the DCMOs, the NCD, the DGHSC, and the Chief operating Officer (COO) of NHS Scotland, where I could challenge and probe the advice and question data. There were regular conversations with the Chief Executives and Chairs of health boards and local authority partners, meeting collectively on most Thursday mornings, and via regular bilateral engagement.

63. There was a range of ad-hoc communication with Scottish Government colleagues via face-to-face meetings, telephone calls, e-mails, video calls and using informal messaging apps such as WhatsApp. Any informal messages that have been previously requested, have been handed over to the Inquiry.

Engagement with ASC Stakeholders

64. As per my Module 3 statement (submitted 16 August 2024) [INQ000480774] at paragraphs 63 to 65, during the pandemic it was not always possible to obtain views from stakeholders prior to decisions being taken, due to the fast-moving nature of the pandemic. However, regular feedback from members representing vulnerable groups and those with a direct lived experience was sought by officials and thereafter relayed to me. Expert groups, such as the Expert Group on Covid 19 and Ethnicity that was established in June 2020 were very helpful in informing Ministers. A copy of the Terms of Reference for the Expert Group is

provided [HY6/019 – INQ000321282]. Direct engagement with stakeholders and those with lived experience was also very important to me.

65. That direct engagement could take a number of forms, from virtual or in-person meetings, to visits made to the ASC sector. Whatever form it took, I found it very insightful. I have already referenced the weekly calls I instructed, on those calls were colleagues who represented public, private and third sector providers of social care. They engaged directly with me on the challenges the sector was facing.

66. My engagement with officials, at least weekly, if not multiple times a week, was useful as they were in-touch with the ASC sector daily and were able to feedback, in real time, the situation on the ground.

67. I also attended, on occasion, gatherings of social care providers, be they roundtables, or larger conferences, such as the annual gathering held by Scottish Care. It was an opportunity for me to communicate the Scottish Government's core message in regards to ASC, and to also engage with the providers directly.

68. I would also have regular catch-ups with my junior ministerial colleague, Kevin Stewart, Minister for Mental Wellbeing and Social Care, who had day-to-day responsibility for ASC.

69. A list of the ASC stakeholders I engaged with:

Date	**Description**
21/07/2021	Meeting: RCN
21/07/2021	Meeting with Unison Reps - MS Teams
28/07/2021	Visit: Vaccination Bus
29/07/2021	Visit: Golden Jubilee National Hospital
02/08/2021	Dr Sandesh Gulhane MSP - Long Covid Clinics
02/08/2021	IJB Chair and Vice-Chair ahead of CO's
02/08/2021	Bauer - Long Covid

Date	Description
03/08/2021	Call with IJB Chief Officers
05/08/2021	Visit to I&S
05/08/2021	Scottish Ambulance Service
17/08/2021	Healthcare Improvement Scotland
18/08/2021	Donald Macaskill, CEO of Scottish Care
19/08/2021	Professor Jackie Taylor - Royal College of Physicians and Surgeons Glasgow
23/08/2021	NHS Chairs Meeting
23/08/2021	Chair and Vice Chair of NHS Chairs Group
24/08/2021	Covid Recovery Stakeholder Meeting
25/08/2021	Launch: NHS Recovery Plan
25/08/2021	BBC Drivetime - Recovery plan & vaccines
26/08/2021	Jim McGoldrick, Interim Chair of PHS - PHS Chair Review Discussion
26/08/2021	GMS - NHS recovery plan
30/08/2021	NHS Lanarkshire - NR
30/08/2021	IJB Chairs and Vice-Chairs - quarterly meeting
30/08/2021	NHS Lanarkshire - Neil Findlay
31/08/2021	NHS Lanarkshire - Donald Reid
01/09/2021	Meeting with stakeholders following FM's Covid Statement
08/09/2021	Meeting with British Medical Association - Scotland
09/09/2021	Long Covid visit to I&S
09/09/2021	Covid 19 Education Recovery Group Meeting
16/09/2021	Meeting with Councillor Currie
17/09/2021	Meeting with Scottish Ambulance Service
22/09/2021	Meeting: Karen Reid, CEO of NHS Education (NES)
30/09/2021	Health and Social Care Workforce Wellbeing and Mental Health Network Oversight Group
30/09/2021	Meeting with Councillor Currie

Date	Description
01/10/2021	Meeting with RCN Scotland
04/10/2021	Meeting: National Care Service Consultation session with Crossreach and Moderator Church of Scotland
05/10/2021	Meeting: NHS Tayside General Adult Psychiatry
05/10/2021	Meeting: Workforce Senior Leadership Group - Funding Package of Measures
06/10/2021	Meeting: Glasgow Disability Alliance
18/10/2021	Meeting: Alliance
20/10/2021	Meeting: Deep End
20/10/2021	Visit: Greenock Health Centre
21/10/2021	Meeting: Chief Executive of NHS Forth Valley
25/10/2021	Meeting: Chair of British Medical Association
25/10/2021	Meeting: NHS Boards Chairs Meeting
26/10/2021	Meeting: Galloway Community Hospital Action Group
15/11/2021	Meeting with Nursing and Midwifery Council
15/11/2021	1 to 1 with UNISON
15/11/2021	NHS Tayside Annual Review
16/11/2021	Royal College of Emergency Medicine Scottish Policy Forum

70. As Cabinet Secretary for Health and Social Care some of the key matters I addressed can be highlighted by the matter relating to people of different backgrounds and their use of protective equipment. It was clear that in certain circumstances the face masks provided for in a healthcare setting were not appropriate for those of the Sikh and Muslim faiths who had long beards and were in certain healthcare roles. Therefore I took the necessary steps to engage, where I could, and ensure people from an ethnic minority background were not impacted detrimentally during the pandemic. Further on in this statement the protective equipment and experiences are covered in detail (see paragraphs 128 and 129).

Visits to Social Care Settings

71. My colleague, Kevin Stewart, Minister for Mental Wellbeing and Social Care, undertook the vast overwhelming majority of care home visits during his time as Minister with responsibility for Social Care. On occasion, I also made visits where it could add value or was required.

72. For example, as I mentioned earlier in this statement, I visited I&S I&S on Monday 5th September 2022, in order to drive home the messaging on the importance of social care staff and residents taking up the offer of the booster vaccine.

73. I also visited the I&S at Home team, based at I&S Hospital, a service which aims to reduce hospital admissions for elderly patients by providing medical care in the comfort and familiarity of their own homes. I announced further funding of £3.6 million to expand Hospital at Home services across Scotland during this visit – to reduce pressures on hospitals. The funding was available for Health Boards to apply to either develop or expand their services, with the aim of doubling the capacity of Hospital at Home by the end of the year. On 4 February 2022, I also visited I&S and on 1 July 2022 I visited I&S

74. A number of issues were raised by ASC stakeholders, mainly in relation to their views on what more the government could do to support the sector. A number of these asks, though not all of them, came down to additional funding. For example, the most frequently raised issue, and I believe one of the most pressing for the ASC sector was both recruitment and retention of staff. There was a call for funding to be made available to increase social care wages, which I was able to do on a couple of occasions during my time as Cabinet Secretary for Health and Social Care. However, again, we were constrained by our budget settlement and the difficult economic climate at the time.

75. We also discussed issues in regards to the ASC sectors response to any potential waves of the virus and new emerging variants and outbreaks. Ensuring

that sufficient PPE, vaccines and testing were available and accessible for both residents and staff in the ASC sector.

76. As referenced throughout this statement, there was a significant issue around ensuring that we maximise capacity in the ASC sector to alleviate the pressure on the health service. The ASC sector would raise this issue in the context of staffing, making it clear that while they may have a number of beds available, ensuring there was staff to manage them was another question.

77. There was also the challenging issue of visits for relatives of those who had a loved one living in an ASC setting. That was an issue that was raised during my time as Cabinet Secretary for Health and Social Care, but probably less pronounced as an issue because routine visiting was already allowed for the most part, however, there were occasions we had to make adjustments, for example during the emergence of the Omicron variant. In December 2021, daily asymptomatic LFD testing was introduced to supplement baseline testing for ASC staff. On 15 December 2021, updated adult care home visiting guidance was issued [HY6/020 - INQ000241683]. Visitors to care homes were also asked to undertake LFD tests prior to each visit to minimise risk of transmission. The guidance was clear, however, to stress that residents in care homes should continue to have opportunities to connect safely with loved ones, if the protective measures were maintained. In the event of a controlled outbreak, named visitors were allowed to continue to visit care home residents – should the Local Health Protection Team agree. Further details regarding visiting guidance are provided at paragraphs 171 to 215 of this statement.

78. In terms of key actions I took in response to concerns raised by ASC stakeholders, there were the issues that were constant (such as issues regarding capacity in the ASC system), and then there was issues that would come as a result of certain circumstances at any particular time. I took a number of actions to try to create more capacity and to ensure that capacity was used – for example, through the increased funding announced in November 2021 and action to increase staff wages (detailed above at paragraphs 22 to 27) and I worked with finance colleagues to successfully argue for significantly increased investment in ASC.

79. We were told by ASC providers that one of the biggest challenges they were facing was staffing. They had significant staffing vacancies and were unable to attract people to ASC because of the level of the wages, particularly in comparison to other health roles. During my time as Cabinet Secretary for Health and Social Care, I recall instructing two pay uplifts.. We were very keen to do this in order to encourage the recruitment and retention of staff. I presented a paper to Cabinet on 5 October 2021 setting out options for a pay increase, outlining the issues raised – which noted that, "*Many commissioned reports from the Scottish Government have been highlighting the issues around recruitment into the sector, with all highlighting low pay, poor conditions and a lack of feeling valued has led to a dramatic erosion of the workforce, loss of skill and talent, and the inability to keep up with demand*". These reports include – The Independent Review of Adult Social Care [HY6/021 - INQ000280640], The Implications of National and Local Labour Markets for the Social Care Workforce [HY6/022 - INQ000587189] and the Fair Work Convention Enquiry into Social Care [HY6/023 – INQ000376409] The Cabinet paper, provided [HY6/024 - INQ000362740] sets out the findings of Scottish Care and Close the Gap research into the ASC sector workforce and recommended that Cabinet agree a pay uplift to £10.02 per hour (to be implemented from December 2021).

80. Further investment of £100 million for Local Government was announced in the Scottish Budget for 2023/24 to support the delivery of an increase in the minimum hourly wage rate for workers provided direct ASC, within commissioned services, from at least £10.50 p/h to £10.90 (from 1 April 2023 onwards) [HY6/025 – INQ000587191].

81. On 6 September 2023, as First Minister, I pledged that that private and voluntary staff working in the ASC sector would receive at least £12.00 per hour (an increase of 10.1% from the £10.90 minimum rate introduced in April 2023 for eligible staff) [HY6/026 – INQ000587192]. This took effect from April 2024.

82. The purpose of the proposed introduction of the National Care Service in Scotland was to try to ensure that we had national standards of care and progression around ASC. That is why I ensured progress towards a National

Care Service and why to this day, I still believe it to be a good policy and an important policy to pursue. With such variation in social care provision across the country, in terms of standards and opportunities for progression in the workplace, we continue to have a postcode lottery of care in Scotland, where staffing issues continue to be a challenge, based on the conversations I continue to have with social care providers in my constituency. I discuss the National Care Service further at paragraphs 317 to 326 of this statement.

83. One of the key challenges we were told about by both the NHS and the local authority partners was people wanting discharged to a specific care home. I made it clear that the Scottish Government must remind NHS colleagues about the flexibility within the Choice Guidelines, and use said flexibility where necessary. I also made it clear in press interviews that those being discharged from hospital may not initially be accommodated in their home of choice if there was not capacity, but there was a staffed bed in another home in the HSCP area.

84. Social care providers, particularly private providers also raised issues with me around the Crown Office Investigation into deaths in care homes, known as Operation Koper, but I said that given this was a live investigation by the Crown, all I could do, and would do in response to their concerns, was write to the Lord Advocate to say that these concerns have been raised with me, and would the Lord Advocate be willing to meet with Scottish Care.

Adequacy of communications with ASC stakeholders

85. The engagement with ASC stakeholders was regular and it was frequent both with myself and the Minister who had day to day responsibility for social care, Kevin Stewart MSP (Minister for Mental Wellbeing and Social Care). That said, the pace at which Cabinet, and at times the FM with delegated responsibility, was making decisions, meant that extensive consultation with stakeholders – including those in ASC – was not always possible. This happened more often during the early days of the emergency response to Covid. I am sure those in the ASC sector would say that while the engagement with Government was frequent, both at official and ministerial level, there were occasions where their

views didn't feel adequately represented in the decisions that were made about the sector.

86. The level of data we were receiving in relation to ASC capacity across the country was not adequate and we got to the point, through our efforts within government, to create a dashboard that effectively allows us to see the staffed care home capacity that's available in any given HSCP.

87. I was absolutely immersed in the challenges that the ASC sector was facing and a lot of my time as Cabinet Secretary for Health and Social Care was devoted to it, so I believe I had a significant degree of understanding of the ASC sector in Scotland. That came from engagement directly with the sector, directly with those living in ASC and working in ASC. I was also speaking to local MSPs from across the political divide, who also represented different constituencies across the country, given the geographical variation in terms of the services being provided.. I would say my understanding of the sector was detailed.

88. Before I was Cabinet Secretary for Health and Social Care, the issues and challenges the ASC sector was facing were well aired during Cabinet discussions by my predecessor. I also had knowledge of the ASC sector, and the challenges they were facing during Covid as a result of my own constituency engagement with care providers I&S

Decision Making

89. The overarching principles for decision-making were principally the Four Harms contained within the Framework for Decision Making, which were always at the forefront of my mind [HY6/027 - INQ000247192]. We knew the vulnerability of the environment in ASC and it was crucial we did whatever we could to protect residents and staff in care homes and day care settings from the worst and most harmful effects of Covid 19.

90. As well as Harm 1, which took primary consideration in decision making, Harms 2 & 3 were also factored into our thinking as principles that guided our decision making in relation to the ASC sector. As well as protecting the residents and staff

from the worst effects of Covid, we also wanted to ensure capacity in the ASC sector was maximised in order to assist with the significant pressure the health service was under.

91. As an example, it became very difficult to resume elective care to the scale that we wanted to, with the pressure of delayed discharge in our hospitals. People on waiting lists for elective surgery were deconditioning and were often in chronic pain. We were working hard to try to ensure that anybody that did not require to be in hospital for clinical reasons was not occupying a hospital bed. By working with the ASC sector to free up as much capacity as possible we could help alleviate pressure acute health settings were facing.

How decisions were made and implemented

92. My colleague, Kevin Stewart MSP, Minister for Mental Wellbeing and Social Care, had a significant degree of autonomy to make decisions in relation to the Adult Social Care sector, without my permission being required. I would be copied into submissions in relation to the ASC where it was judged by officials and/or the Minister to be appropriate. This was usually if the decision being required was of significant importance that it should be flagged to me, and on occasion I was the one required to make the therefore required my sign off or judgement to make a particular decision.

93. Ministers were well supported by a dedicated team of civil servants and clinical advisors, in particular officials from the social care division. Officials would work across the HSC Directorate as well as across Government where required and were represented on a range of decision making bodies, such as the Health and Social Care Management Board. Officials were also regularly engaged with stakeholders from the ASC sector. Both Kevin Stewart and I met with social care division officials on a frequent basis, multiple times a week, to be briefed on the latest challenges facing social care, and to receive updates on the actions we had initiated to support the sector.

94. A number of Advisory Groups, in relation to social care, were also set up to provide expert input to our decision making. These included the Clinical and

Professional Advisory Group for Social Care (CPAG), the National Care Home Rapid Action Group (CHRAG) and the Pandemic Response Adult Social Care Group (PRASCG). The groups brought together a wide-range of experts and stakeholders – from representatives of private social care providers and the third sector right the way through to COSLA representatives - alongside officials and clinical advisors and covered a range of issues affected the ASC sector. As already detailed in the statement, the Minister would also meet with care home providers across the country, and other important stakeholders in the ASC sector bilaterally on a regular occasion. Those discussions also included with our trade union colleagues, who represented those on the front line. They would meet with Ministers as well as write in with concerns they had or issues they wished to raise. This helped me to keep informed of the issues facing those who were on the front line in our social care sector.

Impact Assessments and Decision Making

95. As an overarching comment, Equality Impact Assessments (EIA) were a key part of briefings and advice that was sent to Ministers and Cabinet Secretaries. Of course, this was more challenging, particularly the early days of the pandemic when decisions were having to be made at pace. I would have received details of the EIA in the advice and briefing that came to me on any given issue.

96. As regards how we considered the impacts: Firstly, we tried to engage directly with people that were affected – such as those that had physical disabilities, learning disabilities, those with dementia, with pre-existing health conditions, people from ethnic minority backgrounds and so on – as there wasn't really a better substitute than dealing directly with those individuals or their families to understand the issues that most affected them. We tried to do that regularly as Ministers, and officials were also speaking regularly with those with lived experience, though we were constrained given the NPIs in place at any given time. The bulk of my time as Cabinet Secretary for Health and Social Care would have been on issues affecting the NHS, and as has already been referenced extensively in this statement, both the social care sector and NHS are inextricably linked. Therefore, I would have regular meetings in regards to the social care sector, both internally with officials and Kevin Stewart, but also with

external stakeholders also. Kevin Stewart, as the minister with day-to-day responsibility for the ASC sector would more frequently engage with social care stakeholders. He and I caught up during weekly calls and he would provide me with feedback on any relevant matters, including where he required to flag any potential equality impacts.

97. We also, as a government, had particular groups that were set up during the pandemic that covered some of those people with protected characteristics. For example we had an Expert Reference Group on Covid-19 and Ethnicity. Recommendation 4 of the Expert Reference Group's report [HY6/028 - INQ000241567] highlighted the need for fair work practices, as ethnic minority staff in certain settings were victims of discrimination and unfair work practices, with social care settings being referenced in that particular recommendation. Further information regarding the Expert Reference Group is provided at paragraph 160 of my statement below.

98. The Scottish Government also has a strong track record of working with those in lower socioeconomic backgrounds. The impact of Covid-19 on those from a lower socioeconomic background was a topic of frequent discussion at Cabinet, including before I was appointed as Cabinet Secretary for Health and Social Care. A combined total of £1 billion was allocated between March 2020 and March 2021 to help local communities through the Covid-19 pandemic, and to build resilience in public services. Of this, more than £550 million was committed through the Communities Funding Package – initially launched in March 2020 as a £350m package. This was distributed across councils, local services and initiatives supporting those in need. Key elements included:

- More than £140 million on tackling food insecurity, with over £51 million to enable the continued provision of Free School Meals during school closures and holiday periods
- Help for Local Authorities to meet people's needs over the winter period, with £40 million of financial insecurity funding and £30 million to help people impacted by COVID restrictions and guidance. In conjunction with the

Freephone national assistance helpline, councils provided support to access and afford essentials, including food and fuel

- Almost £80 million awarded to third sector and community organisations through the Wellbeing Fund, Supporting Communities Fund and the Third Sector Resilience Fund.

99. The Scottish Government established the Social Renewal Advisory Board (SRAB) (jointly chaired by the Cabinet Secretary for Communities and Local Government and the Cabinet Secretary for Social Security and Older People) in June 2020, papers provided [HY6/029 - INQ000362701]. The SRAB was focussed on tackling poverty and disadvantage and advancing equality particularly given the disproportionate impacts of Covid in those from a lower socioeconomic background, and also the elderly population in Scotland.

100. The Scottish Government published its own research into how the Covid 19 pandemic had impacted disabled people in Scotland [HY6/030 - INQ000182797]. This considered mortality rates including people with learning disabilities and summarises the wider impacts of Covid-19 on disabled people using evidence from a range of Disabled Peoples' Organisations (DPOs). The research concluded that the pandemic had a disproportionately negative impact on disabled people. Issues included loneliness, increased isolation, accessing food as a result of food shortages, gaps and delays in receiving shielding support and priority deliveries.

101. Ministers received briefing on the risks associated with social distancing, and the impact of various NPIs in relation to those with dementia and Alzheimer's. For example, briefing circulated in advance of the SGoRR(M) meeting on 9 March 2020 [HY6/031 - INQ000510039], [HY6/032 - INQ000510040], [HY6/033 - **INQ000056179** provided details of possible consequences of the proposed societal and behavioural interventions. This outlined potential impacts relating to mental health and loneliness due to limited social contact for 13-16 weeks and that dementia patients may, "*experience permanent loss of skills from reduced contact and care*."

102. In relation to NPIs there was a concern that those with dementia would not sufficiently understand or remember what was being asked of them at any given time. The paper presented to Cabinet on 8 July 2020 regarding the progression to phase 3 and review of the Coronavirus Regulations noted at paragraph 100 concerns regarding the ability of certain population groups to comply with interventions [HY6/034 - INQ000362721]:

> "*there may be specific concerns around the vulnerability of some user groups, for example the Scientific Advisory Committee has previously expressed caution over an Alzheimer Scotland proposal to re-open their day centres for older people with dementia with adaptations and reduced capacity. The committee is currently considering the wider issue of reopening day care and respite supports, bearing in mind the broad spectrum of ages and user groups that this covers. We expect a response this week but clearly this is a complex issue given the wide variety of supports, services and user groups involved. The committee is aware of the urgency of the issue.*"

103. Although we had very stringent measures in place in care homes, particularly during the early days of the pandemic, and certainly before the vaccine was offered, there were mitigations in guidance in regards to those who had dementia. For example, the Scottish Government guidance of 13 March 2020 [HY6/035 – INQ000280689] included mitigating factors to consider such when implementing the guidance around IPC and social distancing;

> *"Implementing these measures including social distancing may have adverse effects that need to be considered. These could include:*
>
> - *Increased immobility and higher falls risk for particular patients.*
> - *Low mood from social isolation*
> - *Boredom*
> - *Loss of contact with families.*
>
> *These factors may be more marked for residents with dementia. Deploying measures to address and mitigate these factors will be important. This may*

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

104. As regards visiting, the 13 March 2020 guidance [HY6/035 - INQ000280689] stated, "*Reducing visitors to the home apart from essential visits. This should seek to reduce external visitors by 75% as with other guidance. This might need to consider visits from appropriate health and care staff as essential. Thought should be given to having a named relative as contact. There may need to be consideration given to a named relative as an essential visitor, but the frequency and duration of visiting will need to be reduced. Obviously there needs to be flexibility where appropriate such as in end of life settings*."

105. Further iterations of the guidance, including the version published on 15 May 2020 [HY6/036 - INQ000383486] included consideration of potential mitigating measures,

"*Supporting residents' well-being and family and friends during this pandemic Implementing these measures including physical distancing may have adverse effects on quality of life that need to be considered. These factors may be more marked for residents with dementia who may be at increased risk of becoming anxious, stressed, frustrated and distressed by physical distancing measures. Therefore the use of appropriate language will need to be carefully considered. The Care Inspectorate has produced a guide on supporting people to keep in touch when care homes are not accepting visitors.*

The use of personal protective equipment may also increase anxiety and distress in someone who is confused or evoke an unexpected reaction. Staff should be aware of this, where possible explain their appearance in ways that the person understands, be thoughtful and try to minimise any negative reaction.

Family members and friends who may not be permitted to visit will also need reassurance and understanding. Many will be anxious about the wellbeing of the person they care about and worry about the impact on their relative or friend of measures to reduce contact with others. Utilising and proactively facilitating alternative ways that they can continue to stay in contact using phone or digital technology, letter will be essential for both the resident, their family and friends. Access to spiritual care through this means may be also be helpful.

Education of residents and families can aid compliance with mitigation strategies, and address considerations of quality of life and anxiety. More information on strategies for promoting the wellbeing residents is contained in Annex 6."

106. The Scottish Government Dementia and Covid-19 – National Action Plan to Continue to Support Recovery For People with Dementia and their Carers" was published in December 2020 and set out the measures which had been taken to support those with dementia, their carers and families, feedback from impacted individuals and their families and priorities for further action [HY6/037 - INQ000516958]. The measures taken to support families included the £350 million Communities funding package, the further £100 million funding package for a Winter Plan for Social Protection announced in November 2020 (including funding for tackling social isolation and loneliness through digital inclusion). The National Action Plan included a series of 21 commitments, including measures regarding the resumption of day services, access to rehabilitation, the use of telecare and addressing digital exclusion for people with dementia and their carers.

Engagement with those with lived experiences

107. Put simply, I would say that the suggestion that more structured conversations and engagement between Government and those individuals with lived experience also applies to ASC sector. We engaged with those in the ASC

sectors including care home providers, staff, residents and relatives as already detailed in the statement. And while this engagement was frequent, it could perhaps have been more structured and even more frequent, as well as cross-government, for example including not just health ministers and officials, but finance and local government ministers and officials too. However, I should say that there were so many issues requiring attention at the time in each of our individual portfolios that we had to be responsive to what was in front of us, so structuring engagement with any regularity may well have been difficult.

Key decisions in respect of ASC sector prior to 19 May 2021

108. ASC was discussed at Cabinet and my predecessor as Cabinet Secretary for Health and Social Care Jeane Freeman, would give an overview of the issues facing the ASC sector to cabinet on a regular basis. Cabinet was a discursive forum where Cabinet Secretaries across portfolios would feed in thoughts as to how to resolve some of the challenges the sector was facing at the time. There was however little overlap between the ASC sector and my previous portfolio, Justice.

Expansion on comments in Module 2A and Module 3 statements

109. I have been asked to respond to the following statements, taken from my previous witness statements in relation to Modules 2A (16 November 2023) [INQ000273973] and Module 3 (16 August 2024) [INQ000480774]:

- Module 2A, (2 November 2023) [INQ000273956], paragraph 200, "*When formulating the initial strategy, the impact on vulnerable and at risk groups in Scotland was a key consideration. Vulnerable groups were considered both in the light of specific clinical vulnerability to the virus and in terms of wider equalities considerations. These matters were discussed in detail at Cabinet meetings and other decision making fora.*"
- Module 2A, (2 November 2023) [INQ000273956], paragraph 345, "*In terms of the role that the management of transmission in care homes and to those receiving care in the community played in the Scottish Government's overall*

strategy to limit transmission, it was an important factor that was considered." [INQ000273956 paragraph 345].

- Module 2A, (2 November 2023) [INQ000273956], paragraph 345 "*The Framework for Decision Making [INQ000182846] highlights that care homes are particularly high risk settings, as these usually have many people living under one roof, in a situation where social distancing is difficult. The elderly are among the most vulnerable, and those living in care homes often require personal care*."
- Module 3, (16 August 2024) [INQ000480774], paragraph 179, *"However, Scottish Government was mindful of the challenges facing social care workers in adult care homes, given the intimate nature of the tasks they were often asked to carry out with frail, elderly residents, a number of whom had dementia."*

110. The above paragraphs, taken from my previous witness statements, which the Inquiry have referred to, relate to early days of the pandemic when the data and science in relation to Covid 19 was evolving, for example, regarding the presence of asymptomatic transmission. Some of those statements cover the response period generally but mostly were made in the context of the early days of pandemic, what is often termed as the emergency phase of the pandemic.

111. Initially our focus was on symptomatic presentations, particularly those being discharged from hospital to care homes. As I have referenced in previous statements to the Inquiry, I believe we should have tested asymptomatic discharges to care homes sooner than we actually did. In the early days of the pandemic, there was little understanding of asymptomatic transmission with a focus on what we knew to be the case i.e. that symptomatic transmission was clearly taking place. As the science, data and knowledge of the virus grew and became better understood, it became clear that asymptomatic transmission was taking place and aiding the spread of the virus.

112. The initial strategy of prevention of transmission to care homes was led by the previous Cabinet Secretary for Health and Sport, Jeane Freeman, and I had very limited input to this. The advice from the World Health Organisation (WHO) was

"test, test, test." We could possibly have started that approach sooner than we did, even if it was by just a matter of weeks, as I have already referenced. I am afraid I cannot recall whether, at this time, testing capacity was an issue.

113. The availability of tests was also an issue in the early days given the global demand for testing kits, and also limitation in lab capacity, therefore we had a decision to make, in the early days of the pandemic in relation to who to prioritise for testing, and in which settings. Health and social care settings were rightly prioritised given the vulnerability of those in such settings to the worst impacts of covid, and also the high risk of nosocomial infection and spread of the virus.

114. The use and availability of Personal Protective Equipment (PPE) was also a key tool in helping us contain the spread of the virus within the care home environment. Given the strain on the global supply chain, we developed our own domestic supply of PPE in Scotland to help with these challenges.

115. The most effective tool we had in combatting the virus was the vaccine, and given the risks prevalent in the care home environment, ASC workers, staff and residents were prioritised for the vaccine. Decisions around prioritisation were informed by the clinical advice ministers received.

116. Another consideration was limiting external transmission of the virus to the care home environment, which resulted in quite severe and challenging visiting restrictions. This was part of the strategy at an early stage, especially in the days before the vaccine was developed. Likewise, day care centres were also closed. This was another key prong of strategy to prevent transmission. I also visited care homes as part of my duties as a constituency MSP. Therefore, through that engagement, and my underlying understanding of the ASC sector, I was aware that physical distancing could be difficult in many ASC settings. This could be for a number of reasons, such as the lack of physical space available, through to the challenges of ensuring those with dementia were supported to follow the rules around physical distancing. There was often discussions at Cabinet, and during other fora a such as Gold Command meetings, about the restrictions being imposed on the ASC sector, which included the impact of continued closure of day care centres. Most Cabinet Secretaries were informed by our own

constituency experiences, and constituency feedback in relation to the impact of ASC restrictions. Cabinet was a discursive forum, however, on a number of occasions, including in relation to ASC, we would delegate responsibility for final decision making to the FM and Cabinet Secretary, given the evolving nature of the virus.

117. Further to this, I cannot speak in detail to the initial strategy deployed as this was not my responsibility at the time.

Expansion on Module 2A oral evidence

118. I have been asked by the Inquiry to expand upon the following oral evidence during my Module 2A hearing on 25 January 2024:

- "*I think the issue around possible asymptomatic transmission of the virus was known as a possibility early on, through various international journals, through various academic articles, and there will be a number of things that we could have done better.*" [see transcript p.208 lines 19-23];
- "*It is in my view, as the current First Minister, that we should have been testing those who were leaving hospitals, going into care homes who were asymptomatic, sooner than we actually did.*" [see transcript p.208 line 24 - p.209 line 2]
- **Question (from Counsel to the Inquiry),** "*So I suppose implicit in your response was that you were aware of the possibility of asymptomatic transfer at the time it was decided to move people from hospitals into care homes?*" **Answer: "***Yes, Yes, I mean I would certainly say that pre-21 April 2020 I think it would be fair to say that there was a possibility…*" [see transcript p.209 lines 6-12].

119. In relation to my statements above, there was a growing body of international evidence suggesting that asymptomatic transmission was possible, in relation to the spread of Covid 19. I recall there being exchanges in Parliament between the FM and opposition parties regarding asymptomatic testing as that evidence was initially emerging. Opposition members were acting on building international evidence of asymptomatic transmission. We did eventually make the decision to

test everyone who was being discharged from hospital to a care setting, but on reflection, I think we could have taken a preventative approach, even as the science was developing. Would it have been sensible from a precautionary perspective, taking into account the potential for a number of false positives and the requirement of those individuals to then self isolate? For me, I have made the point, that this is something the Government should reflect on. As referenced in more detail in paragraphs 111 and 112 of this statement, the lack of scientific data and evidence on asymptomatic transmission, and the pressure on our lab capacity, meant that we did not initially routinely test those who were not displaying symptoms of the virus when being discharged from hospital to a care setting.

Views on action to protect care homes prior to April 2020

120. We were working hard to increase testing availability and were also working, at pace, to expand the capacity of NHS labs and lighthouse labs as a matter of priority, so as to increase testing capacity. We knew how important a tool testing would be in order to identify cases, and contain the spread of the virus. Changes to the testing regime were made as the science developed, including our decision to routinely test all of those individuals being discharged from hospital to a care setting.

Views on management of the pandemic in care homes

121. We certainly did not have the view that management of the pandemic in ASC settings was in any way secondary to that in healthcare settings. A significant focus was on nursing homes and domiciliary settings. We knew the level of vulnerability of those in the ASC sector – both staff and residents - and did not see it as an either-or situation. We dedicated attention and funding to social care in its broadest sense, as well as healthcare settings. This can be demonstrated by the significant increases in funding for the ASC sector during my time as Cabinet Secretary for Health and Social Care. In addition, and as already referenced throughout this statement, the NHS and social care sectors are inextricably linked, therefore ministerial attention was dedicated to resolving the

challenges in both, to the wider benefit of the health and wellbeing of the population we served.

Key decisions made in respect of ASC sector after 19 May 2021

122. Key decisions were made according to the latest scientific advice and evidence available at the time. The emergence of the Delta variant in mid-2021 required additional responses to support action to reduce community transmission. The Scottish Government worked with Glasgow City Council (GCC) and NHS GGC to implement enhanced testing measures locally. In November 2020 enhanced testing in care homes and testing of permanent and visiting staff and personal assistants to a person's home and covering residential settings, sheltered housing and day care [HY6/038 – INQ000240872] would be required. Care home staff were required to undertake twice weekly LFD asymptomatic testing as well as weekly PCR tests. This was implemented on 4 January 2021 along with the requirement of care home visitors professionals and family/friends being required to test prior to entering a care home.

123. In December 2021, concern around the Omicron variant led to further measures being introduced to minimise risk of transmission. As stated above at paragraph 77 of this statement, Care Home Visiting Guidance was amended to introduce testing requirements for visitors, as well as increased testing arrangements for staff. By the time of the wave of late Summer/early Autumn we had been dealing with the pandemic for a year and half. We also had a vaccination programme up and running and the vast majority of staff and residents of care homes would have had two doses of the vaccine. There was no better defence than the vaccine and making sure residents and workers were vaccinated was key. Further action was taken in relation to the Omicron variant as stated in my Module 3 statement (submitted 16 August 2024) [INQ000480774] at paragraphs 116 to 126:

> *"116. When Omicron emerged, we decided to accelerate our vaccination booster programme. As a result, staffing in other areas of the health service felt further pressure.*

117. The increased demand that the Omicron variant placed on acute sites meant that it could inhibit the ability of ambulance staff to respond to emergencies, for example by slowing down ambulance turnaround times. Steps were taken by health boards, with varying degrees of success, to address that risk. For example, NHS Tayside had a consultant-led model for flow navigation within the Accident and Emergency department of **I&S** **I&S** *which worked well and helped to reduce ambulance turnaround times. The Scottish Government also provided additional investment for the Scottish Ambulance Service in order to assist with recruitment of staff.*

118. Early data wasn't suggesting that Omicron possessed significant immune escape, and we knew the vaccine was still effective due to global data. However, we knew that, whatever we did, the pressure on the NHS due to the Omicron variant in the winter of 2021 was going to be very significant. We also had concerns that flu would return in a significant way not seen during the previous winter.

119. Winter is, of course, always a time of extreme pressure on the NHS, and we knew that people would want to attend events throughout the festive and New Year period. We knew there was going to have to be a joint approach of NPIs and vaccines, as they were the two key tools we had to help the Scottish healthcare system respond to Covid-19 and protect the healthcare system during what would be an incredibly pressured winter season.

120. Vaccines were by far the greatest tool that we had to tackle the harms of the virus. It was clear that we would have to accelerate the vaccination programme, so we implemented the 'Boosted by the Bells' campaign and set ourselves the target of having 80% of eligible adults vaccinated by 31 December 2021. The target was set, and that was communicated to health boards who in turn increased capacity. We were delivering record numbers of vaccines per day, all of which helped to reduce the impact on the healthcare system.

121. As mentioned previously, in order to accelerate vaccine rollout, further vaccinators were deployed from other parts of the healthcare system. This was left to individual health boards to determine, and to do in a way that would have minimal impact on other services.

122. As well as expediting the vaccine rollout, we limited the number of spectators at indoor events and allowed a greater number at outdoor events. The numbers were informed by the scientific and clinical evidence, as well as the knowledge that people would want to attend events throughout the festive and New Year period, hence we stipulated that the larger events that were permitted occur outdoors. As ever, we had to strike a balance between keeping society open and containing the spread of the virus. People had received the vaccinations and the most vulnerable would have had a booster, and this gave us further encouragement in relation to allowing for gatherings of controlled numbers to occur.

123. However, on 21 December 2021, Cabinet had to further consider if additional protection measures were required, given the rate at which Omicron was spreading in Scotland. At this point it was known that this variant was more transmissible than Delta and that it was better at evading vaccine-induced antibodies.

124. These further measures included the cancellation of all large events on 26 December 2021. One metre physical distancing measures were reintroduced for the hospitality and leisure sectors, while hospitality had to provide table service only. Nightclubs were required to close for a period of at least three weeks. The hospitality, retail and nighttime economy sector were generally based indoors, traditionally busy over the festive period, and were more likely to involve alcohol consumption that could make people less cautious in their physical distancing behaviours. These factors were all relevant, given our understanding of how the virus spread.

125. By 31 December we had not quite reached the 80% vaccination target, but the Scottish Government and partners had delivered booster vaccinations to 2,979,334 people – 76.7% of the eligible population.

126. The winter of 2021-22 was the most difficult time I had seen the NHS face during my time in Government up until that point, and probably one of the most difficult for the NHS in its history."

124. The Health and Social Care Winter Overview 2021-2022 [HY6/039 - INQ000492663] and ASC Preparedness Plan 2021-22 [HY6/040 - INQ000280634] saw an increased focus on supporting the needs and wellbeing of the ASC sector and unpaid carer – recognising, in particular the issues and pressures experienced across the whole ASC system, as well as standard 'winter' pressures faced by the HSC system. It was considered that Winter 2021 would present different challenges to Winter 2020 as a number of non-pharmaceutical interventions had been lifted – this allowed for example large-scale events to take place. There were concerns that there would be a reemergence of the flu virus given increased social contact. 2021 started to see cumulative impacts being felt – for example, backlogs and waiting lists and the attendant impacts on those who had been unable to access elective care. This, coupled with concerns regarding the transmissibility and impacts of the emerging Omicron variant meant that further consideration was required. It felt like the winter of 2021/2022 would be the most challenging period we had faced up until that point given the Omicron variant, possible re-emergence of flu, usual winter pressures and high levels of delayed discharge.

125. Chronology of key changes made during this period:

Date	**Description / Decision / Event**	**Category**
24 May 2021	DCNO and Director for Mental Health and Social Care wrote to Executive Nurse Directors regarding the continuation of	Finance & staffing

Date	Description / Decision / Event	Category
	oversight arrangements and role of Executive Nurse Directors (as per 17 May 2020) and the funding to support this The original decision was made by my predecessor, the letter in May simply provided further detail, therefore my role in the original decision making was very limited.	
7 June 2021	The Minister for Mental Wellbeing and Social Care wrote to the HSC sector to encourage the reopening of day services and clarify the use of guidance.	Restrictions
7 June 2021	Updated guidance on extended use of face masks – guidance recommended that Fluid Resistant Surgical Masks (FRSM) should be available to adult care home residents. It also indicated that visitors to care homes should wear a FRSM rather than a face covering. Individuals receiving care at home and their visitors were not recommended to wear a face covering, but were encouraged to do so.	PPE, Guidance
22 June 2021	Scottish Ministers asked to agree updated guidance from PHS for Care Home Settings (version 2.2) to align with SG policy	Guidance

Date	Description / Decision / Event	Category
22 June 2021	Ministers approved the ending of temporary joint working inspection arrangements between the Care Inspectorate and Health Improvement Scotland (in relation to inspection of care homes)	Inspections
23 June 2021	Updated extended use of facemasks and supporting guidance – ASC guidance separated from acute/primary care settings – clarified that residents were not required to a wear a FRSM/face covering within care homes but could choose to do so	PPE, Guidance
27 June 2021	Announcement of £2 million funding to provide evidence-based support to meet the needs of those working in primary and social care	Financial
15 July 2021	Scottish Government published 'Open with Care – Improving care home residents meaningful contact and connection – on moving to and past level 0' – guidance on recommended relaxations within care homes for level 0 for visiting, communal activity and outings. Also recommended day services onsite in care homes resume	Guidance
22 July 2021	Scottish Government publishes Care at Home supported housing: clarity on	Guidance

Date	Description / Decision / Event	Category
	guidance applied to supported housing settings.	
22 July 2021	Scottish Government publishes 'Covid-19 Living with Dementia in care homes: Guidance on supporting people to remain safe during periods of isolation'	Guidance
9 August 2021	Removal of physical distancing requirements for supported people in day services	Guidance
18 August 2021	Update on physical distancing in HSC settings – reduced from 2m to 1m	Restrictions
3 September 2021	The Coronavirus (Extension and Expiry) (Scotland) Act 2021 saw the extension of care home provisions from March until the end September 2022 . Section 2, Schedule 1, Part 7 Powers to enable Health Boards to make specific asks of care home providers via directions, emergency intervention orders. Section 2, Schedule 1, Part 8 - Power of local authority to purchase distressed care home or care at home service provider; Power of health body to purchase distressed care home service provider. extension from March – Sept	Legislation

Date	Description / Decision / Event	Category
15 September 2021	Publication of updated Open with Care guidance – named visitor to enable people in care homes to maintain contact with loved ones during Covid-19 outbreaks	Guidance
20 September 2021	Covid-19 booster vaccination programme launched – residents in care homes for older people prioritised	Vaccinations
29 October 2021	Nurse Director support for care homes allocation issued	Financial, Staff
4 October 2021	Additional £300 million winter funding pressures letter issued	Financial, Staff
2 December 2021	Updated visiting professionals to care homes guidance issued – signposting to updated PHS advice recommending a levels based approach to return of services	Guidance
9 December 2021	Letters issued to ASC sector re: Omicron highlighting measures to reduce risk of transmission and including advice on testing, vaccination and visiting. Care homes encouraged to increase opportunities for visiting.	Testing, Vaccination, Guidance, Staff
15 December 2021	Extension of PPE hubs for social care for 6 months until 30 September 2022	PPE

Date	Description / Decision / Event	Category
15 December 2021	FM makes statement to Parliament on Covid-19. Updated advice on adult care home visiting issued. Guidance published on 17 December 2021.	Guidance
22 December 2021	Letter issued to care homes including responses to queries re: 17 December 2021 letter re: visiting	Guidance
19 January 2022	Letter issued with updated advice on self-isolation for residents in adult care homes (precautionary self-isolation and cases/contacts), isolation on admission and indoor visiting.	Guidance
31 January 2022	£1 million funding made available to adult social work/social care organisations to improve staff wellbeing	Financial, Staff
21 February 2022	Letter providing additional guidance on use of winter funding – provided additional guidance on flexibility of winter pressures funding	Financial
22 February 2022	Advice on testing for social care staff issued	Testing, Staff
31 March 2022	Anne's Law – publication of updated HSC standards – visiting rights	Legislation

Date	Description / Decision / Event	Category
14 April 2022	Update on extended use of face masks and supporting guidance	PPE, Guidance
19 April 2022	FFP3 Face Mask Guidance – HSC worker access to FFP3 masks, based on staff preference – issued	PPE, Guidance, Staff
1 June 2022	Open with Care – supporting meaningful contact in adult care homes – principles updated – for fully adopting normalised routine visiting in adult care homes.	Guidance

126. As the chronology above shows, I made no significant decisions regarding testing on admission to a care setting as this would not have changed during my period as Cabinet Secretary for Health and Social Care. The testing regime in respect of symptomatic and asymptomatic visitors did change when Omicron emerged, as set out in the letter issued to adult care homes, setting out updated guidance on visits in and out of adult care homes [HY6/020 - INQ000241683]. This guidance followed the First Minister's parliamentary Covid-19 statement of 14 December 2021 providing guidance to further stem the flow of transmission of the Omicron variant.

127. The letter emphasised that visiting care homes should continue to be supported and the measures that should continue to be in place to more safely enable these visits. This included stringent IPC, testing and recommendations to limit the number of households that meet with a resident at any one time to a maximum of two households.

128. On the issue of Fluid Resistant masks and the availability of FFP3 masks, as per my Module 3 statement (16 August 2024) [INQ000480774], paragraphs 187-188:

"During my time as Cabinet Secretary for Health and Social Care, there was some lobbying by opposition parties, trade unions including the BMA, staff side, the media, Fresh Air (an NHS lobby group), healthcare workers, and infection prevention control specialists to change from using Fluid Resistant Surgical Mask Type IIR ("FRSM") to FFP3 respirators ("FFP3s"), in the light of emerging Covid-19 variants. I requested an evidence paper on the topic on 13 January 2022, given the concerns voiced by trade unions and professional organisations about the psychological safety of their members in relation to not being permitted to wear an FFP3 rather than a FRSM in settings where they were not performing aerosol generating procedures (AGPs) on patients.

"In light of that evidence paper, and further to discussions with stakeholders, discretionary access to FFP3 masks was introduced on 19 April 2022 – not as an IPC measure per se, but to improve the confidence and wellbeing of health and social care staff."

129. While there was no empirical evidence demonstrating that a change of PPE was required. However, very powerful submissions and representations were made by trade unions and professional bodies. Most of these representations centred around anxiety some healthcare professionals felt in regards to the transmission of the virus, and the subsequent reassurances discretionary access to FFP3 masks could provide. In discussion with the FM we therefore agreed to provide discretionary access to FFP3 masks to healthcare and social care staff. Copies of relevant submissions from January and March 2022 regarding these matters are provided [HY6/041 - INQ000378260] [HY6/042 - INQ000240465].

130. The issue of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Notices was not so much of an issue during my tenure as Cabinet Secretary for Health and Social Care. This was more pronounced under the term of my predecessor Jeane Freeman.

131. We were very conscious of the strain the pandemic was putting on our health and social care workers, including on their mental wellbeing. That is why the National Wellbeing Hub was created by my predecessor. During my time as

Cabinet Secretary I provided additional funding the Hub, given the important work it was doing, and as an acknowledgment of the accumulative impacts of the pandemic on the health and social care workforce.

132. On Data, I have already referenced in this statement (see above paragraphs 47, 48 and 86) the challenges and frustrations I had with the lack of data coming from the ASC sector in relation to the available staffed capacity, across HSCP regions, and the steps I took to rectify the data gaps that clearly existed.

133. It was never the case that I, as Cabinet Secretary for Health and Social Care, attempted to make a decision without sufficient clinical, scientific or data-led advice. Each new variant had own characteristics and epidemiology, its own immune escape and effects on individuals. So, to a point, we of course learned from previous waves, but we had to treat each new variant according to its own characteristics. Copies of the clinical advice received to support the decisions referred to in the chronology are provided at the relevant sections of this statement and I believe that copies of clinical advice have been provided to the Inquiry by the Scottish Government. For example, clinical advice regarding asymptomatic testing is provided at paragraph 149 onwards below, and changes to the visiting guidance at paragraphs 192 to 200 below.

134. While we clearly aimed to learn lessons from previous waves of the virus, we had to be careful not to simply transpose learning from one wave to the other, given the varying characteristics of any given variant in terms of its transmissibility, immune escape and so on.

Key decisions and finance

135. A number of decisions we made were constrained by finances. For example, we simply did not have the finances to increase social care wages to £15 an hour. Despite a call from the sector and others such as opposition politicians and trade unions, we simply did not have a spare £1.5 billion to fund that level of increase at the time. It would undoubtedly have helped with the recruitment and retention challenges the ASC sector faced, and would have been warmly welcomed by the sector, but financial constraints made it impossible to deliver. We were able to

provide additional funding towards social care, but the challenges the ASC sector continues to face will not be resolved by a one-off cash injection but systemic change in how we deliver care in Scotland, and across the UK. Other than general funding for the sector in particular for wage increases to £15 p/h, I can not recall a particular instance when funding – or the lack of it – adversely impacted decisions I was making in regards to our response to the pandemic in the ASC sector.

136. We did face some challenges in ensuring money that we gave to local authorities to be invested in social care was actually spent on the ASC sector. This was a source of tension between Government and COSLA in ensuring transparency that money would be spent in that sector. For example, there was an ask from Edinburgh Council for additional funding to create capacity, including in exploring the idea of using hotels to provide care capacity to assist with the high levels of delayed discharge in their hospitals. Funding was provided, however there was ultimately no way of determining whether or not the entirety of the money given was spent on social care or not. That is one of the reasons a National Care Service proposed a centrally-funded and centrally-accountable model of care be developed.

Testing

137. I was not the Cabinet Secretary for Health and Social Care during the entire time in question. Any issues would have been communicated via my predecessor. By the time I was Cabinet Secretary for Health and Social Care, there was well established protocols for testing in relation to health and social care staff, resident and visitors to care homes, in additional to the general public at large.

138. There was good and well established access to testing sites, including in remote, rural and island communities at the time I was appointed as Cabinet Secretary for Health and Social Care. In addition, the testing data I received was extensive. There was little in the way of capacity issues that impacted the processing of tests at the time I was Health Secretary. It stands to reason, that at times of a spike in cases, in any part of the UK, the testing system would be under

pressure, particularly if there was a nationwide surge in cases. As we had a 4 nations lighthouse laboratory network if one part of the UK had capacity issues, other labs were usually able to pick up some of the pressure and assist with processing tests.

Testing policy in June 2021 re hospital to care homes & Routine testing for those discharged from hospital to care homes from 2022 to 3 June 2024

139. In June 2021, PHS and CMO, based on scientific evidence, recommended to Scottish Ministers that COVID recovered care home residents in hospital could be safely discharged home after 14 days from symptom onset or first positive test without further testing. Such individuals were likely to continue to test positive but not be infectious, so it was recommended that people were safe to be discharged after 14 days.

140. As outlined at paragraph 71 of my Module 7 statement (submitted 4 March 2025) [INQ000475071], the decision by the UK Government to end universal testing on 1 April 2022 was made unilaterally by the UK Government and without consultation with the Scottish Government, or indeed any other Devolved Nations. This was an example of where intergovernmental working clearly failed, as we had no prior warning. During my time as Health Secretary, the key critical decision to be made in relation to Test and Protect was off the back of the announcement by UK Government that they would withdraw funding for universal testing. I had discussions with the Finance Secretary and the First Minister, and with Cabinet, about what we wanted to do, what we could afford to do, and what our plans were. A transition plan was put in place which provided for a slightly longer transition than the UK Government had put in place for England. That allowed for a longer lead time to phase out universal testing and then begin to plan further phases of testing and withdrawal, given there was only a limited amount we could do due to UK Government's unilateral decision.

141. The decision to maintain routine testing for those being discharged from hospital into care homes after the transition away from mass population testing in 2022 would have been part of the discussions I had with clinical advisers including the

CMO, CNO, and NCD. Such decisions were always based on the higher risk to the elderly population in the care home environment.

142. The care home environment and in particular the adult care home environment is, by its nature in terms who is cared for therein, particularly high risk. We wanted to make sure that we minimised the risk as much as possible because of the vulnerability of the people residing in care homes. Whilst routine testing had to be phased out for the rest of the population due largely to the UK Government's funding decision, maintaining testing for those discharged from hospital for as long as possible was important due to the significant risk that Covid-19 posed for those in care homes. We were always more risk-averse in relation to the care home environment than we were in relation to the general population as a whole.

143. Scottish Care, in its statement to Module 1 of the Inquiry (submitted 11 July 2023) [INQ000224524] previously expressed the view that, "*the lack of testing in care homes where there were no known Covid-19 positive individuals resulted in failure to adopt a preventative approach to the potential spread of the virus in an area where there was known to be high community transmission*." As previously stated in my statement for Module 2A of the Inquiry [INQ000273956], in response I would again refer to the fact that in the early stages of the pandemic we did not have the scientific understanding about the virus and its transmission that we have now. If a different approach had been taken earlier then it may have had a different impact on the spread of the virus, but I reiterate that we could only work with the clinical advice that was available to us at the time.

144. I have also made reference in previous statements, and am happy to reiterate again, that there was a period early in the pandemic when we were being pushed to consider testing for all patients discharged from hospital to care homes. We could have potentially introduced such testing earlier than we did, given some of the international evidence about asymptomatic transmission that was emerging. One of the key incidents I recall which prompted discussions in regards to asymptomatic transmission was the Diamond Princess Cruise Ship outbreak. This was a major outbreak, well reported on at the time, upon the

Diamond Princess which resulted in the identification of over 700 cases of Covid, with a significant number being asymptomatic. There was also evidence emerging from China's CDC (Centre for Disease Control) that suggested asymptomatic transmission was possible. I am afraid I cannot recall the specific dates involved.

145. In March 2022, asymptomatic testing in social care was paused, with the exception of care homes. The vaccination programme had helped to reduce transmission and mitigate risks. All remaining routine testing of health, social care and prison settings staff continued until 30 August 2023. Routine asymptomatic testing for admissions to care homes from hospitals remained until 3 June 2024. Decisions to pause testing were made in line with clinical and scientific advice received from the CMO and UKHSA. Ministers chose not to end asymptomatic testing of patients being discharged into care homes earlier in line with the approach taken by the other four nations and advice from the CMO. Engagement also needed to take place with relevant sectors who would understandably be concerned about any changes to discharge testing arrangements and the vulnerability of the population needed to be considered. PHS and ARHAI confirmed that they were content to cease routine asymptomatic discharge testing of patients, consistent with the risk assessment approach which takes place under all discharges. Wales ended discharge routine testing to care homes in 2023, Northern Ireland on 19 February 2024 and the UK Government ended it on 1 April 2024.

146. Testing then reverted to testing as appropriate to support clinical diagnosis and care, and for outbreak management – as per the National Infection Prevention Control Manual (NIPCM) [HY6/043 - INQ000544501].

147. Decisions regarding testing were made in accordance with the scientific and clinical advice available at the time, and testing capacity available, which was clearly impacted by unilateral funding decisions made by the UK Government in relation to testing. Decisions regarding testing were kept under review and if there was a change in the assessment of the risk or threat level (i.e. due to a new variant of concern) consideration would be given to whether testing would be reintroduced to mitigate against severe harm for those most at risk.

Whenever decisions were made to pause testing, we were mindful that this may have to change, and testing in some format, may well have to resume if considered necessary.

148. Whilst Scotland transitioned away from mass population asymptomatic testing in 2022, I made the decision to retain routine testing for those being discharged from hospital into care homes.

149. Four nations clinical advice received in June 2022 regarding pausing of asymptomatic testing for the wider community recommended that testing for admission to care homes should be retained at this point (either PCR or LFD). The advice stated as follows [HY6/044 – INQ000605491],

> "*Clinical advice is that those being admitted to a care home (from either setting) should still undertake a COVID test, unless a clinician does not deem it appropriate or possible for such a test to be undertaken. Advice is that this no longer needs to be a PCR and can be an LFD. Testing for those being admitted to a care home will continue across all 4 nations.*"

150. The CMO and CNO wrote to NHS and HSCP staff on 14 September 2022 [HY6/045 - INQ000147373], setting out the rationale for the changes to the asymptomatic testing regime and the process for reviewing changes to the testing regime:

> *"The Test and Protect Transition Plan published in March 2022 stated that routine asymptomatic testing in health and social care would be kept under regular clinical review as pandemic conditions and associated threat levels continue to change. Vaccination and treatment effectiveness and the roll out of the Autumn booster vaccination programme has reduced the risk of severe harm from the transmission of COVID-19. The UK alert level has therefore reduced to level 2, while the Scotland threat level remains at Medium. Current prevalence levels mean testing as part of overall infection and prevention control measures can be paused. In doing so it is hoped that this will make a contribution to supporting patient movement and experience in hospitals. Symptomatic and outbreak testing should be retained, alongside*

testing for admission to care homes and to support appropriate clinical diagnosis and treatment pathways as previously stated.

The rationale for pausing asymptomatic testing in high risk settings includes;

1. *Community prevalence is a key driver of risk of infection in staff working in high-risk settings. At lower prevalence the likelihood that individuals entering these settings are infectious also reduces, and the relative risk of onward transmission into these settings is lower.*
2. *Immunity in the population is high due to vaccination and natural immunity from prior infection. Individuals at highest risk of severe disease have been offered a fourth vaccine dose. Due to immunity, each individual COVID-19 infection episode has a much lower risk of causing severe disease.*
3. *At lower prevalence levels, the proportion of positive results that are false positives increases. False positive results can mean increasing numbers of staff in high risk settings are out of work unnecessarily."*

151. On 25 September, in my role as Cabinet Secretary, I made a public announcement when the decision was made to pause asymptomatic testing for HCW workers, but not for care homes [HY6/046 – INQ000605492].In that statement I made clear that the success of other measures (such as vaccination programmes) had meant it was possible to reduce asymptomatic testing, as follows.

"*Health and social care workers will no longer be required to test for COVID-19 every week as asymptomatic testing is paused by 28 September.*
The four UK Chief Medical Officers agreed it is safe to halt weekly staff testing, visitor and carer testing and hospital admission testing following a change to the Covid-19 alert level and, importantly, a high uptake of vaccinations.
Stakeholders were informed of the change to the guidance on 14 September and some healthcare and social care settings may therefore choose to pause regular testing before the end of the month.

It is the latest restriction to be lifted in health and social care settings – following the decision earlier this month to remove the requirement for facemasks in social care homes.

Testing will remain in place for admissions into care homes and to support appropriate clinical diagnosis and treatment for hospital patients and care home residents.

Unpaid carers and visitors to care homes and hospitals will no longer need to undertake routine testing, but those planning to see family or friends in these settings are advised follow the 'Covid Sense' guidelines and steer clear if they are unwell."

"The huge success of our world-leading vaccination programme means we are now able to pause routine asymptomatic testing in most high-risk settings.

"This is the latest step in our return to normal life, but we must apply Covid Sense to keep these freedoms and ease the pressure on the NHS over winter.

"Vaccination remains our best line of defence against COVID-19 and I urge everyone who is eligible for the winter vaccination programme to take up the offer of an appointment when it's offered."

IPC and PPE

152. The NIPCM for Older People and Adult Care Homes ('the Manual') and the National Cleaning Specification for Older People and Adult Care Homes ('Cleaning Specification') were published on 24 May 2021 and were circulated to relevant groups, Manual and Cleaning Specification provided [HY6/043 – INQ000544501], [HY6/047 – INQ000587193]. The information contained in the Manual was based on the same principles and evidence base as the general NIPCM guidance, however, the language and context were updated to provide clear and practical advice specifically relevant for adult care home settings – the Manual also reflected and linked to Standard Infection Control Precautions as the basic IPC measures necessary to reduce the risk of transmission. The letter of 24 May 2021, provided [HY6/048 - INQ000510054] stated that both the Manual and Cleaning Specification were mandatory for all HSC staff working in care homes and that the aim of both documents was ease of use by care home

staff to support the application of effective IPC precautions (including best practice cleaning processes), to reduce the risk of infections and to align practice, monitoring, quality improvement and scrutiny.

153. The Care Inspectorate subsequently included further questions to Quality Framework for Social Care (for care homes for adults and older people) which asked views regarding the quality of care provided during the pandemic and the IPC measures put in place.

154. As regards reporting, the Coronavirus (Scotland) (No. 2) Act 2020 placed new duties on the Care Inspectorate to report to the Scottish Parliament on its inspection activities and findings. The provisions required care homes to report on the number of deaths in the service. These reporting duties were seen as an extension of existing reporting practice. The reporting duties required reports to include:

- Indicative grades based on existing quality themes
- Summary of observations relating specifically to Covid-19 including, for example IPC, staff awareness and training, availability of PPE.
- Other observations that highlight quality of care or safety concerns, good working practice, or other information the inspector deems relevant.
- Details of those care homes inspected in the 2 week period and the findings of those inspections.

155. These reporting duties were introduced in response to a number of factors, including calls for increased openness and transparency by politicians, the public and the media. The first tranche of reporting to the Scottish Parliament started on 10 June 2020 on a fortnightly basis. The Scottish Government received advanced sight of each report which was shared with the Cabinet Secretary for Health and Sport, and I received these upon taking up post.

<u>Understanding of nosocomial infections in care homes between 19 May 2021 and 28 June 2022</u>

156. There was a good understanding of nosocomial infection in care homes given that we received regular advice at Cabinet from clinical advisors, primarily the CMO and NCD, since the beginning of the pandemic. From the offset, I should emphasise that I was not the Cabinet Secretary for Health and Social Care during the early days of the pandemic, and when I assumed office knowledge of nosocomial infection and transmission of the virus in particular in high-risk settings, such as residential care homes, was well understood, with due protocols established. Clinical Advisors, such as the CMO, NCD and CNO often stressed the risks of nosocomial infection in the care home environment. There were many reasons for this higher risk, including the age and vulnerability of the residents inside adult care homes, the environment of many care homes could make social distancing difficult and the fact that observing lockdown measures and other NPIs could be difficult for all the residents, but particularly difficult for patients with dementia. The CMO and NCD would be present at virtually every cabinet and the CNO as and when required. I would say that there was also a good understanding from other Cabinet Secretaries beyond myself of the risk of nosocomial infection. That is why there was absolute agreement throughout Cabinet for such a stringent testing regime and infection prevention and control measures, both within care homes and for those coming from outside. For example, the paper provided to Cabinet on 16 June 2020, "Progression to Phase 2 and Review of the Coronavirus Regulations" [HY6/049 - INQ000232683] referred to the need to undertake:

> *"early action to address nosocomial infection in healthcare settings that is comprehensive and system wide that delivers sustainably and at pace and ensure for care homes full compliance with the testing policy that we have set out. We also require better information on other residential settings including adult mental health, learning disability and forensic services".*

157. Discussion of that paper took place, minutes provided [HY6/050 - INQ000362880],

> *"..the paper included an assessment of compliance with each of the World Health Organization's criteria for the control of COVID-19. In terms of Criterion 3, which related to the management of risks in "high vulnerability*

settings", the evidence indicated that sufficient measures had been taken so that the requirements of this criterion had been met. The progress that had been made was to be welcomed, but great care would still be needed to ensure continued management of the risks of nosocomial infection in healthcare settings and the safety of long-term care facilities. Proposals to allow a resumption of visiting in care homes would need to be considered with this in mind, and it might be that the time was not yet right to set a definite date for this measure, in view of the heightened risks involved".

158. On 29 July 2020 a paper presented to Cabinet regarding "Review of phasing and of the coronavirus regulations" [HY6/051 - INQ000214555] stated,

> *"The significant public health threat posed by SARS-CoV-2 persists. This threat has reduced over the period since non-pharmaceutical countermeasures were put in place but in the absence of definitive treatments or vaccine and an estimated population exposure of around 5% to this point, it is a threat that may strengthen as society re-opens. The proportion of tests reported as positive continues to suggest that controls remain effective, but at this stage this data does not yet fully reflect the impact of some of the more recent changes in restrictions that establish more opportunities for society to meet. The prevalence of COVID-19, however, remains very low, and whilst we should not become complacent in our approach there is much encouragement to be taken from the low impact of changes to this point in time. Over the next period we should continue to seek evidence that levels of nosocomial and care home infections are negligible and that community transmission remains suppressed to very low levels."*

159. I do not recall any specific discussions in regards to providing quarantining facilities in the community for care home workers. The main discussions in relation to protecting those who worked, and lived in care homes centred around testing, vaccinations and visiting restrictions.

160. I was aware of risks of Covid-19 to those from ethnic minority background. As set out in my Module 3 statement [INQ000480774] (submitted 16 August 2024) at paragraphs 173 to 176,

> *"173. I am not aware of any specific data in relation to the levels of nosocomial infection amongst healthcare workers from a minority ethnic background. However, through the data provided on vaccine uptake and Office of National Statistics Data on Covid-19 mortality, it was clear that people from minority ethnic backgrounds were disproportionately affected by the virus and had a lower uptake in vaccinations. The Scottish Government also established the Expert Reference Group on Covid-19 and Ethnicity to help investigate, in further detail, the impact of the virus on our ethnic minority communities. On 18 September 2020, the Expert Reference Group published a report that included, among other things, analysis of the higher prevalence of Covid19 among ethnic minority communities. The report noted that intersections between socioeconomic status, ethnicity and racism intensify inequalities for ethnic groups and that this required additional vigilance in regards to the disproportionate impact that Covid-19 had on minority ethnic groups.*
>
> *174. The report acknowledged that, at the time of its publication, a lack of high quality data on ethnicity hampered the understanding of ethnic variations on Covid-19 and its outcomes in Scotland. With this caveat in mind, however, the report provided examples of why Covid-19 risks may have disproportionately affected minority ethnic groups. Those included:*
>
> *• differential exposure (such as increased representation in health, care and transportation workplaces, poor living conditions and poverty);*
> *• differential vulnerabilities (including increased risk of diabetes and cardio-vascular disease);and*
> *• differential access to treatment and other forms of support (noting that migrants without formal status have barriers in accessing NHS services and people from a minority ethnic community are more likely to face discrimination).*

175. The report urged the Scottish Government to take action on a number of issues, including taking steps to ensure the inclusivity of public health messaging around Covid-19 for minority ethnic communities and migrants, taking into account language barriers, literacy levels, cultural and religious factors and differential access to health related information and to make sustained improvements to the collection and use of data on ethnicity and health.

176. Following the recommendations of this report, significant efforts were made to improve the Covid vaccine uptake through targeted communications and stronger collaboration with minority ethnic, religious and community groups. The collection of ethnicity data for Covid-19 vaccinations was introduced in November 2021, and is now routinely collected for Covid-19, influenza, shingles and pneumococcal vaccines, where a record is not already held. Ethnicity recording was also made mandatory on hospital admission datasets."

161. In addition, I have referenced in this statement earlier at paragraph 97, the report from the Expert Reference Group which made specific references to fair work practices in health and social care settings. These recommendations were accepted by the government at the time. A copy of the report is provided [HY6/028 - INQ000241567].

Concerns, if any, around the provision and use of PPE in the ASC sector

162. I believed it was important to make FFP3 masks available at the discretion of those who wanted them. During my time as Cabinet Secretary for Health and Social Care, this was made available for HSC workers in response to concerns raised by the sector and some people working in the NHS. As per paragraph 129 of this statement, in January 2022 I received advice regarding the use of FFP3 masks and Respiratory Protective Equipment more generally. Further engagement took place regarding staff concerns and preferences. On 13 April 2022 I agreed that the guidance should be updated to provide all health and social care staff with discretionary access to FFP3, based on their personal

preferences and their perception of the risk of infection from Covid-19, see associated submissions provided [HY6/041 - INQ000378260] and [HY6/042 - INQ000240465]

163. Regarding ethnic minority communities, issues were raised mainly in a healthcare setting. For example, the requirement for masks which could accommodate those with large beards which often affected men from the Sikh and Muslim faiths, many of whom kept a beard for religious reasons. I had one Sikh constituent attend my local surgery raising this particular issue which required a specific type of PPE that was in short supply globally. In this particular instance the issue was ultimately resolved by the health board who managed to procure the bespoke equipment but it meant that for a number of months the doctor was unable to work in the speciality he had trained for until the issue was resolved.

164. There was also an issue with transparent facemasks to assist those with, for example, hearing impairment. From 14 September 2020, the wearing of face coverings became mandatory in certain locations. Guidance and regulations provided that there may be special circumstances where the wearing of face covering could cause difficulties or distress and provided for multiple adjustments and approaches to facilitate communication. In October 2020, the face card exemption scheme was launched in partnership with Disability Equality Scotland to support individuals who were unable to wear face coverings.

Provision of transparent face masks

165. In response to demonstrated demand for transparent face masks, a technical specification was developed by the NHS Transparent Face Mask Working Group during Spring 2021. I am afraid I do not recall the exact date I became aware of the need for transparent face masks, however, it was an issue that was raised before I became Cabinet Secretary for HSC, and the work in regards to the development of a technical specification began before I assumed office.

166. In December 2021, through the "Breathe Easy" workstream – a transparent face mask was approved for use in Scottish health settings- the Alpha Solway mask

(which had a transparent anti-fog panel positioned to prevent reflection and facilitate lip reading). Also in December 2021, four nations approval was agreed for the transparent face mask – which were released for distribution alongside accompanying guidance.

167. I was well aware of the benefits of and need for transparent face masks to support individuals with specific communication needs. On 01 December 2021, I stated in a press release [HY6/052 - **INQ000369744**] that:

- "*Although face masks are essential to reduce the spread of coronavirus, it can cause difficulties for people who rely on lip reading, or have other communication needs.*
- *Patients and staff have rightly been calling for an alternative to the usual surgical face masks in clinical settings, so I am pleased NHS Scotland is rolling out these new, innovative transparent masks.*
- *These masks mean staff and patients can communicate clearly while staying safe.*
- *It is also great news that the masks are being made right here in Scotland. Businesses across Scotland worked hard to set up a new Scottish PPE supply chain at the start of the pandemic.*
- *This was an important part of our response to the coronavirus and this new and innovative product illustrates the long term benefits a domestic PPE supply chain can bring."*

168. By February 2022, 225,500 transparent masks had been issued to social care settings and by March 2022 this had increased to 233,400. By the end of June 2022, a total of 240,250 had been distributed with stock levels indicating that there was unlikely to be an access issue with regards to social care. I was not aware of any specific difficulties in people being able to access these masks. In relation to whether or not transparent masks could have been made available earlier in the pandemic, while this could possibly have been done, it was not an issue that trade unions, or 3rd sector organisations raised with me on a regular basis. The Scottish Government worked to ensure that there was a wide understanding of the need for and role of transparent face masks in enabling and

facilitating communication (alongside other alternative methods). The masks were made available by NSS to social care providers through the Social Care PPE triage service and Social Care PPE Hubs, and were provided to NHS Health Boards and Primary Care Independent Contractors providing NHS services. Transparent face masks were made available from a number of retailers to facilitate access.

Reflections on IPC and PPE guidance, support advice and training

169. I believe that IPC and PPE guidance was adequate and, hopefully, effective. Although I was not Cabinet Secretary for Health and Social Care at the beginning of the pandemic, I was aware that in the early days of the emergency response to covid, that there was a number of issues regarding PPE supply, which would have also impacted social care, as it did virtually every other sector. In terms of IPC, protocols were well established by the time I was appointed to my role as Cabinet Secretary for Health and Socials Care, however, I know from my engagement with care home relatives, that many of them felt we had not got the balance sufficiently right in terms of IPC measures and giving care home residents access to their loved ones. I have every sympathy with that view, and know how difficult this period must have been for those with a loved one in a care home – such as my own family who were in that position. So while I believe our PPE and IPC measures did help contain the spread of the virus in the ASC sector, questions from care home relatives as to whether we got the balance right between containing the virus and allowing families of residents in care homes appropriate access to their loved ones, are perfectly legitimate ones to ask. I will not repeat what I have already said throughout this statement in regards to lessons we could learn in relation to testing those who were not showing any symptoms of the virus and due to be discharged from hospital to a care setting.

170. There was also regular engagement with CNO and those in social care, chief social work officer, around IPC in particular which assisted greatly.

Care home visiting restrictions

171. There was a strategic approach taken to care home visiting. We clearly wanted to get the balance right between protecting those in the care home and their wellbeing needs, of which family visitation was a crucial element. Getting that balance right was undoubtedly a challenging job, and I know from my engagement with care home relatives and others, that many felt we did not get that balance right, particularly in the early days of the pandemic. That challenge was particularly acute at times of an outbreak in a care home, it could be a continuous outbreak, not limited in time, depending on how the virus spread.

172. Any changes made to guidance that were made reflected the current scientific understanding and advice at the time.

173. Guidance was drafted to ensure that visiting could resume safely – with officials engaging with relevant stakeholders. This included the development of the named visitor approach – particularly during controlled Covid-19 outbreaks – as set out in the guidance published on 15 September 2021 [HY6/053 - INQ000505932 (providing Local Health Protection Teams consented, based on the balance of local risks). Guidance was also issued at this time regarding the resumption of communal activities and respite.

Introduction of named visitor

174. In recognition of the role of family and loved ones providing wellbeing support to people living in care homes, the Scottish Government worked with members of CPAG to develop a proposal for enabling people who live in adult care homes to nominate a 'wellbeing supporter' who was able to visit in their room during a controlled Covid-19 outbreak. This was because of concerns about the impact of isolation for prolonged periods when care homes closed following a Covid-19 outbreak (which sometimes involved continuous Covid-19 outbreaks in a care home) or if someone was self-isolating as a precaution.

175. A proposal for a named visitor when residents are self-isolating and during outbreaks was submitted by CHRS (Care Home Relatives Scotland) to Ministers

on 15 August 2021. The Minister for Mental Wellbeing and Social Care, Kevin Stewart, met with CHRS on 26 August 2021 support was indicated and that officials would work with PHS and clinicians to consider further.

176. Following the presentation of paper considered at CPAG on 9 September 2021 [HY6/054 – INQ000509973], members endorsed the approach. They recommended using the term 'named visitor' rather than 'wellbeing supporter' or 'essential care giver' to avoid the assumption that it was only for those families that provided care.

177. As indicated in the submission to the Minister for Mental Wellbeing and Social Care on 10 September 2021 [HY6/055 - INQ000243349],

"*Members expressed broad support about the direction of travel but highlighted concerns about immediate implementation and practical considerations. Key points raised by members were:*

a. *Timing, and current palatability to the sector, in light of wider pressures. Scottish Care indicated that they would not support an announcement at this time and in its current form.*

b. *A range of practical and advice-related factors such as staff and relative hesitancy, competing expectations and priorities in practice, and how to define in guidance the best way of enabling dynamic risk assessments in practice."*

178. Following the discussion at CPAG, the Scottish Government published guidance on 15 September 2021 to support named visitors during controlled COVID-19 outbreaks which ensured that people could remain connected even in an outbreak situation [HY6/056- INQ000509972].

179. The CPAG undertook a stocktake of implementation of the named visitor guidance in March 2022 [HY6/057 - INQ000323349]:

"The named visitor policy to support visiting during managed outbreaks was announced on 15 September 2021, to ensure that people who live in adult care homes can continue to see their loved ones even in an outbreak situation.

Under the policy, which operates across the UK care, home residents can choose a friend or relative as a 'named visitor' who should be supported to visit them, even during a Covid-19 outbreak. Initially, guidance indicated that the named visitor policy could be supported as long as the outbreak was controlled or managed. However it was updated in January to indicate that named visitor should be supported in all but exceptional circumstances.

CPAG has supported a commitment to monitor the implementation of the named visitor during managed outbreaks, in an approach which focuses on capturing the learning in order to support adoption and improvement.

We reported to CPAG initial discussions with relatives, public health and health protection networks, PHS and CPAG oversight group and agreed to provide additional feedback from further discussions with providers"

Key Points

- *The onset of Omicron and with it the increase in care home outbreaks was the first real test of the NV policy in December.*
- *Many care homes and public health teams reported positive experiences in adopting the named visitor, particularly with the arrival of Omicron. It meant that people were able to stay connected with loved ones.*
- *Eg one DPH return: Feel more positive – we have guidance and good processes. Positive all round parties for residents and their families and a process in place for facilitating that.*
- *Care homes reported after two years of the pandemic, the importance of ensuring that people maintain contact with loved ones.*
- *Some have reflected that both care homes and local health protection teams have been on a 'journey' around named visiting, with some initially adopting more cautiously, but moving to more routine implementation.*

- *The move to make named visitor as the default unless exceptional circumstances has been welcomed.*

Provider views from two workshops in February

- *Providers were supportive of the named visitor policy*
- *However a number of providers reported caution from some Public Health teams in adopting named visitor which in some instances required care home managers 'fight' for named visitors for their residents and families:*

PH would not permit named visiting in our case - which was one staff member....

Public Health need to be on board- we were told categorically no named visitors for first two weeks

- *The importance of care homes taking control of risk assessment and decision making in order to do the right thing by residents was stressed by some:*

Autonomy and responsibility needs to come back to the care home and we risk assess accordingly. The sector is frozen at the moment.

I used the guidance as a framework and then risk assessed each situation, family members were supportive as long as information was shared.

- *The fear of Operation Koper in the background was suggested by some as a barrier to doing this.*
- *Care home providers commented more generally on the remaining restrictions in care homes. There were numerous calls to review them as they were felt to be disproportionate and "inhumane and amoral" - keeping healthy older people in their rooms for weeks on end cannot continue.*
- *Providers representing homes for younger adults indicated that PHS guidance for adult care homes was felt to be disproportionate for their residents who are not as vulnerable to respiratory conditions/infections etc.*

TURAS Safety Huddle Tool

180. As regards the TURAS Safety Huddle Tool (SHT) and ASC Stakeholders, TURAS was a helpful tool in providing an overview of how visiting guidance was being implemented locally. Further detail regarding the tool is provided at paragraph 291 below. The ASC sector is fragmented and there are different

operators, private and third sector providers, and in-house Local Authority providers across the country.

181. TURAS was also useful to monitor how care home visiting guidance and protocols were being supported at the local level. ASC stakeholders were engaged with regularly which was also helpful with access to visiting an important topic of discussion. The rationale was, as I have said, balancing the wellbeing impact and the health impact on care home residents. 'Open with Care – Supporting Meaningful Contact in Adult Care Homes' in February 2021 [HY6/058 – INQ000147437] included recent advice from the WHO ad hoc COVID-19 IPC Guidance Development Group. This group had published that visiting should be supported, as long as a range of IPC measures were in place had been incorporated into the guidance. Latterly information gaps were regularly identified and action taken, for example the qualitative intelligence on care home visiting had been raised. The Scottish Government commissioned a survey in July/August 2021 and reported in November 2021, this information gathering provided an understanding from the care home managers' perspective into the barriers and enablers to the implementation of the Open with Care visiting guidance [HY6/058 – INQ000147437]. Questions that were included covered the broad set up of current visiting to the implementation of visiting preference. The survey provided care home managers with an opportunity to provide feedback to the Scottish Government on their experiences of implementing Open with Care to inform future planning in the sector.

182. The TURAS huddle tool helped with our understanding of how the visiting policy was being implemented however some of the most helpful feedback was from relatives of care home residents themselves, and also from elected members raising issues encountered in their local areas. In August 2021 the Scottish Government also undertook an on-line survey of care home managers' experiences of implementing the Open with Care visiting guidance. The aim was to gather experiences and insights from managers to inform future planning and guidance to support the sector. The report was published, [HY6/059 - INQ000496539]. The main findings from the survey questions respondents were supporting a range of visiting options and confirmation that they were planning to

continue to increase contact for residents and their families and friends. Respondents viewed visiting as vitally important for residents and their loved ones, and they were striving to deliver meaningful contact safely. However, it was clear that respondents were dealing with substantial logistical challenges and sensitive issues around visiting, within the context of balancing safety and risk, and were very concerned about future outbreaks and potential repercussions

Concerns regarding visiting policies and/or guidance

183. Concerns were raised with Ministers and officials as well as other organisations that some care homes were not adopting the guidance and that different approaches were being taken by local public health teams based on a different risk appetite in advising care homes on the approach to take in regards to care home visiting.

184. The issue on visiting policy and care homes was raised with me and my junior ministerial colleague – Kevin Stewart – on a fairly regular basis. This was raised often by Scottish Care and a number of representative groups who represented families and those in care homes, such as Care Home Relatives Scotland.

185. While my colleague, Kevin Stewart, who had responsibility for social care met with social care stakeholders on a far more frequent basis, I also met with these groups:

- 7 June 2021 - Care Home Relatives Group
- 18 August 2021 - Scottish Care
- 16 & 30 September 2021 - Councillor Currie
- 1 October 2021 – Royal College of Nursing
- 6 October 2021 Glasgow Disability Alliance
- 18 October 2021 – Glasgow Disability Alliance
- 23 November 2021 – COSLA
- 21 December 2021 – Councillor Currie,
- 5, 10, 12 & 13 January 2022 – COSLA
- 23 February 2022 – UNISON

- 14 March 2022 – COSLA
- 30 March 2022 – Roundtable with RCN
- 30 March 2022 – Coalition of Carers Scotland
- 31 May 2022 - Scottish Care and Coalition of Care and Support Providers (CCPS)
- 15 June 2022 – Long Covid
- 30 June 2022 – COSLA and NHS Boards
- 4 July 2022 – COSLA
- 11 July 2022 – RCN
- 1 August 2022 – COSLA
- 2 August 2022 – Alliance Scotland
- 9 August 2022 – BMA Scotland
- 7 September 2022 – COSLA & NHS Boards
- 28 September 2022 – COSLA
- 11 October 2022 – The Health and Care Professions Council
- 13 October 2022 - CCPS and Scottish Care
- 14 October 2022 – COSLA
- 26 October 2022 – Coalition of Carers
- 3 November 2022 – COSLA
- 17 November 2022 - GMB Union representatives
- 18 November 2022 – Scottish Care
- 24 November 2022 – COSLA
- 7 December 2022 – COSLA
- 14 December 2022 – Scottish Care
- 19 December 2022 – Scottish Trade Union Congress
- 5 January 2023 – Union representatives GMB
- 5 January 2023 – RCN
- 12 January 2023 – Trade Union representatives
- 16 & 26 January 2023 – COSLA
- 2 February 2023 – COSLA
- 3 February 2023 – Unison
- 3 February 2023 – Union representatives GMB

- 24 February 2023 – Unite
- 2 March 2023 – COSLA
- 15 March 2023 – COSLA

186. Right from the beginning of the pandemic, and well before I was appointed Cabinet Secretary for Health and Social Care, we were cognisant of the real and significant impact restrictions with care homes would have on staff and residents in the homes and their families. As well as Cabinet Papers and briefing material highlighting the impact visiting restrictions were having on both care home residents and their families, (including, for example, discussions at Cabinet on 8 and 29 July 2020, discussed above at paragraph 158) there was also public debate in our media, with real life examples, as well as the issue being surfaced regularly during parliamentary debate, including at FMQs. In addition, Cabinet Secretaries and Ministers had personal experience of their own loved ones residing in care homes, and well understood the impacts of visiting restrictions. As referenced previously in this statement, we tried to get the balance right between protecting those in a high risk environment from the worst effects of the virus, and ensuring we met their wellbeing needs.

187. Concerns that some care homes were not implementing visiting procedures in line with applicable guidance was an issue raised by public and members of the Scottish Parliament as well. This is where the Turas Safety Huddle Tool and Dashboard assisted. Those tools allowed us to do a deeper dive into why certain procedures were not being implemented. If we were being informed that certain procedures, for example in Local Authority areas or even care homes themselves, were not being consistently implemented, we could query that and understand why. My colleague, Kevin Stewart, who had day-to-day responsibility for social care, and/or colleagues from the social care division, would have taken forward those conversations with local authorities or care home providers where necessary.

188. Regarding concerns of a lack of consistency between local public health teams, if this was spotted, officials would be tasked to find out why and rectify. However,

this was an issue few and far between as our data showed there was overwhelming consistency.

189. Regarding care home residents' rights and that of their loved ones not being supported, only with regular engagement with those aforementioned groups, like Care Home Relatives Scotland, could we get real time feedback on the impact of the restrictions. As evidence shows, we were regularly receiving clinical advice on whether those restrictions could be relaxed, or guidance could be eased. Sometimes it could, but sometimes clinical advice was clear that the impact of this would be harmful to those we were seeking to protect, so this was not a risk we could or would seek to take at the time.

190. In terms of my own specific involvement in relation to the issue of care home visiting, it was an issue that was raised with me directly from both stakeholders in the ASC sector as well as from relatives of those with a loved one in a care home. Early on into my appointment as Cabinet Secretary for Health and Social Care, the issue of care home visitation was raised with me. During week commencing 26 July 2021, the Scottish Government received 3 letters all of which raised concerns regarding the restrictions, whilst in week commencing 2 August 2021 there were 2 letters which raised similar issues. Care Home Relatives Scotland continue to raise the issues regarding visiting with Ministers and officials, and also raised issues around visiting in outbreaks, supporting essential visiting and consistency across care homes.

191. I requested further detail regarding changes to the number of visits per week as the guidance moved beyond Level 0 during August 2021 [HY6/060 - INQ000243030].

192. On 10 January 2022 there was media interest in the self-isolation period for care home residents – given the reduction in isolation to 7 days for the general population. Media advised that families had stated the guidance was "imprisoning" residents in their rooms. I sought urgent advice on this matter. On 12 January 2022 I received advice on reducing the period of isolation for care home residents when they are Covid-positive (index cases) or close contacts;

and advice on reducing the length of time a care home can be closed due to an outbreak [HY6/061 - INQ000242437].

193. The submission advised that there had been increased stakeholder, care home relative and media scrutiny on these topics and there had also been a change in isolation guidance for the general population. The advice stated that the isolation period for the full vaccinated care home residents could be reduced from 14 days to 10 days, but that the length of time a care home should be closed following an outbreak should remain at 14 days. This was based on clinical advice.

194. I was content to accept the recommendations but requested these were kept under regular review. I asked for a deeper dive into the evidence base for the isolation period and outbreak closure time for care homes.

195. Further advice was provided to me on 18 January 2022 to provide me with an update with regard to precautionary isolation for care home residents, clarification of advice to care home visitors visiting someone who is Covid-19 positive and the weekly PCR test for care home staff and other social care staff [HY6/061 - INQ000242437].

196. I was asked to –

- Approve that I was content to remove precautionary isolation for those care home residents on a non-respiratory pathway
- Note the clarity on arrangements
- Agree that a weekly PCR test for social care staff should remain.

197. Further advice then followed on 21 January asking for my approval to reduce the testing requirement from two to one negative PCR test for Covid-19 recovered patients prior to discharge from hospital to a care home (before the end of their isolation period).

198. In response, on 23 January 2021 I raised concerns regarding the rules for those who wish to visit a family member who is a resident in a care home during an outbreak, but where the resident is not an index case. I queried whether the

individual was only allowed one named visitor and if It needed to be the same person throughout? I advised officials that, if this is the case, I considered this very restrictive given the case rate level and concerns regarding the impacts on the care home resident and their loved ones.

199. Officials advised that the guidance states that ideally it should remain the same visitor throughout, but – in the event that the named visitor could not visit – discussion should take place and an alternative visitor facilitated. I was advised that SG officials provided feedback to PHS on this matter to make it clearer in their updated guidance "the importance of taking into account individual circumstances."

200. I approved the recommendations but requested I be kept informed of further changes. Correspondence and submission chain provided [HY6/062 - INQ000240144].

Access to visiting professionals

201. I had no doubt about the importance of visiting health care officials to a care setting. That multidisciplinary approach was beneficial both to the residents in any given care setting, but also to the NHS, as it ensured residents could be treated at home, and in their care setting, as opposed to already pressured acute sites.

202. The visiting guidance prepared by Scottish Government and stakeholders emphasises the importance of involving a wide range of professionals and individuals in the life of the care home for the wellbeing. The Open for Care - Visiting health, social care and other services in care homes and communal activity', guidance of 14 April 2021 [HY6/063 – INQ000496554] set out principles to support the staged return of visiting professionals to care homes, recognising the importance of the provision of equitable, person-centred and holistic healthcare alongside wider services to improve the wellbeing and overall health of people living in care homes. This guidance was issued just before I was appointed to my role as Cabinet Secretary for Health and Social Care.

203. Other measures were introduced to support access to visiting professionals in care homes. The Digital Approaches in Care Homes programme (which ran from November 2020 to May 2021) offered iPads and MiFi devices to care homes to allow residents to access video consultations with health professionals, and to contact loved ones. Care homes were also made aware that they could access 'Near Me' appointments for residents to minimise the risk of transmission.

204. There was an importance in involving a wide range of healthcare and other professionals in the life of the care home and this was evidenced by the fact that the vast majority of residents in a care home would have health and wellbeing needs. Some of these needs would be acute and need regular checking. When restrictions came into place there is no doubt this would be impacted. There were obviously ways of addressing this but at the time when I was Cabinet Secretary for Health and Social Care, access to healthcare professionals was not an issue that was consistently or regularly raised with me by care home providers, residents, or their families. I therefore I did not consider it to be a significant challenge by the time I assumed the role of Cabinet Secretary for Health and Social Care. Remote, rural and island communities frequently had more acute challenges when it came to the issue of healthcare provision. This was due to both their geography as well as lack of available staff in their regions. These healthcare challenges would also impact on ASC provision.

205. Concerns raised regarding access to healthcare professionals – be that urban or rural - was not particular to the ASC sector alone. The concerns raised to me in the ASC sector were a reflection of the ones raised by the general public and included, for example, access to GPs, the pressure on the acute system particularly in relation to emergency care, and waiting times for elective surgery.

206. Although guidance in relation to visiting health, social care and other professionals supporting the wellbeing of people living in a care setting was published before 19 May 2021, it nevertheless remained in force over the period 19 May 2021- 28 June 2022 (the "specified period"). However, during the specified period, both Kevin Stewart and I oversaw the plans for the development of My Health, My Care, My Home - healthcare framework for adults living in care homes [HY6/064 - INQ000323023]. The Framework, which

was published on 29 June 2022, provided a series of ***recommendations*** to transform healthcare for people living in care homes building on the lessons from the pandemic. In respect of assurance, during the specified period, officials within Scottish Government continued to engage with stakeholders, including through the CPAG, to monitor and address concerns, including in relation to access to healthcare. Similarly Kevin Stewart and I engaged regularly with a range of stakeholders including care home provider representatives, COSLA and Care Home Relatives Scotland. I am not aware of significant concerns being raised with regard to wider policy and practice in relation to access to healthcare through these forums and/or meetings during the specified period. However, issues may have been raised and resolved locally without recourse to Scottish Ministers.

207. Regarding the concern of lack of availability of face-to-face GP appointments, I had regular engagement with the Royal College of GPs, the BMA, and in particular the BMA's GP Council, to take steps to improve the lack of availability of face-to-face GP appointments. We took a number of steps to address this. For example, we increased funding for primary care, we increased headcount of GPs, and recruited more multi-disciplinary team members. I also announced a £7m investment for GP surgeries to aid the expansion of the primary care estate. These improved premises would be used by the wider population, as well as those in the ASC sector.

208. A key concern was that there was a lack of data on GP appointments, broken down by Local Authority, as well as by individual GP practice, and how many appointments were telephone appointments or in person appointments. We worked with the BMA to ensure this data was collected and then available on a dashboard so we could easily monitor progress – or a lack of it.

209. Issues regarding access to ambulance services were raised with me regularly, including by stakeholders in the ASC sector. I took a great deal of my time to try to resolve these issues and improve ambulance turnaround times, particularly in areas that had the longest waits. This was a cross-country issue with some areas being particular challenges, for example Edinburgh, Ayrshire (particularly at Crosshouse Hospital) and Grampian the turnaround times were unacceptably

high. Given the elderly population within the ASC sector, who often had multiple health needs and comorbidities, this was particularly concerning for those in social care.

210. One of the challenges, if not ***the*** key challenge, we faced was high levels of delayed discharge. We had beds in hospital being taken up by people who did not have any clinical reason to be there and that in-turn disrupted the flow of the hospital, both at the front and back door. This has a real impact on the front door and if you can't get people conveyed off ambulances, then of course the ambulance is stuck queued outside of a hospital for hours on end as opposed to being on call, attending to needs of those who require a paramedic.. As such, the time for ambulances to attend calls was far higher than we would have liked, or that was acceptable, which would also have had an impact on the ASC sector, which as I have just referenced, were caring for a vulnerable population often with multiple health needs.

211. A range of actions were taken in relation to improving ambulance turnaround times:

- Military Aid for Civil Authority (MACA) request
- Funding for taxis to ferry others back and forth to the hospital
- Recruitment of more ambulance staff
- Paying a paramedic student bursary for the first time in order to recruit and crucially retain more student paramedics.

212. The impact of long ambulance turnaround times and therefore lengthy waits for ambulances was a nationwide issue, however parts of the country with more remote and expansive rural geography undoubtedly felt these issues more acutely – such as Highland and Islands health board and Grampian Health Board.

213. I cannot recall any specific issues being raised with me in regards to the NHS Near Me system.

214. When Omicron was emerging conversations took place with the ASC sector. From December 2021 various changes were made internally in response to the challenges of this period. Priorities included the social care reform activity and development of the National Care Service. Interim Director Hugh McAloon led a separate Directorate for Mental Health. Donna Bell (Director for Social Care and National Care Service Development) led all the social care divisions that became part of the new Social Care and National Care Service Development Directorate. It is my understanding that this Directorate continues to take forward social care policy and the creation of a National Care Service, to transform community health and social care support and services, empowering people to thrive with human rights at the core.

215. We took some actions as a result of the Omicron variant in the ASC sector which included, for example, increased testing for staff. These changes are covered in the chronology (see paragraph 125).

Details of my involvement in guidance or policy to ensure access to emergency care, NHS support and visits by professionals to care home residents (please refer to the chronology in paragraph 125).

216. In relation to my involvement in guidance, if it was low level changes to guidance then senior clinicians or officials, or the Minister Kevin Stewart would be empowered to make change and then these would be sent to me for noting or comment. If it was more significant then I would have signed off the changes.

217. Regarding access to emergency care, this was an issue not just for the ASC sector, but for the country as a whole. The chronology at paragraph 125 provides details of my involvement and decisions made. As I have already referenced, when I was Cabinet Secretary for Health and Social Care, visits by health professions to nursing homes, and care settings more broadly, was not an issue which was raised with me regularly, that I can recall.

218. My recollection of the £7 million funding for primary care was for the refurbishment of GP practices and expanding the primary care estate. This funding was not specific to the ASC sector. It was clear that a number of GP

practices, when they purchased or leased, the premises did not envisage that there would be a future need, in the midst of a pandemic, for social distancing. For example, waiting rooms or consultation rooms were not designed with social distancing in mind and ventilation was often poor. As such, this investment was announced to help GPs with their primary care estate to, for example, increase space and support multidisciplinary teams. These multidisciplinary teams were crucial for the ASC sector as those in a care setting often had multiple and complex health needs, that could be supported by a range of healthcare professionals, such as those in multi-disciplinary teams.

219. The digitisation of GP records was also important. Some rooms in GP surgeries were almost entirely taken up with paper records and therefore digitisation freed space physically within GP practices.

220. The investment was helpful for the general public's access to GP practices but also helpful for the ASC sector. The money could be also used for other things like widening spaces for wheelchairs.

221. The £5 million from the Primary Care Fund covered:

- Premises Improvement Grants to GP contractors who own or lease from private landlords
- Digitisation of paper GP records to release space
- Improved ventilation
- Increased space in NHS-owned or leased premises to support multi-disciplinary teams.

222. I believe that access to visiting professionals was adequate during my time as Cabinet Secretary for Health and Social Care but there would be some variations during certain times, for example, during the time of winter pressures on the NHS and the emergence of the omicron variant. There may well be some variations due to these factors, but I generally think the issues regarding access of visiting healthcare professionals was not one raised with regularity at the time, as I recall.

Workforce

223. The Covid-19 pandemic emphasised the crucial role of key workers in social care support and unpaid carers for supporting wellbeing and independent living, as part of an integrated health and social care system.

224. My understanding, from my time in government and cabinet, is that ministers and officials had regular engagement with care sector representatives, COSLA, HSCPs and unions pre-pandemic on workforce issues and this engagement intensified as the pandemic progressed, ensuring that Scottish Government had a full understanding of workforce concerns and could respond quickly to address them.

225. Communication and guidance was issued to the sector on a regular basis regarding a wide range of matters, including PPE, self-isolation, IPC guidance, visiting and visiting professionals, support and wellbeing, please refer to paragraph 113

226. The Social Care Staff Support Fund (SCSSF) was established in June 2020, by my predecessor, to support social care workers absent from work with illness due to Covid-19 by the Social Care Staff Support Fund (Coronavirus) (Scotland) Regulations 2020. The SCSSF was extended in January 2021 to include those shielding during the pandemic – this fund was specifically for social care workers who were eligible for the UK Government's Coronavirus Job Retention Scheme (CJRS), but were not placed on this by their employer. An Equalities Impact Assessment (EQIA) was carried out in March 2021 when extending the SCSSF to include shielding workers, [HY6/065 – INQ000182728] which provided up to 80% of their income (in line with they would have received under CJRS) to ensure that workers who were required to shield and not placed on the CJRS were not financially disadvantaged (and so less likely to fall into poverty) when compared to their co-workers. It was advised that this will assist with the retention of staff who may have had to leave the sector, which would have had negative effects on people such as the elderly or disabled, who rely on this care to maintain their quality of life. Other measures included the social care worker

death in service payment scheme (launched 30 July 2020), which made payments for eligible claims between 17 March 2020 and 30 September 2021. The Coronavirus (Extension and Expiry) (Scotland) Act 2021 received Royal Assent on 4 August 2021 during my tenure as Cabinet Secretary for Health and Social Care, and extended the powers for the Fund from 30 September 2021 until the end of March 2022 (with the possibility for Ministers to extend further). It was then extended to 30 September 2022.

227. The Self Isolation Support grant was introduced on 13 October 2020 for those required to isolate post 28 September 2020, to support those workers who earned less than the real living wage or were on a low income and had lost earnings due to them, their child or a person they cared for being required to stay at home to prevent the spread of Covid-19. The grant closed to new claims from 3 January 2023.

228. On 30 November 2020 the First Minister announced a £500 one off 'thank you' payment for health and social care staff [HY6/066 - INQ000507867]. Adult social care staff, personal assistants, social care staff working in children's residential services and social workers who had been employed since 17 March 2020 were eligible to receive the £500 thank you payment.

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

230. As part of the announcement of the Programme for Government 2020, the Scottish Government allocated £5 million in 2020/21 for a comprehensive package of national wellbeing support for the workforce. This included a National Wellbeing Hub (referenced at paragraph 131 above), digital therapies, Coaching for Wellbeing, the National Wellbeing Helpline, funding for psychological therapies and a new Workforce Specialist Service. In January 2021, £500,000

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

231. In July 2020, the Scottish Government developed Occupational Risk Assessment guidance to provide individuals and employers with an individualised and evidence-based approach to understanding how COVID-19 affects certain groups in the population, and what employers could do to make the workplace as safe as possible [HY6/067 – INQ000241364] This also recognised that underlying health conditions and ethnicity, when viewed in isolation, did not accurately predict an individual's vulnerability to Covid-19. The Scottish Government therefore recommended that an individual assessment should be carried out by line managers that takes multiple personal characteristics into account. The Risk Assessment used factors including age, ethnicity, and BMI in addition to underlying health conditions to stratify risk. It was not intended to view medical conditions in isolation, as this does not accurately predict an individual's vulnerability. The tool was aimed with the individual in mind, to help them to understand their own individual risk factors. The guidance highlighted the responsibilities of the employer to minimise the risks in the workplace, making adjustments where possible, and referring to Occupational Health as appropriate.

232. Throughout the emergency response to the pandemic, our ASC workers went above and beyond. They sacrificed time with family to provide care for those who needed it.

233. The ASC workforce was probably the issue that was raised with me most frequently by ASC stakeholders. These issues included staff vacancies and challenges with retaining the ASC workforce. These capacity issues played out during the course of the pandemic. A number of steps were taken to help with recruitment and retention, many of these are noted in the paragraphs below. As well as the support referenced in paragraphs 25 to 27, 79 and 135 above, I also

made it clear to my Cabinet colleagues, including the Finance Secretary and First Minister, that we had to prioritise an increase in wages for social care workers or we could, according to ASC stakeholders, face a crippling social care sector. I, therefore, as I have mentioned previously in this statement, instructed two pay uplifts during my time as Cabinet Secretary for Health and Social Care. We also looked to see what we could do regarding any improvement to terms and conditions although this was not always primarily within our gift to do so given that third sector and private companies were also providing social care.

234. Regarding ASC workers' physical health resilience, we insisted on regular testing for their protection and those they cared for. The testing regime was quite stringent in order to help with sector resilience.

235. Regarding ethnic minority staff, there was the Expert Reference Group on Covid 19 and Ethnicity, already referenced in the statement. They provided recommendations regarding fair work amongst ethnic minority staff who they said suffered disproportionately from discrimination and unfair work practices. The group's recommendations and report were accepted by the Government. Report provided, [HY6/028 - INQ000241567].

236. We were significantly concerned with the risk of infection within care settings, hence why there was stringent testing regimes in force for staff, residents and those visiting a loved one in care homes. As well as priority given for vaccinations for staff and residents in care.

237. Given the intense pressure of the pandemic (which became more acute at times e.g. wave of virus or emergence of new variants) issues regarding ongoing training and suitability of roles to which ASC staff were redeployed were raised with us. It was a challenge for staff to fit in their relevant training or CPD in the given time. The guidance of 15 May 2020 [HY6/036 - INQ000383486] included additional material regarding training, and set out details of the educational and induction resources available from SSSC and NHS NES. There were less issues around training and guidance for those who had been deployed, which was primarily an issue for the NHS side rather than ASC, and the guidance of 15 May 2020 also included details of additional information and education resources

for registered nurses working in care homes available through the NES Turas site and NMC.

238. Staff movement potentially resulting in transmission of the virus was a key concern raised and that is why we had more stringent testing in place for health care workers and ASC staff. Especially regarding ingress and bringing virus into a care environment and the danger this could cause.

239. Regarding consideration and decision making for potential workforce interventions, MACA assistance was not explored for the ASC sector.

240. In January 2021, 12 military planners were supporting the programmes for vaccination and testing. A further 23 planners were attached to each territorial health board to support local planning arrangements. Joint Military Command Scotland also provided support to Local Resilience Partnerships. In September 2021, due to exceptional pressures, an additional £20 million in funding was provided to the Scottish Ambulance Service (SAS) (as part of the overarching £1billion NHS Recovery Plan). SAS used this to secure military personnel as a temporary measure to support mobile testing units, enlist around 100 2nd year paramedic students and support in the ambulance control rooms.

241. When it came to ASC students, they were able to enter and help the ASC sector from an earlier time in their training or course. This was introduced prior to my time as Cabinet Secretary for Health and Social Care but it was a programme which we continued during my tenure. For example, changes were made to workforce registration requirements to enable returning and new staff to join the workforce more quickly. A dedicated national accelerated recruitment portal, with streamlined checks by SSSC was introduced in March 2020 to allocate staff to the ASC sector. In January 2022, new staff joining the social care workforce had entry costs paid – including SSSC registration fees and PVG checks. Work was also undertaken at a UK-wide level with nursing professional bodies to enable student nurses to join the workforce.

242. There were general appeals which I would make to the UK Government regarding the migration system. The system worked against us in terms of the

ASC sector. There were appeals made to the UKG where I made representations on changes to migration system as this could impact ASC sector.

243. The Scottish social care sector is regulated and qualified to the level specified by the MAC (to be attained within five years of registration) unlike England for example. A sticking point for the MAC was the time workers in Scotland have to get their qualification. It was important for Scotland to have a differentiated approach provided for in migration policy, recognising our unique demographic and geographical requirements. For example, recruitment challenges existed in remote and rural areas.

244. The Scottish Government is committed to improving career opportunities, terms and conditions for the sector, and thus improving recruitment and retention in the domestic labour market. However, this could only be achieved over a longer time frame, which required flexibility that international recruitment options can provide, to address significant vacancy levels in the sector at that time.

245. Changes to the immigration system cannot be determined solely by the needs or characteristics of the ASC workforce in England. As set out in the Scottish Government's response to the Migration Advisory Committee Call for Evidence (21 February 2022) [HY6/068 – INQ000587194],

> "The challenges in social care recruitment have a number of potential *solutions, some of which are within the devolved competencies of the Scottish Government and some of which rest with the UK Government notably the changes to the immigration system. The Scottish Government is taking a range of actions to support the social care sector and improve the attractiveness of working in the sector. However, it is important that this work is seen within the wider context. As a result of the ending of freedom of movement Scotland is facing a declining working age population[22] .The impact of this is likely to be felt most acutely in rural authorities. The National Records of Scotland 2020 mid-year population estimates confirmed that Around two thirds of council areas (20 out of 32) experienced population decline with the worst affected areas being Inverclyde, Na h-Eieanan Sar and*

West Dunbartonshire[23]. Meanwhile, the same report found that all 32 Scottish council areas have seen an increase in their population aged 65 and over in the last decade – including those areas where the total population fell. The greatest increases in the population aged 65 and over were in West Lothian (32%), Orkney Islands (31%) and Clackmannanshire (31%)."

246. The Scottish Government and its partners put in place arrangements to increase social care workforce capacity, by engaging in discussions from early March 2020. While these discussions pre-dated my time as Cabinet Secretary for Health and Social Care, I understand they explored the use of nursing, midwifery and allied health profession students in the workforce. Ultimately seeking to increase the health and social care workforce capacity as staff sick absence and health and social care services demands were expected to increase.

247. Regular updates were provided by the WSLG (Workforce Senior Leadership Group) regarding workforce pressures across the system. Details provided the current levels and numbers of staff being recruited to support the health and social care system. WSLG members worked to take collective action enabling a timely co-ordinated response.

248. Executive Nursing Directors were given the responsibility to ensure locally that care homes had sufficient staffing including where necessary providing mutual staffing aid.

249. In May 2020 the former Cabinet Secretary for Health and Sport requested that NHS boards and local authorities provide enhanced multidisciplinary support for care homes, this built on earlier support arrangements for care homes. In addition enhanced MDT support arrangements, mutual staffing aid was provided. Nursing staff were deployed in care homes to service the staffing shortages, and where concerns existed regarding the care and support being provided to residents. This was informed by information gathered from the care homes about challenges faced, and through NHS, Local Authority and Care Inspectorate working with care homes. The TURAS SHT was used by care homes to escalate matters relating to staffing and other issues.

250. The Care Home Nursing National Working Group established in August 2021 considered matters regarding nurse staffing levels. The group discussed recruitment, defining roles/transforming roles, continuous training and development and the need for quality workforce data.

251. Winter planning work in Autumn 2021 involved consideration of approaches to maximise staff capacity in relation to retired and returning nurses and doctors, including:

- Maximising the opportunities for professionals who were on temporary emergency registers held by GMC, NMC, HPCP and GPhC to return to the service;
- A nationally coordinated recruitment campaign across Scotland and the rest of the UK to address shortages for care at home nurses and band 5 nurses;
- A renewed 'call to arms' to retired staff or those who had left the service, directly linked to local recruitment opportunities as advertised via JobTrain, NHS Scotland's recruitment IT system.

252. Discussions with the regulatory bodies (GMC and NMC) covered communication with temporary medical and nursing registrants to encourage applications for vacant roles. As part of a wider national 'call to arms' it was anticipated that communications would be issued by the relevant senior officer to those on the emergency registers of the regulatory bodies, encouraging them to return to the service if they continue to be interested in doing so.

253. On 6 April 2020 the emergency register was expanded to include overseas nurses and midwives that had completed their entire NMC registration process. A further expansion of the register took place on 15 April 2020 to include nurses and midwives that had left the register in the previous four or five years.

Involvement in evolution of guidance issued to ASC workers

254. On 21 May 2020, joint NHS Scotland and Scottish Government Interim guidance for HSC employers on staff from Black, Asian and Minority Ethnic (BAME) Background was issued. This was issued in response to emerging evidence that

people from BAME backgrounds may be disproportionately affected by Covid-19. The interim guidance was intended to help staff and employers by providing best practice to support BAME staff.

255. Covid-19 Occupational Risk Assessment Guidance was published on 27 July 2020 covering new risks posed to HSC staff by Covid-19 [HY6/067 - INQ000241364]. This was designed to provide support to both staff and line managers in understanding the risks and capability to conduct an effective risk assessments, this replaced the guidance issued for HSC and emergency service workers with underlying health issues (30 March 2020) [HY6/069 - INQ000510046] and 'Interim guidance for HSC employers on staff from BAME Background' (21 May 2020) [HY6/070 - INQ000510047].

256. Guidance for the ASC workforce was updated to reflect the latest evidence and advice, and in response to specific requests from the sector. For example, accompanying Q&A documents would be provided to supplement guidance where feedback was that the guidance was unclear.

Financial support was made available for care providers.

257. The Scottish Government was acutely aware of the increasing financial pressures which were faced by providers – including loss of income, increased staff costs and increase costs associated with IPC measures (such as PPE, or physical changes to buildings).

258. The Financial Support for Adult Social Care Providers' scheme (often referred to as 'Sustainability Payments') was introduced on 4 December 2020 [HY6/071 – INQ000241259]. The scheme's aim was to support resilience in the social care sector and reassure the sector that additional costs related to COVID-19 would be reimbursed. This financial support supplemented national reliefs and grants for costs specific to the social care sector. An initial £50 million of support for the social care sector was announced on 12 May 2020. The funding announced was intended to support the sustainability of care providers. A second tranche of funding of £50 million was announced on 3 November 2020. A set of principles to govern the implementation of support payments were developed initially by

COSLA and Integration Authority (IA) Chief Finance Officers, before being reviewed and agreed by Scottish Government and shared with key stakeholders, including Scottish Care and CCPS. Sustainability payments comprised of the following elements:

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

259. A revised approach to sustainability payments was agreed with the sector in December 2020 – to minimise the administrative burden on local authorities and providers, ensure transparency, equity and best value. It was agreed that additional costs relating to remobilisation and public health measures (additional staffing and non-staffing costs related to the pandemic; additional costs for pandemic related administration required by the care homes; and the Staff Social Care Support Fund until 30 March 2022). It was agreed that the restriction of staff movement payments would be ceased from June 2021 and that claims for sustainability funding for PPE should continue to be permitted, but with work to continue on a possible transition to using the Hub-only model by September 2021. It was agreed that there would be an extension of enhanced support for care homes and Chief Social Work Officer oversight responsibilities until March 2022.

260. Further advice was provided to myself and the Minister for Mental Wellbeing and Social Care in September 2021 regarding ongoing financial support – data showed that overall occupancy rates in care homes had risen consistently (only 2% below pre-pandemic rates), but that there had been a sharp rise in community cases in recent weeks [HY6/072 - INQ000239978]. It was noted that

"Confirmed positive cases in care homes have remained lower in comparison but positive cases among care home staff have been rising in recent weeks. IPC and vaccination measures are, however, showing to be effective." Liaison with the sector highlighted that there were some concerns around the system (including impacts of the roll out of home first approach – impacting on care home occupancy rates) and that the continued payment of under-occupancy payments was working as a disincentive. It was therefore agreed to remove this clause in the guidance from 30 September 2021 (although an exception clause was included to allow under occupancy claims to be made in certain instances).

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

262. The role of the Cabinet Secretary for Health and Social Care was to ensure the best possible settlement for health services and ASC sector. We had a manifesto commitment to increase funding for ASC sector (official to find out more – 25% of health budget to go to social care. As Cabinet Secretary for Health and Social Care, I argued for funding to allow for an uplift to ASC pay. I was successful in arguing for this on more than one occasion.

263. We made it clear that employers should be understanding of the needs of workers if they required to self-isolate and not to unduly punish them with support being made available for those impacted by isolation requirements, as already referenced in my statement.

264. Regarding vaccinations, by the time I was Cabinet Secretary for Health and Social Care, protocols were already established and health and social care workers were prioritised. My job was to make sure the offer was being taken up by health and social care workers, as well as people who were in care, and the data demonstrated that the offer was being taken up by the overwhelming majority of people in those settings. At one point there was an issue with vaccination rate with ASC workers beginning to drop so I personally took part in

a media opportunity with a visit to a care home to emphasise the need for and importance of social care staff taking up the offer of a vaccination, 5 September 2022.

265. Regarding testing, the regime was well established by the time I became Cabinet Secretary for Health and Social Care. This would change with surges in virus or the emergence of new variants. For example, with the emergence of the Omicron variant, testing in social care settings was changed from once to twice weekly to daily.

266. Regarding the protection of staff, we were guided by the framework for decision making and the four harms underpinned this. We considered alternative options, but we went with the options where we thought we got the balance right of protecting those in a high-risk environment and the wellbeing needs of vulnerable.

267. Allocations of £1.8 billion were made in 2021-22 to NHS Boards and Integration Authorities to meet costs of the pandemic and remobilising health services. This was on top of the £1.7 billion already provided to NHS Boards and IAs in 2020-21.

268. The recovery of our NHS was not simply focussed on recovery to just its pre-pandemic level but beyond. This programme committed to record funding levels across our health and social care services, with an increase of at least £2.5 billion by the end of this Parliament – from investment in new and upgraded facilities, and increasing capacity, to reforming the system so everyone had access to the treatment they need as quickly as possible, in new and innovative ways, and closer to where they live. It committed to working quickly to establish the single greatest public service reform since the establishment of the NHS – the creation of a National Care Service – ensuring the voices of those who work in and use the service are at its heart.

269. Funding was there generally to ensure that the ASC sector could continue to provide the excellent service they do. This was also there to assist with costs like maintenance. It was recognised that individuals who work in health and social

care experienced high levels of mental ill health, including depression, anxiety and PTSD. As a result, the Scottish Government allocated £5 million in 2020/21 to provide national support to the workforce, which included a National Wellbeing Hub, digital therapies, Coaching for Wellbeing, the National Wellbeing Helpline, funding for psychological therapies and a new Workforce Specialist Service.

270. By the time I was Cabinet Secretary for Health and Social Care the £500 Thank You Payment was already initiated, and I supported it. There were some administration issues given we were dealing with given the different HR systems across Local Authorities, but my colleague Kevin Stewart, working with social care division colleagues, was able to work with local authorities to resolve the issue.

Reflection on adequacy of additional funding and support

271. During the pandemic we were operating within difficult financial constraints. If there was more funding available we could have increased, for example, the hourly rate of pay for ASC workers. Some trade unions and opposition politicians were demanding we increase pay for ASC workers to £15 per hour, which was not an unreasonable ask, given the work undertaken by ASC workers, but such an ask was simply impossible to fund without taking significant money from other services across government. The costs associated with public sector pay (around £14.8bn per year in 2021, excluding local government) are equivalent to around half of the SG resource budget. Replicating this in 2022-23 across the public sector (including local government) would cost around £397 million.

272. I do not recall discussions in relation to other funding mechanisms for the ASC sector.

Care at Home

273. For those who were receiving care packages at home, there was obviously a range of issues to consider. One was ensuring that those in need of care packages were actually receiving the adequate support they required. Given the

significant pressure on the ASC workforce, due to the pandemic, social care stakeholders were telling me that care at home providers were only able to provide minimum levels of care, which was clearly not what any of us wanted. Social Care packages for those who receive care at home were already under pressure across the country prior to the pandemic, due to both staffing challenges and financial pressure local authorities were under, given we were operating in a difficult and constraining funding environment. With the emergence of Covid, those pressures were exacerbated multiple times over with staffing challenges becoming even more acute, given that social care staff would also have to self-isolate and not be able to carry out caring duties if infected with Covid. That is why I took the measures I did around staffing recruitment and retention. One of the risks we considered was people receiving a minimum care package rather than the enhanced package which they may well have received in non-pandemic times. I also argued, internally, for greater funding for my portfolio which I could then spend on social care, which I am pleased was provided for during the 2022/23 budget.

274. Regarding vulnerability of those at home, we had to ensure those providing care at home were following a stringent testing regime and had access to, and were using, adequate PPE. There was, at the time when we had a levels system for NPIs across the country, a challenge for ASC workers who were working in one tier or another. If a particular local authority was in a tier that had a high prevalence of the virus, travelling from that tier to another local authority was restricted. While travel was allowed for essential workers, there was, understandably, anxiety for social care staff having to travel into a local authority area with a high incidence of Covid.

Consideration of care at home when making key decisions on the ASC sector

275. Those receiving care at home were also being considered when we discussed the ASC sector.. We were aware that a significant proportion of those receiving care were doing so while being cared for at home. When we talked to, and about, the social care sector, not just ASC, but other organisations, we were keen to emphasise we were also mindful about, and considering those who were receiving care at home. When we introduced measures on vaccinations and

testing, we made it clear these changes also applied to those providing care at home. As explained above, decisions were made utilising the policy advice, professional advice, data and advisory groups with, where appropriate, the input of equality impact assessments.

Concerns reported to me around new care at home packages being implemented

276. Regarding recruitment and staff absences including for those who provided care at home support, these were regular challenges, not just in care homes but among those delivering care packages generally. This is why we often had stories in the press, or examples raised in parliament of cases of individuals receiving care at home who were struggling due to levels of staff absence. This was especially prevalent during surges with the virus. As a result, we implemented changes to guidance to effectively reduce self-isolation requirements for social care staff if they were fully vaccinated and had their boosters, this was designed to assist with the staffing pressures the ASC sector was facing, including amongst staff who were providing care at home.

277. There has been an ongoing issue of demand for large care packages due to increased acuity of need, this was an issue pre-pandemic given our ageing population, who are living longer, but with more complex healthcare needs. The way to address this was to try and increase recruitment and retention of ASC staff and to get the balance right between a stringent testing and vaccination regime for ASC staff but also flexibility where clinically possible so staff were not out of service for an inordinate period of time. .

Oversight of local management of ASC at home sector's response to the pandemic

278. In Government, we were conscious of the different elements of the ASC sector, from residential care homes, day care centres right through to care at home. While each component of the ASC sector was understood in terms of its unique characteristics, it is fair to say that the challenges in regards to social care were mirrored across the ASC sector. For example, the issues in regards to staffing vacancies were prevalent across the ASC sector from care homes right through

to care at home being provided. We did not have a separate division within government looking at care at home vs the care home setting.

279. In our contact with health boards and health and social care partnerships there would be discussion about the social care sector and of course, if there were particular issues that affected the at home sector, those would be raised by local authority colleagues, health and social care partnerships, care providers, or those in receipt of care directly, or their relatives. This was a very helpful feedback loop for us.

280. The Scottish Government Adult Social Care Gold Group was established in November 2020 to support the resilience of the care sector and ensure that a quality service was maintained through Winter 2020. The high level objective was to "*establish an early warning system that complements oversight arrangements and prioritises the protection of adults and the resilience of services*" as set out in the Terms of Reference for the group, provided [HY6/073 - INQ000510014].

281. All available data on outbreaks and sectoral performance was considered by the Group to identify trends, issues or areas of concern. This included themes for consideration such as; outbreak management and local challenges (including Covid-19 vaccination delivery), adult protection concerns, short-term sustainability (resilience of wraparound care), medium/long-term sustainability of residential services (i.e. health and wellbeing of ASC staff, care home occupancy rates), improvement requirements and to maintain awareness of winter management of hospital discharge. Meetings were held twice a week on and every week I received a summary of the Group's outputs.

<u>Views on adequacy of steps taken in relation to the care at home sector's response to the pandemic</u>

282. I believe those involved in the care home sector were doing everything they could to provide the best level of care for those they cared for. From a Scottish Government perspective we tried to address challenges of recruitment and retention but also protection of those who were providing and receiving care,

whether through prioritisation of the vaccination or testing regime. That said, we were being told by those in care, their relatives, elected members and care providers, that there were clearly people receiving care at home but only receiving the minimum package to meet their needs. In normal times, when there was not the pressures a global pandemic places upon a health and social care system, those individuals would have received further enhanced packages, not just the bare minimum to meet their daily needs. We were aware we needed to get back to this better position as soon as we possibly could.

283. The ASC sector was significant and of high priority to me but also for the First Minister who took a significant interest as well. She understood the importance of that sector, particularly given her prior roles.

DNACPR

284. Over my time as Cabinet Secretary for Health and Social Care, the issue of DNACPR notices were not as frequently raised with me as they were with my predecessor, as the issue was more prevalent during the early days of the emergency response to the pandemic. I was aware of the issue, given it was raised on many occasions by the media, politicians and other stakeholders in the early days of the pandemic. As I recall, a variety of steps were taken to address concerns before my appointment as Cabinet Secretary for Health and Social Care. These steps included clarification being on behalf of the CMO, BMA and RCGPs to primary care providers making it clear that no one should ever feel pressured to sign a DNACPR form. Early in the response to the pandemic the Scottish Government published its Covid-19 Guidance; Ethical Advice and Support Framework, outlining the key principles to underpin the approach to ethical decision-making during pandemic. It was updated regularly to take account of feedback and concerns and support good practice around decision making in challenging circumstances [HY6/074 – INQ000363462].

285. In relation to the ASC sector, guidance was updated with additional material including links to further advice and tools on ACP (anticipatory care planning) and emphasised the importance of working closely with people living in care

homes and their families to discuss what matters most when making plans for care in the future.

286. The issues raised by MENCAP in February 2021 were done before my time as Cabinet Secretary for Health and Social Care. My understanding is that, following the publication by MENCAP, further reassurances were provided to stakeholders. Ultimately, this was not an issue raised with me in much detail as it was before my time as Cabinet Secretary for Health and Social Care and, as I understand it, there were a number of steps taken to address it at the time by my predecessor

287. During my time as First Minister, I had a number of engagements with disabled people's organisations. I particularly remember an engagement with the Glasgow Disability Alliance ("GDA") on 14 August 2023, during my time as First Minister, during which those gathered told me that they felt that people with disabilities had lost a fair degree of confidence in the health services due to the DNACPR notices issue during the pandemic and this is something clearly the Scottish Government needs to reflect on and we should take on the learnings of the various public Inquiries. The GDA did not ask for specific action to be taken in regards to DNACPR at this particular meeting, they were making the point in relation to a broader discussion on the issue of the Assisted Dying Bill due to be discussed in Parliament.

288. In terms of the broader issues around DNACPR as I understood them, they were mainly linked to reports from members of the public that they only found out they, or a family member had a DNACPR form upon investigation of their medical notes, or in the case of a medical emergency. There was a feeling amongst a number of people, and this was vocalised both in public discourse and within the Parliamentary chamber, that DNACPR forms were being instructed by healthcare professionals without due consent of the person involved.

289. In addition, there was concerns raised, such as those from Age Scotland, that older people in particular felt somewhat pressured into signing DNACPR forms. In addition those with disabilities, both physical and neurodevelopmental,

reportedly felt like they were being treated in a blanket fashion and that there was effectively a blanket approach to the use of DNACPR forms for those with disabilities. These concerns were raised before my time as Cabinet Secretary for Health and Social Care, therefore I cannot comment in detail what specific action was taken at the time.

Deaths and Data

290. The Scottish Government established a Covid-19 Health and Social Care Analysis Hub at the outset of the pandemic to develop, collect, report and brief on Covid-19 data on a daily basis – including daily situational reports. This included a range of national level measures relevant to the ASC sector such as;

- Data on number of confirmed cases of Covid-19 amongst care home residents and staff
- The number of adult care homes with current suspected cases of Covid-19
- Covid-19 related staff absences in care homes
- Covid-19 related deaths in care homes
- Visiting status of care homes
- Covid-19 vaccinations for care home residents and social care workers.

291. In August 2020, the Scottish Government developed the TURAS SHT for the care home sector with care homes and NES (hosted on the 'Turas' platform) which captured data around IPC measures, occupancy, staffing, outbreak levels, visiting. This was available on daily basis and was used by Oversight Teams to identify trends and take action if/as needed. The Care Inspectorate also gathered further data around absence levels which could be used to understand impacts of measures such as self-isolation time periods on staffing levels. This data was circulated to the GOLD group on a weekly basis (from January 2021 to December 2022) to inform decision making and changes to guidance.

292. The Scottish Government's Central Analysis Division closely monitored Covid-19 in other nations, regularly monitoring the international epidemiological picture

(case numbers, hospital admission/occupancy and deaths), including for emerging variants.

293. Modelling was completed to create a daily Scotland Reasonable Worst-Case Scenario (RWC) impact assessment which included total number of infections, estimates of hospitalisations, estimates of those needing ICU; numbers of people recovered and fatalities. The model was extended to help understand how the virus was spreading in different parts of Scotland (identifying likely future hotspots), and how the impact would be felt by different levels of community deprivation. The data fed into other mobilisation planning across social care, primary care, and secondary care, as well as wider public service impact. It was shared with technical experts working in other hubs on issues such as the economy, transport, and vulnerable communities.

294. Data collections were developed alongside and shared with other nations. For example, throughout the pandemic, a series of indicators were shared with the UK Cabinet Office covering a number of themes including cases, deaths, testing, healthcare staff absences, ventilator stock, hospitalisations, social care metrics, shielding, school attendance, other staff absences, prisons, and vaccinations. Social care data, including the number of confirmed Covid-19 cases in care homes, live outbreaks in care homes, care home size, deaths in care homes and staff absences in care homes was provided on a weekly basis. The indicators were included in the return as requested by the UK Cabinet Office in response to their requirements, and key headline measures were included in a published UK Covid dashboard. The UK Government shared Covid-19 Situational Awareness Briefs to the devolved administrations, which also included care homes.

295. Social care data and analysis was regularly communicated to Ministers to aid decision making and used in a wide range of briefings and papers. This included providing daily Covid-19 briefings (seven days per week) from 2020 to 2022 on key Covid-19 statistics, including weekly social care data and evidence. This data was used to inform statements made by the First Minister in the Scottish Parliament and media interviews.

296. In terms of data collection, it is my belief that we got the balance right between collecting it and not overburdening the ASC sector during a time of extreme pressure. On the whole, I did not feel in my time as Cabinet Secretary for Health and Social Care that there was a significant issue around lack of data in the ASC sector, except in the areas already identified in this statement such as a lack of data in regards to the available staffed capacity in the sector.

297. During the emergence of a new variant data would always be evolving as clinicians and scientists gained a greater knowledge and understanding oof a new emerging variant. As their understanding evolved, it would help inform Ministers on the characteristics of a new variant, such as its level of immune escape or transmissibility.

298. There was regular reporting on PPE levels. As stated in my Module 3 statement (submitted 16 August 2024) [INQ000480774] at paragraph 189,

"in order to keep me informed of available stocks of PPE, there was some regular reporting on PPE levels to me. From taking up post in May 2021 through to 15 September 2021 I received a weekly PPE demand and supply briefing… The briefing began with an overview of the current situation, including stock levels, projection of future demand, and whether potential requirements were likely to be met, along with any relevant operational information. The briefing was completed with a description of the PPE modelling assumptions used to inform the forecasts." As outlined at paragraph 194, the Adult Social Care PPE Steering Group "*was established in November 2020 to manage the Social Care PPE Hub Network from a strategic perspective. This included monitoring the use of the Hub Network, the levels of supply and demand, in addition to addressing ad hoc issues of concern raised by Steering Group members*."

Further information on Deaths and Data

299. There were gaps in the data when the pandemic first emerged but I give credit to both my predecessors and officials who worked hard to put in place the necessary data collection tools. The level of data from the social sector vastly

improved as a result, and regular, weekly and daily data was available by the time I was in post.

300. Early in the pandemic it became clear that there were gaps in the data available – much of pre-pandemic data was reported on an annual basis. Analysts across organisations worked to understand the data available and develop new collection methods and infrastructure. This led to the introduction of new tools, such as the SHT Turas platform. The SHT tool collated management information which was self-reported and not all care homes submitted the information daily – this impacted on reported trends in data. That said, there was a good response rate, and my colleague Kevin Stewart was quick to spot any gaps and ask officials to chase up with relevant HSCPs.

301. Efforts were made to reduce duplication of reporting (and the attendant burden on social care providers). Much of the data collected was at an 'aggregate' level – disaggregated data would have assisted in identifying the most vulnerable. These issues have been identified as a key lesson learned through the Care Home Data review.

302. By the time I was Cabinet Secretary for Health and Social Care, there was a significant amount of information available to me that my predecessor would not have had. In terms of qualitative intelligence, we relied more heavily, perhaps more so than necessary, on the direct feedback loops we had. However, we could have had more structured qualitative data. The online survey we asked Care Home Managers to complete is perhaps, upon reflection, a survey we could have replicated on a more regular basis. A more structured survey of qualitative responses from care home residents, and those receiving care at home, is something that should also be considered, if it has not already been done so.

303. As referenced above, data in relation to care home visiting policies was available as part of the SHT Turas platform.

304. As I have referenced throughout my statement, the biggest data gap in relation to the ASC sector, at the time I was Cabinet Secretary for Health and Socials

Care, was not having a complete picture of the availability of staffed capacity in the ASC sector. This made it difficult to pressure Local Authorities and Health and Social Care Partnerships to fill those gaps and help alleviate the pressures our acute hospital sites were facing, which impacted the levels of delayed discharges, which in turn impacted waiting times for emergency A&E care. Through a collective effort, working collaboratively with local authorities, HSCPs, and care providers, we got to a point where a dashboard became available showing us how many beds were available, how many of those beds were staffed beds, which in turn allowed Ministers to then bear down some pressure upon Local Authorities and HSCPs to accommodate people who were ready to be discharged from hospital to a care setting, or to go home with an appropriate care package in place.

305. The data I received as Cabinet Secretary was helpful for us to determine various responses in terms of the decisions we had to take in regards to responding to the pandemic, whether that was NPIs or prioritisation in relation to testing and vaccinations. Also, clinical data regarding the effect of the vaccine and the potency of any new variant and severity of impact, was all helpful when there was a surge of the virus.

Lessons Learned and Recommendations

306. It is important to state that those working in the ASC sector were unbelievably committed to providing the best possible care they could, given the pressure they were under, especially during difficult periods such as winter or during surges of the virus. Especially in the early days of the emergency response, ASC staff went above and beyond in regards to the care they provided. Many sacrificed significant time with their family so that they could attend to the needs of those they cared for. That is testament to their character and integrity and there were times when ASC stakeholders told me they felt social care workers did not get enough recognition for their efforts, in comparison, for example, to nurses in the NHS. As a result I was made a conscious effort to mention the efforts of social care workers, alongside health care workers, whenever I had the opportunity.

307. Given the exceptional pressure, the vaccination programme worked well. The vaccine was the most impactful tool to safeguard against the virus. The fact that the ASC sector was able, for the most part, to ensure their staff and residents were vaccinated with such speed and coverage. The available statistics do show that a large number of residents and staff were vaccinated in a very short space of time which is impressive.

308. For the most part, the testing regime worked incredibly well. Also, the initiatives put in place for the supply of PPE worked well (PPE hubs and direct supply into care homes).

309. In my view, there was good, regular engagement with the providers of care, local authorities, HSCPs, COSLA, trade unions and relatives of those in care homes. Of course, there was disagreements in approach, for example I know a number of care home relatives groups believed the visiting restrictions we imposed, particularly in the early days of the pandemic, were too restrictive and were negatively impacting those who were receiving care.

Lessons Learned re ASC sector's response to the pandemic

310. The Scottish Government undertook a number of lessons learned exercises throughout the pandemic, including:

- Lessons learned from reducing delayed discharges (July 2020) [HY6/075 – INQ000280365]
- PHS Report on Discharges from NHS Scotland Hospitals to Care Homes (October 2020 and April 2021) [HY6/076 - INQ000343840]
- Covid-19 Care Home Outbreaks – Root Cause Analysis (3 November 2020) [HY6/077 - INQ000280638]
- Short Life Delayed Discharge Expert Working Group (August 2021)
- Covid-19 Initial Health and Social Care Response – Lessons Identified (6 August 2021) [HY6/078 - INQ000147847].

311. The lessons from these exercises informed our response to the pandemic, as the reports and evaluations were completed. I also hope they will provide helpful material in the government's planning for future pandemics.

312. While we had a plethora of quantitative data, which was incredibly useful, we lacked regular and structured qualitative data, from a range of sources, such as those working on the front line in a care setting or providing care at home, from residents in a care setting and those receiving care at home, and from those with relatives in a care setting or receiving care at home. As a government we were always trying to strike the balance between protecting a very vulnerable group, in a high risk environment, from the worst impacts of the virus and ensuring their wellbeing needs, including family visitation, were met. Clinical data is of course incredibly important in trying to correctly strike that balance, but more regular and structured qualitative data could have also been helpful in that regard.

313. The primary lesson for me is that, as far as I am aware, to this day, we do not have adequate mechanisms, centrally within government, to ensure that those who are clinically safe to be discharged from hospital are discharged to a care home setting in their local authority region. There are parts of the country where we have availability and staff in a care home, but huge numbers of people are having their discharge from hospital delayed, at a time when virtually every hospital in the country is struggling with flow and facing a demand on their services. Alleviating hospital bed space for those who don't require it is one of the top issues our NHS is facing, impacting our performances in emergency care, as well as impacting our ability to reduce waiting times. We still do not have the powers centrally, within government, to ensure immediate transfers happen from hospital to an appropriate care setting. This needs resolved ahead of any future pandemic we may face, otherwise we will find ourselves in a potentially worse situation given the ageing population we have in the UK and the greater demand that there will be for care home places and care at home packages. In my view, the best way to resolve this would be to have a fully functioning National Care Service, that is centrally accountable to the Scottish Parliament, and where necessary powers of direction would lie with a Cabinet Secretary for Health and Social Care. This would help deal with the issue of the postcode

lottery of care which currently persists in Scotland from one local authority to the other. It would also allow the Cabinet Secretary to direct a local Care Board to ensure maximum staffed care capacity was being utilised. A National Care Service would also help with the staffing challenges we face, with a clearly defined career progression route that was standardised across the country, with appropriate terms and conditions attached.

314. The Government should, of course, continue to invest in care in the community and interventions such as Hospital at Home, thereby ensuring hospitals are only utilised for those who are in need of urgent emergency care, and where necessary elective care that cannot be done at community level.

315. I would add that I believe that ASC is far too fragmented a sector, with inconsistencies of approach between private providers and Local Authority providers. A postcode lottery of care still very much exists in Scotland.

Recommendations for Chair to consider

316. The Inquiry has asked whether I have any further reflections or recommendations for the Chair to consider. I would refer to my comments in the above paragraphs. I hope the statement I provide would help the Chair in the recommendations she will make. The job of those in government will be to listen to these concerns, accept the recommendations where appropriate and ensure they are acted upon.

Social Care Reform in Scotland

317. The independent review into ASC in Scotland which was published on 3 February 2021 [HY6/021 - INQ000280640] was commenced before my tenure as Cabinet Secretary for Health and Social Care. However, I read through the detail of the independent review and agreed with most aspects of it, including the central recommendation that Scotland create a National Care Service. I was not necessarily convinced by the figures quoted in the independent review, I think

they vastly underestimated the cost involved in the creation of an effective National Care Service.

318. The National Health and Social Care Workforce Strategy (published 11 March 2022) [HY6/079 - INQ000147338] was a joint endeavour between the Scottish Government and our local government partners in COSLA. The Strategy was co-signed by me, as Cabinet Secretary for Health and Social Care and Councillor Stuart Currie in his capacity and HSC Spokesperson for COSLA.I am unable to provide an update on the current status of the Strategy as I left Government in May 2023.

319. The National HSC Workforce Strategy [HY6/079 - INQ000147338] sets out the:

- Changing demands on the HSC sector and the workforce
- The workforce vision, values and principles
- The five pillars of the workforce journey (plan, attract, train, employ & nurture).

320. Delivery of the strategy was to be supported at a local level by 3 year workforce plans developed by the 31 HSCPs across Scotland.

321. The 3 year workforce plans were to provide evidence to support indicative HSC workforce growth projections.

322. The purpose of the strategy was to ensure that there was better workforce planning than had been in place previously. This had always been a challenge which can be evidenced by the level of vacancies historically within the sector. That is why it was crucial to work collaboratively with local authority partners, so that in the case of social care, the workforce plans were not imposed top down centrally from government without sufficient local authority input. The strategy enabled a number of key changes to be made as to how workforce plans were developed:

- Instead of traditional one year plans, 3 year plans were to be developed and the longer scope was seen as more helpful for planning purposes.
- Having a more in-depth methodology to approaching workforce planning.

- Ensuring consistency across the local authority/HSCP landscape.

323. In terms of the National Care Service, I have been supportive of the introduction of a National Care Service for Scotland for a number of years. The care service in Scotland is currently a post code lottery, with inconsistency in terms of the level of care received and staffing. There are also inconsistencies with pay, conditions, terms and progression for staff. Put simply the current system is not delivering the best system of care that we could, for both residents and staff working in the sector. In a country with an ageing population, demands on social care will become more acute. We need a better social care system than the one we already have. It is of course easier said than done and it will need significant investment, more than the Independent Review of Social Care estimated [HY6/021 - **INQ000280640** so serious and innovative thinking has to go into how such a system would be funded. However, if we maintain the system we currently have, with only marginal tweaks around the margins, we will only continue to have a fragmented system, that will creak under future pressure, that is before we even encounter another pandemic in the future. As already referenced in this statement, I am no longer a member of the Scottish Government so can not comment in detail on the Government's plans and timescales involved, other than at a high level and commenting on what is already in the public domain. On 23 January 2025, the Minister for Social Care, Mental Wellbeing and Sport, Maree Todd, announced the Scottish Government's intentions to remove Part 1 of the National Care Bill. Part 1 was, in effect, the creation of the National Care Service. The Scottish Government will instead establish a non-statutory Advisory Board, instead of a National Board, which will provide advice to Ministers and is anticipated to meet for the first time in Spring 2025. The Chair is yet to be chosen. The Advisory Board will advise on how Ministers might use their existing powers of guidance, direction and funding in cases where agreed standards are still not met after support has been offered. It will help to ensure consistent, fair, high-quality service for everyone.

324. Membership of the Advisory Board will include representatives of:

- People who access and deliver support

- Trade unions
- NHS leadership
- Local authorities
- Integration Joint Boards
- The Third Sector
- Scottish Government.

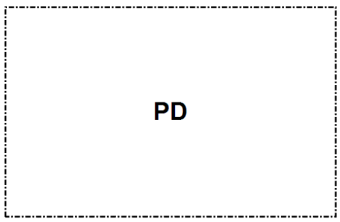
325. Subject to Parliament's agreement, parts 2 and 3 of the original Bill will remain and will cover some of the original proposals and will include provisions relating to:

- Anne's Law
- Improved information sharing and information standards
- A new right to breaks for unpaid carers
- Independent advocacy – The Scottish Government will consider how to ensure that this support is available to those who need it.

326. Given the delay in introducing a National Care Service, and the significant funding involved, at a time when public finances continue to be constrained, I do not see the establishment of a National Care Service happening in Scotland in the near future, unfortunately.

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: _____ _____

Dated: _____13 May 2025_____