Health and Social Care Provision in Rural and Island Communities During the COVID-19 Pandemic

Final Report

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Disclaimer:

This report was commissioned by the Scottish Covid-19 Inquiry as introductory scoping research. It was written to assist the inquiry with its planning process about the shape and direction of its investigation, and is published in the interests of transparency. The inquiry is grateful to the author[s] for their work. The inquiry is an independent body, and will be carrying out its own investigations to fulfil its terms of reference. The introductory research represents the views of those who wrote it, and nothing in it is binding on the inquiry. The introductory research is one of many sources which will be considered by the inquiry during the course of its investigation.

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Summary

This project aimed to understand the provision of health and social care services during the pandemic from the perspectives of different rural and island communities in Scotland, specifically addressing the provision of healthcare services, including the management and support of staff, and in care and nursing homes: the transfer of residents to or from homes, treatment and care of residents, restrictions on visiting, infection prevention and control, and inspections.

Evidence suggests that the rapid disruption to healthcare provision during the pandemic in rural and island communities led to a significant reduction in people with medical concerns being seen, closures of key services, and had a considerable impact on clinical training and the wellbeing of staff. The decision to prioritise the acute healthcare sector severely impacted social care provision, aided only by community organisations who partnered with both health and social care providers to meet the needs of community members as stop-gap measures. This prioritisation also had devastating consequences for care home staff and residents. Inhumane policy, implemented at the time to keep coronavirus at bay, has negatively impacted the mental health of residents, staff and carers.

A whole systems approach may not have stopped this prioritization but at least, strategic planners and managers could have mapped out the knock-on effects on other parts of the care system. Such an approach is crucial in rural and island communities, and required at national and local levels.

More attention also needs to be paid to continuously develop community care capacity and the care infrastructure so that communities can be quickly mobilized in crisis situations. We

visualize this as networks within networks, where resources, learning and capacities are shared. Finally, the risk of infection during a pandemic must be weighed against the risk of losing humanity. Balancing these risks should be decided by the nation, by local communities and within each family. The Covid Public Inquiry is not just about reflecting on the pandemic but should be a catalyst for change and a call to action.

Chapter 1: Introduction

Rural Scotland accounts for 98% of the land mass of Scotland and nearly a fifth of the population are resident there. According to the last Census in 2011, there were 93 inhabited islands with a total population of 103,700, which represents 2 per cent of the population of Scotland. There are 12 'non-doctor' islands (e.g. an advanced nurse practitioner delivers care on these islands) that come under the jurisdiction of NHS Shetland, NHS Orkney and NHS Highland. Rural populations are growing at a faster rate compared to urban populations and compared to the rest of Scotland, rural communities have a higher proportion of people aged 65 and over, a higher percentage of 'older smaller' households where one or both adults are of pensionable age, and a higher percentage of single pensioner households (**footnote 1**). Less than half of people living in rural areas of Scotland live within a 15 minute drive time to a GP by public transport (**footnote 1**). Both geography and weather present significant challenges to the provision of 24 hour healthcare, as well as to other services such as education and social care.

This report acknowledges that Scotland's rural and island communities are heterogeneous and there are multiple voices and perspectives between and within rural areas of Scotland. It also assumes that local people are experts in their own lives and should be heard from to inform policy and practice. People in rural and islands communities of Scotland have, and can continue to play an active role in developing and implementing strategies for recovery and renewal. As such, in this report, we adopt an inclusive approach covering all rural areas of Scotland.

Project Scope

In this project, we aim to understand the provision of health and social care services during the pandemic from the perspectives of different rural and island communities in Scotland. The purpose of the project is to address the two following strategic elements of handling the pandemic that were identified in the Scottish Covid-19 Inquiry Brief in rural and island communities of Scotland:

- the provision of healthcare services, including the management and support of staff (h),
- in care and nursing homes: the transfer of residents to or from homes, treatment and care of residents, restrictions on visiting, infection prevention and control, and inspections (g).

Structure of the Report

Chapter 2 defines terms used in the report while Chapter 3 provides an overview of the evidence gathered by the academic team. Chapters 4, 5 and 6 present the evidence gathered through both the scoping review and personal communication with key community stakeholders on the topics of health care provision, social care provision and care home processes, respectively. Chapter 7 of the report evaluates this evidence base before Chapter 8 lays out overall report conclusions and recommendations. Finally, Appendix 1 discusses the methods used by the academic team to gather evidence, while Appendix 2 lists contributing community stakeholders and Appendix 3 provides the initial call for perspectives issued by the academic team in collaboration with the Scottish Rural Health Partnership. The documents of the scoping review are cited in footnotes. The contributions from key community stakeholders are references in the narrative text. H refers to Highland mainland

and I refers to islands; M refers to managerial, S to strategic and P to practitioner roles.

Acknowledgements

The academic team would like to acknowledge the contributions of Rob Polson, Information Specialist at UHI for his assistance with the rapid scoping review; and Leigh Mair, Development Manager for the Scottish Rural Health Partnership for her assistance with issuing the call for perspectives and its dissemination through email and social media networks. Finally, the academic team acknowledges all their personal and professional contacts who circulated the call for perspectives and referred it to several others in the community for their inclusion.

Chapter 2: Definitions

For the purposes of this project and written report, we have used the following definitions:

- **Rural** - we have chosen an 8-fold classification from the Urban-Rural Classification developed by the Scottish Executive in 2000 and subsequently updated every two years (**footnote 3**). This methodology provides a simple classification which distinguishes between urban, rural and remote areas on a six and eight category basis, according to population as defined by the National Records of Scotland, and accessibility based on drive time analysis.
- **Social care** - we have used the Scottish Government's definition of social care as "all forms of personal and practical support for children, young people and adults who need extra support, including services and other types of help, such as care homes and supporting unpaid carers to help them continue in their caring role" (**footnote 4**).
- **Mental health** - we adopt the World Health Organisation definition of mental health (**footnote 5**). An important implication of this definition is that mental health is more than just the absence of mental disorders or disabilities and multiple social, psychological, and biological factors determine the level of mental health of a person at any point of time.

Chapter 3: Description of the Evidence Base

This chapter provides an overview of the two main sources of evidence gathered on the provision of health and social care and care homes in rural and island communities during the COVID-19 pandemic.

Rapid Scoping Review

Table 1 summarises the documents included in the rapid scoping review.

Table 1: Summary of Search Documents

- Search Source: CINAHL
  Records reviewed for title and abstract: 6
  Records eligible for full text review: 2
  Records included in project: 2

- Search Source: SCOPUS
  Records reviewed for title and abstract: 44
  Records eligible for full text review: 5
  Records included in project: 2

- Search Source: Embase
  Records reviewed for title and abstract: 25
  Records eligible for full text review: 4
  Records included in project: 4

- Search Source: EBSCO
  Records reviewed for title and abstract: 6
  Records eligible for full text review: 2
  Records included in project: 2

- Search Source: AMED
  Records reviewed for title and abstract: 18
  Records eligible for full text review: 2
  Records included in project: 2

- Search Source: HMIC
  Records reviewed for title and abstract: 0
  Records eligible for full text review: 0
  Records included in project: 0

- Search Source: Medline
  Records reviewed for title and abstract: 10
  Records eligible for full text review: 0
  Records included in project: 0

- Search Source: APA Psych Info
  Records reviewed for title and abstract: 13
  Records eligible for full text review: 0
  Records included in project: 0

- Search Source: Proquest
  Records reviewed for title and abstract: 24
  Records eligible for full text review: 3
  Records included in project: 3

- Search Source: NHS Public Health COVID 19 Repository
  Records reviewed for title and abstract: 9
  Records eligible for full text review: 3
  Records included in project: 3

- Search Source: Social Care Online
  Records reviewed for title and abstract: 74
  Records eligible for full text review: 2
  Records included in project: 0

- Search Source: Advanced Google Searches
  Records reviewed for title and abstract: 100
  Records eligible for full text review: 16
  Records included in project: 8

- **Search Source: Total**
  Records reviewed for title and abstract: 329
  Records eligible for full text review: 39
  Records included in project: 26

The database searches for health and social care provision and care homes during the pandemic in published academic literature contained considerable duplications, highlighting a main consistent set of studies. Searches for care home studies within these academic databases yielded few records outside the Social Care Online database. This database, alongside the COVID-19 research repository within the Public Health Directorate, contained literature exploring COVID-19 and care homes but only a small subset was tangentially linked to rural communities in Scotland and contained guidelines and policies. It should also be noted that many of the care home studies in these databases were conducted prior to the COVID-19 pandemic and therefore excluded. Finally, there was also considerable overlap and duplication in the google and database searches of grey literature which were conducted generally for Scotland and then more specifically for rural and Island settings. In the following chapters, Tables 2 and 3 describe the included documents as follows: author, title, type (e.g., research, case study, website), rural location. If a document was reporting research, then sample size, participants, method, and service involved/setting were also included in the table.

Personal Communication with Key Community Stakeholders

From February 4 to February 25, 2022, the academic team gathered anecdotal evidence. Twenty-two contributions from key community stakeholders in rural and island communities were received. The Scottish Rural Health Partnership issued a call for perspectives (presented in Appendix 3) through their email and social media networks between February 7 to February 11 (see Appendix 2 for details). The 22 contributions received by the academic team were spread relatively evenly across the three fields of care provision, with 7 contributions from health care providers, 8 from social care providers and 7 from care homes (2 came from the same care home). Further contributor details can be found in Appendix 2. The following chapters outline the evidence gathered for each of these three forms of care provision. It should be noted that while the contributors came from distinct sectors of care provision, they provided input on as many of those sectors with which they had experience.

Chapter 4: Healthcare Provision in Rural and Island Communities

This chapter presents evidence gathered through the rapid scoping review and personal communication with key community stakeholders on the provision of health care in rural and island communities during the COVID-19 pandemic. To a significant degree, these two sources of evidence overlap thematically, and as a result, have been presented together. Conclusions and recommendations are presented at the end of the chapter.

Table 2 summarises documents relevant to the provision of healthcare in rural and island communities during the COVID-19 pandemic. Ten documents were included in the scoping review, with two being the same data published in different academic journals (**footnotes 6, 7**). Six out of ten documents were published research articles or reports (**footnotes 7, 8, 8, 9, 10, 11**), one published clinical case report (**footnote 12**),and three unpublished research articles (**footnotes 13, 14, 15**). All of this research is descriptive in nature; four research studies used qualitative interviews, three used questionnaires, one was mixed methods, one was a clinical case study and one did not disclose methodology. The studies ranged from including a rural site within the sample, to being completely rurally focussed.

Table 2: Summary of Health Care Provision Documents

- **Author:** Jones and MacRury (2021)
  Title: Future-proofing diabetes foot services in remote and rural health settings post-COVID-19.
  Type: Research
  Rural location(s): Highlands and islands
  Sample size: unclear
  Participants: Podiatrists

Methods: Unclear
Service involved / Healthcare setting: Podiatry

- **Author:** Fixsen et al (2021)
  Title: Supporting Vulnerable Populations During the Pandemic: Stakeholders' Experiences and Perceptions of Social Prescribing in Scotland During Covid-19
  Type: Research
  Rural location(s): Glasgow and Isles of Barra, N. and S. Uist, Benbecula, Harris and Lewis
  Sample size: 23
  Participants: Professional and volunteers in social prescribing schemes
  Methods: Interviews
  Service involved / Healthcare setting: Social Prescribing

- **Author:** Fixsen et al (2021)
  Title: Weathering the storm: A qualitative study of social prescribing in urban and rural Scotland during the COVID-19 pandemic.
  Type: Research
  Rural location(s): Glasgow and Isles of Barra, N. and S. Uist, Benbecula, Harris and Lewis
  Sample size: 23
  Participants: Professional and volunteers in social prescribing schemes
  Methods: Interviews
  Service involved / Healthcare setting: Social Prescribing

- **Author:** Wherton et al (2021)
  Title: Expanding Video Consultation Services at Pace and Scale in Scotland During the COVID-19 Pandemic: National Mixed Methods Case Study
  Type: Research
  Rural location(s): Scotland – Forth Valley, Highland, Golden Jubilee, Grampian, Greater Glasgow and Clyde, Lothian, Orkney and Western Isles

Sample size: 223
Participants: Patients, staff, technology providers and policy makers
Methods: Mixed methods
Service involved / Healthcare setting: All services

- **Author:** Bradley et al (unpublished)
  Title: Understanding the Experience of the COVID-19 Pandemic for People Living Rurally with Long Term Conditions (LTCs)
  Type: Research
  Rural location(s): Highlands and Islands
  Sample size: 30
  Participants: Patients with 1 or more long term conditions
  Methods: Interviews
  Service involved / Healthcare setting: Long Term Conditions

- **Author:** Coldron et al (unpublished)
  Title: A survey looking at self-management of Diabetes during the pandemic
  Type: Research
  Rural location(s): Highlands
  Sample size: 40
  Participants: Diabetes patients
  Methods: Online survey
  Service involved / Healthcare setting: Diabetes care

- **Author:** Carolan and Davies (unpublished)
  Title: Help seeking among remote and rural populations during the CVOVID-19 pandemic: An exploratory qualitative study
  Type: Research
  Rural location(s): Highlands and Islands
  Sample size: 9
  Participants: Patients with new symptoms

Methods: Interviews
Service involved / Healthcare setting: General practice

- **Author:** Shepherd et al (2021)
  Title: The use of telemedicine to assess a paediatric patient with arrhythmia presenting to a remote community coronavirus assessment centre
  Type: Clinical case
  Rural location(s): Islands
  Sample size: 1
  Participants: Paediatric patient
  Methods: n/a
  Service involved / Healthcare setting: General practice

- **Author:** De Kock et al (2022)
  Title: The mental health of NHS staff during the COVID-19 pandemic: two-wave Scottish cohort study
  Type: Research
  Rural location(s): NHS Highland
  Sample size: 169
  Participants: Health and social care professionals
  Methods: Validated measures of psychological wellbeing and demographic survey
  Service involved / Healthcare setting: Mental Health

- **Author:** Carrera et al (2021)
  Title: Impact of COVID-19 pandemic on urology trainees in the West of Scotland
  Type: Research
  Rural location(s): West of Scotland
  Sample size: 25
  Participants: trainees
  Methods: Online survey
  Service involved / Healthcare setting: Urology

Themes raised from these documents and reflected in the key community stakeholder contributions around the provision of healthcare services during the COVID-19 pandemic were:

- Transformations in Service Provision
- Challenges of Remote Consultations
- Reduction in Clinical Preparation of Trainees
- Staff Mental Wellbeing
- Changing professional roles.

Transformations in Service Provision

The following points were identified in five documents (**footnotes 16, 17, 18, 19, 20**) and from eight key community stakeholders.

Public awareness of service provision and the practicalities of service access was impacted by the pandemic. People's knowledge about services being suspended or changed was derived from multiple sources including national and local media and word of mouth via informal social networks; however, this could be contradictory and was perceived to pose risks to service access. As a result, there was significant disruption to health and social care for many, particularly those who had high support needs or needed personal care and who required assessment to access appropriate social care and support. People who had face-to-face support had that support either removed altogether or significantly reduced for some or part of the pandemic. For people with diabetes, the general anxiety about attending face-to-face appointments appeared to result in reduced use of services, potentially escalating care needs and avoidable complications.

Transformations in service provision also featured heavily in contributions from key community stakeholders, often connected to the use of video consultations. Some General Practices adopted a triage system whereby patients either had a face-to-face appointment or received a video consultation.

Not seeing some patients face-to-face was perceived to have negative clinical consequences, however. (HP4, IM1, HP3, HS2) Chronic conditions worsened without management, other patients suffered through 'painful conditions such as osteoarthritis without treatment', non-urgent services were pared down, while others such as inpatient geriatric services disappeared. This meant that patients who had no access to non-urgent preventative services during the first wave of the pandemic returned in the second wave of the pandemic with advanced and now critical conditions.

Changes in healthcare provision was also perceived to ripple out into social and palliative care services as providers **"…saw a significant increase in the number of patients who are receiving end of life/palliative care at home. These patients qualify for and have been awarded a care package, but unfortunately there are no care staff available."** (HP2) Carers were believed to have been disproportionately affected by a lack of daycare and respite care services. (HP6, HS3, HS1)

Some contributors described healthcare provision as still uncertain at this point in the pandemic, with ongoing staff shortages due to staff having to self-isolate, and a lack of access to some health centres which had been closed by GPs. (HS4, HM7, HP5, HM4)

Challenges of Remote Consultations

The points below were identified in seven documents (**footnotes 21, 22, 23, 24, 25, 26, 27**) and from four key community stakeholders.

Many remote and rural healthcare centres were not well equipped to deal with the rapid changes needed to manage remote video consultations during the pandemic. Clinicians had to adapt and learn new technological systems, transforming consultations and communication methods. While disruption consequent from the pandemic accelerated technological innovation in remote care consultation, digital exclusion was highlighted as an issue. Remote consulting was perceived by health and social care staff to reduce the risk of infection from the coronavirus but introduced challenges to gaining more clinical information should it be required, as it does not provide all the information clinicians are used to having available through face-to-face examination and the nuances of non-verbal communication. For those with diabetes, for example, greater access to telehealth services did not appear to compensate for the potential negative effects on prevention screening and self-management that had been disrupted during the pandemic.

Key community stakeholders also reflected on changes posed by the move to remote video consultations citing the significant time and effort put into new ways of working. They referred to video consultations but also email consultations whereby patients would share photographs in order to avoid a home visit during lockdown. (HM7, HP6, HP1)

Key community stakeholders appreciated that this technology allowed ‘more patients to be seen’ but as reported in the scoping review, video consultations were no substitute for face-

to-face consultations, especially for complex patients such as those with dementia or those uncomfortable with technology. (HS2, IM1) One contributor explained she believed that face-to-face consultations were essential for people with dementia: **"Lack of hospital visiting meant a loss of knowledge and benefits of carers for people with dementia – all patients have dementia. Restrictions on carers and service provision was terrible as they can't say how you are. People with dementia are not good at using Teams."** (HP3).

Reduction in Clinical Preparation of Trainees

Only one document addressed the clinical preparation of healthcare trainees (**footnote 28**). Anecdotal evidence from one key community stakeholder also referred to trainees.

COVID-19 resulted in a significant reduction in medical urology training opportunities across elective theatre, clinic exposure and education as elective operating was significantly reduced and trainee attendance at multidisciplinary team meetings halved during the pandemic, reducing their clinical preparation. However, trainees were more adaptable, learned to work remotely, had opportunities to develop leadership and can help redesign services.

For nursing students, changes in healthcare provision during the pandemic led to a significant reduction in clinical placements for nursing students. (HE1) The rapid shift to digital health for some specialties (e.g., specialist nurses, public health, CPN service) also reduced the provision of placements for nursing students. There was also a loss of placements with district nursing teams, GP practices, and family teams. The contributor was concerned that students will have completed and enter the nursing register without having had practical

experience in some clinical settings. This lack of experience however, may be off-set by the experience gained through working as nursing assistants in clinical settings during the pandemic. The contributor believed that this clinical experience may be of ultimate benefit to student competence. (HE1)

Staff Mental Wellbeing

Only one document addressed staff mental wellbeing (**footnote 29**) while contributions are presented from six key community stakeholders.

Health and social care professionals working in areas **outside of COVID-19 hotspots** (i.e. urban areas of Scotland) experienced levels of adverse mental health outcomes in keeping with those working in COVID-19 hotspots. Working directly with COVID-19 patients was significantly associated with higher rates of depression. Relatively high levels of anxiety and depressive symptoms persisted over time, raising concerns that health and social care professionals may face immediate and ongoing adverse mental health consequences.

While only one document addressed staff mental well-being in the scoping review, this was of significant concern for key community stakeholders. Contributors explained what they believed were causal factors for poor staff well-being during the pandemic.

As more patients moved home for end of life care with home care packages, there were no staff available to meet their needs as self isolation stretched the workforce (HP1, IM1). One contributor wrote, **“unpaid carers who had little support and had clearly reached breaking point. I think staffing shortages impacted on both services prior to the pandemic**

and therefore when it hit [the pandemic] services struggled badly. It is clear that staff did their best to try and provide cover at the detriment of their own welfare." (HS2)

Contributors also shared frustrations with unnecessary pressures and stress resulting from absenteeism due to self-isolating, media and government messaging of over-exaggerations of COVID-19 related mortality and morbidity and ever-changing information and guidance. (HP4, HP5, HM7) As one contributor stated, **"As the hospital waiting lists grow, the conditions people present with get worse and the knock-on effect creates great frustration – both to patients and the teams within the community attempting to do their best for them. It does appear that we are beginning to lose "global" heath care under the NHS umbrella. There is a staff shortage which will only grow."** (HP4)

Changing Professional Roles

Three documents addressed changing professional roles in relation to social prescribing Link Workers (**footnotes 30, 31, 32**). Anecdotal evidence from two key community stakeholders also referred to changing professional roles.

The social prescribing landscape was described as complex with different funding schemes, structures and forms of service delivery. Working remotely made service provision more challenging. Many GP practice-attached 'Link Workers' had taken on counselling and advocacy roles, sometimes for serious mental health cases. Community-based social prescribers had mostly assumed a health education role, and those on some islands, a digital support role, to support overburdened statutory services and a third sector under financial strain.

Contributions from key community stakeholders also spoke to their blurred or changing roles as health and social care providers. Both HP6 and HS3 discussed ways in which carers had expanded their traditional roles as a result of service provision changes and one contributor (HS3) described how, **"At times I feel social care were often pushed to act outwith their traditional roles due to significant lack of further support available – remote GP, reduced integrated team support, increased stress and distress in residents etc,"** while another (HM4) added, **"Within my area I think Health professionals worked safely but often outwith their normal field of practice to support Social care colleagues. Likewise, Care home staff took on simple nursing techniques to minimize footfall using Near Me and video calls for support. Team working and blurring of roles worked well most of the time but pressure did show on people and little support was given to staff at the time of the pandemic."**

Recommendations

Recommendations for healthcare provision in rural and island communities made by document authors and key community stakeholders included the following:

- Telehealth is not a panacea and blended approaches are required due to the need for screening tests and the more open and personal communication possible in face-to-face appointments. These approaches need to be patient centred with patients having the ability to opt in for face-to-face consultations if need be, and especially in the case of complex patients. (HS2, IM1, HM7, HP6). As one contributor suggests, **"continue with option hybrid provision as digital appointments reduce cost travel in carbon and**

time, particularly accessible for younger/ people of working age, but older adults and those with learning and cognitive impairments have increased challenge in this arena." (HP6, HP5)

- Sustaining video conferencing as the new normal will depend on multiple issues such as digital infrastructure, human and financial resources (distributed fairly across the system), training (including digital literacy and teleconsulting skills), workforce (including extent to which video can help compensate for staff shortages), data security (including overcoming the tendency for regulations to be overly restrictive), and research into remote clinical examinations (**footnote 33**). (HE1)
- Future co-design approaches to healthcare service delivery should acknowledge local context and include public involvement of remote and rural healthcare users (**footnote 34**). (HS3, IM1)
- Further research is needed to explore subjective healthcare provider perspectives, objective measures of continuity of care and longitudinal impacts on healthcare outcomes (**footnote 35**).
- Mental health support for staff is needed across different working contexts. There should be monitoring of staff mental health and additional psychological support for health and social care professionals and departments that work directly with COVID-19 should be provided. Although individual-level interventions that foster mental well-being and resilience may be beneficial, there is a need for wider, structural adaptations which would lead to resilient working systems, not just resilient individuals. Rigorous further longitudinal data is needed to respond to the potential long-term mental health effects of the COVID-19 pandemic on health and social care professionals (**footnote 36**).
- Implementing non-hospital care requires a well-established network of clinicians working together with agreed upon

referral arrangements either in person or via telemedicine (**footnote 37**). Triage waiting lists and increase services to address backlog. Focus particularly on GP service provision as the most affected service and recruit, train and support more healthcare staff. (IS1, HM4, HS2, HP1, HP5)

Conclusions

Overall, the evidence highlights a rapid and consequential disruption to healthcare provision. There was a perception that this had the following negative consequences:

- Some people with medical concerns were not being seen at all (either in-person or remotely) and their condition deteriorated.
- The closure of key healthcare services left social care to pick up the pieces but they were significantly overstretched and short-staffed.
- Face-to-face consultations for some patients were essential but were not available.
- It is currently unclear if the lack of trainee clinical placements opportunities during the pandemic will lead to lack of competency in key areas.
- Staff and carers' mental health suffered due to stress.
- There is a question whether changing professional roles, with Link Workers for instance, taking on possibly complex mental health cases, is appropriate.

Chapter 5: Social Care and Community Care Provision in Rural and Island Communities

This chapter presents the evidence gathered on social and community care provision in rural and island communities through both the rapid scoping review and contributions from key community stakeholders. These two sources of evidence diverge thematically with very little connection between reviewed documents and stakeholder experiences. As a result, evidence gathered from the scoping review is presented separately from that gathered from key community stakeholders. Conclusions and recommendations are presented at the end of the chapter.

Rapid Scoping Review Evidence

Table 3 summarises included documents relevant to the provision of social and community care in rural and island communities during the COVID-19 pandemic. Twelve documents were included in the review. Five out of twelve documents were unpublished research (**footnotes 38, 39, 40, 41, 42**); six documents were community or community organisation websites (**footnotes 43, 44, 45, 46, 47, 48**); and one document was a study summary (**footnote 49**). Documents ranged from being very community specific to discussions of rural areas in a national report.

Table 3: Summary of Social and Community Care Provision Documents

- **Author:** Bryce et al 2021 (unpublished)
  Title: Community Change-scapes of COVID-19 Recovery Cross-case Report for the Highlands and Island
  Type: Research Summary
  Rural location(s): Caithness, Orkney, Merkinch and South Kessock, Kyle and Lochalsh
  Sample size: NA
  Participants: NA
  Methods: Overview of Remers et al, Heddle et al, Chambers et al.
  Services Provided/ Setting: Community

- **Author:** Remers and Davidson 2021 (unpublished)
  Title: Covid Changescapes: Our Caithness Community
  Type: Research
  Rural location(s): Caithness
  Sample size: 54
  Participants: General public
  Methods: Interviews and online surveys
  Services Provided/ Setting: Community

- **Author:** Heddle et al 2021 (unpublished)
  Title: Experiences of the Orkney community during the COVID-19 pandemic with particular reference to the tourism industry
  Type: Research
  Rural location(s): Orkney islands
  Sample size: 82
  Participants: General public
  Methods: Interviews
  Services Provided/ Setting: Community

- **Author:** Chambers et al (unpublished)
  Title: Community perspectives on the COVID-19 Pandemic in Lochalsh
  Type: Research
  Rural location(s): Kyle and Lochalsh
  Sample size: 50
  Participants: General Public
  Methods: Interviews with key contacts
  Services Provided/ Setting: Community

- **Author:** Scottish rural network
  Title: Covid-19 Information Hub
  Type: Web site
  Rural location(s): Nation-wide
  Sample size: NA
  Participants: NA
  Methods: NA
  Services Provided/ Setting: Community

- **Author:** Westray Development Trust
  Title: Covid-19 Westray
  Type: Web site
  Rural location(s): Westray (Orkney)
  Sample size: NA
  Participants: NA
  Methods: NA
  Services Provided/ Setting: Community

- **Author:** Shapinsay community
  Title: Covid Shapinsay: Shapinsay community
  Type: Web site
  Rural location(s): Shapinsay (Orkney)
  Sample size: NA
  Participants: NA
  Methods: NA
  Services Provided/ Setting: Community

- **Author:** Highland and Islands Enterprise
  Title: East Sutherland COVID-19 response
  Type: Website
  Rural location(s): East Sutherland
  Sample size: NA
  Participants: NA
  Methods: NA
  Services Provided/ Setting: Community

- **Author:** Age Scotland
  Title: Life after lockdown
  Type: Web site
  Rural location(s): Nation-wide
  Sample size: NA
  Participants: NA
  Methods: NA
  Services Provided/ Setting: Community

- **Author:** Highland and Islands Enterprise
  Title: Community spirit in the heart of Covid-19,
  Type: Web site
  Rural location(s): Caithness
  Sample size: NA
  Participants: NA
  Methods: NA
  Services Provided/ Setting: Community

- **Author:** Glass et al (2021) (unpublished)
  Title: Covid-19, lockdowns and financial hardship in rural areas: Insights from the Rural Lives project.
  Type: Research
  Rural location(s): Harris and Blairgowrie
  Sample size: NA
  Participants: NA
  Methods: Interviews and focus groups
  Services Provided/ Setting: community

- **Author:** Generation Scotland
  Title: Rural COVIDLife Survey Report
  Type: Study summary
  Rural location(s): All rural areas
  Sample size: 3080
  Participants: General public
  Methods: Online survey
  Services Provided/ Setting: Community

Four main themes were identified:

- Demographic Vulnerabilities and Peripherality
- Isolation, Loneliness and Mental Health
- Information Resources for Health, Safety and Wellbeing
- Community Resilience and Recovery.

Demographic Vulnerabilities and Peripherality

The points below were identified in eight documents (**footnotes 50, 51, 52, 53, 54, 55, 56, 57**).

Specific factors that increased the vulnerability of rural and island communities during the pandemic include reliance on limited employment sectors; being located far from centralised services (e.g. hospitals); limited digital connectivity; and an ageing population.

COVID-19 further exposed the vulnerability of Scotland's most disadvantaged communities, particularly in rural areas, but it also demonstrated the capabilities and resourcefulness of those same communities to act in support of each other. While all documents in the review express significant concern around the vulnerabilities wrought by years of disadvantage, they also recognised that even communities with recognised local assets, skills and knowledge, require secure and sustained investment

to develop and fully exploit their potential to recover and sustain themselves. The context of peripherality brought both advantages and disadvantages to rural and island communities. Cut off from service provision, these communities drew from within to support their residents, and benefitted from flexible funding programming to meet their needs. In Kyle and Lochalsh for instance, many felt the community was lucky as it was sheltered from the worst of the crisis and was not as heavily impacted as those living in urban areas. Some people felt relatively isolated from the health risks posed by the coronavirus compared to more densely populated urban areas. Many people reported advantages of having the outdoor environment to help them cope with the pandemic, having natural areas on the doorstep and being able to exercise.

Isolation, Loneliness and Mental Health

The points below were identified in nine documents (**footnotes 58, 59, 60, 61, 62, 63, 64, 65, 66**).

Some people in rural areas reported a negative impact of the pandemic on mental health. Individuals with long term conditions, for example, often reported negative emotions being generated by the pandemic because it reminded them of their own condition and its associated health vulnerabilities. The pandemic exacerbated existing mental health problems such as the stress of dealing with difficult financial circumstance and poverty, experiences of social isolation, and feelings of hopelessness and uncertainty, for others. Waiting for treatment for mental health problems also intensified during the pandemic. For example, in Caithness, people had already been on long waiting lists to see the mental health team or receive Cognitive Behaviour Therapy. The Caithness Resilience Network developed an action plan to address poor mental health, which includes identifying and responding to gaps in

provision, educating communities how to stay well and providing clarity by improving understanding of pathways to available services. Isolation in palliative care and experiences of grief were particularly difficult to cope with during the pandemic with a lack of human contact especially difficult during bereavement.

Economically, many people in the tourism industry experienced business disruptions with subsequent stresses and strains of coping with a significant loss of income. For example, tourism is a cornerstone of the Orkney economy. Due to the pandemic, the number of visitors arriving on ferries declined by 71% in the 2020 season. The 160 cruise ships on the manifest for 2020 did not arrive. Hotels and guest houses lost income as visitors shifted to self-catering accommodation or camping and campervans. Artists and crafts people lost their main source of income as a result of the collapse of tourism. In Kyle and Lochalsh, an area also heavily dependent on the tourism industry, lockdowns precluded employment opportunities for many workers.

People on low income had increased heating and food costs because all family members were at home all day which led to worry and stress. Some people suggested that the demands of home-schooling were an issue that impacted people's ability to work. People in employment were concerned about staff 'burnout'. People praised those employers who allowed flexible hours, provided mental health support and kept all staff updated with information. In the face of adversity, people in tourist-related industries applied for grants to develop their businesses (e.g., expand product range, develop web site and social media presence, learn new skills, set up new businesses).

Some older people felt supported during the crisis while younger people on the contrary felt less supported and, in some cases, uncertain about where to turn for information and help.

In Kyle and Lochalsh for instance, impacts were apparent for young adults struggling with changes to their employment but also in terms of isolation and anxiety brought about by the lock down restrictions. Concerns were also raised about the indirect effect of the pandemic on school student's mental health due to disrupted education and social exclusion, as children were unable to meet with friends.

Finally, documents reported that social isolation and loneliness were potentially and partially ameliorated by online technology. A key inequality however, was digital poverty, such as differences between those who had access to devices and connectivity and online skills.

Information Resources for Health, Safety and Wellbeing

The points below were identified from community and organisational websites (**footnotes 67, 68, 69**).

Existing national rural networks set up Covid-19 information hubs. The Scottish rural network for instance, signposted to advice for pet and livestock owners, tourism and hospitality sector, community support and funding, business support and funding, third sector funding and information, well-being and mental health support. Local communities also acted as information hubs during the pandemic. For example, Westray Development Trust, which supports an island population of 600, set up a Covid-19 web page listing for instance, community closures (and openings) such as, the 'Chippy', the youth centre, the health centre, play and schools. The Muir of Ord Development Trust wanted to reach everyone in the community to let them know what support existed and because not everyone has access to the internet, sent over 2200 flyers to everyone in the village, with information about the community support helpline which ran 7 days a week from 10am to 4pm.

This example highlights that interconnectivity did not necessarily mean being online.

Community Resilience and Recovery

The points below were identified from eleven documents (**footnotes 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80**).

Communities with a more resilient response were reported to have some or all of the following features: a strong sense of community; community organisations and local businesses that are responsive to local needs; the existence of strategic partnerships between community organisations and the public/private sector; and good digital connectivity.

Community organisations mobilised quickly to support their communities. Community organisations set up befriending by phone, shopping services, meals on wheels, mini-bus services, food parcels and putting out leaflets with contacts for help as informal community support had filled the gaps where statutory health and social services had failed. It was noted that a community's ability to respond depended on volunteer capacity, which could vary according to location.

The relaxation of red tape to respond quickly to need was seen as a positive outcome for a majority of organisations. Local authorities and national funding organisations listened to the requirements of frontline groups and many found new ways to meet them. Some set aside new or adapted funding for rapid COVID response needs. Others made it clear that funding for a programme that could no longer meet 'required' criteria for face-to-face interaction, could be used to meet the cost of reshaping the programmes to respond to actual need.

Mutual aid groups also sprung up across Scotland, including in remote and rural areas. Mutual aid groups are informal groups

of people that came together spontaneously to support people in their communities during the pandemic. Examples of people mobilising to support vulnerable people who faced greater isolation due to shielding or living alone in rural communities include:

- **Westray, Orkney:** the islands' care homes gathered residents together at 3:00pm every Sunday afternoon to listen to the half-hour service on the 'wireless'.
- **Shapinsay, Orkney:** During the first lockdown, the Development Trust were given a grant to establish a team of volunteers who made up grocery boxes or delivered ready meals to those that needed it.
- **Boleskine Community Care Forum in Highland** used an Age Scotland grant to establish a mobile hairdressing unit for older villagers in this part of rural Highland.
- **Islay and Jura Senior Citizens Association** used an Age Scotland grant to distribute Activity Boxes including knitting and crafts materials, puzzles and challenges catering for islanders' interests.
- **Harbourlea Residents Group in Anstruther** received a grant to create a sensory garden and vegetable growing space at their sheltered housing complex. This will provide a safe outdoor space for them to meet and spend time together, albeit physically distanced.
- **Caithness Resilience Network** was launched to coordinate the activity of the main different organisations (development trusts, community councils, local resilience groups, and wellbeing centres) and provide a forum for groups to learn and support each other. In June 2020, the Covid Resilience Group moved from resilience to recovery and collectively decided to tackle some of the issues in thematic groups. At this point, the two subgroups that have continued are those focussed on Social Isolation and Mental Health, and Food and Fuel Insecurity.

- **Kyle and Lochalsh COVID-19 Group** provided a telephone help line, community newsletter, inline activities and 'blessing boxes' - through which people could share food and other supplies. Many community members attributed greater cohesion as a result of these efforts, alongside a sense of self-sufficiency, with a perception that the community needed to mobilise its own response, as resources aren't available from elsewhere.

Contributions From Key Community Stakeholders

Contributions from key community stakeholders on social care provision in rural and island communities during the COVID-19 pandemic thematically mirrored those presented in the chapter on healthcare provision, covering the following themes:

- Service Struggles and Transformations
- Staffing Challenges
- Impact of Isolation on Wellbeing.

Service Struggles and Transformation

Providing social care services during the pandemic faced multiple challenges. Information about cases in the community was difficult to find (HP4), community teams lacked adequate protection from the coronavirus and communication between team management and staff deteriorated (HP4). Some services such as daycare and respite care were stopped completely as services became over-stretched (HM7, HM5) and organisations felt abandoned without support or guidance on how to continue to provide for their service users (HP5). As one contributor (HP4) describes, **"Social care options for our community were extremely limited at times. Many families lost their**

soft help from more distant family and became reliant on neighbours, or the informal volunteer groups that emerged from the first lockdown period. Many people struggled and hospital discharges at times appeared rushed, in relation to unmet social care needs at home."

The overwhelming impression given by key community stakeholders was that by protecting the acute sector, other care sectors were unable to cope, which meant that staff, carers and clients ultimately suffered. A contributor (HP3) summed up the tension between different forms of care provision as **"In the early stages the majority of focus/resource and energy from government and our own health board was directed to acute care which meant community staff and patients were left vulnerable. There was so much focus on protecting ITU capacity that the issues for care homes and community staff were overlooked, so that inevitable outbreaks [of COVID-19] and problems with staffing ensued."** Some social care providers found themselves redeployed to serve 'contact tracing' which left a hole in social care services, **"We were unable to use our own relief/bank staff as they had care/nursing jobs elsewhere so this posed a challenge with all residents being kept in their rooms with their only human interaction being with a diminished staff base."** (HM6, HM2)

In the face of such challenges however, as seen in the scoping review, social care services reached out to community partners and the voluntary sector and modified their services to continue to support and remain connected to their users. An example of this is provided at length by one contributor from a day centre for people with learning disabilities: **"We ensured all service users had access to the internet, access to equipment and then provided verbal and pictorial training on how to use their equipment, use the internet, and use zoom. We produced a programme of activities with various themes**

e.g., wellbeing, nature, seasons, art, photography, IT training etc. This meant all staff researched and produced resources specific to each service user, all saved on the Google drive and then this was collated, printed and delivered to each service user, weekly. We held 2-3 zoom sessions weekly so the whole group of service users and staff, came together and enjoyed quizzes, games, (Play Your Cards Right, bingo, sing and sign (Makaton), Zumba, yoga. In addition, we set up and supported smaller groups of service users to meet up on zoom and do their own games and quizzes. We formed new partnerships with organisations in our area… One provided zoom ceilidhs specifically for our organisation with various musicians performing and interacting. Another engaged in various projects which included restoring our trike, making items out of metal, puppet workshop etc. One organisation conducted various outdoor activities e.g., bracken whacking, insect studies, making items out of natural products, etc. Another partner held zoom sessions on how to use your digital camera, upload onto your device and print to make cards etc. We secured additional funding for specific projects, some mentioned above, but one was to encourage our service users, staff and our community to become more active and get out into the fresh air! We collectively walked, swam, cycled, and ran the distance of Land's End to John O Groats. This was done through attending our local leisure centre (gym and pool), walking outdoors and one service users raised money for us through cycling with her father on a tandem throughout lockdown! We provided supported outdoor walks to help our service users wellbeing and to provide some respite for their carers/families. We met all together for sessions in our local gym and swimming pool, with specific sessions for us." (HM5)

Staffing challenges

As social care providers pivoted to meet their clients' needs, persistent staffing problems in the sector were exacerbated and **"remained fragile impacting the flow from hospital/community."** (HS3)

Self isolation, **"feeling unwell as a result of not having access to non-COVID related healthcare,"** (HM3), and social care providers unable to use their bank of staff as they were deployed elsewhere, strained the services and stressed the social care providers. Additionally, their need to constantly recruit staff, which was already impacted by a need for better recognition, pay and career support compounded the problem. (HM2, HP6)

Impact of Isolation on Wellbeing

In an effort to sustain the social care workforce, wellbeing initiatives were put into place, but the need for social connection for both staff and patients was considerable. An unintended consequence of shielding and isolation for example, was that **"A lot of groups have re-established and having face to face connections but many target groups aren't coming out as readily due to a combination of loss of confidence, social anxiety, shielding and loss of fitness, so some of the barriers to community access are bigger than they were pre pandemic."** (HM6)

Continuing restrictions have also been difficult for many to understand. Judgements about health risk arising from the coronavirus were contested by community stakeholders. One contributor wrote, **"Although restrictions are easing within Scotland and the UK, they are not in our environment. There has been no consultation with services in respect of**

this and after contacting NHSH and the Care Inspectorate very recently, there are no plans by the Scottish Government to even review our situation. This is very disappointing and disheartening as there does not seem to be any light at the end of the tunnel. It is also very confusing to our service users (and staff) who, in their own lives can do many things now, but within our service are not allowed to. I understand the need to keep people safe but some of the restrictions are not logic! Communication seems to have deteriorated and I feel people with disabilities and day services have been forgotten." (HM5)

One contributor summed up the situation for social care services as follows, **"The NHS and social care feel broken, with the government and execs banging on about remobilisation and increased activity when we are still at crisis point."** (HM3)

In the next section, recommendations from community stakeholders are added to those from the scoping review authors.

Recommendations

Recommendations for social and community care provision include:

- Social care needs to be funded adequately and perhaps commissioning local care hubs to support General Practice to assist keeping patients at home safely is a concept that should be looked at. Local people helping local people may help retention – this type of model could work if supported appropriately. Community care needs to be adequately

funded and for staff to be valued and rewarded more appropriately. (HM3, HM2) (HP4)

- Continue connections with other services, staff training and financial support, including extending service contracts to 3 years or more. Workplace wellbeing initiatives should be continued. There is a need to continue working with big employers and connections in the region. (HP6) (HM5).
- Economic diversification is needed to lessen dependence on the tourism industry in rural areas (**footnotes 81, 82, 83**).
- Support small and medium sized enterprises, particularly in hospitality and tourism, to develop post- pandemic plans and to plan for renewal in a post pandemic world (**footnotes 84, 85**).
- The pandemic illustrated the vulnerability of supply chains and dependence on a small number of retail outlets during a time of intense disruption. This has led to a renewed interest in strengthening local supply chains, particularly in remote and rural areas (**footnotes 86,**).
- There are many people in communities who are willing to volunteer their time and expertise, but this requires coordination and resources. Community-based organisations are key to recovery in a post pandemic world and need ongoing support in order to identify the hardest hit and reach the appropriate people in communities who need the most support. There needs to be a longer-term commitment to funding and flexibility from funders to meet organisational needs (**footnotes 87, 88, 89**). (HP6)
- Improve support for mental health and better social spaces and activities for a more connected community during recovery – particularly for younger people, and people living by themselves to address the problem of social isolation (**footnote 90**). (HP6)
- Introduce fast and affordable broadband connectivity as well as essential training in the use of devices and navigating the online environment (**footnotes 91, 92**)

- Support is needed for the poorest so that people are not suffering from food and fuel poverty and struggling to get by on universal credit (**footnotes 93, 94, 95**).
- Improve the knowledge base about local-regional vulnerabilities and encourage strategic partnerships which deliver place-based solutions (**footnote 96**).

Conclusions

The pandemic exposed existing weaknesses in the care system. Low staffing levels – particularly in social care – became intolerable during the pandemic. The decision to prioritise the acute sector by discharging patients from hospital to community services and by appropriating staff from other health and social care sectors brought social care almost to a standstill. If it were not for the resilience and initiative of social care staff and support from community organisations, services would have collapsed. Documents in the scoping review outlined how community organisations filled gaps in care, partnering with both health and social care providers to meet the needs of community members, but these were stop-gap measures. Social and community care is in serious need of assistance and redesign to meet the needs of rural and island communities.

Chapter 6: Care Home Provision in Rural and Island Communities

In this chapter, we present evidence gathered on care home processes and provisions in rural and island communities during the COVID-19 pandemic. No documents about care homes provision in rural and island communities during the pandemic were found in the rapid scoping review. As a result, the following thematic discussions are drawn from personal communication with key community stakeholders and centred around the following topics:

- Documentation, Staffing and Transforming Care Home Processes
- Service Struggles and Resource Coordination
- Impact of Isolation on Wellbeing

Recommendations by stakeholders and conclusions are presented at the end of the chapter.

Documentation, Staffing and Transforming Care Home Processes

As discussed in the previous chapter, a whole systems approach to care was lacking, to the detriment of social care and care homes. As one stakeholder commented, **"Care homes were largely forgotten by society and this was revealed during the pandemic. People weren't aware. Provision for hospitals but not care homes. Govt needs to look across the whole spectrum for supplies, staff and procedures – better preparedness and support is required. Documents that were provided to managers for procedures were complicated and full of jargon and many people who**

work there found it difficult to understand. Language needed to be simpler and easier to follow." (HP2) Another contributor wrote, **"It may be that care homes were seen as 2nd class regarding provision of PPE with delays and training for them and more emphasis on NHS but the "whole system" needs to be in the right place, right time and treated the same way."** (HP6)

Several community stakeholders discussed the impact of ever-changing policy guidance and the uncertainty, fear and ambiguity this created. (IM2, HP7, HM2) HM2 reported that one day the guidance was updated several times, while HS3 reported, **"Huge challenges around delivery of information from Scottish Government often late on a Friday afternoon when limited wider MDT access – this was incredibly stressful for Care Home managers."** In the Islands, IM1 spoke to the stress caused by vaccination guidance and provision, saying, **"We hear things at the same time as the population, and then have a delay in vaccination order and delivery – caused stress on team and staff…Lots of changes and no advance notice…If there are changes that impact resources, need to be given advance warning and contingency plans created."**

This sense of feeling forgotten was echoed in discussion of care home processes with contributors sharing that before the pandemic they had to buy their own PPE, which was also a struggle at the beginning of the pandemic. (HP7, HP2). Additionally, there was inadequate staffing due to funding with hours allocated to cleaning insufficient to maintain the standard for infection control if a person was symptomatic as a result of overstretched staff (HP2, HS2, IM1, HM2).

While some contributors felt the processes put in place made the care homes cleaner (HP7) and safer by dividing spaces for minimal footfall and surface clearing (IM2), the removal of social

connection and insertion of severe hygiene protocols contributed to distressing levels of isolation and stress for care home residents and staff as care homes became ‘prisons’, as described by several contributors. (HS2, HM1, HP6)

Staffing shortages increased during outbreaks and while staff adapted quickly, it was clear more education was needed to assure standards, with one stakeholder stating that the appointment of a lead nurse had been a positive contribution to their organisation (HM4) and others reported recent assistance from NHS Covid teams (HP2, HS3).

The human cost of not supporting care homes was made clear by several contributors:

“Heartbreaking. Having been involved in 3 major outbreaks where many residents died, the impact on staff and families was huge. The care inspectorate made things worse by crucifying care homes that were in crisis, refusing to accept what is “good enough” and making homes jump through hoops. Similarly the health board was expected to provide staff to support the care homes when they had no staff themselves.” (HM3)

Service Struggles and Resource Coordination

As care homes struggled internally to keep up with guidance and standards, resource coordination with external partners was not always assured or adequately resourced in some areas, and yet effort was duplicated in others. (HP7) Coordinating healthcare provision to care homes could be difficult given different standard operating procedures as described by HM7, **“The service from GPs Mon to Fri 9-6 is excellent but out of hours is consistently failing nursing**

homes, waiting 50-60 mins average to get through to NHS 24, 30 mins on a call, then an ambulance who transfers the patient to hospital inappropriately then they are too ill to move back to die. NHS 24 and the ambulance services are just following flow charts and protocols but these are not always the best for some one living with advanced dementia." In many communities, GPs stepped in to support care homes through vaccine rollouts (IS1) and test provision when homes were not able to transfer or admit new patients without a test. (HP4) The use of GP telephone consultations also allowed care homes to access support faster (HP7) and Care @Home services added support to those who had family support to enable them to stay there as care homes came under pressure. (IM2) Services like Care@Home, daycare and respite care were precarious for many however, as described by one contributor, **"Focus on care homes but forgotten about respite and support services which is precarious for families. Focused on hospital and care home admissions but day care support and respite are key. Seem to have been forgotten as they keep people out of hospital and at home as long as possible."** (HM1) When patients needed to be transferred either to or from the care home, infection control processes delayed discharge and added pressure to other services. (IM1) Other residents were inappropriately transferred to hospital due to protocols and consequently died alone (HM1), leading some to believe transfers were made solely for financial reasons. (HS2)

The Impact of Isolation on Wellbeing

The combined impact of processes, staffing concerns and service struggles was ultimately isolation and the detrimental effect it had on the wellbeing of residents, staff, carers and families. Several contributors discussed the isolation rules and

visitor restrictions and the impact on resident wellbeing. We have used this report to give voice to what many contributors perceived as an inhumane policy:

“Lots of blanket decision making which was not fair or appropriate and was damaging to restrict visitors than to allow them in… Residents would not have understood the restrictions. I would live less time and have people visit me than those years in such regimens. People did not have a good quality of life during the pandemic.” (HP1)

“If there is an outbreak they are confined to their rooms and become depressed. Now even if there is an outbreak, visitors can continue to come as that is needed for their mental health. Visitor restrictions were very tough for residents – shut up in their rooms like a prison. There needed to be something different – staggered times, allowed out of their rooms. They are still made to stay in their rooms.” (HP2)

“I think there has been a huge learning curve re the physical and mental impact that isolation from family members had on both residents and their family. Not being able to be with a loved one at end of life, for people living with dementia (PlWD) there was exacerbated decline with lack social contacts, even within the care homes itself: accelerated cognitive decline, reduction in physical strength/conditioning as at times residents had to be kept in their own room: so yes for many “it must surely have felt like prison”. Must have placed an enormous demand on care staff trying to keep residents within own rooms who did not understand, needed to “walk… One of the most difficult situations was not being able to see relatives in care home, people at end of life were denied support from close family, this will leave its own legacy: feelings of guilt, anger, sadness are experienced by many people I have

contact with and personally I lost a family member whom I was not able to see in a care home for the last 2/12 of their life. She must have felt abandoned." (HP6)

"Depriving elderly people in care homes visits from their families seemed cruel. Depriving people with a learning disability day care diminished their day to day interest in life. Should there have been a different balance between safety of clients and their enjoyment of life?" (HS4).

Aiming to lessen the impact, care homes found ways to sustain connection with families for staff and residents using telephone calls, iPads and zoom (IM2, HP4). These measures still created work for staff who now had to assist with calls and ensure all documentation, testing and infection control procedures were in place when visiting resumed. (HP7, HM2) However, even at time of writing, a full service is not available to vulnerable adults in rural and island communities.

Recommendations

Contributors were asked what they would start, stop or keep with regards to care home processes. What follows below are their recommendations.

Stop

- Regimented and institutionalised environments (HS1)
- Visitor restrictions (HP3, HP4, HP6, Hs2, IM1, HM3)
- Use of bank staff from wider locations (i.e. non local) (HP4)
- Lack of management coordination and duplication of effort (IM1)
- Focus on organisations before people

- “absolute obsession with keeping covid out of every care home. People need to have a choice about how to live their lives. If they only have a few months, whether they want to risk and be with families and friends, or stay safe with covid. Stop making blanket decisions, look at individual risk and listen to what people are saying.” (HM1)
- Deprioritising care homes and opportunistic discharges (HP5)
- Sector inconsistencies (HM7)

Start

- Person, family and community centred care (HS1, HP3, HP6, HP1, HS2, HM1, IM1, HP5)
- Simplify procedures (HP7)
- Staff retention, in house training and wellbeing initiatives (HP4, HP2, HM1, HS3, HM3)
- Risk assessment and evidence based guidelines (HP4, HP6)
- Improve test result returns (HP4)
- Provide PPE as done in hospitals (HP6)
- Provide digital capabilities and champions in care homes (HP6)
- Provide nature based activities and support (HP6, HM6)
- Engage stopped services (HM1, HM2)
- Come into alignment with national guidance (HS3)
- A supportive Care Inspectorate (HM3)

Keep

- Creative care homes which supported staff and residents – share their learning and practices (HS1)
- Scrubs, appropriate uniforms and infection control standards (IM1, HP7, HP3)
- GP telephone support (HP7)
- Staff support (HM1)

Conclusions

Care homes and the services they provide, including day care and respite services, suffered greatly during the COVID-19 pandemic on all fronts. Prioritising the acute sector was perceived to have come at the expense of care homes and had devastating consequences for care home staff and residents. Inhumane policy, implemented to keep coronavirus at bay at the time, is having a negative long-term effect on staff and carer mental health.

Chapter 7: Evaluating the Evidence

This report uses two forms of evidence – documents gathered through a rapid scoping review and personal communication collected from key community stakeholders. This chapter evaluates these two forms of evidence.

Rapid Scoping Review

The rapid scoping review found 22 documents, of which seven were published research and eight were unpublished research. The rest of the documents were websites, study summaries or case studies. The nature of this document sample severely restricts our ability to draw any conclusions about the health and social care provision in rural and island communities during the pandemic. Moreover, significant areas of rural Scotland are missing from this limited evidence base; for example, we found no documents on health and social care provision in the Scottish borders, only one document included the experiences of staff, and only one document reported the experiences of trainees, representing a significant gap in knowledge about health and social care provision. Additionally, traditionally under-represented groups such as those with legally protected characteristics or who traditionally have experienced health inequalities are also missing from the evidence base. No documents about care homes in rural and island communities were found in the scoping review which, considering the impact of COVID-19, represents a serious gap in understanding people's experiences during the pandemic. There were also no documents identified regarding health and social care provision during the pandemic for people in rural areas with life-threatening conditions requiring treatment and access to the primary and acute care.

Personal Communication with Key Community Stakeholders

Contributions from key community stakeholders in rural and island communities shed some light on the gaps in the document evidence base collected through the rapid scoping review. While contributors ranged geographically from Caithness, to the west of Scotland, and as far south as Argyll and Bute, the loss of perspectives from providers from the full geographical breadth of rural Scotland and island communities limits our understandings of how health and social care provision occurred in those locations. The tight timeline of the project precluded many responses, even with an extension, as the time period fell over school breaks in the Highlands and Islands regions. Furthermore, one health board stated that their staff are unable to respond to the Inquiry, until it has been approved by their legal team and Counsel. Nonetheless, the 22 contributions collected still provide a richly textured series of experiences to guide the Inquiry.

Chapter 8: Conclusions and Recommendations

Previous chapters provide conclusions for healthcare provision, social care provision and care homes and we do not repeat them here. Instead, we draw over-arching conclusions. The evidence highlights both positive and negative experiences of care provision during the pandemic in rural and island communities.

There was a failure to grasp the negative impact of prioritizing the acute healthcare sector on other parts of the care system. A whole systems approach may not have stopped this prioritization but at least, strategic planners and managers could have mapped out the knock-on effects on other parts of the care system because they would have considered the repercussions on social services and care homes. A whole systems approach is crucial in rural and island communities where there are fewer services and possibly even one service available. When these few services are knocked out, people have no services available to them. A whole systems perspective is required at a national and local level. Indeed, local intelligence about service availability and capacity enabled communities to act quickly and address gaps in care provision.

Nonetheless, greater awareness of knock-on effects may not have been sufficient to have plugged the gaps in social care and care home provision. A lack of staff, equipment and support from senior leadership almost brought social care and care homes to a standstill. If it were not for staff resilience, initiative and the coming together of community organisations and the voluntary sector, the situation may have been far worse for these communities. Rural communities, due to small populations, cannot always address gaps in staffing. More attention needs to be paid to continuously develop community

care capacity and the care infrastructure so that communities can be quickly mobilized in crisis situations such as, pandemics. This development is required at a national, regional and local level. We visualize this as networks within networks so that resources, learning and capacity is shared.

The inhumane policy for care homes, where residents were unable to see their families, contained in their rooms 24/7 and where some residents died alone, should be acknowledged and not repeated. Risk of infection during a pandemic must be weighed against the risk of losing humanity. Balancing these risks should be decided by the nation, by local communities and within each family. The effect of these extreme circumstances has been traumatic and how this translates to poor mental health and complicated grief for individuals, families and communities at the point of writing is unclear.

The Covid Public Inquiry is not just about reflecting on the pandemic but should be a catalyst for change and a call to action.

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Appendix 1: Methodology

To understand the provision of health and social care services during the pandemic from the perspectives of different rural and island communities in Scotland, evidence was gathered from two different sources:

1. A rapid scoping review of the published and grey literature
2. Personal communication with key community stakeholders.

The rapid scoping review was conducted between February 1 and February 20, 2022. Personal communication with key community stakeholders was conducted from February 4 to February 25, 2022 inclusive.

Rapid Scoping Review

Search terms used in both academic and grey literature included: remote, rural, Scotland, Coronavirus, COVID, COVID-19, rural health, social care, health care, care homes, as well as combinations of terms. Specific searches were also conducted using island names such as Eigg, Lewis, Harris, Orkney, Shetland etc., however, these searches were often too specific and yielded no results. As a result, we chose to keep the location open and use descriptors such as ‘rural’ and ‘remote’. An information specialist from UHI searched several electronic databases including CINAHL, Embase, Medline, APA PsychInfo, SCOPUS, ProQuest Coronavirus, AMED and the Health Management Information Consortium. Grey literature was searched using advanced Google searches as well as the Social Care Online database, and the COVID-19 Research Repository housed in the NHS Public Health Directorate. Finally, lateral searches of reference lists for included studies and consultations with academic colleagues were also

conducted to gather literature sources. All initial searches were conducted between January 31 and February 8, 2022. More refined searches were conducted February 15-16, 2022 to exhaust all evidence possibilities.

Two researchers screened titles and abstracts of peer-reviewed publications and the full texts of grey literature. For the purposes of the report, all sources of evidence are referred to as a ‘document’. Peer-reviewed publications of academic research and grey literature (e.g., blogs, websites, reports, newsletters, and case studies) were included in the scoping review if the subject matter was about health and social care provision or care home processes and procedures in rural areas of Scotland. Documents were also included if they covered all areas of Scotland and if rural experiences were reported separately and could be extracted. Some documents referred to 'rural' health and social care provision in introduction/background sections but were not about or conducted in rural Scotland and were therefore excluded. Other documents were not about health and social care provision or care home processes during the pandemic and therefore excluded such as a summary blog post on a series of reports written on peripheral regions and COVID-19 (**footnote 97**).

A data extraction form was created using Microsoft Excel and recorded document details. A researcher read each included document and summarized the key points and any recommendations for health and social care provision, social care and community care, and care homes. The researchers then identified key themes across all documents.

Personal Communication

Personal communication with key community stakeholders was gathered through a call for perspectives issued by the Scottish Rural Health Partnership housed within UHI, and then researcher personal and professional networks in the region (see Appendix 3). The Scottish Rural Health Partnership is hosted by the Division of Rural Health and Wellbeing, part of the Institute of Health Research and Innovation at the University of Highlands and Islands. It is supported by funding from the Universities Innovation Fund, to provide development and administrative input to enable the partnership to grow and develop. The SRHP's aim is to provide a single source of knowledge about rural and remote healthcare, to foster collaboration, innovation and idea sharing between its educational, academic, industry, community and NHS members, and to influence and shape rural and remote healthcare policy. The partnership has 206 registered members, split over NHS and 3rd sector organisations, education, research, individuals, and industry. 89% of members are from Scotland.

Partnership administration disseminated the call for perspectives 3 times through email, twitter and LinkedIn networks over the week February 7-11, 2022.

In total, the research team received 22 contributions over both telephone and email, covering both mainland highland and island communities. Contributors ranged from clinical service providers to care home residents, organisational founders and community councillors as well as a political representative. Contributors were asked to describe their experiences of health and social care provision during the COVID-10 pandemic as well as their experiences with care home processes. They were also asked if they had any recommendations based on their

experiences for next steps or future pandemics. Contributors could respond to any questions and to the degree they preferred. Contributors chose to remain anonymous and have been assigned a code through the report, indicating their organisational role (Practitioner, Manager or Strategic) and general location (Highlands or Islands). A full table of contributor details is presented in Appendix 2.

In the course of perspective gathering, the research team received an email from NHS Western Isles informing the team that no member of their organisation would be responding to our call for perspectives and that the organisation would provide input to the Inquiry through their management team. The research team made no further attempts to contact service providers within the Western Isles from email receipt.

Two researchers read all key stakeholder contributions and summarised key points as well as any recommendations for health and social care provision and care home processes. The researchers then identified common themes across all contributions. Thematic summaries and contributor examples are reported in each chapter alongside the relevant evidence from the scoping review as far as possible.

Appendix 2: List of Key Community Stakeholder Contributions

Contributors to this project are indicated throughout the report by their geographical location (Highlands or Islands) and their organisational role (Practitioner, Manager or Strategic). A ‘practitioner’’s main role is the provision of a clinical or social service. A ‘manager’ could also be a practitioner but was also a supervisor or initiative lead within their organisation. A ‘strategic’ role could be that of an organisational founder, community leader, or community/regional representative.

‘Highlands’ could refer to a specific locale within the mainland Highlands but also denoted Highlands-wide coverage. ‘Islands’ was used to denote an Island based organisation or provider. Evidence is listed in order of receipt.

Oral/Telephone Contributions

- **Contributor:** HP5
  Care Provision: Healthcare
  Contribution Date: February 8, 2022

- **Contributor:** HS1
  Care Provision: Social Care
  Contribution Date: February 16, 2022

- **Contributor:** IM1
  Care Provision: Healthcare
  Contribution Date: February 16, 2022

- **Contributor:** IM2
  Care Provision: Care Home
  Contribution Date: February 21, 2022

- **Contributor:** HP2
  Care Provision: Care Home
  Contribution Date: February 24, 2022

- **Contributor:** HM6
  Care Provision: Social Care
  Contribution Date: February 25, 2022

Email Contributions

- **Contributor:** HE1
  Care Provision: Healthcare
  Contribution Date: February 11, 2022

- **Contributor:** HP1
  Care Provision: Healthcare
  Contribution Date: February 15, 2022

- **Contributor:** HM2
  Care Provision: Social care
  Contribution Date: February 17, 2022

- **Contributor:** HM1
  Care Provision: Care Home
  Contribution Date: February 17, 2022

- **Contributor:** HM3
  Care Provision: Healthcare
  Contribution Date: February 18, 2022

- **Contributor:** HS2
  Care Provision: N/a
  Contribution Date: February 18, 2022

- **Contributor:** HS3
  Care Provision: Social care
  Contribution Date: February 21, 2022

- **Contributor:** HS4
  Care Provision: Social care
  Contribution Date: February 22, 2022

- **Contributor:** HM5
  Care Provision: Social care
  Contribution Date: February 23, 2022

- **Contributor:** HM4
  Care Provision: Social care
  Contribution Date: February 24, 2022

- **Contributor:** HP3
  Care Provision: Healthcare
  Contribution Date: February 24, 2022

- **Contributor:** HP4
  Care Provision: Healthcare
  Contribution Date: February 25, 2022

- **Contributor:** HP6
  Care Provision: Social care
  Contribution Date: February 25, 2022

- **Contributor:** IS1
  Care Provision: Care Home
  Contribution Date: February 25, 2022

- **Contributor:** HM7
  Care Provision: Care Home
  Contribution Date: February 25, 2022

- **Contributor:** HP7
  Care Provision: Care Home
  Contribution Date: February 25, 2022

Appendix 3: Call for Perspectives/ Contributions

Covid-19 Public Inquiry – Seeking Your Perspective and Experience

On 14 December 2021, John Swinney, Deputy First Minister announced to Parliament the establishment of a statutory inquiry under the Inquiries Act 2005 to examine the handling of the COVID-19 pandemic in Scotland - **Covid Public Inquiry**.

One specific objective for the inquiry focuses on the provision of health and social care in rural areas.

The **Scottish Rural Health Partnership** (SRHP) and the **School of Health**, University of Highlands and Islands have been commissioned to investigate two aspects of handling the pandemic in rural and island communities of Scotland:

1. The provision of healthcare services, including the management and support of staff
2. The experiences in care and nursing homes: the transfer of residents to or from homes, treatment and care of residents, restrictions on visiting, infection prevention and control, and inspections

The investigating team is:

- Prof Gill Hubbard, Professor of Health Services Research, Department of Nursing and Midwifery, UHI
- Prof Sandra MacRury, Academic Lead, Scottish Rural Health Partnership
- Prof Sarah-Anne Munoz, Acting Head of Division of Rural Health and Well-being, UHI
- Dr Kirsten Broadfoot, Sterena Consultancy

Can you help?

It is important that the views and experiences of people in rural and island communities inform this Public Inquiry.

We wish to speak with health and social care service commissioners, managers, practitioners, charities, grassroots organisations and patient groups in rural and island areas of Scotland. These conversations are not formal interviews, but considered to be consultations, and to respect people's privacy, all views and opinions will be reported by the investigating team to the Scottish Parliamentary Inquiry anonymously.

If you are willing to share your views and experiences and/or know others who would, then please get in touch with Gill Hubbard by email: **gill.hubbard@uhi.ac.uk** or Kirsten Broadfoot by mobile telephone: **07769581380** or email: **kirsti@sterenasgardens.com** by **February 25, 2022.**

We wish to provide as many diverse perspectives as possible in the report, so please share this email widely amongst your networks.

We will be sending our report to the Honourable Lady Poole who has agreed to chair the Scottish COVID-19 Inquiry on 1st March 2022.

Kindest regards,

Professor Gill Hubbard

Footnotes

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