# Scottish Covid-19 Inquiry Research Commission: Final Report

## Portfolio 3: The Provision of Health and Social Care Services


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# Research Commission: Final Report

## Portfolio 3: The Provision of Health and Social Care Services

**1 March 2022**

**Anne-Maree Farrell and Rhiannon Frowde**

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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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# List of Abbreviations

AGP: Aerosol Generating Procedures
AnCP: Anticipatory Care Plans
AZ: Astra Zeneca

BAME: Black, Asian and Ethnic Minority
BIHR: British Institute of Human Rights
BMA: British Medical Association
BMI: Body Mass Index

CDIT: COVID-19 Deaths Investigation Team
CFS: Clinical Frailty Scale
CHCPs: Community Health Care Partnerships
CHIPCM: Care Home Infection Prevention and Control Manual
CHP: Community Health Partnership
CHSCP: Community Health and Social Care Partnership
CI: Care Inspectorate
CMO: Chief Medical Officer
CNRG: Scottish Government COVID-19 Nosocomial Review Group
COP: Court of Protection (England and Wales)
COSLA: Convention Of Scottish Local Authorities
CPAG: Clinical Professional and Advisory Group
CPR: Cardiopulmonary Resuscitation
CQC: Care Quality Commission
CRAG: Charging For Residential Accommodation Guidelines

DHSC: UK Department of Health and Social Care
DNACPR: Do Not Attempt Cardiopulmonary Resuscitation
DNAR: Do Not Attempt Resuscitation
DNR: Do Not Resuscitate
DWP: Department of Work and Pensions

ECHR: European Convention on Human Rights
ECS: Emergency Care Summary
ECTP: Emergency Care and Treatment Plans

FRSM: Fluid Resistant Surgical Mask

GMC: General Medical Council

HPT: Health Protection Team
HRA: Health Research Authority
HSCP: Health and Social Care Partnership

IJB: Integration Joint Board
ILF: Independent Living Fund
IPC: Infection Prevention and Control Manual
ISD: NHS Information Services Division

JCHR: Joint Committee on Human Rights
JCVI: Joint Committee on Vaccination and Immunisation

KIS: Key Information Summary

LFD: Lateral Flow Device

MCA: Mental Capacity Act 2005
MHRA: Medicines And Healthcare Regulatory Authority
mRNA: Messenger Ribonucleic Acid

NES: NHS Education for Scotland
NHS: National Health Service
NHSS: National Health Service Scotland
NICE: National Institute for Health and Care Excellence
NIPCM: National Infection Prevention and Control Manual
NRS: National Records Scotland
NSS: NHS National Services Scotland

ONS: Office for National Statistics

PHIEC: Public Health Emergency of International Concern
PHS : Public Health Scotland
PIPP: Pandemic Influenza Preparedness Programme
PPE: Personal Protective Equipment
PRIEST: Pandemic Respiratory Infection Emergency System Triage
PVS: Persistent Vegetative State

RCN: Royal College of Nursing
RCUK: Resuscitation Council UK
ReSPECT: Recommended Summary Plan for Emergency Care and Treatment

SBARs: Situation, Background, Assessment Recommendations
SDS: Self-Directed Support
SICPs: Standard Infection Control Precautions
SPICe: Scottish Parliament Information Centre
SSSC: Scottish Social Services Council

TBPs: Transmission Based Precautions
TEP: Treatment Escalation Plan

UKSC: UK Supreme Court

VHI: Voluntary Health Insurance

WHO: World Health Organization
WTE: Whole Time Equivalent

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# Part I: Executive Summary

On 14 December 2021, a public inquiry into the COVID-19 pandemic was announced by the Scottish Government. It aims to examine the strategic response to the pandemic in Scotland, identify lessons learned and make recommendations, as appropriate. The Terms of Reference (ToR) for the Inquiry were developed following a period of public engagement and covers twelve areas of investigation relevant to the strategic handling of the pandemic. The period to be examined under the ToR is 1 January 2020 to 31 December 2022, in addition to taking account of pandemic planning undertaken prior to this time.

This report presents an examination of relevant areas of investigation in relation to the provision of health and social care services as part of the strategic response to the COVID-19 pandemic in Scotland (Portfolio 3). Specifically, this covers the provision of health care services, including the management and support of staff; care and nursing homes, including the transfer of residents to or from homes, treatment and care of residents, restrictions on visiting, infection prevention and control, and inspections; and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision-making.

Matters covered in the report include key events, the main bodies and key persons involved in decision-making and implementation activities as part of the strategic response to the COVID-19 pandemic in Scotland. Such matters are examined in Parts II-V of the report, with key points from each Part summarised below. An annotated chronology of key events in relation to the COVID-19 pandemic in Scotland is also set out in Appendix A to the report.

The report has been prepared in order to assist the Inquiry with its investigations in line with its ToR, which is focused on

Scotland. Reference is made to examples of policy-making and laws from other parts of the UK and internationally, but this is done for comparison purposes only.

## Part II: The Provision of Health Care Services in Scotland

- **Devolution and health:** Scotland has moved towards a more autonomous, distinctive approach to health policy and law under current devolution arrangements, with Brexit and the COVID-19 pandemic further contributing to such an approach.

- **Scotland's health system:** Scotland operates a National Health Service (NHS), which is separate to other NHS systems in the UK. NHS Scotland directly owns hospitals, contracts with general practitioners and employs staff in a system that is centrally financed out of general taxation and is provided free at the point of service.

- **Organisation of Scotland's health system:** NHS Scotland has a range of regional and national boards. In relation to the former, there are 14 regional (territorial) health boards that are collectively responsible for managing budgets for health, wellbeing and sport. The regional boards vary in size, role, functions and governance arrangements, with some being health-only structures, and others being community health and (social) care partnerships (CHCPs/CHSCPs). There is also a range of national boards providing specialist services. Local authorities work closely with NHS health boards to facilitate delivery of community health and social care services.

- **Funding of Scotland's health system:** there is an annual block grant from the UK government to fund NHS Scotland. It consists of a baseline allocation comprising the total block grant from the previous year, plus an annual increment. What is known as the Barnett Formula determines the increment and reflects health care spending in England, while also taking account of regional differences in population and service delivery.

- **Scottish health care policy and budget allocation** is the responsibility of the Scottish Government's Health Directorates. Due to the pressures created by the COVID-19 pandemic, there has been a record level of health spending, which is based on a formula which respects the relative needs of different NHS Scotland health boards.

- **Provision of health care services:** this includes both primary and secondary care. Although the majority of such services is free at the point of need and available to those 'ordinarily resident in the UK', there is a small independent health care sector (for-profit and not-for-profit). In the past ten years, Scotland has provided basic eye tests and dental check-ups and prescriptions free of charge. Certain groups can also access a range of other services free of charge depending on age, level of income and pregnancy.

- **The Scottish health care workforce** is predominantly female, with the majority working full-time. There has been substantial recruitment of health care staff to address staffing issues due to the COVID-19 pandemic. Staff retention rates in NHS Scotland have remained relatively stable in the last five years.

- **Public health** is overseen by Public Health Scotland (PHS), which is a national health board and accountable to the Scottish Government and the Convention of Scottish Local Authorities (COSLA). PHS is responsible at a national level for public health protection and health care improvement, as well as providing services to support public health research, development, education and training. PHS cooperates with a range of NHS Scotland health boards, public sector and third sector organisations.

## Part III: The Provision of Social Care Services in Scotland

- **Adult social care** This report focuses solely on adult social care, rather than social care for children and young people. It comprises all forms of personal and practical support for adults who need extra support. This may involve services and other types of help, including care homes and supporting unpaid carers to help them continue in their caring roles. The Care Inspectorate registers and inspects social care services in Scotland.

- **Integration of health and social care** took place as a result of legislative reform in 2016. New bodies, called Integration Authorities (Integration Joint Boards), were established as part of such reform. They are responsible for ensuring that the health and social care of local populations is organised collaboratively between NHS Scotland health boards and local authorities, with services being delivered through health and social care partnerships. There is currently no national health and social care service, which is free based on need. This means that depending on their financial circumstances, individuals may be required to pay for social care support, including in care homes.

- **Funding of social care** involves both public and private provision, with the latter being funded by individual voluntary contributions. Public provision is dependent upon assessment of a person's needs based on income and assets, but such assessments may vary across different local authorities. There is a paucity of available data on how many people fund all their social care and/or receive (some) public provision. Attempts to increase access to social care support in Scotland have been constrained by public funding difficulties, against a background of rising demand and costs, inadequate staffing levels, high care costs for some people and a lack of public awareness about how social care operates.

- **Funding for care home places** is a mixture of self-funding (34%) and public provision (66%). Public funding is determined by reference to standard rates negotiated on an annual basis between COSLA, the body that represents local authorities and Scottish Care, the body that represents the majority of (private) care home providers. Some care homes require a person to pay full fees for a number of years, after which time when their assets and income have fallen below the annually set capital limit, they can stay on in the home, supported at the rate paid by the local authority. In recent years, the number of care home places has been falling. Reasons for this include the fact that some care home providers are withdrawing from the market due to a lack of funds.

- **Free personal and nursing care services** are available to adults whatever their condition, capital or income, based on an assessment of need. The assessments are done by local authorities which commissions and procures such services from a range of public, private and third sector providers. Self-directed support (SDS) has become the main organising mechanism for adult social care and support in Scotland, with

the most favoured option being the local authority selecting and making arrangements for the provision of support for the supported individual in question. Where it is provided by someone other than the authority itself, then the authority organises for payment in respect of the cost of that provision.

- **The social care workforce** is regulated by the Scottish Social Services Council (SSSC). It operates the SSSC Register, regulates social care service workers and promotes their education and training. In the year 2019-20, 83% of social care workers operated in frontline care roles; 34% of the workforce were employed by the public sector; and 11% were on zero-hours type contracts. There was a significant level of social care staffing vacancies (36%). Most of the social care workforce in Scotland is white and female, with many employed by independent nursing agencies. For the most part, they provide social care in the community, including care in the home.

- **Reform of social care** has been taking place over an extended period in Scotland. In recent times, this has involved a shift towards greater integration of health and social care, as well as attempts to increase accessibility to social care. Against a background of rising demand, the need for greater funding support, as well as insufficiency in staffing and residential care home places, remain problematic issues. Prior to the COVID-19 pandemic, the Scottish Government had embarked upon social care reform, but the pandemic highlighted significant problems with the sector. In 2021, the findings from the Feeley Review into adult social care were published, which recommended the establishment of a National Care Service in Scotland.

# Part IV: The COVID-19 Pandemic in Scotland

- **Strategic response and timeline** During the first wave of the COVID-19 pandemic between March and June 2020, there was a stronger governmental focus on supporting a UK-wide approach to the pandemic. This was exemplified in the adoption of the bespoke Coronavirus Act 2020 which was passed by the UK Parliament with the assent of the devolved legislatures. Over time, the Scottish government has pursued a more distinctive approach in line with its devolved health competence under current constitutional arrangements. The period between March 2020 and April 2021 is the key time during which the parameters were set for the strategic response by the Scottish government to the pandemic.

- **Key guidance and laws addressing risks posed by COVID-19** There was a proliferation of UK-wide and Scottish guidance and laws to address the risks posed by COVID-19, particularly during the first wave of the COVID019 pandemic between March and June 2020. Due to the rapidly changing state of knowledge and spread of the virus, the main option was to use the mechanism of guidance, which could be updated easily. Tracking successive versions of such guidance assists in understanding the evolution in thinking that took place on the part of key decision-makers in developing their strategic response to the pandemic. This is particularly so in relation to understanding the approach taken to risks faced by vulnerable groups, such as older adults in care homes, for example.

- **Impact on health and social care workforce** A range of advice and resources were developed by Scotland to assess risks posed to the healthcare workforce by the COVID-19 pandemic. This was in addition to the adoption of a framework approach, which exempted healthcare staff from self-isolation notwithstanding likely exposure to COVID-19.

This was recognised as being necessary during the first two waves of the pandemic, as NHS Scotland was operating 'in extremis' conditions. Both the health and social care workforce experienced significant difficulties in accessing (suitable) PPE, which placed them at risk of contracting COVID-19 particularly due to involvement in aerosol generating procedures. The supply of PPE for NHS Scotland staff was also extended to social care staff, where the sourcing of supplies proved difficult during the pandemic. During the first wave of the pandemic, it was found that the risk posed to frontline health and social care staff and their families was higher when compared with other working age adults. By February 2022, there have been 27 reported COVID-19 related deaths of healthcare workers and 34 involving social care workers.

- **Human rights and equality protections** Many of the parliamentary and third sector reviews undertaken to date, which examine governmental responses to the COVID-19 pandemic, have explored whether there was adherence to human rights and equality protections in policy-making and implementation activities. This is against a background where the evidence collected as part of such reviews points to certain groups being disproportionately impacted by the pandemic due to age, disability and gender. In Scotland, there have been specific calls for a human-rights based approach to any public COVID-19 Inquiry by both the Scottish Human Rights Commission and the Scottish Parliament's Equalities, Human Rights and Civil Justice Committee.

- **Managing the risks posed by COVID-19 to care home residents** The vast majority of residents in care homes are older adults, often with a range of mental and/or physical impairments. They represented a high-risk group in terms of both infection and death from COVID-19. Key findings from a literature review into this issue include the following:

1. 50% of all COVID-19 related deaths in Scotland involved care home residents during the first wave of the pandemic between March and June 2020.
2. Scotland had the highest rate of COVID-19 related deaths care residents in the UK during the first wave of the pandemic.
3. A lack of COVID-19 testing of care home residents prior to hospital discharge and transfer back to care homes contributed to seeding COVID-19 outbreaks in care homes in Scotland during the first wave of the pandemic.
4. There were prolonged periods where significant restrictions were placed on visits by family/friends to care home residents impacting their health and wellbeing, as well as potentially infringing their human rights.
5. Access to sufficient PPE proved difficult for care homes and other social care providers during the first wave of the pandemic.
6. The Care Inspectorate (CI) is the social care sector regulator, responsible for ensuring the care home sector meets national Health and Social Care Standards, as well as adheres to its quality framework. Access to data evidencing findings from CI inspections of care homes during the COVID-19 pandemic would be useful in assessing the extent to which care home providers met relevant standards and frameworks.
7. There are difficulties in obtaining clear and comprehensive data on COVID-19 deaths involving care home residents in Scotland, with such data being held by different public bodies. Accessing such data is also complicated by Operation Koper, which is investigating COVID-19 deaths in care homes and in health and social care settings.
8. There was a lack of integration of the social care sector into the strategic response to the COVID-19 pandemic, which for the most part focused on ensuring sufficient hospital and staff capacity in NHS Scotland.

# Part V: Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

- **Cardiopulmonary Resuscitation (CPR)** is a treatment that can be given when a person stops breathing, suffers respiratory or cardiac arrest. The aim of CPR is to re-start a person's breathing and heartbeat. The success of CPR may turn on whether a person had pre-existing health problems. Empirical data reveals a success rate of around 18%, which is at odds with a public perception of success, which is closer to 50%..In the event of survival, consequences can include (significant) impairment of physical and mental functions. Very few people make a full recovery following CPR.

- **Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)** means that if a person's heart beat stops, or they stop breathing, then there will be no attempt to try and restart their heart. A DNACPR decision by a person (or their legal representative) is ordinarily recorded on a special form, known as a DNACPR form, a treatment escalation plan (TEP) or a recommended summary plan for emergency care and treatment (ReSPECT).

- **Ethical principles** which should underpin DNACPR policy and practice include showing due respect for autonomy and bodily integrity, as part of upholding a person's dignity. In the healthcare context, this involves patients being provided with information and being able to make decisions about their end-of-life care. Where a person does not have capacity, then their legal representatives should be consulted in line with relevant mental capacity laws. Healthcare professionals have ethical obligations to uphold the principles of beneficence (striving to do good) and non-maleficence (do no harm) in the context of DNACPR decision-making and practice.

- **Scotland’s DNACPR policy** was originally published in 2010 but was updated in 2016 in light of the ‘Tracey’ and ‘Montgomery’ judgments, as well as changes to professional guidance. It also now incorporates a stronger human rights-based approach. The policy applies to all NHS Scotland staff and the care of adult patients in all health and social care settings within the remit of NHS Scotland. Independent care organisations and facilities are encouraged to make use of the policy for the benefit of individuals under their care. The policy should be used in conjunction with the revised NHS Scotland DNACPR form, decision-making framework and designated patient information leaflet.

- **COVID-19 pandemic and DNACPR decision-making** concerns have been expressed about the imposition of blanket or inappropriate imposition of DNACPR decisions, particularly during the first wave of the COVID-19 pandemic between March and June 2020. This is contrary to both human rights and equality legal protections. There is some evidence available that this took place, in addition to futile or inappropriate CPR attempts, difficult and delayed conversations about DNACPR decisions and the inappropriate withholding of other treatments. Unlike the rest of the UK, Scotland had a clear and coherent policy approach to DNACPR policy although further data is needed on how this was implemented in practice during the COVID-19 pandemic.

# Part II: The Provision of Health Care Services in Scotland

## Key Points

**Devolution and health:** Scotland has moved towards a more autonomous, distinctive approach to health policy and law under current devolution arrangements, with Brexit and the COVID-19 pandemic further contributing to such an approach.

**Scotland's health system:** Scotland operates a National Health Service (NHS), which is separate to other NHS systems in the UK. NHS Scotland directly owns hospitals, contracts with general practitioners and employs staff in a system that is centrally financed out of general taxation and is provided free at the point of service.

**Organisation of Scotland's health system:** NHS Scotland has a range of regional and national boards. In relation to the former, there are 14 regional (territorial) health boards that are collectively responsible for managing budgets for health, wellbeing and sport. The regional boards vary in size, role, functions and governance arrangements, with some being health-only structures, and others being community health and (social) care partnerships (CHCPs/CHSCPs). There is also a range of national boards providing specialist services. Local authorities work closely with NHS health boards to facilitate delivery of community health and social care services.

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reflects health care spending in England, while also taking account of regional differences in population and service delivery.

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**Public health** is overseen by Public Health Scotland (PHS), which is a national health board and accountable to the Scottish Government and the Convention of Scottish Local Authorities (COSLA). PHS is responsible at a national level for public health protection and health care improvement, as well as providing services to support public health research, development, education and training. PHS cooperates with a range of NHS Scotland health boards, public sector and third sector organisations.

# A. Devolution and Health

For much of the twentieth century, devolution arrangements in Scotland were characterised by increasing ‘administrative independence’, which was also reflected in the area of health (**footnote 1**). Scotland was the more advanced in terms of asserting its independence in health policy with the establishment of the Scottish Board of Health in 1919, which was subsequently replaced by the Department of Health in 1929 (**footnote 2**).

Prior to the ushering in of new devolution arrangements in the late 1990s, health policy was substantively similar across the United Kingdom’s (UK) health systems. There was a tendency to view Scottish health policy as a ‘kilted’ version of English’ (**footnote 3**). The origins of such views were to be found in the degree of centralised health policy and administrative control with the UK government, which mainly operated with England in mind. While health policy may have been ‘distinctive’ in Scotland, it was nevertheless viewed from this centralised position as being ‘distinctive at the margins.’ (**Footnote 4**)

Since the late 1990s, health has become one of the most important policy areas devolved to Scotland under current constitutional arrangements. Such competence permits a degree of autonomy to pursue an approach that was more focused on the health needs of its local populations (**footnote 5**). In the case of Scotland, there had previously been a largely administrative focus on the part of Scottish Office to adapting Westminster policy and legislation to its local separate legal and educational systems. However, with the new devolution arrangements, the Scottish Government and Parliament quickly moved towards a more autonomous, distinctive approach to policy-making and regulatory approach aided by devolved powers in areas such as health. In recent times, a combination

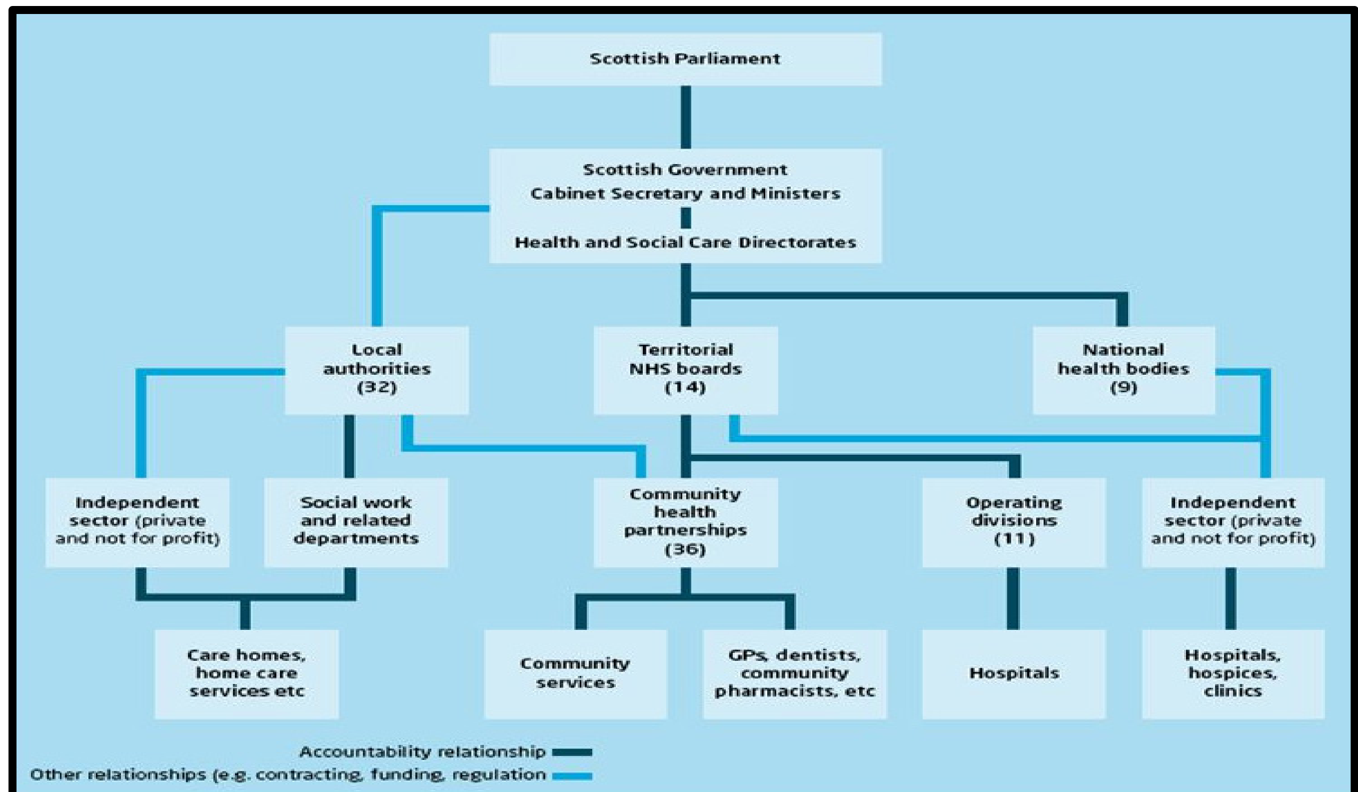
of both Brexit and the COVID-19 pandemic have further promoted such an approach (**footnote 6**).

## B. Organisation of Health Care Services

The UK’s four health systems are all National Health Service (NHS) systems, with the devolved governments directly owning hospitals, contracting with primary care practitioners and employing most other staff in a system centrally financed out of general taxation and provided for free at the point of service. Scotland’s NHS was established at the same time as the English NHS in 1948 (**footnote 7**). Similarities between the four UK health systems include a high degree of service integration, low costs, effective gatekeeping and planning (by international standards). They also share similar disadvantages such as vulnerability to underfunding, a propensity towards centralisation and regular rounds of organisational reform (**footnote 8**).

NHS Scotland is the major provider of healthcare in Scotland. It offers healthcare to all permanent residents free at the point of need, funded by general taxation. Created by the National Health Service (Scotland) Act 1947, it remains a separate body from the other public health systems in the UK. Many sections of the Act were repealed by the National Health Service (Scotland) Act 1972 and the remaining provisions were repealed by the National Health Service (Scotland) Act 1978. The framework for the integration of health and social care in Scotland is provided for by the Public Bodies (Joint Working) (Scotland) Act 2014.

## Figure 1 - Organisation of Health Care in Scotland




[Figure 1 shows a flow chart with the following information. Level 1 is at the top. There are 2 types of line linking the levels, which are labelled as either 'Accountability relationship' or 'Other relationships e.g. contracting, funding, regulation'.

**Level 1:**
Scottish Parliament
[Level 1 leads to level 2 (Accountability relationship)]

**Level 2:**
Scottish Government Cabinet Secretary and Ministers
Health and Social Care Directorates
[Level 2 leads to level 3 which is split into 3 sections. It leads to 3a (Other relationships e.g. contracting, funding, regulation); 3b (Accountability relationship) and 3c (Accountability relationship)]

**Level 3**
3a:
Local authorities (32)
[Level 3 leads to level 4 which is split into 5 sections.
3a leads to 4a (Other relationships e.g. contracting, funding, regulation); 4b (Accountability relationship) and 4c (Other relationships e.g. contracting, funding, regulation)]

3b:
Territorial NHS boards (14)
[3b leads to 4c (Accountability relationship); 4d (Accountability relationship) and 4e (Other relationships e.g. contracting, funding, regulation)]

3c:
National Health Bodies (9)
[3c leads to 4e (Other relationships e.g. contracting, funding, regulation)]

**Level 4**
4a:
Independent sector (private and not for profit)
[Level 4 leads to level 5 which is split into 5 sections.
4a leads to 5a (Accountability relationship)]

4b:
Social work and related departments
[4b leads to 5a (Accountability relationship)]

4c:
Community health partnerships (36)
[4c leads to 5b (Accountability relationship) and 5c (Accountability relationship)]

4d:
Operating divisions (11)
[4d leads to 5d (Accountability relationship)]

4e:
Independent sector (private and not for profit)
[4e leads to 5e (Accountability relationship)]

**Level 5**
5a:
Care homes, home care services etc

5b:
Community services

5c:
GPs, dentists, community pharmacists, etc

5d:
Hospitals

5e:
Hospitals, hospices, clinics

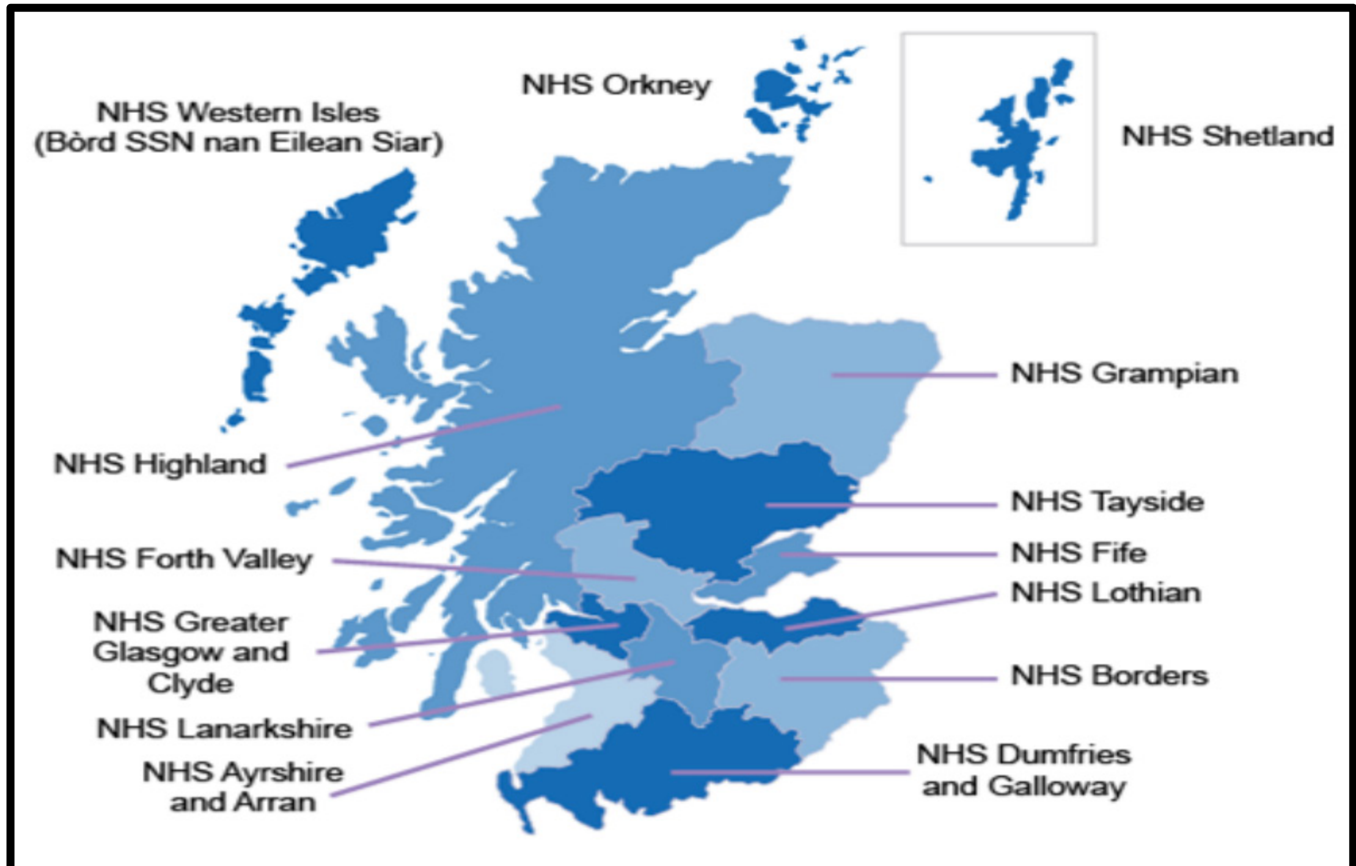
End of Figure 1]

The provision of healthcare is the responsibility of fourteen geographically based local NHS boards (which are further subdivided into Health and Social Care Partnerships (HSCP)), seven national non-geographic special health boards, and many small contractors for primary care services (**footnote 9**). Also known as 'territorial' health boards, these are responsible for the improvement of their population's health and for the delivery of frontline healthcare services. They are therefore essentially responsible for the public health of their population through the provision of health services to their regional area.

In organisational terms, NHS Scotland currently has 14 regional ('territorial') boards, and these are collectively responsible for the budget for health, wellbeing and sport. The regional boards are supported by the special boards, which provide a range of specialist and national services. The regional boards have established different arrangements across Scotland, meaning that there is variation in the size, role, function and governance arrangements of each body. The current regional health boards are as follows:

- **NHS Ayrshire and Arran** (East Ayrshire, North Ayrshire, South Ayrshire)
- **NHS Borders** (Scottish Borders)
- **NHS Dumfries and Galloway** (Dumfries and Galloway)
- **NHS Western Isles** (Outer Hebrides)
- **NHS Fife** (Fife)
- **NHS Forth Valley** (Clackmannanshire, Falkirk, Stirling)
- **NHS Grampian** (Aberdeenshire, City of Aberdeen, Moray)
- **NHS Greater Glasgow and Clyde** (City of Glasgow, East Dunbartonshire, East Renfrewshire, Inverclyde, Renfrewshire, West Dunbartonshire)
- **NHS Highland** (Highland, Argyll, Bute)
- **NHS Lanarkshire** (North Lanarkshire, South Lanarkshire)
- **NHS Lothian** (City of Edinburgh, East Lothian, Midlothian, West Lothian)
- **NHS Orkney** (Orkney Islands)
- **NHS Shetland** (Shetland Islands)
- **NHS Tayside** (Angus, City of Dundee, Perth and Kinross)

## Figure 2 – NHS Scotland Regional Health Boards




[Figure 2 shows a map of Scotland which details the geographic areas covered by the following Regional Health Boards:

- NHS Ayrshire and Arran
- NHS Lanarkshire
- NHS Greater Glasgow and Clyde
- NHS Forth Valley
- NHS Highland
- NHS Western Isles (Bòrd SSN nan Eilean Siar)
- NHS Orkney
- NHS Shetland
- NHS Grampian
- NHS Tayside
- NHS Fife
- NHS Lothian
- NHS Borders (Scottish Borders)
- NHS Dumfries and Galloway

End of Figure 2]

There are two types of health boards:

(i) **health-only structures**, which there are currently 29, known as Community Health Partnerships (CHPs);

(ii) **integrated health and social care structures**, known as community health and care partnerships (CHCPs) or community health and social care partnerships (CHSCPs). Each regional board comprises a non-executive chair, appointed by ministers after open competition, varying numbers (currently between 9 and 23) of non-executive directors (some lay, appointed by ministers after open competition; others, also appointed by ministers but as representatives of particular stakeholder interests such as the board's employees, the area clinical forum, and each of the local authorities in the board's area), and normally around six executive directors appointed by virtue of their position (e.g. Chief Executive, Medical Director, Nursing Director, Finance Director, Director of Public Health.

In contrast to the regional health boards, there are a number of boards which operate across Scotland, providing specialist services. These include:

- **Public Health Scotland:** responsible for public health (including national health protection) and, since April 2020, health education

- **Healthcare Improvement Scotland:** responsible for improving quality of health and social care including quality assurance and improvement initiatives, providing quality assurance and facilitating the best use of health and social care resources

- **Scottish Ambulance Service** provides ambulance care to patients who need support to attend appointments, as well as assistance with transport for hospital admission, transfer and discharge.

- **Golden Jubilee:** comprising a national hospital, research institute, innovation centre and conference hotel. Focuses on healthcare innovation and home to a range of specialist heart services

- **State Hospitals Board for Scotland:** responsible for the secure psychiatric hospital at Carstairs, which provides high security services for mentally disordered offenders and others who pose a high risk to themselves or others

- **NHS 24:** a telephone advice and triage service that cover the out of hours period.

- **NHS Education for Scotland:** responsible for training and the e-library

- **NHS National Services for Scotland:** Common Services Agency (CSA) which provides services and goods for the regional health boards.

There are 32 local authorities which work closely with the regional NHS Boards to ensure the effective delivery of community health and social work services (**footnote 10**). This relationship is formalised through the representation of each local health authority on the board of each relevant NHS board, through local authority membership of all CHPs and joint accountability of CHCPs and CHSCPs, and through some joint appointments (e.g. in Glasgow the Director of Public Health works for both the NHS Board and the City Council).

# C. Funding For Health Care Services

Funding for the UK’s four health systems is organised on the basis of an annual block grant to the devolved administrations, which consists of a baseline allocation, plus an annual increment. Each year the baseline consists of the total block grant from the previous year. What is known as the Barnett Formula determines the increment and reflects the change in spending in England; the extent to which the relevant English departmental programme is comparable with the services carried out by the devolved administration; and the proportion of the population in each devolved administration in relation to the appropriate one used for the UK government’s programmes (**footnote 11**).

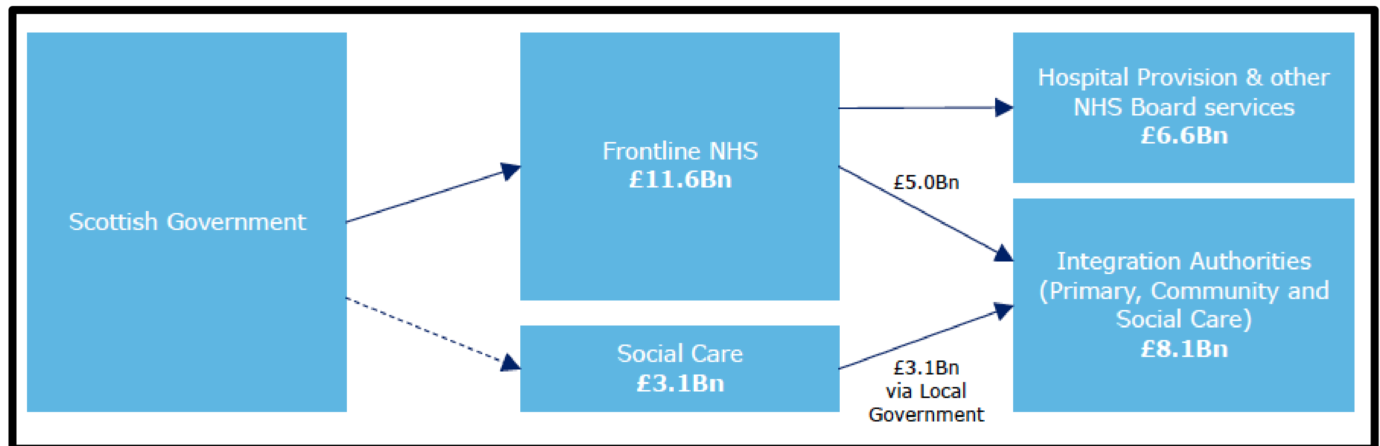
Around 83% of total health spending in the United Kingdom (separate Scottish data are not available) is publicly funded. The remainder comes from private VHI (which covers 8.5% of the population in Scotland) (**footnote 12**); user charges for dental care and ophthalmic services (prescription charges were abolished in 2011); and direct payments for dental care, ophthalmic services and private treatment in independent or NHS facilities.

Unlike in England, there is no ‘divide between purchasers of care and providers of health care.’ (**Footnote 13**). As a result, there are no contracts between boards and their operating divisions. Most primary care providers are independent contractors reimbursed for the services they provide to the NHS under the terms of their contracts. NHS boards directly employ, on a salaried basis, the staff working in hospitals and the community. They also manage, through CHPs, the contracts of independent contractors in primary care (GPs, dentists and community pharmacists).

Healthcare policy and funding is the responsibility of the Scottish Government's Health Directorates. The Health Portfolio will receive over £16 billion this year, as announced in the 2021-22 Scottish Budget (**footnote 14**), an increase of 5.3% on 2020-21 spending. In 2021-22, 'investment in the Health and Sport Portfolio will increase to over £16 billion, with a further £869 million in funding to address pressures related to COVID-19.' (**Footnote 15**). This compares to a budget of £12.9 billion in 2016/17 (**footnote 16**). Further broken down, funding for frontline NHS Boards is £11.6 billion (a record level of health spending). Allocation is based on a formula that reflects the relative needs of different geographical areas.

The 2021-22 Scottish Budget includes: £550 million capital funding for NHS Scotland, including funding for the construction of new Elective Care Centres and the Baird Family Hospital and Anchor Centre in Aberdeen; £883 million to invest in social care and integration, including funding for local authorities to deliver the Living Wage, implementation of the Carers Act and uprating of free personal care; £139 million investment in mental health services, supporting overall mental health spending of more than £1.1 billion; and £145.3 million for alcohol and drugs services, including £50 million for our national mission to reduce drug death Scotland publishes annual 'Cost Book' through the IDB with the support of the Scottish Government Health Department. This is the only source of published costs information for NHS Scotland and provides a detailed analysis of where its resources are spent (**footnote 17**). NHS financial flows are illustrated in the following diagrams (based on figures from 2016/2017) (**footnote 18**):

## Figure 3 - NHS Scotland Financial Flows




[Figure 3 shows a diagram. On the left is a box labelled 'Scottish Government'.
2 arrows go from this to 2 boxes in the centre of the diagram. A solid arrow goes to the top box labelled 'Frontline NHS £11.6Bn' and a dotted arrow goes to the bottom box labelled 'Social care £3.1Bn'.
On the right of the diagram are 2 more boxes. The top box is labelled 'Hospital Provision and other NHS Board services £6.6Bn' and the bottom box is labelled 'Integration Authorities (Primary, Community and Social care) £8.1Bn'.
Solid arrows go from the box in the centre labelled 'Frontline NHS £11.6Bn' to each of the boxes on the right. The arrow to the bottom 'Integration Authorities (Primary, Community and Social care) £8.1Bn' box is labelled '£5.0bn'.
1 arrow goes from the box in the centre labelled 'Social care £3.1Bn' to the bottom box on the right labelled 'Integration Authorities (Primary, Community and Social care) £8.1Bn'. This arrow is labelled '£3.1Bn via Local Government'.

End of Figure 3]

## D. Provision Of Health Care Services

Primary and secondary care are integrated in Scotland. Although health services are largely free at the point of need and available to all inhabitants, there is a very small independent health care sector, both private and not for profit. Comprehensive free healthcare is available to all people living in Scotland. Entitlement to health care under the NHS depends upon an individual being 'ordinarily resident in the UK'. This means that not only residents of Scotland but also residents of the other parts of the UK have access to NHS services when in Scotland. Statutory regulations govern access to treatment for "overseas visitors" (generally they are entitled to free treatment in accident and emergency departments or walk-in centres in an emergency, but any subsequent inpatient or outpatient treatment must be paid for, for various specific services such as infectious diseases and for compulsory forms of psychiatric treatment).

Since 2011, prescriptions filled in Scotland are free of charge, unlike in England. In similar contrast, eye tests and dental check-ups are also free for the entire population. Scotland is also the only one of the four countries to offer domestic personal care and nursing services for over 65s. There is no defined list of benefits. Under the NHS (Scotland) Act 1978, Scottish ministers are required to provide or secure a comprehensive and integrated health service and the overarching principle since the inception of the NHS has been that coverage should be comprehensive. In practice, this is not a promise to provide anything and everything that might be deemed to be a health service.

Most of these decisions are taken by the Scottish Government and apply in all parts of Scotland. However, individual NHS boards also make choices about the type and quantity of

services to be provided locally within their allocated budgets. This has led to some inter-area variation in the range of services provided, which at times is controversial, leading to accusations of ‘postcode rationing’ and to fears that one of the fundamental tenets of a national service is being eroded. Certain categories of the Scottish population can also access a range of free services. These include pregnant women, children, full-time students, people over 60, people with low resources or with specific medical conditions. They may also receive vouchers towards optical costs. Travel costs for hospital appointments are subsidised for people with low resources.

Like other UK heath systems, NHS Scotland, suffers problems of long waiting times to see a specialist or to receive certain treatments. When using the NHS some limitations identified include that: patients have the choice of which doctors’ surgery to register with (within the geographical/catchment area it covers), but not necessarily their choice of general practitioner; the consultation time with the general practitioner is considered too short (the average duration is ten minutes) and in general only one medical problem is treated per consultation. It is necessary to go through a general practitioner to get referrals to specialists, including gynaecologists or paediatricians. A patient cannot choose their specialist/consultant and will usually be treated by the doctor on-duty at the time of their appointment.

There is a relatively small independent (or private) healthcare sector in Scotland. This includes 7 acute medical and surgical hospitals (306 beds) offering inpatient, outpatient and day-care services ranging from routine investigations to complex surgery; 10 mental health hospitals and clinics (342 beds and 50 day-case places), providing assessment, treatment and rehabilitation for children and young people with eating disorders, people with learning disabilities, people requiring intensive psychiatric care, and people with drug and alcohol problems; 15 voluntary hospices (286 beds and 160 day-case

places) providing specialist palliative care on an inpatient, outpatient and day-care basis; 2 specialist clinics providing cosmetic and laser treatment (**footnote 19**). With the exception of hospice care, this sector is funded mainly by Voluntary Health Contributions (VHI) or paid directly by patients. Hospices have charitable status and do not charge for their services; they receive a substantial part of their funding from the NHS. The NHS also contracts to a very limited extent with the private sector for the provision of certain services to NHS patients.

Healthcare Improvement Scotland regulates independent healthcare services in Scotland. Independent clinics are defined in the National Health Service (Scotland) Act 1978 as clinics that are not part of a hospital and from which a medical practitioner, dental practitioner, registered nurse, registered midwife or dental care professional (clinical dental technician, dental hygienist, dental nurse, dental technician, dental therapist, orthodontic therapist). provides a service, which is not part of the National Health Service. The term ‘service’ includes consultations, investigations and treatments.

There is very limited data on the share of health care services provided by the public and private sectors in Scotland. Data from 2012 showed that approximately 8.5% of persons in Scotland are thought to have had some form of voluntary private health insurance as of 2012 (**footnote 20**). The number of referrals to private companies by NHS Scotland increased from almost 13,000 in 2013/4 to more than 28,000 in 2014/5 at a cost of £37 million (**footnote 21**). Overall, NHS Scotland spent £82.5m in the private sector, including service contracts, in 2014-15, according to Audit Scotland.

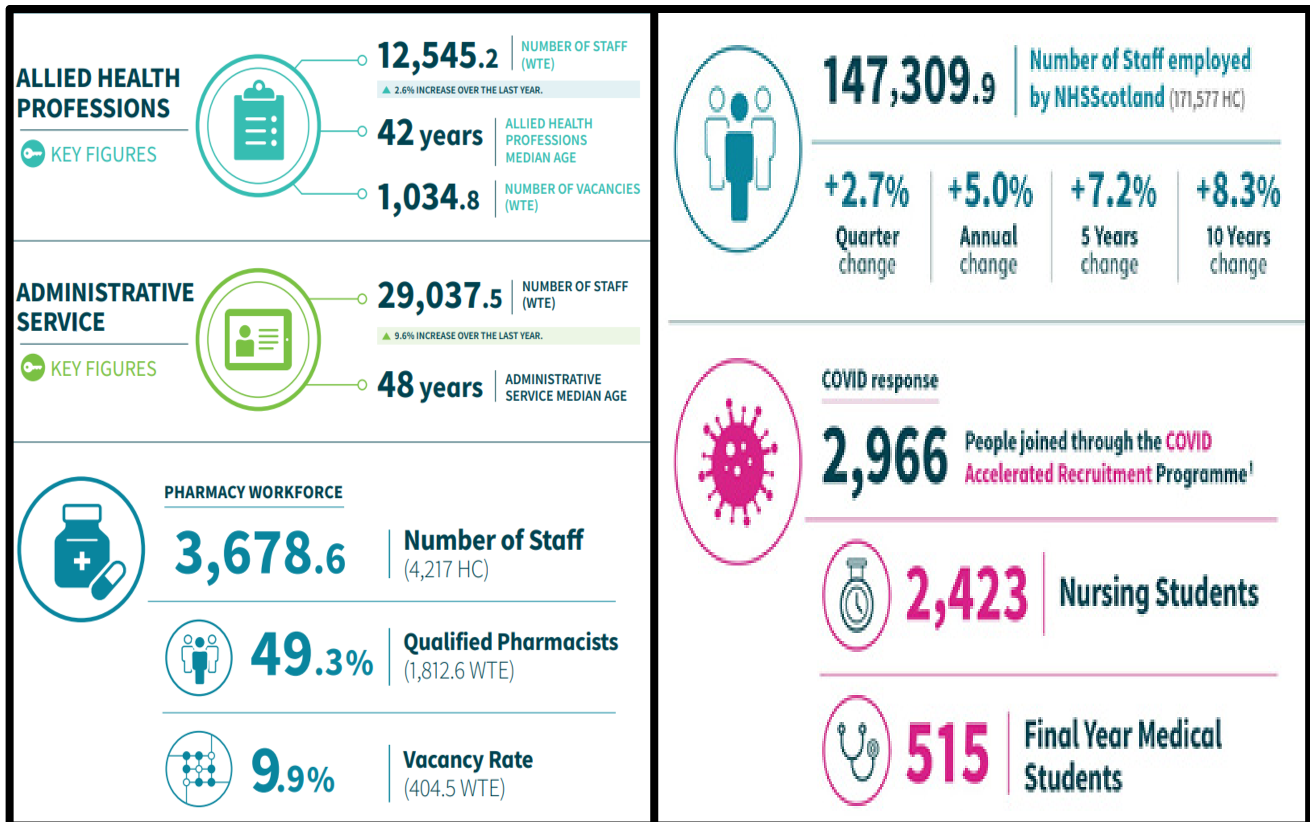
# E. Overview Of Health Care Workforce

Healthcare workforce data is published by NHS Education for Scotland (NES). Based on the latest published data for 2019/20 shows the following:

- 171,577 staff were employed by NHS Scotland, the highest reported to date and a 4.9% annual increase; the whole time equivalent (WTE) has also grown by 5.0% over the same period to 147,309.9 WTE.
- 2,966 of these staff joined the NHS workforce through the COVID accelerated recruitment programme; of these 2,423 (81.7%) were nursing students and 515 (17.3%) were final year medical students.
- The nursing and midwifery staff group is the largest in NHS Scotland, accounting for 63,178.1 WTE (42.4%) of the workforce; it has increased by 3.9% over the past year.
- There were 14,297.8 WTE medical and dental staff in post, an annual increase of 0.7%; doctors in training and consultants account for 38.7% (5,527.0) and 29.9% (4,192.8 WTE) of the medical and dental workforce, respectively.
- There were 12,196.3 WTE allied health professions in post, an annual increase of 1.1%.
- Retention: the number of staff joining and leaving NHS Scotland has remained relatively stable over the last five years, the gap between the two is gradually narrowing.
- Contract Type and Gender: 77.4% female staff as at 31 March 2019 (22.6% male).
- Equality and diversity statistics: raw data is available (**footnote 22**).

Although NES's full/latest report for 2020/21 is not yet available, the infographic below provides some further up-to-date information on the NHS Scotland workforce for 2020/21 (**footnote 23**):

## Figure 4 - NHS Scotland Workforce Statistics (2020/2021)




[Figure 4 shows an infographic giving the following information:

### Allied Health Professions

Key Figures

- 12,545.2 Number of staff (WTE) (2.6% increase over the last year)
- 42 years Allied Health Professions median age
- 1,034.8 Number of vacancies (WTE)

### Administrative Service

Key Figures

- 29,037.5 Number of staff (WTE) (9.6% increase over the last year)
- 48 years Administrative Service median age

### Pharmacy Workforce

- 3,678.6 Number of staff (4,217 HC)
- 49.3% Qualified Pharmacists (1,812.6 WTE)
- 9.9% Vacancy rate (404.5 WTE)

147,309.9 **Number of staff employed by NHSScotland**
(171,577,HC): 147, 309.9
+2.7% Quarter change
+5.0% Annual change
+7.2% 5 years change
+8.3% 10 years change

**COVID response**

- 2,966 People joined through the COVID Accelerated Recruitment Programme
- 2,423 Nursing students
- 515 Final Year Medical Students

End of figure 4]

# F. Public Health Scotland

Public Health Scotland (PHS) was established on 1 April 2020, as a result of a reorganisation of public health in Scotland (**footnote 24**). It consolidates a number of health functions into a single body, including functions and activities previously undertaken by NHS Health Scotland (a Special Health Board established under the Health Education Board for Scotland Order 1990), Health Protection Scotland and Information Services Division (both Divisions of NHS National Services Scotland (NSS)). NHS Health Scotland was dissolved, and other functions now run under PHS. As a national Health Board, PHS is jointly accountable to the Scottish Government and the Convention of Scottish Local Authorities (COSLA), which is representative body for local government in Scotland (**footnote 25**). In 2019, NHS Scotland had a budget of about £14bn per year, with approximately 156,000 staff, providing services to about 5.5m persons. Within the context of this budget, PHS had

a budget of approximately £61m (with a core budget of £35m, and additional in-year funding of about £26m) (**footnote 26**).

PHS is responsible at a national level for the public health domains of health protection and health care improvement, supported by data and intelligence functions. It is also responsible for providing services in respect of public health related research, development, training and education. The role of PHS is to increase health life expectancy and reduce premature mortality, focusing on areas such as COVID-19, mental health and well-being, community and place, and poverty and children (**footnote 27**).

The PHS has a duty to promote the improvement of the physical and mental health of the people of Scotland and engage in activities which PHS considers likely to assist in discharging that duty. The PHS carries out its duties by working collaboratively across the whole public health system - with local communities, third sector organisations, and other public sector organisations such as local health and social care partnerships, local authorities, community planning partnerships, the Scottish Fire and Rescue Service and Police Scotland to address Scotland's public health challenges which include relative poor health, significant and persistent inequalities in health outcomes, and unsustainable pressures on health and social care services.

# Part III: The Provision of Social Care Services in Scotland

## Key Points

**Adult social care** This report focuses solely on adult social care, rather than social care for children and young people. It comprises all forms of personal and practical support for adults who need extra support. This may involve services and other types of help, including care homes and supporting unpaid carers to help them continue in their caring roles. The Care Inspectorate registers and inspects social care services in Scotland.

**Integration of health and social care** took place as a result of legislative reform in 2016. New bodies, called Integration Authorities (Integration Joint Boards), were established as part of such reform. They are responsible for ensuring that the health and social care of local populations is organised collaboratively between NHS Scotland health boards and local authorities, with services being delivered through health and social care partnerships. There is currently no national health and social care service, which is free based on need. This means that depending on their financial circumstances, individuals may be required to pay for social care support, including in care homes.

**Funding of social care** involves both public and private provision, with the latter being funded by individual voluntary contributions. Public provision is dependent upon assessment of a person's needs based on income and assets, but such assessments may vary across different local authorities. There is a paucity of available data on how many people fund all their social care and/or receive (some) public provision. Attempts to

increase access to social care support in Scotland have been constrained by public funding difficulties, against a background of rising demand and costs, inadequate staffing levels, high care costs for some people and a lack of public awareness about how social care operates.

**Funding for care home places** is a mixture of self-funding (34%) and public provision (66%). Public funding is determined by reference to standard rates negotiated on an annual basis between COSLA, the body that represents local authorities and Scottish Care, the body that represents the majority of (private) care home providers. Some care homes require a person to pay full fees for a number of years, after which time when their assets and income have fallen below the annually set capital limit, they can stay on in the home, supported at the rate paid by the local authority. In recent years, the number of care home places has been falling. Reasons for this include the fact that some care home providers are withdrawing from the market due to a lack of funds.

**Free personal and nursing care services** are available to adults whatever their condition, capital or income, based on an assessment of need. The assessments are done by local authorities which commissions and procures such services from a range of public, private and third sector providers. Self-directed support (SDS) has become the main organising mechanism for adult social care and support in Scotland, with the most favoured option being the local authority selecting and making arrangements for the provision of support for the supported individual in question. Where it is provided by someone other than the authority itself, then the authority organises for payment in respect of the cost of that provision.

**The social care workforce** is regulated by the Scottish Social Services Council (SSSC). It operates the SSSC Register, regulates social care service workers and promotes their

education and training. In the year 2019-20, 83% of social care workers operated in frontline care roles; 34% of the workforce were employed by the public sector; and 11% were on zero-hours type contracts. There was a significant level of social care staffing vacancies (36%). Most of the social care workforce in Scotland is white and female, with many employed by independent nursing agencies. For the most part, they provide social care in the community, including care in the home.

**Reform of social care** has been taking place over an extended period in Scotland. In recent times, this has involved a shift towards greater integration of health and social care, as well as attempts to increase accessibility to social care. Against a background of rising demand, the need for greater funding support, as well as insufficiency in staffing and residential care home places, remain problematic issues. Prior to the COVID-19 pandemic, the Scottish Government had embarked upon social care reform, but the pandemic highlighted significant problems with the sector. In 2021, the findings from the Feeley Review into adult social care were published, which recommended the establishment of a National Care Service in Scotland.

## A. Organisation of Social Care Services

In this section, we focus solely on the provision of adult social care in Scotland, which comprises all forms of personal and practical support for adults who need extra support. It describes services and other types of help, including care homes and supporting unpaid carers to help them continue in their caring role (**footnote 28**). This is done to provide important background context to the way in which health and social care was provided to older adults, who were a high-risk group during the COVID-19 pandemic (see Parts IV and V of the report).

The provision of (health and) social care emerged from poor law legislation. What is known as the 'Old Poor Law' dates from 1574 and was the main legislation governing how those who could not afford to support themselves or their families. Between 1875 and 1929, a series of UK-wide laws were introduced, which paved the way for a system of local government to be established, which also included responsibility for public health covering matters such as infectious diseases.

The National Assistance Act 1948 contained provisions about welfare and accommodation for those in need of care and support on a UK-wide basis. Most of these legislative provisions were replaced by the Social Work (Scotland) Act 1968 and then subsequently repealed by the National Health Service (Scotland) Acts 1972 and 1978. These Acts established the separation of health and social care.

Attempts at legislating for the modern integration of health and social are to be found in the NHS and Community Care Act 1990. It was the first piece of Scottish legislation that sought to bridge the gap between health boards and local council social services. Under the Act, social care departments within local councils were given the responsibility for community care for older people. Following this Act, The National Assistance (Assessment of Resources) Regulations 1992 and the associated Charging for Residential Accommodation Guidance (CRAG) permitted, but did not mandate, local authorities to charge for the residential care they provided or arranged. This also involved setting out how care home residents' income and capital should be treated during the financial assessment of needs, which was established by the 1990 Act.

In 2016, formal legislative integration of health and social care took place through the Carers (Scotland) Act 2016, which was commenced through the Public Bodies (Joint Working) Scotland

Act 2014. New bodies, called Integration Authorities, were established and these were responsible for ensuring that health and social care of local populations was organised collaboratively by NHS Scotland health boards and local authorities, with services being delivered through health and social care partnerships. Despite this formal attempt at integration, it was not a national health and care service which was free based on need. Some persons (depending on their financial circumstances) would still be required to pay for social care support, as well as accommodation costs, if they sought to become a resident in a care home.

Strategic planning of health and social care services, commissioning of services and budgets of health boards and local authorities covering health and social care are currently the responsibility of new integration authority boards, usually referred to as an Integration Joint Board (IJB). The IJB is responsible for planning health and care services and has full power to decide how to use resources and deliver the services, delegated to them from the NHS boards and the local authorities.

The legislative context for charging for care delivered at home is largely still based on the Social Work (Scotland) Act 1968. However, charging guidance for care at home is issued annually by COSLA, which provides templates that local authorities can use to explain their charging policies. COSLA also publishes each local authority's charging policy, together with guidance to allow for an easy comparison.

The Community Care and Health (Scotland) Act 2002 introduced two key policy initiatives: the introduction of free personal and nursing care for older people, regardless of income or whether they live at home or in residential care. The Act was amended in June 2018 (The Community Care (Personal Care and Nursing Care) (Scotland) Amendment

(Regulations) 2018) when Parliament agreed to extend free personal and nursing care to adults under the age of 65, regardless of their condition.

Social care services are regulated by the Care Inspectorate, which registers and inspects care services across Scotland. Note the Health and Care (Staffing)(Scotland) Act 2019 which now requires that there should be appropriate staffing in all health and social care settings to provide safe and high-quality services, and to ensure the best health care and/or care outcomes for service users.

## B. Funding of Social Care Services

The integration of health and social care has resulted in changes as to how data on social care in Scotland is collected and published. The funding for social care comes from the monies that local authorities receive from the Scottish Government, council taxes, financial reserves and from charges they make to those receiving social care support. It used to be the case that all social care service spending was reported by local government; however, since the integration reforms in 2016 this is now the responsibility of the Integration Authorities (see above) (**footnote 29**).

Between 2011 and 2016, approximately £3.3 billion was spent on social services on a per annum basis. In 2018-19, it was reported that Integration Authorities spent £8.6 billion on social care services, of which £2.5 billion was delegated from local authority budgets, with the remainder coming from NHS Scotland health boards (**footnote 30**).

The Integrated Resource Framework shows current total net expenditure on health and social care provided by NHS health

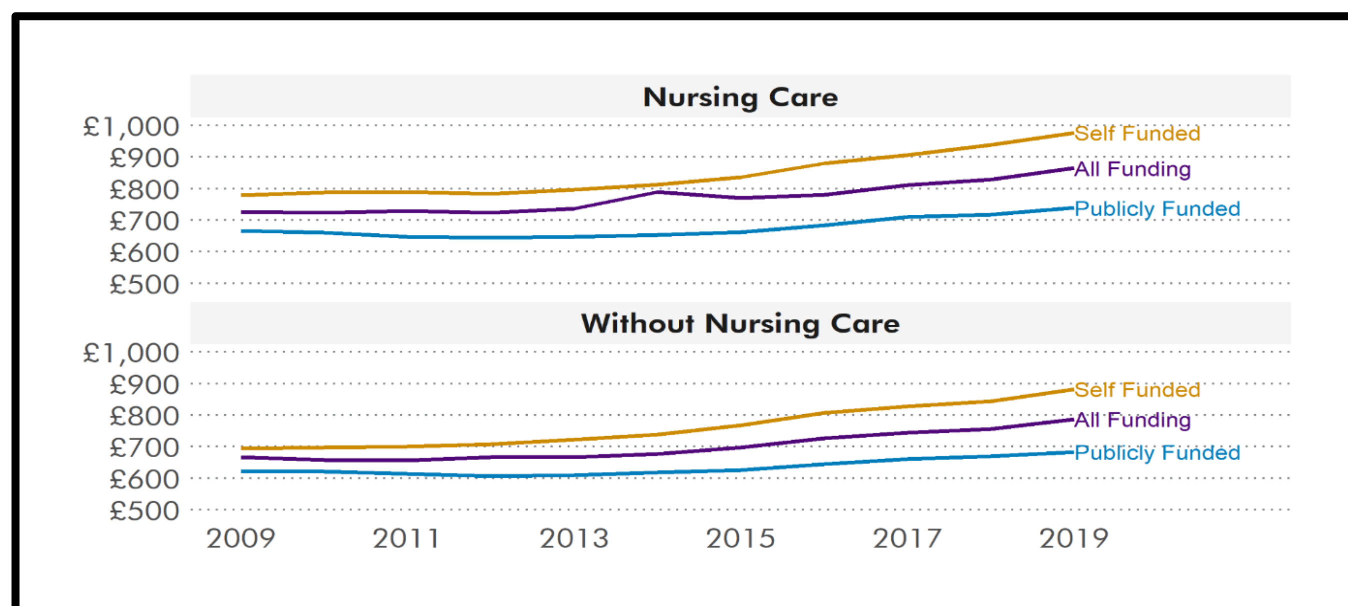
boards and at local authority level. It states that: ‘In 2017/18 there was £13.5bn of net expenditure on health (£10.4bn) and social care (£3.1bn) in Scotland.’ This amount was spread across the following areas:

- Care that is delivered in a community setting accounted for 47% (£6.3bn) of total health and social care expenditure, with the remaining 53% (£7.2bn) being provided in either a hospital or a care home.
- Of the total health and social care expenditure, 40% (£5.4bn) was spent on delivering services to people aged 65 and over, who account for 19% of the population.
- For those services delivered to people aged 65 and over, £4.1bn (76%) was spent in a health care setting and £1.3bn (24%) in a social care setting.
- Almost a third of the total expenditure (£1.6bn) that was spent within NHS Scotland for people aged 65 and over was as a result of unplanned hospital admissions.

Alongside public funding, a large part of social care funding is made through voluntary contributions by individuals towards their support and care, dependent upon assessment of needs based on their income and assets. Despite policy decisions and efforts made to increase accessibility to social care in Scotland, funding difficulties remain against a background of rising demand, rising costs, inequity, staffing, 'catastrophic care costs' for some individuals and a widespread lack of awareness among the public of how social care operates (**footnote 31**). The amount that people contribute varies widely across the country depending on a local authority's charging policy. Each year, COSLA and the Scottish Government set what are called the 'standard rates' for publicly funded residents. COSLA negotiates these standard rates with Scottish Care, the body that represents independent care providers (**footnote 32**).

In 2020, the Care Home Census found that 34% of care home places were self-funded, and the remaining 66% were publicly funded. However, data has not yet been published which provides a breakdown of contributions towards care received at home, from those who receive fully funded packages and those who pay for all the care themselves in Scotland. In the circumstances, it is not known how many people fund all of their care, where they have approached their local councils and what decisions have been made on eligibility. Data also shows that care home rates have risen considerably in recent years, although it has remained consistent that people paying for care and accommodation themselves is greater than local authorities have paid to providers, whether or not they receive nursing care (**footnote 33**).

**Figure 5 - Funding of Social Care Services (Privately and Publicly Funded)**




[Figure 5 shows 2 line graphs. They are labelled 'Nursing Care' and 'Without Nursing Care'. The x axis of each graph is labelled 2009 to 2019 in 2 year increments. The y axis of each graph is labelled £500 to £1,000 in £100 increments. Each graph has 3 lines: 'Self funded' at the top, 'All funding' in the middle and 'Publicly funded' at the bottom.

‘Nursing Care’ graph: The ‘Self Funded’ line increases gradually over time from approximately £790 to £990 in 2019. The ‘All funding’ line increases gradually over time from approximately £710 to £880 in 2019, but with a brief more rapid increase between 2013 and 2015. The ‘Publicly funded’ line increases gradually over time from approximately £680 to £730 in 2019. ‘Without Nursing Care’ graph: The ‘Self Funded’ line increases gradually over time from approximately £700 to £890 in 2019. The ‘All funding’ line increases gradually over time from approximately £680 to £790 in 2019. The ‘Publicly funded’ line starts at approximately £610, decreases gradually to approximately £600 in 2013, then increases gradually over time to approximately £690 in 2019.

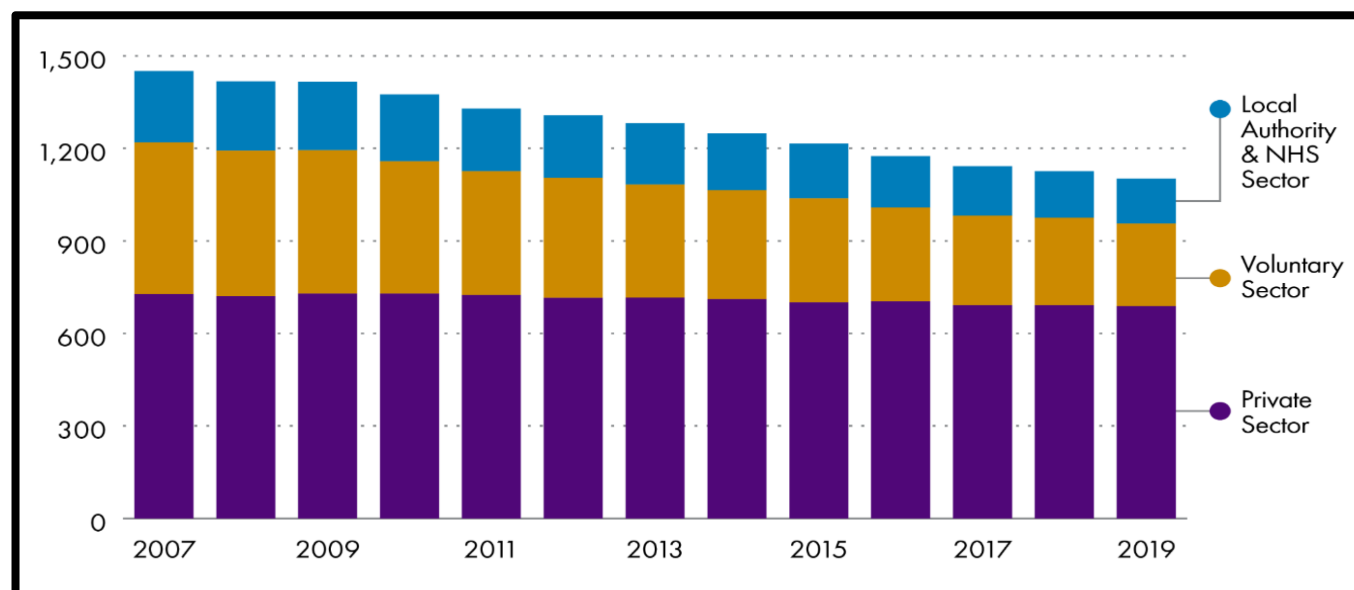
End of Figure 5]

## C. Provision of Social Care Services

**Residential care:** there are a range of providers of residential care including health and social care Partnerships, local authorities, private companies, housing associations and voluntary organisations. There are also a range of models for providing residential care and sizes of care homes from a few rooms in a domestic setting to over 50 beds in a purpose-built home. Some private homes will only take people who can pay for themselves, some will take a mixture of private and local authority funded residents. Some care homes require that a person guarantee to cover the full fees for a number of years, after which time when their assets and income have fallen below the annually set capital limit (currently £28,500), the person can stay on in the home, supported at the rate paid by the local authority. In recent years, the number of care home places has been falling. Reasons for this include the fact that some providers are withdrawing from the market as a result of insufficient funds.

The figure below shows the number of care homes over time, demonstrating a decline in the number of care homes in both the voluntary and statutory sector.

**Figure 6 - Numbers of Care Homes in Scotland (2007-2019)**



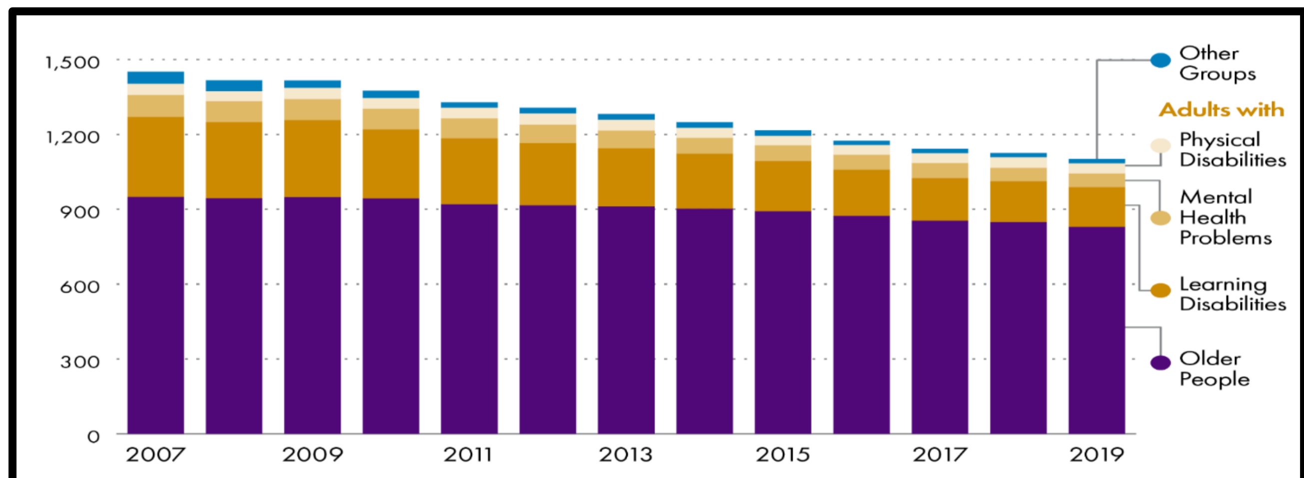

[Figure 6 shows a bar graph. The x axis is labelled 2007 to 2019 in 2 year increments. The y axis is labelled 0 to 1,500 in increments of 300. Each bar is split into 3 sections: ‘Private Sector’ at the bottom, ‘Voluntary Sector’ in the middle and ‘Local Authority and NHS Sector’ at the top. The general trends shown are as follows:

- the height of the bars reduce gradually over time from approximately 1,450 in 2007 to approximately 1,100 in 2019.
- the number of ‘Private Sector’ Care Homes remains steady.
- the number of ‘Voluntary Sector’ Care Homes reduces over time from approximately 475 in 2007 to approximately 275 in 2019.
- the number of ‘Local Authority and NHS Sector’ Care Homes reduces over time from approximately 225 in 2007 to approximately 150 in 2019.

End of Figure 6]

Moreover, the following figure demonstrates the changes in numbers of residential care home residents:

**Figure 7 - Numbers of Care Home Residents in Scotland (2007-2019)**




[Figure 7 shows a bar graph. The x axis is labelled 2007 to 2019 in yearly increments. The y axis is labelled 0 to 1,500 in increments of 300. Each bar is split into 5 sections: 'Older People' at the bottom, 'Adults with Learning Disabilities', 'Adults with Mental Health Problems' in the middle, 'Adults with Physical Disabilities' and 'Other Groups' at the top. The general trends shown are as follows:

- the height of the bars reduce gradually over time from approximately 1,450 in 2007 to approximately 1,100 in 2019.
- the number of 'Older People' Care Homes Residents reduces over time from approximately 950 in 2007 to approximately 825 in 2019.
- the number of 'Adults with Learning Disabilities' Care Homes Residents reduces over time from approximately 300 in 2007 to approximately 150 in 2019.
- the number of 'Adults with Mental Health Problems' Care Homes Residents is a small proportion and reduces slightly over time from approximately 100 in 2007 to approximately 75 in 2019.

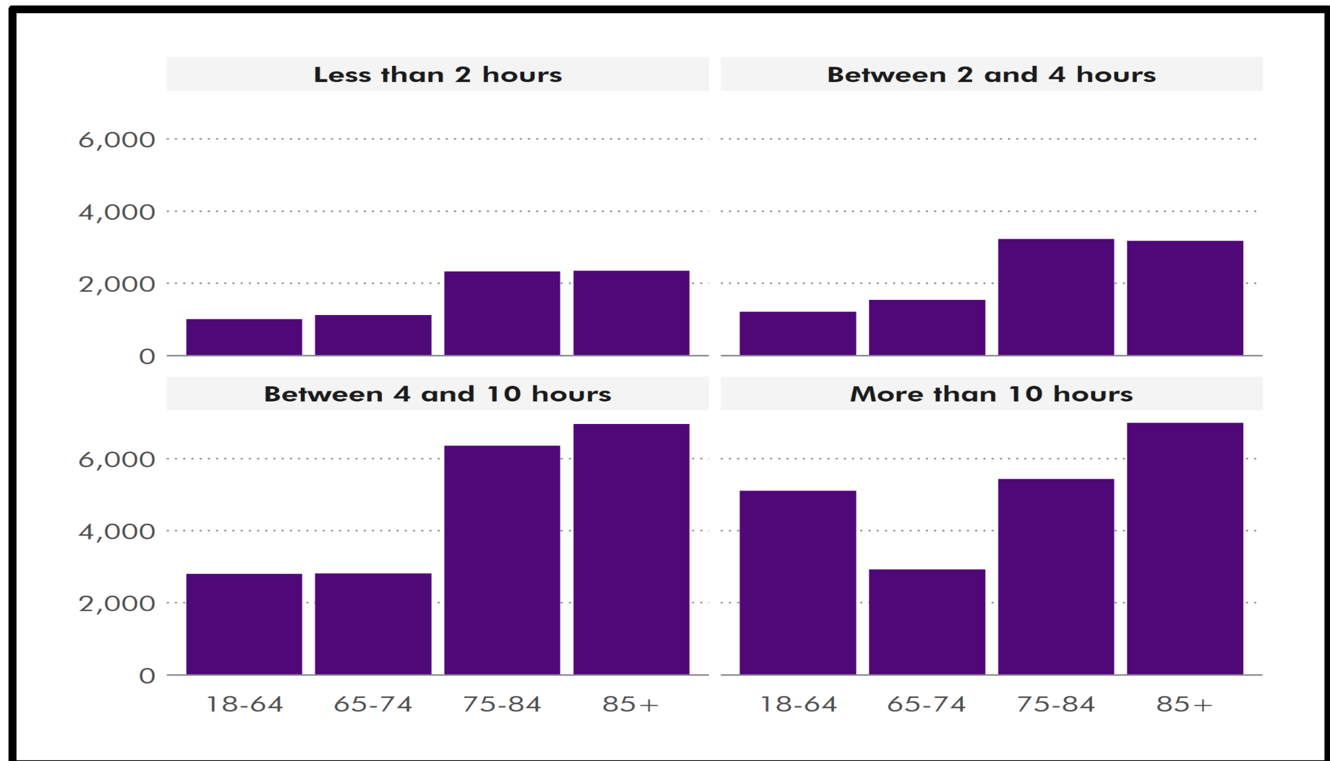
- the number of ‘Adults with Physical Disabilities’ Care Homes Residents is a small proportion of about 40 and remains steady of time.
- the number of ‘Other Groups’ Care Homes Residents is a small proportion of about 40 in 2007 and reduces over time to approximately 20 in 2019.

End of Figure 7]

**Care at home** is an umbrella term for a range of statutory and non-statutory provisions, some of which is free to all adults, such as personal and nursing care. Other services, such as cleaning, shopping, safety alarms, laundry, collecting pensions, prescriptions and help with paying bills are not covered in the definition of 'free personal care'. Local authorities can arrange or provide this type of care, but it can also be provided by private home care providers/companies, the voluntary sector, family, or personal assistants.

The following figure shows the number of people and hours of care and support provided in different age groups for care at home:

## Figure 8 - Hours of Care and Support Provided in Scottish Care Homes




[Figure 8 shows 4 bar graphs: 'Less than 2 hours', 'Between 2 and 4 hours', 'Between 4 and 10 hours' and 'More than 10 hours'. There are 4 bars on each labelled on the x axis as 18-64, 65-74, 75-84 and 85+. The y axis is labelled 0 to 6,000 in increments of 2,000. The approximate figures given are:

- Less than 2 hours:
  18-64: 1,000
  65-74: 1,100
  75-84: 2,150
  85+: 2,150
- Between 2 and 4 hours
  18-64: 1,200
  65-74: 1,500
  75-84: 3,300
  85+: 3,250

- Between 4 and 10 hours
  18-64: 2,800
  65-74: 2,800
  75-84: 6,200
  85+: 7,000
- More than 10 hours
  18-64: 5,200
  65-74: 2,800
  75-84: 5,700
  85+: 7,000

End of Figure 8]

**Housing support services** are intended to help people to live as independently as possible in the community. These services are mainly provided by local authorities, housing associations and voluntary sector organisations, while the Scottish Government is responsible for overall policy. The social care element of housing support is provided by the local authority and operates in exactly the same way, whether someone lives in social rented housing, private rented housing or if they own their own home. The type of support provided depends on the specific needs of the individual but may include assistance and support to claim welfare benefit; to fill in forms; to manage a household budget; to keep safe and secure; and to obtain specialist services to acquire furniture and furnishings and help with shopping and housework.

According to the Scottish Government's Social Tenants in Scotland Report 2017, which contains most recent available data, there were an estimated 1.14 million people living in social rented housing in 2017, which represented a decrease of around 18% from the estimated 1.49 million people living in such housing in 1999. In the social housing rental sector, 25% of adults were retired from work and 12% were chronically ill or disabled. Payment for supported housing can be managed by

local authorities, a private company, charity or housing association. Charges for the support services received as part of such housing are normally included in the rent (footnote 34).

**Accessing social care and support:** care and support is provided to all adults who are assessed as needing it, although not everyone turns to social services for this help and support. Many older people choose to organise their care privately and pay for it, however, once they have exhausted their financial assets to a certain level, they can seek an assessment of need from local authorities. In contrast, young persons will become subject to an assessment of their needs and a financial assessment when they turn 18. The legislation governing children's and adult services is different and the young person will have to transition between services governed by different policy and legislation (footnote 35). For adults aged 18 years and over, support is available through NHS services, local authorities, a wide range of third sector organisations, further education providers, housing associations and others. Financial support for those with disabilities and/or caring responsibilities is available through the social security system (see below).

**Costs for accessing social care:** while local authorities provide some or all of the funding for those they support, they do not provide all social care services. There is a mix of private, voluntary sector, not-for-profit and in-house (local authority/HSCPs) provision. Most care and support (around 70%) are provided by private providers (footnote 36). The two primary support systems are **free personal care** and **self-directed support**. In addition, there is also an allowance to support the provision of social care, including an attendance allowance and a carers allowance.

**Free personal care:** this type of care has been available in Scotland for adults aged 65 or over since 2002 (footnote 37). Since 1 April 2019, adults of any age, no matter their condition,

capital or income, who are assessed by their local authority as needing this service, are entitled to receive this, without charge. Free nursing care is similar and has been available to all who are assessed as requiring nursing care services, regardless of age. Eligibility for free personal care is identified by an assessment of need, which is carried out by a member of staff of the local authority's social work department. The cost of free personal care and nursing care is borne by the local authority, which commissions and procures the care from a range of providers: in-house, local authority provision, private providers and third sector providers.

**Self-directed support (SDS):** the Self-directed Support (Scotland) Act 2013 established a new framework, which aims to increase the choice and control individuals may exercise in how their care is organised and delivered, and by whom. Since the legislation was passed, SDS has become the main organising mechanism for child and adult social care and support in Scotland. The four options provided under the 2013 Act are as follows:

**Option 1:** The making of a direct payment by the local authority to the supported person for the provision of support.

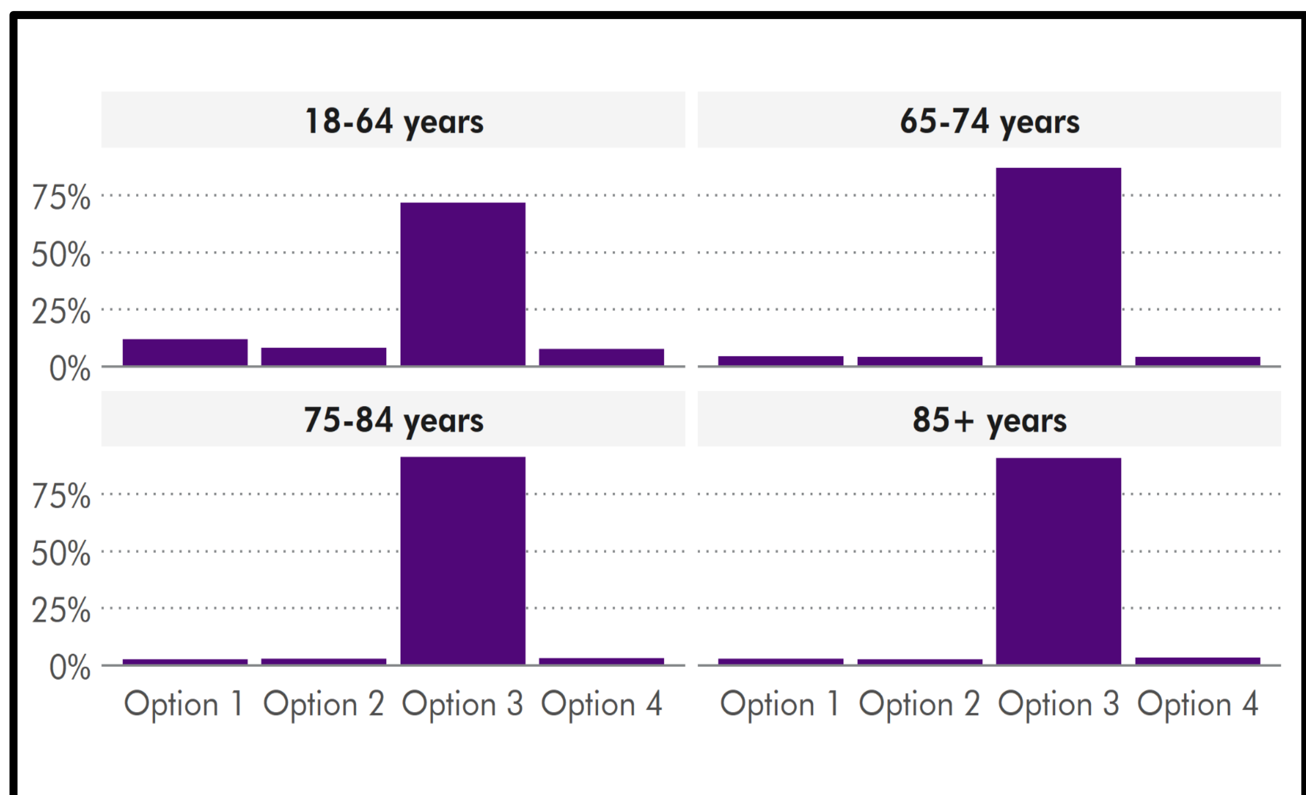
**Option 2:** The selection of support by the supported person, the making of arrangements for the provision of it by the local authority on behalf of the supported person. Where it is provided by someone other than the local authority, the payment by the authority of the relevant amount in respect of the cost of that provision.

**Option 3:** The selection of support for the supported person by the local authority, the making of arrangements for the provision of it by the authority. Where it is provided by someone other than the authority, the payment by the authority of the relevant amount in respect of the cost of that provision.

**Option 4:** The selection by the supported person of Option 1, 2 or 3 for each type of support and, where it is provided by someone other than the authority, the payment by the local authority of the relevant amount in respect of the cost of the support.

See the following figure on how persons choose to use SDS (based on SPICEe using data from NHS ISD) (**footnote 38**):

**Figure 9 - Uptake of Self-Directed Support (SDS) Options by Age Group**




[Figure 9 shows 4 bar graphs: '18-64 years', '65-74 years', '75-84 years' and '85+ years'. There are 4 bars on each labelled on the x axis as 'Option 1', 'Option 2', 'Option 3', and 'Option 4'. The y axis is labelled 0% to 75% in increments of 25%. The approximate figures given are:

- 18-64 years:
  Option 1: 10%
  Option 2: 8%
  Option 3: 73%
  Option 4: 8%

- 65-74 years
  Option 1: 5%
  Option 2: 5%
  Option 3: 85%
  Option 4: 5%

- 75-84 years
  Option 1: 2%
  Option 2: 2%
  Option 3: 90%
  Option 4: 2%

- 85+ years
  Option 1: 2%
  Option 2: 2%
  Option 3: 90%
  Option 4: 2%

End of Figure 9]

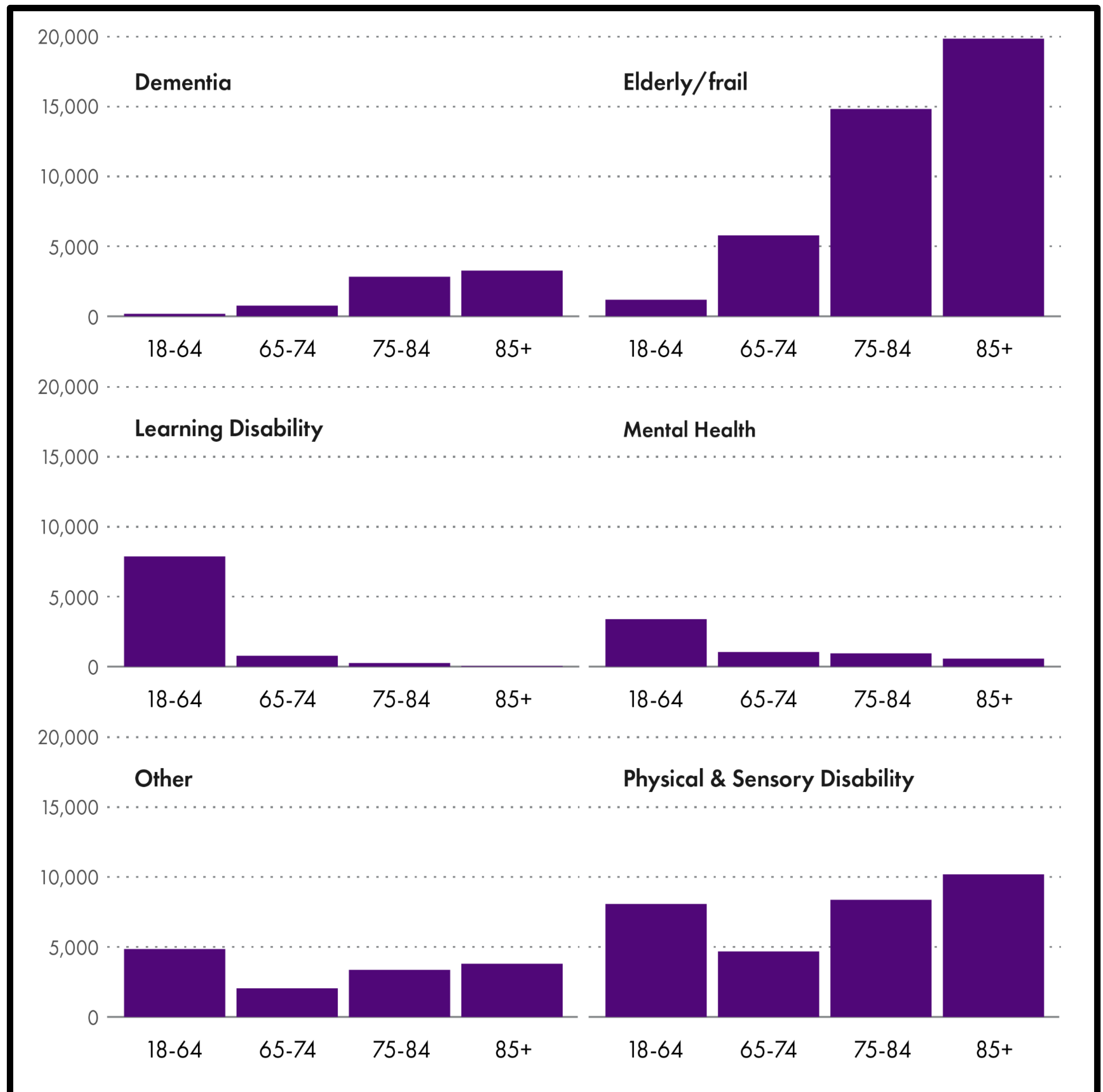
**Attendance allowance and the carers allowance:** a person who is over the age of 65 is currently entitled to an attendance allowance (not means tested, and not subject to a social work assessment), if they have care and support needs. Someone who cares for them could also be entitled to a carer's allowance, which is means tested. Both these allowances are currently administered by the UK Government. Individuals cannot usually get the attendance allowance if they live in a care home and their care is paid for by their local authority.

However, if someone self-funds all their care home costs, then they can still claim for an attendance allowance. By 2022, the attendance allowance will be replaced in Scotland by disability assistance for older people and the carer's allowance by carer's assistance (**footnote 39**).  In September 2018, the carer's allowance supplement was introduced in Scotland, which is an automated, twice-yearly payment made to those receiving a carer's allowance. This is a temporary benefit which will no longer be needed, once the transition to carer's assistance is finalised.

**Independent Living Fund (ILF)** is a discretionary national system for making payments directly to certain severely disabled people so that they can purchase their own care and support. Although originally managed as part of the national social security system through the UK Department of Work and Pensions (DWP), it now delivers support largely in a social care context. The UK-wide ILF was closed by the DWP in June 2015. Since July 2015 the Scottish Government has maintained the model for those already funded in Scotland through a new public body, known as ILF Scotland which is company limited by guarantee, accountable to the Scottish Ministers. Because social care and support is now delivered through self-directed support, the number of people receiving ILF payments is gradually reducing because they are moving into residential care or passing away.

**Demography of Social Care Use:** the following figure provides an age-related breakdown in relation to people receiving social care and support by condition:

## Figure 10 - Demography of Social Care Use in Scotland




[Figure 10 shows 6 bar graphs: ‘Dementia’, ‘Elderly/Frail’, ‘Learning Disability’, ‘Mental Health’, ‘Other’ and ‘Physical and Sensory Disability’. There are 4 bars on each labelled on the x axis as ‘18-64’, ‘65-74’, ‘75-84’, and ‘85+’. The y axis is labelled 0 to 20,000 in increments of 5,000. The approximate figures given are:

- Dementia
  18-64: 100
  65-74: 500
  75-84: 2,800
  85+: 3,000

- Elderly/Frail
  18-64: 1,000
  65-74: 6,000
  75-84: 15,000
  85+: 20,000

- Learning Disability
  18-64: 8,000
  65-74: 500
  75-84: 100
  85+: 10

- Mental Health
  18-64: 3,500
  65-74: 800
  75-84: 700
  85+: 200

- Other
  18-64: 5,000
  65-74: 2,000
  75-84: 3,500
  85+: 4,000

- Physical and Sensory Disability
  18-64: 8,000
  65-74: 4,800
  75-84: 8,500
  85+: 10,000

End of Figure 10]

# D. Overview of Social Care Workforce

Social care staff are regulated by the Scottish Social Services Council (SSSC). The SSSC liaises with the Care Inspectorate, the regulator for social care provision, as well as other partners such as Skills Development Scotland. The SSSC Register was established under the Regulation of Care (Scotland) Act 2001 to regulate social care service workers and to promote their education and training. Key headlines from the SSSC from their Annual Reports include the following (**footnote 40**):

## Figure 11 - Key Headlines from the Scottish Social Services Council (SSSC)

[Figure 11 shows an infographic giving the following information:

- 80.8% of people remained in the same post as in 2019
  as measured by the stability index
- Exclusive MHOs rose by 6.4%
  non-exclusive fell by 1.9% and cover fell by 8.6%
- 221,852 SSSC registrations
  across 23 parts of the register
- A whole-time equivalent (WTE) measure of 159,260
  an increase of 2.6% between 2019 and 2020
- 209,690 workers in the sector
  a rise of 1.6% between 2019 and 2020
- 63% of MHOs are based in specialist mental health teams
  445 MHOs work in mental health teams
- 34% of workforce employed by the public sector
  ranges from 21% to 89%by local authority area
- Increase in average weekly estimated hours worked by MHO
  from 16.0 hours in 2019 to 16.6 in 2020
- 11% of the workforce on zero-hours type contracts
  no change between 2019 and 2020
- 83% of the workforce work in frontline care roles
  this has increased by 6pp since 2011
- 36% of services reported having vacancies
  joint SSSC/Care Inspectorate publication

- Adult social care has GVA of £3.4b in Scotland productivity highest of all the UK nations

End of Figure 11]

Note: MHOs refers to Mental Health Officers; and GVA refers to 'Gross Value Added', which is the value generated by any unit engaged in the production of goods and services. GVA per head can provide a useful way of comparing regions of different sizes.

The most recent report by SSSC on Workforce Data shows demographics by age, gender and ethnicity (among others) (**footnote 41**):

## Figure 12 - Median Age of the Workforce by Sub-Sector and Employer Type (2020)

| Sub-sector | Public | Private | Voluntary | All |
|---|---|---|---|---|
| **Adoption services** | 49 | - | 51 | **49** |
| **Adult day care** | 52 | 50 | 46 | **50** |
| **Adult placement services** | 52.5 | - | 48 | **52** |
| **Care homes for adults** | 50 | 43 | 46 | **45** |
| **Central and strategic staff** | 49 | - | - | **49** |
| **Child care agencies[12]** | NA | 36.5 | 33 | **34** |
| **Childminding** | - | 48 | - | **48** |
| **Day care of children** | 40 | 29 | 37 | **36** |
| **Fieldwork service (adults)** | 49 | - | - | **49** |
| **Fieldwork service (children)** | 45 | - | - | **45** |
| **Fieldwork service (generic)** | 50 | - | - | **50** |
| **Fieldwork service (offenders)** | 48 | - | - | **48** |
| **Fostering services** | 49 | - | 47 | **48** |
| **Housing support/care at home** | 52 | 41 | 44 | **46** |
| **Nurse agencies** | - | 45 | 54.5 | **46** |
| **Offender accommodation services** | 40 | - | 45 | **44** |
| **Residential child care** | 48 | 38 | 40 | **41** |
| **School care accommodation** | 54 | - | 47 | **48** |
| **All** | **47** | **40** | **43** | **44** |

[Figure 12 shows a table with 5 columns. The information given is as follows:

Sub-sector: Adoption services
- Public: 49
- Private: -
- Voluntary: 51
- **All: 49**

Sub-sector: Adult day care
- Public: 52
- Private: 50
- Voluntary: 46
- **All: 50**

Sub-sector: Adult placement services
- Public: 52.5
- Private: -
- Voluntary: 48
- **All: 52**

Sub-sector: Care homes for adults
- Public: 50
- Private: 43
- Voluntary: 46
- **All: 45**

Sub-sector: Central and strategic staff
- Public: 49
- Private: -
- Voluntary: -
- **All: 49**

Sub-sector: Child care agencies (see note 12)
- Public: NA
- Private: 36.5
- Voluntary: 33
- **All: 34**

Sub-sector: Childminding
- Public: -
- Private: 48
- Voluntary: -
- **All: 48**

Sub-sector: Day care of children
- Public: 40
- Private: 29
- Voluntary: 37
- **All: 36**

Sub-sector: Fieldwork service (adults)
- Public: 49
- Private: -
- Voluntary:-
- **All: 49**

Sub-sector: Fieldwork service (children)
- Public: 45
- Private: -
- Voluntary: -
- **All: 45**

Sub-sector: Fieldwork service (generic)
- Public: 50
- Private: -
- Voluntary: -
- **All: 50**

Sub-sector: Fieldwork service (offenders)
- Public: 48
- Private: -
- Voluntary: -
- **All: 48**

Sub-sector: Fostering services
- Public: 49
- Private: -
- Voluntary: 47
- **All: 48**

Sub-sector: Housing support/care at home
- Public: 52
- Private: 41
- Voluntary: 44
- **All: 46**

Sub-sector: Nurse agencies
- Public: -
- Private: 45
- Voluntary: 54.5
- **All: 46**

Sub-sector: Offender accommodation services
- Public: 40
- Private: -
- Voluntary: 45
- **All: 44**

Sub-sector: Residential child care
- Public: 48
- Private: 38
- Voluntary: 40
- **All: 41**

Sub-sector: School care accommodation

- Public: 54
- Private: -
- Voluntary:47
- **All: 48**

**Sub-sector: All**

- **Public: 47**
- **Private: 40**
- **Voluntary: 43**
- **All: 44**

End of Figure 12]

## Figure 13 - Percentage of Staff by Gender and Sub-Sector (2020)

| Sub-sector | Female | Male | Other | Unknown |
|---|---|---|---|---|
| Adoption services | 88 | 12 | 0 | 0 |
| Adult day care | 77 | 23 | 0 | 0 |
| Adult placement services | 86 | 14 | 0 | 0 |
| Care homes for adults | 85 | 15 | 0 | 0 |
| Central and strategic staff | 79 | 20 | 0 | 0 |
| Child care agencies | 95 | 5 | 0 | 0 |
| Childminding | 98 | 2 | 0 | 0 |
| Day care of children | 96 | 4 | 0 | 0 |
| Fieldwork service (adults) | 81 | 19 | 0 | 0 |
| Fieldwork service (children) | 85 | 14 | 0 | 0 |
| Fieldwork service (generic) | 73 | 26 | 0 | 0 |
| Fieldwork service (offenders) | 67 | 33 | 0 | 0 |
| Fostering services | 88 | 12 | 0 | 0 |
| Housing support/care at home | 77 | 17 | 0 | 6 |
| Nurse agencies | 83 | 17 | 0 | 0 |
| Offender accommodation services | 76 | 24 | 0 | 0 |
| Residential child care | 70 | 30 | 0 | 0 |
| School care accommodation | 62 | 38 | 0 | 0 |
| **All** | **83** | **15** | **0** | **2** |

[Figure 13 shows a table with 5 columns. The information given is as follows:

Sub-sector: Adoption services
- Female: 88
- Male: 12
- Other: 0
- Unknown: 0

Sub-sector: Adult day care
- Female: 77
- Male: 23
- Other: 0
- Unknown: 0

Sub-sector: Adult placement services
- Female: 86
- Male: 14
- Other: 0
- Unknown: 0

Sub-sector: Care homes for adults
- Female: 85
- Male: 15
- Other: 0
- Unknown: 0

Sub-sector: Central and strategic staff
- Female: 79
- Male: 20
- Other: 0
- Unknown: 0

Sub-sector: Child care agencies

- Female: 95
- Male: 5
- Other: 0
- Unknown: 0

Sub-sector: Childminding

- Female: 98
- Male: 2
- Other: 0
- Unknown: 0

Sub-sector: Day care of children

- Female: 96
- Male: 4
- Other: 0
- Unknown: 0

Sub-sector: Fieldwork service (adults)

- Female: 81
- Male: 19
- Other: 0
- Unknown: 0

Sub-sector: Fieldwork service (children)

- Female: 85
- Male: 14
- Other: 0
- Unknown: 0

Sub-sector: Fieldwork service (generic)

- Female: 73
- Male: 26
- Other: 0
- Unknown: 0

Sub-sector: Fieldwork service (offenders)
- Female: 67
- Male: 33
- Other: 0
- Unknown: 0

Sub-sector: Fostering services
- Female: 88
- Male: 12
- Other: 0
- Unknown: 0

Sub-sector: Housing support/care at home
- Female: 77
- Male: 17
- Other: 0
- Unknown: 6

Sub-sector: Nurse agencies
- Female: 83
- Male: 17
- Other: 0
- Unknown: 0

Sub-sector: Offender accommodation services
- Female: 76
- Male: 24
- Other: 0
- Unknown: 0

Sub-sector: Residential child care
- Female: 70
- Male: 30
- Other: 0
- Unknown: 0

Sub-sector: School care accommodation
- Female: 62
- Male: 38
- Other: 0
- Unknown: 0

**Sub-sector: All**
- **Female: 83**
- **Male: 15**
- **Other: 0**
- **Unknown: 2**

End of Figure 13]

## Figure 14 - Percentage of Staff by Ethnic Classification and Employer Type (2020)

| Employer type | White | Mixed | Asian | Black[14] | Other | Unknown |
|---|---|---|---|---|---|---|
| Public | 76 | 0 | 1 | 0 | 0 | 23 |
| Private | 73 | 0 | 2 | 2 | 1 | 22 |
| Voluntary | 72 | 0 | 1 | 1 | 0 | 25 |
| **All** | **74** | **0** | **1** | **1** | **0** | **23** |

[Figure 14 shows a table with 7 columns. The information given is as follows:

Employer type: Public
- White: 76
- Mixed: 0
- Asian: 1
- Black (see note 14): 0
- Other: 0
- Unknown: 23

Employer type: Private
- White: 73
- Mixed: 0
- Asian: 2
- Black (see note 14): 2
- Other: 1
- Unknown: 22

Employer type: Voluntary
- White: 72
- Mixed: 0
- Asian: 1
- Black (see note 14): 1
- Other: 0
- Unknown: 25

**Employer type: All**
- **White: 74**
- **Mixed: 0**
- **Asian: 1**
- **Black (see note 14): 1**
- **Other: 0**
- **Unknown: 23**

End of Figure 14]

### Figure 15 - Percentage of Staff by Disability and Sub-Sector (2020)

| Sub-sector | No disability | Disability | Unknown |
|---|---|---|---|
| Adoption services | 86 | 1 | 12 |
| Adult day care | 88 | 3 | 9 |
| Adult placement services | 85 | 1 | 14 |
| Care homes for adults | 89 | 2 | 10 |
| Central and strategic staff | 56 | 4 | 40 |
| Child care agencies | 94 | 2 | 4 |
| Childminding | 96 | 1 | 2 |
| Day care of children | 95 | 2 | 3 |
| Fieldwork service (adults) | 52 | 4 | 44 |
| Fieldwork service (children) | 43 | 2 | 54 |
| Fieldwork service (generic) | 45 | 5 | 50 |
| Fieldwork service (offenders) | 51 | 3 | 46 |
| Fostering services | 85 | 2 | 13 |
| Housing support/care at home | 76 | 2 | 23 |
| Nurse agencies | 95 | 1 | 4 |
| Offender accommodation services | 78 | 3 | 19 |
| Residential child care | 88 | 1 | 11 |
| School care accommodation | 46 | 0 | 54 |
| **Total** | **82** | **2** | **17** |

[Figure 15 shows a table with 4 columns. The information given is as follows:

Sub-sector: Adoption services
- No disability: 86
- Disability: 1
- Unknown: 12

Sub-sector: Adult day care
- No disability: 88
- Disability: 3
- Unknown: 9

Sub-sector: Adult placement services
- No disability: 85
- Disability: 1
- Unknown: 14

Sub-sector: Care homes for adults
- No disability: 89
- Disability: 2
- Unknown: 10

Sub-sector: Central and strategic staff
- No disability: 56
- Disability: 4
- Unknown: 40

Sub-sector: Child care agencies
- No disability: 94
- Disability: 2
- Unknown: 4

Sub-sector: Childminding
- No disability: 96
- Disability: 1
- Unknown: 2

Sub-sector: Day care of children
- No disability: 95
- Disability: 2
- Unknown: 3

Sub-sector: Fieldwork service (adults)
- No disability: 52
- Disability: 4
- Unknown: 44

Sub-sector: Fieldwork service (children)
- No disability: 43
- Disability: 2
- Unknown: 54

Sub-sector: Fieldwork service (generic)
- No disability: 45
- Disability: 5
- Unknown: 50

Sub-sector: Fieldwork service (offenders)
- No disability: 51
- Disability: 3
- Unknown: 46

Sub-sector: Fostering services
- No disability: 85
- Disability: 2
- Unknown: 13

Sub-sector: Housing support/care at home
- No disability: 76
- Disability: 2
- Unknown: 23

Sub-sector: Nurse agencies
- No disability: 95
- Disability: 1
- Unknown: 4

Sub-sector: Offender accommodation services
- No disability: 78
- Disability: 3
- Unknown: 19

Sub-sector: Residential child care
- No disability: 88
- Disability: 1
- Unknown: 11

Sub-sector: School care accommodation

- No disability: 46
- Disability: 0
- Unknown: 54

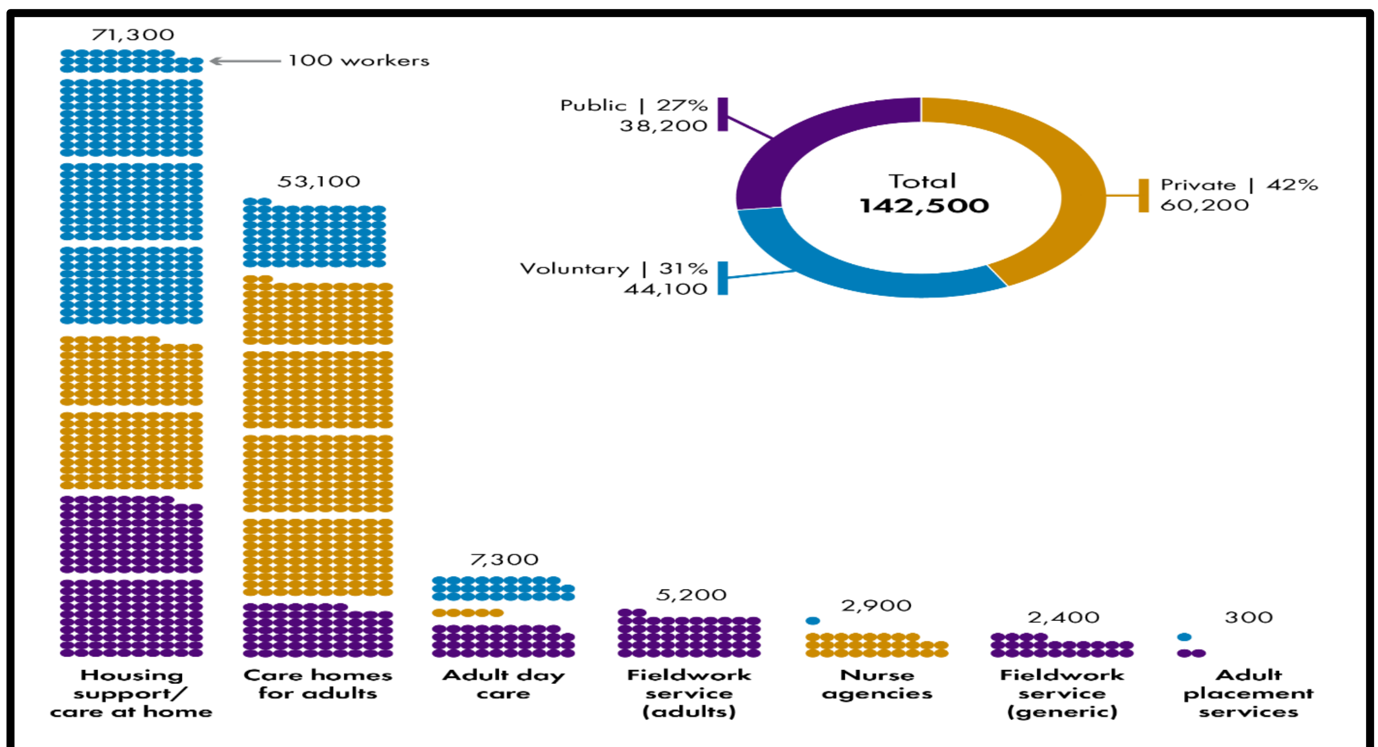
**Sub-sector: All**

- **No disability: 82**
- **Disability: 2**
- **Unknown: 17**

End of Figure 15]

The figure below provides data and information on staffing in social care and support, demonstrating the number of staff employed in different aspects of social care in 2019, based on SPICe using data from SSSC workforce data (2019):

**Figure 16 - Numbers of Staff Employed in Different Aspects of Social Care (2019)**



[Figure 16 shows a diagram giving the following information:

**Total: 142,500**
- Public: 27% 38,200
- Private: 42% 60,200
- Voluntary: 31% 44,100

Housing support/care at home: 71,300 workers
- Public: 19,800
- Private: 18,700
- Voluntary: 32,800

Care homes for adults: 53,100 workers
- Public: 6,700
- Private: 38,200
- Voluntary: 8,200

Adult day care: 7,300 workers
- Public: 3,900
- Private: 500
- Voluntary: 2,900

Fieldwork service (adults): 5,200 workers
- Public: 5,200
- Private: 0
- Voluntary: 0

Nurse agencies: 2,900 workers
- Public: 0
- Private: 2,800
- Voluntary: 100

Fieldwork service (generic): 2,400
- Public: 2,400
- Private: 0
- Voluntary: 0

Adult placement services: 300

- Public: 200
- Private: 0
- Voluntary: 100

End of Figure 16]

## E. Reform of Social Care

On 12 June 2019, the Scottish Government launched a national reform programme for social care (**footnote 42**). The priorities included implementing reforms to invest in social care support, changing attitudes towards such support, and achieving a 'shared agreement' on social care support with an emphasis on human rights (**footnote 43**). This was accompanied by a vision statement for the future of adult social care (**footnote 44**).

In September 2020, the Scottish Government announced a review of social care, as the impact of the COVID-19 pandemic had made it 'clear' that 'we needed to do things better in [the] future.' (**Footnote 45**) The pandemic had seen the introduction of emergency legislation which relieved local authorities of the duty to carry out full assessments of need and to consult the person or the family in advance of arranging care. However, if they did not carry out a full assessment, they could not charge for support provided until a full assessment was completed. Alongside these developments, testing capacity was not adequate to carry out testing in any widespread or consistent way to protect care home residents from incoming infection, and reliance was put on the use of Personal Protection Equipment (PPE) and infection control measures to protect staff and residents. However, PPE was not always available, especially during the early stages of the pandemic (**footnote 46**). As a result, social care providers were provided with

access to local NHS Scotland PPE hubs for emergency PPE supplies, if their existing supply routes failed. This support was also made available to all social care providers, including unpaid carers and personal assistants (**footnote 47**).

During the period 2016-2020, Audit Scotland published a number of outputs examining aspects of adult social care, which was underpinned by a recognition of the impact of policy and structural innovation that been involved in health and social care integration (**footnote 48**). In a briefing provided to the Scottish Parliament's Public Audit Committee in 2019, it recognised that the greatest issue impacting social care reform was how best to secure additional funding resources, referred to as 'catastrophic costs'. This was because many people still had to pay for their own social care, with those with significant care and support needs paying large sums in excess of £100,000 (**footnote 49**).

In 2018, the Scottish Parliament's Health and Sport Committee hosted an event, Scotland 2030: A Sustainable Future for Social Care for Older People (**footnote 50**), in collaboration with Scotland's Futures Forum, to consider the future of social care for older adults in Scotland. The event produced a report, finding the future challenges for social care were the rising number of patients requiring substantial care, that care is becoming more complex, the prevalence of those with a range of diseases is increasing, requiring staff to have more training, and the need for more flexible working (**footnote 51**).

On 3 February 2021, the Feeley Review's report was published, which provided a comprehensive overview of adult social care in Scotland. The report recognised that current structures for adult social care had not fully delivered on the objective of facilitating integration of health and social care to date. It was recommended that a new National Care Service be created, with Scottish Ministers being accountable for adult social care

support. In the same month, the Scottish Parliament's Health and Sport Committee also published a report into the Future of Social Care and Support in Scotland (**footnote 52**). In August 2021, the Scottish Government published details of a consultation process which set out its proposals to improve the way in which social care is delivered in Scotland, following the recommendations of the Feeley Review (**footnote 53**).

On 12 October 2021, the Scottish Parliament's Health and Sport Committee published a report examining lessons to be learned from the COVID-19 pandemic (**footnote 54**). The report highlighted, among other issues, that social care had not been given sufficient priority in the early stages of the pandemic. In turn, this had a significant impact on social care services, including how people received their care. The Committee noted that it had received many reports showing how local communities became the focus of social care support and how the sluggish progress of integration had suddenly accelerated and changes thought too difficult were quickly implemented by local partnerships between public bodies, as well as between public bodies and the third sector.

# Part IV: The Covid-19 Pandemic in Scotland

## Key Points

**Strategic response and timeline** During the first wave of the COVID-19 pandemic between March and June 2020, there was a stronger governmental focus on supporting a UK-wide approach to the pandemic. This was exemplified in the adoption of the bespoke Coronavirus Act 2020 which was passed by the UK Parliament with the assent of the devolved legislatures. Over time, the Scottish government has pursued a more distinctive approach in line with its devolved health competence under current constitutional arrangements. The period between March 2020 and April 2021 is the key time during which the parameters were set for the strategic response by the Scottish government to the pandemic.

**Key guidance and laws addressing risks posed by COVID-19** There was a proliferation of UK-wide and Scottish guidance and laws to address the risks posed by COVID-19, particularly during the first wave of the COVID-19 pandemic between March and June 2020. Due to the rapidly changing state of knowledge and spread of the virus, the main option was to use the mechanism of guidance, which could be updated easily. Tracking successive versions of such guidance assists in understanding the evolution in thinking that took place on the part of key decision-makers in developing their strategic response to the pandemic. This is particularly so in relation to understanding the approach taken to risks faced by vulnerable groups, such as older adults in care homes, for example.

**Impact on health and social care workforce** A range of advice and resources were developed by Scotland to assess

risks posed to the healthcare workforce by the COVID-19 pandemic. This was in addition to the adoption of a framework approach, which exempted healthcare staff from self-isolation notwithstanding likely exposure to COVID-19. This was recognised as being necessary during the first two waves of the pandemic, as NHS Scotland was operating ‘in extremis’ conditions. Both the health and social care workforce experienced significant difficulties in accessing (suitable) PPE, which placed them at risk of contracting COVID-19 particularly due to involvement in aerosol generating procedures. The supply of PPE for NHS Scotland staff was also extended to social care staff, where the sourcing of supplies proved difficult during the pandemic. During the first wave of the pandemic, it was found that the risk posed to frontline health and social care staff and their families was higher when compared with other working age adults. By February 2022, there have been 27 reported COVID-19 related deaths of healthcare workers and 34 involving social care workers.

**Human rights and equality protections** Many of the parliamentary and third sector reviews undertaken to date, which examine governmental responses to the COVID-19 pandemic, have explored whether there was adherence to human rights and equality protections in policy-making and implementation activities. This is against a background where the evidence collected as part of such reviews points to certain groups being disproportionately impacted by the pandemic due to age, disability and gender. In Scotland, there have been specific calls for a human-rights based approach to any public COVID-19 Inquiry by both the Scottish Human Rights Commission and the Scottish Parliament’s Equalities, Human Rights and Civil Justice Committee.

## Managing the risks posed by COVID-19 to care home residents

The vast majority of residents in care homes are older adults, often with a range of mental and/or physical impairments. They represented a high-risk group in terms of both infection and death from COVID-19. Key findings from a literature review into this issue include the following:

1. 50% of all COVID-19 related deaths in Scotland involved care home residents during the first wave of the pandemic between March and June 2020.

2. Scotland had the highest rate of COVID-19 related deaths care residents in the UK during the first wave of the pandemic.

3. A lack of COVID-19 testing of care home residents prior to hospital discharge and transfer back to care homes contributed to seeding COVID-19 outbreaks in care homes in Scotland during the first wave of the pandemic.

4. There were prolonged periods where significant restrictions were placed on visits by family/friends to care home residents impacting their health and wellbeing, as well as potentially infringing their human rights.

5. Access to sufficient PPE proved difficult for care homes and other social care providers during the first wave of the pandemic.

6. The Care Inspectorate (CI) is the social care sector regulator, responsible for ensuring the care home sector meets national Health and Social Care Standards, as well as adheres to its quality framework. Access to data evidencing findings from CI

inspections of care homes during the COVID-19 pandemic would be useful in assessing the extent to which care home providers met relevant standards and frameworks.

7. There are difficulties in obtaining clear and comprehensive data on COVID-19 deaths involving care home residents in Scotland, with such data being held by different public bodies. Accessing such data is also complicated by Operation Koper, which is investigating COVID-19 deaths in care homes and in health and social care settings.

8. There was a lack of integration of the social care sector into the strategic response to the COVID-19 pandemic, which for the most part focused on ensuring sufficient hospital and staff capacity in NHS Scotland.

## A. Overview

On 31 December 2019, the World Health Organization (WHO) was informed that a number of cases of pneumonia of unknown origin had been identified in the city of Wuhan in China (**footnote 55**). It soon became apparent that a coronavirus – which causes respiratory illness in human beings – was likely to be implicated. Within a few weeks, cases of human-to-human transmission were increasing exponentially within and across borders. At the end of January 2020, the WHO declared a Public Health Emergency of International Concern (PHEIC) pursuant to the International Health Regulations (**footnote 56**). This facilitated an internationally coordinated response to what became known as COVID-19, which was attributable to a new coronavirus, SARS-CoV-2. On 11 March 2020, the WHO declared COVID-19 to be a global pandemic (**footnote 57**).

In the UK, the first cases of COVID-19 were reported at the end of January and involved visitors to England (**footnote 58**). The first case of a person contracting COVID-19 within the UK occurred at the end of February (**footnote 59**). As the risk grew, an initial set of Health Protection Regulations were adopted to enable action to be taken by the UK government to minimise the spread of COVID-19 in the population (**footnote 60**). At the same time, the government and their scientific advisors continued to support what was described as a 'herd immunity' approach to managing the disease. This involved allowing the virus to spread naturally through the British population in order to build up population immunity (**footnote 61**).

On 3 March 2020, the UK government published a Coronavirus Action Plan. It stated that the 'The UK government and the devolved administrations have been planning an initial response based on information available at the time, in a context of uncertainty, that can be scaled up and down in response to new information to ensure a flexible and proportionate response.' While noting that the emergence of COVID-19 represented a 'significant challenge for the entire world. The UK government and devolved administrations, including the health and social care system, have planned extensively over the years for an event like this. The UK is therefore well prepared to respond in a way that offers substantial protection to the public.' (**Footnote 62**)

The fundamental objectives that were to guide the plan could be summed up as 'Contain, Delay, and Mitigate any outbreak, using Research to inform policy development'. This would involve the following: (i) contain: detect early cases, follow up close contacts, and prevent the disease taking hold in this country for as long as is reasonably possible; (ii) delay: slow the spread in this country, if it does take hold, lowering the peak impact and pushing it away from the winter season; (iii)

research: better understand the virus and the actions that will lessen its effect on the UK population; innovate responses including diagnostics, drugs and vaccines; use the evidence to inform the development of the most effective models of care; and (iv) mitigate: provide the best care possible for people who become ill, support hospitals to maintain essential services and ensure ongoing support for people ill in the community to minimise the overall impact of the disease on society, public services and on the economy (**footnote 63**).

By mid-March 2020, however, the findings from pandemic modelling by experts at Imperial College revealed that such an approach would soon overwhelm capacity to manage COVID-19 cases within the National Health Service (NHS). Indeed, there were very real concerns that if the government did not take immediate mitigation measures, then the UK might face more than 500,000 deaths from COVID-19 (**footnote 64**). In the wake of such findings, the UK government switched tack and announced a range of new lockdown measures designed to restrict people's movements involving social distancing, working from home and only undertaking essential travel, leading to the cancellation of large social and sporting events (**footnote 65**). By the end of March, both the Prime Minister Boris Johnson and the Secretary of State for Health and Social Care Matt Hancock were in self-imposed isolation with COVID-19 symptoms, as were several members of the government leadership team involved in managing the response to the pandemic (**footnote 66**).

In order to place the lockdown measures on a legislative footing, the UK government introduced the Coronavirus Bill into the UK Parliament on 19 March 2020 (**footnote 67**). In putting forward the Bill, it was clear the UK government was seeking a wide range of legal powers to manage the lockdown measures, as well as to address a myriad of issues that had arisen in relation to responding to the COVID-19 pandemic. The

preferred way forward now was bespoke primary legislation. It was argued that this approach would provide the UK government and the devolved administrations with greater flexibility and a wider range of regulatory options to respond to the pandemic, as well as enabling the UK Parliament to undertake more detailed scrutiny of the use of government powers ‘in the round’. (**Footnote 68**)

The purpose of the legislation was ‘to respond to an emergency situation and manage the effects of the COVID-19 pandemic’, given that it was likely to lead to a ‘reduced workforce, increased pressure on health services and death management processes.’ In doing so, the aims were to increase the health and social care workforce; to ease the burden on frontline staff in health and other public bodies; to contain and slow the spread of the virus; and to manage the deceased in a respectful and dignified manner (**footnote 69**).

In drafting the legislation, the decision had also been taken that there would be a UK-wide approach, save where specific measures were required in the devolved administrations. Following a short period of scrutiny by both Houses, the Bill was quickly passed by the UK Parliament in the face of minimal opposition. The Coronavirus Act 2020 (Coronavirus Act) received Royal Assent on 25 March 2020. The Act is due to expire two years from this date on 25 March 2022, subject to a limited number of exceptions. In contrast to other emergency legislation such as the Civil Contingencies Act 2004, the Act’s parliamentary review mechanisms are more limited and spread over an extended period. They involve bi-monthly government reporting, in addition to the UK Parliament being able to express its views (at six months) or vote (at twelve months) on whether the Act should remain in force (**footnote 70**).

As a result of the COVID-19 pandemic, there has been a noticeable divergence over time between the approach taken in

devolved administrations such as Scotland as opposed to England. Scottish political leaders have profiled their more often more cautious approaches to lockdown in contradistinction with that taken in London.

On 31 March 2020, the Scottish Government introduced the Coronavirus (Scotland) Bill, to make changes to some of the duties of public bodies to let them focus on work which responded to the coronavirus outbreak. The Bill was considered by a Committee of the Whole Parliament on 1 April and became law on 6 April 2020. Under the Act, the Scottish Government must report back to the Parliament every two months, and the Scottish Parliament will review the application of the powers under the emergency legislation every six months; the powers under the legislation can be extended for six months at a time, up to a total period of 18 months (**footnote 71**).

On 21 May 2020, the Scottish Government published Scotland's route map through and beyond the COVID-19 pandemic. This was in addition to previously published documents such as the Coronavirus (COVID-19) Framework for Decision Making (published, 23 April 2020) (**footnote 72**), and the supporting evidence underpinning the framework was published on 7 May 2020.

On 23 October 2020, the Scottish First Minister announced Scotland's Strategic Framework, a five-level plan to vary the rules for a rapid but proportionate response to Covid-19. This was used to inform the Scottish Government's approach to suppress localised outbreaks across Scotland (**footnote 73**). The new local authority protection measures were announced on 29 October, and they came into force on 2 November 2020 (**footnote 74**).

# B. Key UK-Wide Covid-19 Guidance: Health and Social Care Services

At the start of the first wave of the pandemic, there was already in existence a range of professional guidance that would be relevant in addressing the risks posed by the COVID-19 pandemic for patients, staff and the NHS. By March 2020, it was becoming clearer that the UK was experiencing what would be the first wave of the COVID-19 pandemic. During the months March to May 2020, there was a proliferation of professional, institutional and governmental guidance on addressing a range of risks and other aspects of the pandemic. They have since been updated, often multiple times since this period.

During this period, it appeared that the UK government, as well as the devolved administrations, published and borrowed from a range of guidance, statements and advice in what was considered to be an emergency situation for the NHS and for those in political leadership as well. Over time, the guidance has become more differentiated to take account of local/regional political and policy preferences, as well as devolved health systems.

We highlight key guidance which was adopted during the first two waves of the pandemic in 2020-21. We recognise that specific guidance was issued in Scotland, and we refer to that in more detail later in the report. It would be necessary to track earlier versions of such guidance, if that was considered relevant for examining the Terms of Reference for the Inquiry.

# CMO Joint Statements

## Joint Statement from Healthcare Regulators: How we will continue to regulate in light of novel coronavirus (COVID-19)

The statement recognised the 'highly challenging circumstances' in which healthcare professionals are now operating, which may involve the need to 'depart from established procedures in order to care for patients using health and social care services. They emphasised that regulatory standards were designed to be flexible, creating a framework for decision-making in light of key principles. Where any concerns are raised, regulators will also consider the specific facts of the case, and the surrounding workplace environment. They would also take account of any information about resources guidelines or protocols in place at the relevant time (**footnote 75**).

## Joint statement by the CMOs of England, Scotland, Wales and Northern Ireland: Supporting doctors in the event of a COVID-19 epidemic in the UK

The statement recognised that doctors would likely be required to work in unfamiliar circumstances or surroundings or would be working in clinical areas outside of their usual practice. The emphasis was placed on continuing to adhere to the principles of being a good doctor. All doctors would be expected to follow GMC guidance and use their judgement in applying the principles to the situations they face. In partnership with patients, doctors should always use their professional judgement to assess risk and to make sure people receive safe care, informed by the values and principles set out in their professional standards. They should be supported in doing so by those in charge of the UK's health systems, recognising that they may need to depart, possibly significantly, from established

procedures in order to care for patients in highly challenging circumstances (**footnote 76**).

## National Institute for Health and Care Excellence

**Covid-19 Rapid Guideline**
This NICE Guideline has been updated over time. Initially, it predominantly addressed triaging issues in relation to admission to hospital with (suspected) COVID-19 during the first wave of the pandemic. It recommended triaging admission to intensive care based on a frailty assessment. In an initial version of the Guideline published on 20 March 2020 (**footnote 77**), NICE had recommended that all adults should be assessed for frailty on admission to hospital using the Clinical Frailty Scale (CFS) (**footnote 78**).

Organisations representing disabled people voiced their concerns about the application of CFS for those with learning disabilities and other neuro-developmental conditions such as autism, as this could result in them being denied treatment (**footnote 79**). In response, NICE quickly amended its guidance to clarify when and how to use the CFS as part of a holistic assessment, issuing updated guidance on 31 March 2020 (**footnote 80**). An omission from the initial version also did not provide a pathway for treatment, including access to ventilators, once the patient was admitted to an intensive care unit (**footnote 81**).

NICE also published a separate COVID-19 rapid guideline for managing symptoms (including at the end of life) in the community [NG163], which was initially published on 3 April 2020, and was then updated again on 13 October 2020. This was particularly relevant to managing COVID-19 in care homes and social care settings. This and the earlier guideline have

now incorporated into the one COVID-19 Rapid Guideline [NG191] (**footnote 82**).

## British Geriatrics Society

**COVID-19: Managing the COVID-19 pandemic in care homes for older people**
This guidance was initially written during the first wave of the COVID-19 pandemic and was then updated during the second wave. It was designed to be applicable to care home residents across all four nations of the UK. The guidance recognised that residents of care homes – most of whom are aged 80 years and above – had been particularly affected by COVID-19. It took account of all relevant guidance to date and covered the following: infection control; staff and resident testing; admissions to care homes; family visiting; diagnosing COVID-19 in care homes; management and treatment of COVID-19 in care homes; advance care planning; end of life care; and continuing routine healthcare (**footnote 83**).

## British Medical Association

**COVID-19: guidance for doctors on the impact of coronavirus The BMA has provided a range of advice and guidance for its members** on the Impact of Coronavirus on their work, training, education and wellbeing as medical professionals (**footnote 84**).

**Joint guidance from the BMA, Resuscitation Council (UK) and Royal College of Nursing (RCN): Decisions relating to CPR (cardiopulmonary resuscitation), including decisions not to attempt CPR** The guidance identifies the key ethical and legal principles that should inform all CPR decisions. The high-level ethical principles are the same for all people, in all settings, but differences in clinical and personal circumstances

make it essential that all CPR decisions are made on an individual basis. How these individual decisions are made is also guided by the law, which differs between adults and children and differs in England and Wales, in Scotland and in Northern Ireland. For example, a central tenet of the mental capacity legislation in England and Wales is 'best interests' and in Scotland it is 'benefit'. These terms can be interpreted in largely the same way and so, for the purposes of this guidance, are used interchangeably in parts of the guidance. This guidance provides a framework to support decisions relating to CPR and effective communication of those decisions. It also highlights relevant legal requirements and differences (**footnote 85**).

**COVID-19 – Ethical Issues. A Guidance Note, 1 April 2020**
The British Medical Association published an ethical framework on 1 April 2020 to guide the actions of its members in the context of the public health emergency. It noted that there had 'always been an ethical tension in medicine between a doctor's concern for the health and welfare of the individual patient and concern for the health of populations. In dangerous pandemics the ethical balance of all doctors and health care workers must shift towards the utilitarian objective of equitable concern for all – while maintaining respect for all as "ends in themselves.' The guidance drew predominantly on the ethical framework that had been designed to address an emergency arising from pandemic influenza, which took the form of several 'guiding principles': (equal) respect; minimise the harm of the pandemic; working together; reciprocity; flexibility; and open and transparent decision-making. In relation to resource allocation, it was stated that all decisions made in this regard must be reasonable in the circumstances; based on the best available clinical data and opinion; and based on coherent ethical principles and reasoning agreed on in advance where practicable, while recognising that decisions may need to be rapidly revised in changing circumstances; consistent between different professionals as

far as possible; communicated openly and transparently; and subject to modification and review as the situation develops (**footnote 86**).

## COVID-19: Ethical Issues When Demand for Life-Saving Treatment is at Capacity

The BMA advised that 'it would be both lawful and ethical to refuse someone potentially life-saving treatment where another patient is expected to benefit more from the available treatment. Such decisions must be based on clinically relevant factors. Although a 'capacity to benefit quickly' test would have a disproportionate effect on the elderly and those with clinically relevant underlying conditions, where decisions are taken with the considerations discussed above, it would be lawful in the circumstances of a serious pandemic. It would amount to 'a proportionate means of achieving a legitimate aim', under s19 (1) of the Equality Act 2010 – namely saving the maximum number of lives by fulfilling the requirement to use limited NHS resources to their best effect. There is no exemption from the legal duties under the Act because of the pressure of a pandemic. However, the duty is to make 'reasonable' adjustments and what is reasonable will be affected by the pandemic and the resulting pressures on NHS services. The BMA's view is that, if there is undue pressure on life-saving or life-sustaining treatment, the duty to make reasonable adjustments should not substantially affect decisions about access to such treatment under a 'capacity to benefit quickly' test (**footnote 87**).

## COVID-19: Lessons Learned Inquiry

The BMA is gathering evidence from its members across the UK and seeking accounts from stakeholders to inform the resulting conclusions and recommendations of its review. It will pose questions for policy makers to answer and identify questions the public inquiries need to ask. The reviewing is focusing on five main areas: (i) the protection of healthcare

workers from COVID-19; (ii) the impact of the pandemic on healthcare workers; (iii) delivery of healthcare during the pandemic; (iv) the public health response to the pandemic; and (v) the impact of the pandemic on population health (**footnote 88**).

## General Medical Council

**Good Medical Practice**
The guidance sets out what it means to be a ‘good doctor’, which should include the following: make the care of your patient your first concern; ensure that you are competent and keep your professional knowledge and skills up to date; take prompt action if you think patient safety is being compromised; establish and maintain good partnerships with your patients and colleagues; maintain trust in you and the profession by being open, honest and acting with integrity (**footnote 89**).

**Confidentiality: good practice in handling patient information**
The guidance sets out eight principles to be applied in clinical practice, to assist in deciding where information can be shared in line with ethical and legal obligations. Advice is also provided on doctors’ personal responsibilities for protecting patient information. This guidance is accompanied by six shorter pieces of guidance explaining how the principles of confidentiality apply to specific situations including for education and training purposes, disclosure in relation to patients’ employment and insurance, disclosing patients’ fitness to drive, reporting gunshot and knife wounds, and responding to the media (**footnote 90**).

### Treatment and care towards the end of life: good practice in decision making

This guidance provides a framework for doctors to support them in meeting the needs of their patients as the come towards the end of their lives. It covers topics such as making decisions when patients have capacity and when they do not; how to assess the overall benefit of treatment; engaging in advance care planning with patients; meeting patients' nutrition and hydration needs; cardiopulmonary resuscitation; the role of relatives, partners and other close to patients; and organ donation and care after death (**footnote 91**).

### General Medical Council: Coronavirus FAQs

All the GMC's ethical guidance continues to apply as far as is practicable in the circumstances. The primary requirement is for doctors to act responsibly and reasonably. Doctors should follow GMC guidance, 'Treatment and care towards the end-of-life' guidance covering anticipatory care planning (paragraphs 50-74) and CPR (paragraphs 128-146). As far as possible, be honest about any uncertainties or likely outcomes for the patient (**footnote 92**).

## Resuscitation Council UK

### Family Discussions and Clinical Decision-Making, 8 April 2020

This guidance was directed to the public, as well as healthcare professionals. In relation to the public, it was recommended that conversations take place between family members about preferences regarding medical treatment in the event of contracting COVID-19, as well as whether resuscitation was wanted or not. In relation to healthcare professions, it was recommended that conversations 'take place with patients early, when they are well and are able to communicate what care and treatment they would want or not want to receive in an

emergency situation (should they become unwell and unable to communicate themselves). This is important in patients with COVID-19, especially those that have underlying co-morbidities'. While recognising the pressure that healthcare professionals were under, it was emphasised that 'having these conversations is an important part of care during COVID-19'. (**Footnote 93**)

### Statement of the Role of the ReSPECT Process During COVID-19

This guidance was published on 23 April 2020 and emphasised the importance of having 'conversations to understand and record a person's wishes has never been more important than during the current COVID-19 pandemic. Those using the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) must ensure that having conversations with the individuals concerned remains at the heart of the process.' This included conversations concerning the use of CPR. The guidance also emphasised that it was 'appropriate to have a ReSPECT conversation with residents in a residential/ nursing care home, but this must be done on an individual basis. If a person lacks capacity to make decisions, a discussion should take place with those who know the person best to ensure the ReSPECT plan is as close to what the person would have wanted.' (**Footnote 94**)

### Statement on COVID-19 in Relation to CPR and Resuscitation in First Aid and Community Settings, updated 13 May 2020

This guidance was directed towards 'anyone who is performing CPR/defibrillation in an out-of-hospital setting'. In terms of performing CPR on an individual who was suspected of having COVID-19, the advice stated: 'do not listen or feel for breathing by placing your ear and cheek close to the patient's mouth. If you are in any doubt about confirming cardiac arrest, the default position is to start chest compressions until help arrives…If

there is a perceived risk of infection, rescuers should place a cloth/towel over the victim’s mouth and nose and attempt compression only CPR and early defibrillation until the ambulance (or advanced care team) arrives. Put hands together in the middle of the chest and push hard and fast. If the rescuer has access to any form of personal protective equipment (PPE) this should be worn. After performing compression-only CPR, all rescuers should wash their hands thoroughly with soap and water; alcohol-based hand gel is a convenient alternative. They should also seek advice from the NHS 111 coronavirus advice service or medical adviser.’ (**Footnote 95**)

**UK Government, COVID-19 Guidance for First Responders**
Note that the RCUK guidance on this issue was subsequently adopted in UK government guidance issued for first responders regarding the use of CPR where an individual was suspected of, or had tested positive, for COVID-19. In the event that a first responder was subsequently diagnosed with COVID-19, then the person was advised to self-isolate, inform their employer and follow the UK government’s applicable ‘stay at home’ guidance (**footnote 96**).

## Royal College of Nursing

**RCN Position on COVID-19**
The RCN identified a number of expectations for employers and governments across the UK. Nursing staff should have the resources they need, including PPE for their health, safety and wellbeing. The RCN expects employers to discharge their legal duties to manage risks posed to employees and protect them in the workplace. The RCN also expects employers to ensure that members do not suffer any financial detriment or loss of pay as a result of being away from work due to public safety rules and legislation. The RCN is clear that essential health and care

needs of patients must always be undertaken by appropriately trained staff (**footnote 97**).

### RCN position on staff living in care homes

RCN expressed concern about nursing and care staff being requested or coerced in to complying with 'locked-in staffing' arrangements to enhance the shielding of residents. This may lead to staff being subject to prolonged exposure to the risk of infection with COVID-19, as well as impacting their mental and physical wellbeing, as well as being deprived of quality time with their families. Care homes employ a high proportion of BAME staff, many from overseas on sponsored immigration visa and they may feel compelled to agree to these living arrangements at increased risk to themselves. The staffing crisis means that many such staff are working extended hours, exceeding the Working Time Regulations. Greater emphasis needs to be placed on adherence to infection control guidance, adequate provision of PPE, COVID-19 testing for all staff and residents; staff provision to meet current demands of the services; and the availability of private changing, showering and staff laundry facilities. The RCN cannot accept staff living in care homes (**footnote 98**).

## Personal Protective Equipment (PPE)

### UK Government, Coronavirus (COVID-19): personal protective equipment (PPE) hub (footnote 99)

Guidance on appropriate PPE for health and social care workers was reviewed by all 4 UK public health bodies and informed by NHS infection prevention control experts. It is also consistent with relevant World Health Organization (WHO):

- **Personal protective equipment (PPE) illustrated guide for community and social care settings, updated 9 June 2021**

- **Covid-19: Infection prevention and control (IPC), updated 17 January 2022**

- **COVID-19: how to work safely in care homes, updated 16 August 2021**

- **COVID-19: Personal protective equipment use for aerosol generating procedures, updated 21 August 2020**

## Nursing and Midwifery Council

**NMC statement on personal protective equipment during the Covid-19 pandemic**
The statement notes that NMC Code and Standards support nurses, midwives and nursing associates during the COVID-19 pandemic situations by setting out the key principles to follow to keep themselves, those they lead or manage and those they care for safe (**footnote 100**). To support our registrants further, the NMC provided further guidance on keeping safe in the workplace, including the use of PPE; how to raise concerns about safety and what to do when presented with treatment or care situations when there are concerns about risks for yourself and others. Emphasis was also placed on the importance of keeping a record on decision-making regarding how any safety concerns are handled (**footnote 101**).

# C. Key Covid-19 Guidance in Scotland: Health and Social Care Services

There has been a voluminous amount of COVID-19 guidance which has been published the Scottish Government, as well as Scottish Government bodies, in relation to addressing the risks posed by the COVID-19 pandemic between 2020 and 2022. Most such guidance has also been updated over time, so there

are multiple versions. The Scottish Government has now brought together such guidance into a series of online topic ‘hubs’, which also track earlier versions of the guidance (**footnote 102**). We do not propose to provide an overview of all such guidance covering COVID-19 and the provision of health and social care. Instead, we have highlighted some key topic-based guidance below.

## COVID-19 guidance: ethical framework

Sponsored by the Scottish CMO, the framework was initially published in April 2020. It went through several iterations following stakeholder and policy feedback, as well as equality impact assessment (**footnote 103**).

A review was also undertaken in line with the Fairer Scotland Duty (**footnote 104**). A revised version taking account of such feedback was published on 29 July 2020 (**footnote 105**). A summary is provided which set out the key principles guiding the document. It stated that during COVID-19 pandemic, clinical and healthcare decision-makers continue to be duty-bound to respect, protect and fulfil human rights, prevent discrimination and to ensure equality and human dignity are at the heart of clinical practice.

The ethical approach to clinical decision making in Scotland will be consistent with the UK framework but will be adapted to the Scottish context. This will ensure that the principles of equity, respect and fairness are upheld across Scotland throughout this pandemic.

## COVID-19 guidance: infection prevention and control

Public Health Scotland (PHS) maintains a webpage, which provides a range of education resources regarding the National Infection Prevention and Control Manual (NIPCM), which is a general IPC manual which has also been adapted to managing the risks posed by COVID-19. This is provided in partnership with a range of stakeholders and align with relevant national IPC guidance (**footnote 106**).

The NIPCM was first published in January 2012 and is subject to regular updates. It provides guidance to all those involved in care provision and should be adopted for infection prevention and control practices and procedures. The national manual is mandatory for NHS Scotland, in all other care settings to support with health and social care integration the content of this manual is considered best practice. The Infection Prevention and Control Manual for Older People and Adult Care homes is mandatory within the care home setting (**footnote 107**).

The NIPCM aims to make it easy for care staff to apply effective infection prevention and control precautions; reduce variation, promote standardisation and optimise infection prevention and control practices throughout Scotland; improve the application of knowledge and skills in infection prevention and control; help reduce the risk of Healthcare Associated Infection (HAI); and help alignment of practice, education, monitoring, quality improvement and scrutiny (**footnote 108**).

In the context of COVID-19, a specific initiative has involved undertaking a series of rapid reviews and SBARs to support the IPC response to the COVID-19 pandemic, with the latest review being published on 15 December 2021. The rapid methodology

and governance/sign-off process differs from the 'development process' used for the NIPCM systematic literature reviews. Governance was provided by the Scottish Government COVID-19 Nosocomial Review Group (CNRG) (**footnote 109**).

There was also specific guidance published to address the likelihood of a surge in other respiratory viruses in addition to COVID-19 over the winter season of 2021/22 and supersedes the 3 COVID-19 addenda (Acute, Care home and Community health and care settings) first published in October 2020. This guidance is aligned with the relevant UK IPC guidance (**footnote 110**).

Key changes include the removal of the 3 distinct COVID-19 care pathways (high/red, medium/amber and low/green) to respiratory and non–respiratory pathways; A return to Standard Infection Control Precautions (SICPs) and Transmission Based Precautions (TBPs) as per National Infection Prevention and Control Manual (NIPCM) and the Care Home Infection Prevention and Control Manual (CHIPCM); An algorithm to support placement of service users within health and care settings; respiratory screening questions to include COVID-19 AND other respiratory pathogens; and ongoing rapid testing for COVID-19 AND to now include other respiratory pathogens in some settings (**footnote 111**).

## COVID-19 guidance: Health Protection Teams

This guidance was initially published on 23 January 2020 and has been updated multiple times since that date. For example, during the first wave of the COVID-19 pandemic it was updated 20 times. In initial published guidance, clinicians were advised to be 'alert to the possibility of atypical presentations in patients who are immunocompromised. Any individual reporting any contact with a confirmed case of COVID-19, even if

asymptomatic, should be reported to the local Health Protection Team immediately. By 13 February, HPTs are advised to ensure that a patient with suspected COVID-19 is isolated and appropriate PPE is being used in line with IPC guidance for severe respiratory illness from novel or emerging pathogens (**footnote 112**).

## COVID-19 guidance: health and social services

**Scottish Government, Clinical Guidance for Nursing Home and Residential Care Residents and COVID-19** (**footnote 113**).

This is guidance provides advice and support for those working with adults in care homes during this pandemic. It was first published on 13 March and was updated on 26 March. This version was updated by the Chief Medical Officer and Chief Nursing Officer Care Homes Clinical and Professional Advisory Group (CPAG), a short life multi-disciplinary group, which has been established to provide clinical and professional advice throughout the evolution of the COVID-19 pandemic. The guidance is based on the Health Protection Scotland updated Information and Guidance for Care Homes but provides more detail on some practical steps that are required to support good infection control within care homes and ensure the provision of safe and effective person-centred care during this pandemic. The evidence also points to the need for a whole system health and social care response to Covid-19 to support our care homes.

**COVID-19: Advice for Social or Community Care and Residential Settings Staff**

This guidance was initially published on 17 April 2020. The guidance addresses staff responsibilities to prevent spread of COVID-19. Staff who come into contact with an individual who has tested positive for COVID-19 while not wearing PPE, can

remain at work. This is because in most instances this will be a short-lived exposure, unlike exposure in a household setting that is ongoing. These are guiding principles and there should be an individual risk assessment based on staff circumstances. For staff who have COVID-19 symptoms, they should: not attend work if they develop symptoms; notify their line manager immediately; self-isolate for 7 days. Staff with underlying health conditions that put them at increased risk of severe illness from COVID-19, including those who are immunosuppressed, should not provide direct care to individuals with possible or confirmed COVID-19.

**COVID-19: Information and Guidance for Care Home Settings, 26 April 2020**

This guidance is to support those working in care home settings to give advice to their staff and users of their services about COVID-19. It should be used for care home settings including nursing homes and residential care where appropriate. This guidance covers: what COVID-19 is and how it is spread; advice on how to prevent spread of all respiratory infections including COVID-19; advice on what to do if someone is ill in a workplace or care home setting; advice on what will happen if an individual is being investigated as a possible case or is a confirmed case of COVID-19 and guidance on their care provision (**footnote 114**).

Thereafter updates focused on matters relating to COVID-19 testing for care home residents and staff. By mid 2020 onwards, updates focused on risk assessments, testing, shielding and as well as how to address the issue of visiting. Note that this was also subsequently accompanied by a Care Homes Outbreak checklist that was first published on 1 July 2020 and then subsequently updated over the course of the next 12 months (**footnote 115**).

**COVID-19: Information and Guidance for Social, Community and Residential Care Settings, 4 May 2020** (footnote 116)

This guidance is to support those working in social, community and residential care settings to give advice to their staff and users of their services about COVID-19. Social, community and residential care settings is taken to include community-based settings for people with mental health needs; people with a learning disability; people who misuse substances; supported accommodation settings; rehabilitation services; residential children's homes; residential respite (non-care homes); and sheltered housing. For care home settings, there is separate COVID-19 Guidance and Information for Care Home Settings that should be followed instead of this guidance.

**COVID-19 Guidance for Healthcare Settings**

This guidance was initially published 1 November 2020 and updated on a regular basis. This guidance has been prepared for healthcare settings providing core services during the COVID-19 pandemic. It covers core public health principles and measures for managing COVID-19 that apply in most healthcare settings and provides additional information for specified healthcare settings. Settings included are primary care (including healthcare delivered in the community), secondary care (i.e. hospitals), hospice care and ambulance settings.

**Coronavirus (COVID-19): minimising the risk over winter and updated protective measures for Omicron variant - additional protective measures for adult care homes** (footnote 117)

The guidance aims to balance the current COVID-19 risk and the need to keep people safe in line with clinical advice provided about the risks of Omicron variant, and what actions may help reduce the risk of infection or spread of infection. They are based on the principle that, where it is safe to do so,

people living in care homes should continue be supported to see and spend time with those important to them as outlined in Open with Care visiting guidance, recognising that this is essential to the wellbeing of both residents and their families/friends. The additional measures also recognise the importance of ensuring all existing Infection Prevention Control (IPC) measures are in place; all visitors should undertake a Lateral Flow Device (LFD) test before attending; vaccinations and boosters are to be encouraged; and no-one with symptoms or identified as a close contact meet with residents in and out with the care home. Key points to note:

- **Care home residents testing** Residents are also recommended to undertake an LFD test before leaving the care home to meet with individuals indoors, and after returning from visits out. Residents are also recommended to test every other day for up to 14 days. Testing is recommended, it is not mandatory and should not be encouraged if this will cause harm or distress to the resident.

- **Self-Isolation periods for residents** on 19th January 2022, updated guidance was published on self-isolation for residents where they test positive for COVID-19 (**footnote 118**). Self-isolation periods for residents who are contacts of Covid-19 positive case or are themselves Covid positive has now changed from 14 days to 10 days. Precautionary 14 days self-isolation of residents following discharge from hospital to a care home has now been removed for residents on the non-respiratory pathway and has reduced from 14 to 10 days for residents on the respiratory pathway.

- **Visiting care homes** The Scottish government recognises the importance of care home visits for residents by family and friends. The expectation is that visiting should have increased from the minimum of twice weekly, to more routine normalised visiting unless an outbreak is suspected or has

been declared. From 24 January 2022, the Scottish government removed the guidance asking people to limit indoor gatherings to three-households. Anyone who visits an adult care home – family/ friends (including children) and visiting professionals should undertake an LFD test before every visit. There should be no restrictions placed on frequency of visiting. This will be guided by care home arrangements, which take into account the ability of the home to manage the number of people attending at any one time to ensure safe visiting practices can be maintained. All visitors to care homes should wear a Fluid Resistant Surgical mask (FRSM) as per Open with Care guidance. Guidance has also been issued to enable visiting to still take place during COVID-19 outbreaks in adult care homes (**footnote 119**).

The framework recognises the increased pressure placed on the healthcare system and resources due to the pandemic which would likely result in changes to healthcare scope and delivery across the UK, including in Scotland. Doctors were assured that decisions taken in good faith, in accordance with national actions and guidance to counter COVID-19 will not be held against them as individuals.

Practising 'Realistic Medicine' (**footnote 120**) means finding out what matters to people and providing them with the information they need to make an informed choice about their treatment and care. The framework outlines the structures and principles for ensuring ethical decision-making, as well as how ethical advice and support will be provided if needed through structures at both local and national levels. The advice should be read alongside the Clinical Pathways Guidance. It also refers to the option of mutual aid agreements, whereby expertise, networks and support on ethically difficult decisions could be accessed. Reference is made to key principles guiding ethical practice during the COVID-19 pandemic including respect, fairness, minimising harm, working together, flexibility,

reciprocity. Notwithstanding the increased pressures arising from the COVID-19 pandemic, clinicians must continue to ‘act within the law’ and ‘should ensure that they are continuing to meet their obligation to uphold it. This involves ensuring adhered to equality and human rights principles and laws as set out in the Human Rights Act and the Equality Act 2010.

## D. Covid-19 Vaccination in Scotland

A brief overview is provided of the approach taken to the design of the UK COVID-19 vaccination programme and its implementation in Scotland, with a particular focus on how the prioritisation of vulnerable groups, such as older adults. This is relevant to examining the strategic response to addressing the risks posed by COVID-19 to older adults in care homes. A number of COVID-19 vaccines were authorised by the UK regulator, the Medicines and Healthcare Regulatory Authority (MHRA). On 2 December 2020, the MHRA approved the Pfizer/BioNTech vaccine, which is an mRNA vaccine (**footnote 121**).  In regulatory terms, the MHRA were able to authorise the rapid temporary approval of the vaccine, due to the serious public health concerns pertaining to the COVID-19 pandemic. The temporary authorisation allowed for the vaccine to be used by people over the age of 16 to prevent COVID-19, but it did not allow for a marketing authorisation (**footnote 122**).

On 8 December 2020, the first individual outside of the clinical trials, a 90-year-old woman from NI, received a COVID-19 vaccine. On 14 December 2020, the first Pfizer vaccines were administered in Scottish care homes. On 15 December, over 70 vaccination centres were opened in England. Care home vaccine centre locations opened on 16 December in England, where larger care homes were initially priorities. GPs started to provided vaccines later that week in December. On 30

December 2020, the AstraZeneca (AZ) vaccine received regulatory approval by the MHRA for people over the age of 18 in the UK. The AZ vaccine was also approved under the 2012 Regulations. On 8 January 2020, the Moderna vaccine, another mRNA vaccine, was approved by the MHRA.

The assessment of who should be prioritised for vaccination was conducted on a UK-wide basis by the Joint Committee on Vaccination and Immunisation (JCVI). It was recognised that the single greatest risk of mortality from COVID-19 is increasing age and that the risk increased exponentially with age.

### Figure 17 - Priority Groups and COVID-19 Vaccination in the UK (footnote 123)

**Figure 17 - Priority Groups and COVID-19 Vaccination in the UK**[123]

| Priority | Risk group | Phase | Timeline |
|---|---|---|---|
| 1 | Older adults, resident in a care home and care home workers (12k residents and 16K staff) | Phase 1 | Dec/Jan 2021 |
| 2 | All those 80 years of age and over (<72K) and health and social care (70K) and domestically care workers (<25K) | Phase 1 | Dec/Jan 2021 |
| 3 | All those 75 years of age not already vaccinated (<62K) | Phase 2 | Jan/Feb 2021 |
| 4 | All those 70 years of age not already vaccinated (<81K) and extremely clinically vulnerable (95K) and Carers. | Phase 2 | Jan/Feb 2021 |
| 5 | All those 65 years of age not already vaccinated (<90K) | Phase 2 | Jan/Feb 2021 |
| 6 | All individuals aged 16 years to 64 years with underlying health conditions which put them at higher risk of serious disease and mortality + the Carers | Phase 2 | Jan/Feb 2021 |
| 7 | All those 60+ years of age not already vaccinated (<106K) | Phase 3 | Mar/April 2021 |
| 8 | All those 55+ years of age not already vaccinated (<125K) | Phase 3 | Mar/April 2021 |
| 9 | All those 50+ years of age not already vaccinated (<132K) | Phase 3 | Mar/April 2021 |
| 10 | All those 40+ years of age not already vaccinated (<242k) | Phase 4 | Mar/April 2021 |
| 11 | All those 30+ years of age not already vaccinated (<251k) | Phase 4 | Apr/May 2021 |
| 12 | All those 18+ years of age not already vaccinated (<282k) | Phase 4 | Apr/May 2021 |
| 13 | Autumn/ Winter booster programme 2021 | Phase 5 | Winter 2021 onwards |

[Figure 17 is a table with 4 columns, giving the following information:

Priority 1

- Risk group: Older adults, resident in a care home and care home workers (12k residents and 16K staff)
- Phase: Phase 1
- Timeline: Dec/Jan 2021

Priority 2

- Risk group: All those 80 years of age and over (<72K) and health and social care (70K) and domestically care workers (<25K)
- Phase: Phase 1
- Timeline: Dec/Jan 2021

Priority 3

- Risk group: All those 75 years of age not already vaccinated (<62K)
- Phase: Phase 2
- Timeline: Jan/Feb 2021

Priority 4

- Risk group: All those 70 years of age not already vaccinated (<81K) and extremely clinically vulnerable (95K) and Carers.
- Phase: Phase 2
- Timeline: Jan/Feb 2021

Priority 5

- Risk group: All those 65 years of age not already vaccinated (<90K)
- Phase: Phase 2
- Timeline: Jan/Feb 2021

Priority 6

- Risk group: All individuals aged 16 years to 64 years with underlying health conditions which put them at higher risk of serious disease and mortality + the Carers
- Phase: Phase 2
- Timeline: Jan/Feb 2021

Priority 7

- Risk group: All those 60+ years of age not already vaccinated (<106K)
- Phase: Phase 3
- Timeline: Mar/April 2021

Priority 8

- Risk group: All those 55+ years of age not already vaccinated (<125K)
- Phase: Phase 3
- Timeline: Mar/April 2021

Priority 9

- Risk group: All those 50+ years of age not already vaccinated (<132K)
- Phase: Phase 3
- Timeline: Mar/April 2021

Priority 10

- Risk group: All those 40+ years of age not already vaccinated (<242k)
- Phase: Phase 4
- Timeline: Mar/April 2021

Priority 11

- Risk group: All those 30+ years of age not already vaccinated (<251k)
- Phase: Phase 4
- Timeline: Apr/May 2021

Priority 12

- Risk group: All those 18+ years of age not already vaccinated (<282k)
- Phase: Phase 4
- Timeline: Apr/May 2021

Priority 13

- Risk group: Autumn/ Winter booster programme 2021
- Phase: Phase 5
- Timeline: Winter 2021 onwards

End of Figure 17]

Therefore, the optimum strategy for reducing COVID-19 related deaths was to offer vaccination to older age groups first, particular those aged 65 years and over. It was also recognised that there was ‘clear evidence’ that those living in residential car homes for older adults had been ‘disproportionately affected by COVID-19. As stated by the JCVI:

“[Care homes] have had a high risk of exposure to infection and are at higher clinical risk of severe disease and mortality. Given the increased risk of outbreaks, morbidity and mortality in these closed settings, these adults are considered to be at very high risk. The committee’s advice is that this group should be the highest priority for vaccination. Vaccination of residents and staff at the same time is considered to be a highly efficient strategy within a mass vaccination programme with the greatest potential impact.” (**Footnote 124**)

The JCVI also recognised that ‘frontline health and social care workers were also at increased personal risk of exposure to infection with COVID-19 and of transmitting that infection to susceptible and vulnerable patients in health and social care settings. The committee considers frontline health and social

care workers who provide care to vulnerable people a high priority for vaccination. Protecting them protects the health and social care service and recognises the risks that they face in this service.' In particular, the JCVI recognised that a sub-group of such workers – namely residential care home staff – were at particular risk of both contracting COVID-19, as well as passing it on to vulnerable individuals in care home settings. As such, it was recognised that they should 'therefore considered a very high priority for vaccination.' (**Footnote 125**). The first four priority groups were given their vaccines during this initial stage, in line with the vaccination strategy. By 14 February, these priority groups had all been given their first dose on a UK wide basis.

The position of the Scottish Government in relation to the COVID-19 vaccination rollout in Scotland was to follow the advice produced by the JCVI. It emphasised that 'decisions to prioritise one population group over another are not taken lightly, nor are they straightforward… The JCVI priority groups are based on either vulnerability to COVID-19, or on interacting with (and therefore possibly spreading to) people who are vulnerable to COVID-19.' In line with that prioritisation process, the Scottish Government offered vaccinations to all residents and staff in care homes for older people as part of Priority Group 1, quickly followed by frontline health and social care workers with a focus on workers in care homes (**footnote 126**).

## E. COVID-19 and Care Homes in Scotland

It is recognised that older adults living in care homes often have multiple health and care needs and many are frail with varying levels of dependence. It is current estimated that there are over 40,000 residents living in 1083 adult care homes across Scotland. The vast majority of adult care homes are for older

people (75%) but care homes also include those for people with learning disabilities (14%) and physical disabilities / sensory impairment (3.3%).

Most adult care homes are run by the private / independent sector (63%). This rises to 75% in care homes for older people, followed by the third/voluntary sector (24%) and local authority/ health board sectors (14%). In some care homes, there are registered nurses who work alongside social care workers. In other care homes, there are no registered nurses and nursing support is provided through an in-reach district nursing/ care home liaison model. The average age of residents is estimated to be 84 years.

Fifty percent of residents have a formal diagnosis of dementia, however, the actual numbers of residents with a formal diagnosis or a significant cognitive impairment is thought to be much higher. Ordinarily, annual mortality rates for these residents is between 13 and 17%, making this a highly vulnerable group for a range of illnesses, including COVID-19 (**footnote 127**).

During the first wave, and to a lesser extent the second wave, nursing and residential care homes in the UK became 'hotspots' for the spread of COVID-19 (**footnote 128**). This has proved to be particularly problematic in Scotland, 50% of all COVID-19 deaths in the first wave of the pandemic occurring in such settings.

While this potentially raises a range of civil, criminal and regulatory issues, on human rights grounds it is likely that questions regarding infringement of individuals' human rights will engage Articles 2, 3, 5, 8 and 14. Specifically, in relation to deprivation of liberty under Article 5 ECHR. In doing so, it would be important to take account of both patients lacking capacity who have been discharged from a hospital to a care or nursing home, and those persons lacking capacity who are already

resident in such facilities. In the former case, the initial rationale for the hospital discharge may have been that the person was likely to be at much less risk of contracting COVID-19, in addition to the fact that the discharge was likely to create additional bed capacity for those suffering from COVID-19 who require hospital admission (**footnote 129**).

## Testing and transfer of care home residents

Due to Operation Koper, as well as broader problems in getting an accurate picture of data around COVID-19 testing and deaths of residents in care homes, it is difficult to estimate how many residents were not tested for COVID-19 before being discharged back to care homes, particularly during the first wave of the pandemic where most of the COVID-19 deaths of care home residents occurred. It has been reported that during the first wave, ‘more than half of elderly hospital patients discharged to nearly 200 Scottish care homes’ had not been tested for COVID-19, drawing on data provided by Public Health Scotland. This was during the period when there were concerns about the need for spare capacity in NHS Scotland hospitals, to accommodate coronavirus cases. It was also before COVID-19 testing had become widely available (**footnote 130**).

It was not until 21 April 2020 it became mandatory for hospital patients to have two negative COVID-19 tests before being discharged, and for all new care home admissions to be isolated for 14 days. Between 1 March and 21 April 2020 in Scotland, 82% of the 3,595 discharged patients were not tested. 843 care homes received 5,198 residents who had been discharged from hospital between 1 March and 31 May 2020. The data also shows the 752 homes which took in untested patients between 1 March and 21 April 2020. 75 care homes also took in at least one patient who had tested COVID-19

positive, and who had not received a negative test prior to discharge. Such data was only provided after the BBC had submitted an FOI request regarding every hospital charge by individual care home in Scotland, to which a response was received 11 months after submission of the initial request (**footnote 131**).

The position of Scottish Care, which represents independent providers of residential and care homes, has been reported as stating that it is 'absolutely right' to examine COVID-19 deaths. However, it is concerned at the 'disproportionate' impact of Operation Koper on their operations, as well as the adverse impact upon staff:

"We regret the fact that deaths occurring in hospitals especially in wards and areas which were not directly covid-related are not receiving the same focus. In addition, we regret that deaths from covid in the community are not being investigated. "We cannot avoid the conclusion that this process is treating the care home sector, regardless of whether operated by a local authority, charitable or private provider, in an unequal and disproportionate manner." (**Footnote 132**)

In terms of the Scottish Government's position on the hospital discharge of elderly care home residents without COVID-19 testing being in place during the first phase of the pandemic, the First Minister has described what happened as a 'mistake' with the benefit of 'hindsight (**footnote 133**), echoing similar comments made by the then Health Secretary, Jeane Freeman. In a BBC podcast, Political Thinking with Nick Robinson, Ms Freeman was reported as stating:

"I think our failures were not understanding the social care sector well enough. So we didn't respond quickly enough to what was needed in our care homes, but also in social care in the community…. we wanted people who didn't need to stay in hospital any longer, because they'd been treated and they were

clinically well, to be discharged as quickly as possible so we freed up those beds for Covid patients." (**Footnote 134**)

## Care home visits

In February 2021, the Open with Care guidance was published by the Scottish government to supports 'meaningful contact' to resume between adult care home residents and their loved ones, beginning with visiting up to twice a week (**footnote 135**). The guidance had been developed with input from the following partners: Chief Nursing Officer, Chief Medical Officer, National Clinical Director, Office of the Chief Social Work Adviser, Scottish Care; Care home staff, managers and providers; Clinical Professional and Advisory Group (CPAG) members, CPAG engagement subgroup whose membership includes Age Scotland, Alzheimer Scotland, Care Home Relatives Scotland, National Dementia Carers Action Network PAMIS, Scottish Autism, Tide UK, Care Inspectorate. Health and Social Care Partnerships (HSCPs), Directors Public Health, Nurse Directors and Chief Officers. Key aspects of the guidance include the following:

- Care homes should work to increase the frequency and duration of meaningful contact with residents. In the first instance, resuming indoor visiting should involve up to two designated visitors weekly, visiting one at a time. This should however be seen as the minimum starting point with consideration given to increasing the number of visitors and frequency of visiting, as and when the care home judges it is safe to do so, with expert advice and support from oversight arrangements where appropriate. Care home providers can work up towards daily visits and also multiple visitors in line with general COVID-19 restrictions on meeting size, as well as environment and IPC considerations. This is supported with a checklist for ensuring indoor visits.

- The principles to be taken into account by everyone when considering approaches to visiting: this includes residents, relatives, care home managers, staff and local oversight arrangements: responsibility; maintaining wellbeing; safely balancing risks of harm; equitable access for all residents; an individualised approach, so that any restrictions to meaningful contact are proportionate; equality/choice: residents (and/or their representative decision-makers) have the right to choose their designated visitors; and flexibility.

- There should also be respect for human rights. In this regard, local visiting policies should take account of the ECHR, in particular Article 8. Whilst it is important that any visiting policies take account of the evolving evidence about the harm posed from the virus, these need to be carefully balanced with the evidence about the positive impact on health and wellbeing from seeing family and loved ones has on residents in considering what is necessary, justified and proportionate.

On 15 September 2021, the Scottish Government published interim guidance, aligned to Open with Care, which recommended a framework whereby adult care homes can support residents to choose a named visitor who may visit indoors during a managed COVID-19 outbreak, where visiting can be safely supported. This interim was subsequently integrated into Public Health Scotland updated guidance, COVID-19 Information and Guidance for care home settings. A COVID-19 outbreak is defined as two or more linked cases of disease within a defined setting over a period of 14 days. Specific guidance is included on who residents (or their representatives) can nominate as a 'named visitor', as well as their eligibility to visit (**footnote 136**).

On 2 December 2021, health and social care professionals were advised that updated guidance from that issued in April 2021 was being provided to encourage allow a return to care

homes to provide anticipatory, preventative and rehabilitative care for all residents. Some limitations on visiting professionals may be required, for example if there is an active, confirmed outbreak, but the local Health Protection Team will advise on this. Essential visits from visiting professionals should always be supported. Care home residents remain a vulnerable population, so it remains crucial that the multiple layers of protections against COVID-19 (**footnote 137**).

On 10 December 2021, the Scottish Government updated its care home visit guidance. It stated that it recognised the importance of care home visits for residents by family and friends. The expectation is that visiting should have increased from the minimum of twice weekly, to more routine normalised visiting unless an outbreak is suspected or has been declared. was also announced that anyone who visits an adult care home or meets a care home resident outside the care home – family/friends (including children) and visiting professionals – should undertake an LFD test before every visit (one per day). The exception to this is in exceptional circumstances e.g. end of life/distress, however all IPC measures to be followed. Care homes have the discretion of supporting visitor testing at the care home or recommending visitors test before they come to the care home through community testing routes. Testing of all visitors is recommended but it is not mandatory.

From 24 January 2022, the Scottish government removed the guidance asking people to limit indoor gatherings to three-households. Anyone who visits an adult care home – family/friends (including children) and visiting professionals – should undertake an LFD test before every visit. There should be no restrictions placed on frequency of visiting. This will be guided by care home arrangements, which take into account the ability of the home to manage the number of people attending at any one time to ensure safe visiting practices can be maintained. All visitors to care homes should wear a Fluid Resistant Surgical

mask (FRSM) as per Open with Care guidance. Guidance has also been issued to enable visiting to still take place during COVID-19 outbreaks in adult care homes (**footnote 138**).

## Care home inspections

The Care Inspectorate (CI) examines quality of care in Scotland to ensure it meets high standards. Where improvement is needed, CI provides support services to make positive changes. CI employs 600 staff work across Scotland specialising, inter alia, in health and social care. There are approximately 14,000 registered care services in Scotland subject to regular inspection by CI. Higher-risk services are inspected more often (**footnote 139**).  The inspectors talk to people using the service, staff and managers, in order to assess whether people are experiencing high-quality care, and that care services are making a positive impact on people's lives, based on their needs, rights and choices.

CI awards care services grades following inspection, and look at key areas like care and support, physical environment, quality of staffing, and quality of management and leadership. Each area of each care service is assessed on a scale from 1 to 6, where 1 in unsatisfactory and 6 is excellent. After every inspection, an inspection report is published showing CI findings.

CI also liaises with other scrutiny and improvement bodies to look at how local authorities, community planning partnerships and health and social care partnerships are delivering a range of services in their communities across Scotland. These inspections look at how well services are working together to support positive experiences and outcomes for people, as well as working out what could be improved. Where standards need to improve, CI works with services to support them, offering

advice, guidance and sharing good practice to help care reach the highest standards. CI maintains and updates a dedicated website, The Hub, which provides a range of resources and advice for care professionals (**footnote 140**).

In terms of standards to be met, Scotland has Health and Social Care Standards which set out what people should expect when using health, social care or social work services in Scotland. The latest version of the Standards was published by the Scottish Government in June 2017 and have applied from April 2018 onwards. The Standards seek to provide better outcomes for everyone and to ensure that individuals are treated with respect and dignity and that the basic human rights we are all entitled to are upheld. Specifically, the principles underpinning the Standards include the need to show dignity and respect; compassion, to be inclusive; to provide responsive care and support, and to ensure wellbeing. In relation to this last principle, it includes being supported to make informed choices, even if this means taking personal risks; and to feel safe and protected from neglect, abuse or avoidable harm (**footnote 141**).

The CI must follow the Scottish Regulators' Strategic Code (**footnote 142**). The Code is issued by the Scottish Ministers and sets out the approaches to be taken in dealing with persons or care facilities that are subject to oversight by regulators, such as the CI. The CI is required to comply with the requirements of the Code, ensuring that the safety, health and wellbeing of vulnerable people is prioritised over commercial or business interests (**footnote 143**).

Complaints can also be made if a person has concerns about a care service or considers that it is not performing well (**footnote 144**). When care is not being provided in accordance with the Standards, then the CI can make recommendations for improvement and issue requirements for change and check

these have been implemented. If a care service still does not improve, then the CI can take enforcement action, which may involve closing down the facility subject to court judgment.

Specifically in relation to COVID-19, the CI maintains a webpage where it regularly updates information and guidance on Covid-19. Some of the information comes from the CI itself and some from other Scottish bodies involved in managing the COVID-19 pandemic response across social care (**footnote 145**). In order to assess care home arrangements in response to the COVID-19 pandemic, it is stated that 'CI inspections are placing particular focus on infection prevention and control, personal protective equipment and staffing in care settings.' (**Footnote 146**). On 10 June 2020, the CI added Key Question 7 to augment both its quality framework for care homes for older people and its quality framework for care homes for adults. This was done in order to meet its obligations under the Coronavirus (Scotland) (No. 2) Act 2020 and subsequent guidance which requires that an evaluation must be made (with a grade made) regarding infection prevention and control and staffing in care homes. During the COVID-19 pandemic, the CI indicated that it planned to carry out targeted inspections that were short, focused, in conjunction with Public Health Scotland and Health Improvement Scotland.

Key CI COVID-19 guidance:

- **Tell Us Once service** (last updated 08 April 2020)
- **Information and guidance for social or community care and residential settings** Version 1.6 (last updated 2 April 2020)
- **Coronavirus (Covid-19): social distancing in education and childcare settings** (31 March 2020)
- **Coronavirus (Covid-19): childcare closures and emergency provision** (30 March 2020)

- **Clinical guidance for the management of clients accessing care at home, housing support and sheltered housing** (last updated 26 March 2020)
- **Clinical guidance for nursing home and residential care residents** (last updated 26 March 2020)
- **Letter from the Chief Medical Officer, Chief Nursing Officer and Chief Social Work Adviser about Covid-19 clinical guidance for social care settings** (last updated 26 March 2020)
- **Advice note** for practitioners from Mental Welfare Commission (updated 26 March 2020)
- **Guidance for non-healthcare settings** (last updated 25 March 2020)
- **Guidance for childminders** (last updated 25 March 2020)
- **Social care at heart of response to coronavirus** (updated 23 March 2020)
- **Guidance for non-healthcare settings** (last updated 20 March 2020) (guidance for educational and early learning and childcare settings has now been updated and incorporated into this guidance)
- **Letter from Deputy First Minister to local authorities on school and ELC closures** (19 March 2020)
- **Letter from Care Inspectorate chief executive** (17 March 2020)
- **Letter from Cabinet Secretary for Health and Sport - social care guidance** (13 March 2020)
- **Factsheet on the coronavirus for places of education**

## Care homes and COVID-19 deaths

The UK incurred one of the highest death rates from COVID-19 in the world, during the first and second waves of the pandemic. National Records Scotland (NRS) has published data on a regular basis setting out deaths from COVID-19 in Scotland, as well as breaking it down by ethnicity and location. At the time of

writing, the latest analysis was published by NRS on 17 November 2021 (**footnote 147**). Note that the analysis is based on what is registered on death certificates, so there is necessarily a time lag in reporting statistics and analysis by the NRS. This report states that there have been 11,933 deaths registered since April 2020, where COVID-19 was mentioned on the death certificate.

Excess deaths have been above average for 25 consecutive weeks (all causes) in 2021 As of 8th November, deaths are 20% higher than average in 2021. In 2021, excess deaths peaked in week 1 at 35% above average. The age standardised death rate for deaths involving COVID-19 in October 2021 was (125 per 100,000) to September 2021, with the highest rate being recorded in April 2020 where it was 585 deaths per 100,000. Along with COVID-19 deaths occurring in hospital or at home, the other key location is care homes and that has remained the case during the pandemic.

In terms of breakdown of COVID-19 deaths by ethnicity, the NRS reported a higher likelihood of deaths involving COVID-19 for some ethnic groups. Deaths amongst people with Pakistani, Chinese, Indian and Other Asian ethnicities were more likely to involve COVID-19 than people with White Scottish ethnicity. Deaths among people with White Other British ethnicity were less likely to involve COVID-19 than people with White Scottish ethnicity.

After adjusting for age, people living in the most deprived areas were 2.5 times as likely to die with COVID-19 as those in the least deprived areas. The size of this gap has slowly widened from 2.1 to 2.5 over the period of the pandemic. Of the 11,774 deaths involving COVID-19 between March 2020 and October 2021, 93% (10,934) had at least one pre-existing condition. Just under one quarter of people whose death involved COVID-19

had dementia or Alzheimer's disease. This was the most common main pre-existing condition.

Separate to reporting of COVID-19 related deaths by the NRS, is a daily reporting tally provided by the Scottish Government and Public Health Scotland, and this also feeds into UK government daily reporting as well. For example, as at 17 February 2022, the Scottish Government reported that 10,566 people had died who had tested positive as at 17 February 2022; 13,157 deaths had been registered in Scotland where COVID-19 was mentioned on the death certificate up to 13 February 2022; and 29% of COVID-19 registered deaths related to deaths in care homes, 64% were in hospitals and 7% were at home or non-institutional settings (**footnote 148**).

Scotland has had a very high death rate for residents in care homes (**footnote 149**). By mid 2020, care home residents accounted for 50% of all COVID-19 related deaths in Scotland, which was the highest in the UK at the time with England at 39% and Wales at 34% (**footnote 150**). However, identifying deaths arising from COVID-19 in care homes in Scotland is not straightforward for a number of reasons. In the first wave of the pandemic between March and June 2020, concerns were raised as to whether there was accurate recording of such deaths, particularly in the absence of on-demand testing. There was also evidence that many elderly people who were suspected of having COVID-19 were discharged from hospital without testing and returned to care homes which seeded subsequent outbreaks in such homes.

A key source of data collection and analysis in the area is National Records Scotland (NRS). During the first wave of the pandemic, NRS maintained a blog on statistics relevant to COVID-19, including deaths, but this does not appear to have been updated since 23 April 2020 (**footnote 151**). Further data has been published on COVID-19 deaths by ethnic group,

which was published initially on 8 July 2020, and then updated in November 2021 (see above) (**footnote 152**).

Although the Scottish Government / Public Health Scotland has reported that just under 30% of all COVID-19 deaths since the start of the pandemic related to deaths in care homes, this figure has varied over time and was much higher during the first wave of the pandemic between March and June 2020. It was reported in early June 2020 that more people had now died of COVID-19 related causes in Scottish care homes than in hospitals, with reported weekly COVID-related deaths at 1,818 occurring in care, compared with 1,815 such deaths recorded in hospitals. Week-on-week figures for Scottish facilities showed that the number of care home deaths had been higher than that in hospitals for the past six weeks up until early June 2020 (**footnote 153**).

At the time, there were concerns being expressed in the media and in political fora that it was proving difficult to get accurate data on COVID-19 related deaths in care homes and the Scottish First Minister stated in Parliament that 'her government would publish up-to-date data "as soon as we are able to do that in a robust and reliable manner"' (**footnote 154**). The government also claimed that the 'data needed to be accurate and published in a way that protected people's right to confidentiality.' (**Footnote 155**)

Nevertheless, getting an accurate (and indeed user-friendly) overview of data relating to COVID-19 deaths has remained a problem. In late July 2020, a detailed report on such deaths was published by BBC Scotland (**footnote 156**). It was reported that 'nearly half of Scotland's 4,193 coronavirus deaths have been linked to care homes' to date, with 2,365 excess deaths in Scottish care homes as measured against the five-year average since mid-March 2020. However, the BBC report observed that a further important question need to be asked,

which was 'what do we know about these men and women who succumbed to a disease that has ravaged the world? Surprisingly, the answer is very little.'

Based on investigations conducted by BBC Scotland, it appeared that both care homes and government bodies were reluctant to release what data they had on the issue and this was based on the reporter sending hundreds of emails to 1,080 public and private care homes in Scotland. Even where there had been reports in the media setting out deaths from COVID-19 outbreaks in specific care homes, the proprietors of such homes would not confirm the data. What data could be found pointed to HC-One, which ran over 50 care homes in Scotland, and Four Seasons, which ran over 30 care homes, recording the highest rates of COVID-19 deaths involving their residents during the first wave of the pandemic.

The Care Inspectorate also refused to release a breakdown of COVID-19 related deaths in care homes (**footnote 157**). This was on the stated ground that death numbers 'may not necessarily be related to a service's quality of care, hygiene standards, and use of PPE. To release information, even at provider level, could have significant impact on the ability of the provider, and consequently their services, to function commercially in already challenging economic circumstances. Releasing information at this level would also likely impact on their ability to engage new staff and/or attract new residents.' (**Footnote 158**) It was not until May 2021 that the Care Inspectorate published its data on the issue, following a ruling from the Office of the Scottish Information Commissioner.

The Care Inspectorate data was reported as showing that it had received its first notification of a COVID-19 death at a care home on 16 March 2020 and that from then until the end of March 2021, it had received 3,774 notifications of care home residents' deaths. The data also showed that care homes for

older people were most affected by the Coronavirus outbreak, with 3,761 (99.7%) of the deaths occurring in that setting. A total of 510 care homes for older people reported at least one COVID-19 related death. As the size of a care home increased, so did the rate of residents dying from COVID-19. There were 2.1 deaths per 100 places in care homes with up to 20 beds, rising to 12.6 per 100 places in those with more than 80 beds (**footnote 159**).

Academic analyses have also made an important contribution to understanding the nature and scope of COVID-19 infections and deaths in Scotland, particularly during the first wave of the pandemic. In May 2020, Bell et al published their findings on the impact of COVID-19 on Scottish care homes. In general terms, they found that the care home sector had not expanded in response to demographic change: instead, the focus of care provision had shifted to care at home.

Many of the characteristics of the care home sector in Scotland are similar to those in the rest of the UK. Although the impact of COVID-19 on deaths in care homes lagged those in hospitals they have now surpassed deaths in all other settings. This further confirmed the ongoing difficulties with accessing accurate data on COVID-19 related deaths involving care home residents, noting that 'Scotland, unlike England, does not report the number of deaths of care home residents who die in hospital and elsewhere. If the shares of such deaths are similar across both jurisdictions, then the number of care home resident deaths in Scotland attributable to COVID-19-would be significantly larger.' (**Footnote 160**)

Burton et al undertook a population analysis of testing, cases, and deaths in care homes in the NHS Lothian region. They reported the following during the period March to August 2020:

"Residents at 189 care homes (5843 beds) were tested for COVID-19 when symptomatic. A COVID-19 outbreak was confirmed at 69 (37%) care homes, of which 66 (96%) were care homes for older people. The size of care homes for older people was strongly associated with a COVID-19 outbreak (odds ratio per 20-bed increase 3·35, 95% CI 1·99-5·63). 907 confirmed cases of SARS-CoV-2 infection were recorded during the study period, and 432 COVID-19-related deaths. 229 (25%) COVID-19-related cases and 99 (24%) COVID-related deaths occurred in five (3%) of 189 care homes, and 441 (49%) cases and 207 (50%) deaths were in 13 (7%) care homes. 411 (95%) COVID-19-related deaths occurred in the 69 care homes with a confirmed COVID-19 outbreak, 19 (4%) deaths were in hospital, and two (<1%) were in one of the 120 care homes without a confirmed COVID-19 outbreak. At the 69 care homes with a confirmed COVID-19 outbreak, 74 excess non-COVID-19-related deaths were reported, whereas ten non-COVID-19-related excess deaths were observed in the 120 care homes without a confirmed COVID-19 outbreak. 32 fewer non-COVID-19-related deaths than expected were reported among care home residents in hospital."

The conclusions drawn from such analysis were that 'the effect of COVID-19 on care homes [had] been substantial but concentrated in care homes with known outbreaks. A key implication from our findings is that, if community incidence of COVID-19 increases again, many care home residents will be susceptible. Shielding care home residents from potential sources of infection and ensuring rapid action to minimise outbreak size if infection is introduced [is important].' (**Footnote 161**)

A complicating factor in terms of obtaining accurate data has been the launch of, and the conduct of investigations into COVID-19 related deaths, that is occurring as a result of Operation Koper. This was established in May 2020 in the wake

of the high number of care home COVID-19 deaths in Scotland during the first wave of the pandemic. The investigation is being conducted by the COVID-19 Deaths Investigation Team (CDIT). CDIT has a core team of 14 staff, including eight lawyers, who also work with other agencies such as the Care Inspectorate and Police Scotland. Following investigation by the Unit, prosecutors will decide if the deaths should be the subject of a fatal accident inquiry or prosecution (**footnote 162**). While an examination of Operation Koper is outside the remit of the Inquiry's Terms of Reference, the conduct of investigations that may lead to criminal charges and prosecutions has meant that again, it is currently difficult to get an accurate overall picture involving data relevant to COVID-19 deaths related to care homes to date.

# F. COVID-19 and Care Homes in England: A Comparison

## Overview

On 3 March 2020, the UK Government published its Coronavirus Action Plan (see previously). The plan did not address the specific risks faced by care homes in the context of COVID-19. However, reference was made to 'health and social care services [working] together to support early discharge from hospital, and to look after people in their own homes' (**footnote 163**).

New guidance was then issued on 13 March 2020. Care home providers were asked to consider different techniques in order to keep people safe, such as through the increased use of Skype, rather than in-person visits. Arrangements were made for increased use of Personal Protective Equipment (PPE) (**footnote 164**). Care homes were advised to isolate residents

who tested positive to COVID-19 and that a resident's room could be used for this purpose. In the context of visitation, the guidance stated the following:

"To minimise the risk of transmission, care home providers are advised to review their visiting policy, by asking no one to visit who has suspected COVID-19 or is generally unwell, and by emphasising good hand hygiene for visitors. Contractors on site should be kept to a minimum. The review should also consider the wellbeing of residents, and the positive impact of seeing friends and family." (**Footnote 165**)

Shortly after this guidance was published, patients were discharged from hospitals to care homes without mandatory testing. By the end of March 2020, the UK had entered into a national lockdown following the adoption of the Coronavirus Act 2020. Restrictions included working from home, one daily exercise per day and minimising contact with others. The guidance for care homes was subsequently amended. It stated that 'any [care home] resident presenting with symptoms of COVID-19 should be promptly isolated' and that 'negative tests are [were] not required prior to transfers / admissions into the care home.' Visitation should only be permitted in very serious situations, such as when residents were dying (**footnote 166**).

In April 2020, the UK government announced a care home action plan and support package (**footnote 167**). The action plan focused on four issues: (i) controlling the spread of infection; (ii) supporting the workforce; supporting independence; (iii) supporting people at the end of their lives and responding to individual needs; and (iv) supporting local authorities and the providers of care (**footnote 168**).

On 2 April 2020, guidance on visitation in care homes was also published (**footnote 169**). It stated that 'family and friends should be advised not to visit care homes, except next of kin in

exceptional situations such as end of life.' The guidance also mentioned that 'alternatives to in-person visiting should be explored, including the use of telephones or video, or the use of plastic or glass barriers between residents and visitors.'

On 15 April, the UK government said that before being transferred to a care home, hospital patients needed to be tested for COVID-19. Note that the requirement for patients to be tested following discharge was not included in the earlier Coronavirus action plan published in early March 2020. During the period March to April 2020, it has been estimated that 25,000 patients were discharged from hospitals in England and moved to nursing homes without COVID-19 testing (**footnote 170**). On 28 April, testing was expanded to include the testing of all care home residents (**footnote 171**).

In May 2020, a new UK government support package of £699 million was introduced for the care sector (**footnote 172**). The package was intended to help local authorities cover the costs pertaining to measures adopted in order to reduce the transmission of COVID-19. Care homes were asked to restrict staff to working in only one care home, where possible. The funding was also aimed at covering payments for care home staff who were self-isolating (**footnote 173**). Up to this point very little had been done financially to support care homes (in comparison with the actions taken in hospital settings.

On 22 June 2020, visitors were permitted to visit relatives in England, but this could only include one visitor per resident (**footnote 174**). In July 2020, the UK government advised that limited visitation would be allowed. Specific guidance was produced for parts of the UK that were in Tier 1 (medium level) (**footnote 175**). This guidance said that factors would have to be considered by care homes as part of their risk assessments. For example, visits were limited to a single visitor, where possible, with a maximum of two constant visitors per resident

in the care home, PPE had to be work and the visits were supervised 'at all times to ensure that social distancing and infection control measures [were] adhered to.' (**Footnote 176**). For tiers 2 and 3 (high and very high respectively), the government declared that people 'should not visit a care home except in exceptional circumstances, e.g. to visit someone who [was] at the end of their life.' (**Footnote 177**)

On 09 August 2020, the rules were also changed in Scotland – three outdoor visitors per resident were allowed from two different households (**footnote 178**). Indoor visits were permitted in Wales from 28 August 2020. However, although it seemed that the situation was improving, the UK government wrote to care homes in September 2020, indicating that there was a rise in COVID-19 cases in care homes (**footnote 179**). Residents were still permitted to receive visits.

On 1 December 2020, in England, family members were allowed to visit residents if they had a negative COVID-19 test (**footnote 180**). During this period, the UK government said that 'receiving visitors is an important part of care home life' (**footnote 181**). They also said that 'maintaining some opportunities for visiting to take place is critical for supporting the health and wellbeing of residents and their relationships with friends and family.' (**Footnote 182**). The UK government also stated that 'visiting should be supported and enabled wherever it is possible to do so safely—in line with this guidance and within a care home environment that takes proportionate steps to manage risks.' (**Footnote 183**)

In January 2021, a new UK wide lockdown was announced during the peak of the second wave of the pandemic. During this period, residents in care homes in England could not receive visits from family members. Updated guidance stated that '[v]isits to care homes [could] take place with arrangements such as substantial screens, visiting pods, or behind windows.

Close contact indoor visits [were] not allowed. No visits [were] permitted in the event of an outbreak.’ (**Footnote 184**). Following this national lockdown, there has been a gradual easing of restrictions.

The significant restrictions on visits to care homes caused significant distress to not only care home residents, but also their family and friends. In research conducted by the British Institute of Human Rights, 53.5% of people who contacted them about such restrictions said that the restrictions had affected their wellbeing. This included family and friends not being allowed to visit or not being allowed to exercise like they used to. The restrictions were imposed without consideration being given to any alternatives to help residents stay in touch with family and friends (**footnote 185**).

On 8 March 2021, care home residents were permitted to hold hands with regular visitors indoors if the visitors had a negative test. They were allowed a regular visitor (which was extended to two visitors from 12 March 2021). They were not allowed to hug or kiss their visitors (**footnote 186**). Recent guidance allows visitors provided they take a lateral flow test on the day of the visit. If a patient who has capacity wishes to leave a care home for a visit, this will usually not result in the patient having to isolate for self-isolation if certain criteria are met (**footnote 187**).

On 2 February 2022, updated guidance was published that now allows visitors into care homes provided they take a lateral flow test on the day of the visit. If a patient who has capacity wishes to leave a care home for a visit, this will usually not result in the patient having to isolate for self-isolation if certain criteria are met (**footnote 188**).

## Care homes and COVID-19 deaths

According to Public Health England, the policy that allowed for patients to be moved from hospitals to care homes may have impacted upon the significant death rate – the patients were not tested for COVID-19 (**footnote 189**). During the first wave of the pandemic, there were problems with the way in which COVID-19 related deaths were recorded.

It was only from 20 April 2020 onwards that COVID-19 mortality data included residents of care homes. Prior to this, there was no explicit classification of their deaths as a consequence of COVID-19. The deaths of care home residents were, thus, rendered invisible between February to April 2020, where proper accounting for care home deaths in England did not take place. This change in practice to ensure proper recording of COVI-19 deaths in care homes only took place on foot of public disquiet and media pressure (**footnote 190**).

On 29 April 2020, official figures included deaths in care homes as well as deaths in the community. The mortality rate from COVID-19 jumped from 4,419 to 26,097 (**footnote 191**). On 19 April, the Chair of Care England, Professor Martin Green criticised the government and said that a priority should have been given to care homes from the start of the pandemic (**footnote 192**). On this date, it had been reported that 11,600 residents in care homes had died from COVID-19 in UK care homes (**footnote 193**).

## COVID-19 and care homes: reviews and reports

On 21 September 2020, the UK Parliament's Joint Committee on Human Rights published a report into human rights implications arising from the first wave of the pandemic. It noted the very high number of deaths from COVD-19 in care homes

as being ‘a matter of deepest concern to us and engages the operational duty to secure life (Art 2 ECHR). The causes behind it are complex … imperative that they be interrogated thoroughly in order to meet the state’s procedural obligations under Article 2 ECHR.’ (**Footnote 194**). The UK government should give serious thought to establishing a Commissioner for Article 2 compliance to ensure correct processes are followed requiring Article 2 ECHR investigations, without relying on bereaved families for ensuring appropriate follow up (**footnote 195**).

On 5 May 2021, the JCHR published a further report examining visiting restrictions imposed on care homes during the COVID-19 pandemic to date (**footnote 196**). The report criticised the approach taken to the UK government in relation to care home residents during the pandemic. The Committee found that t there had likely been interference with the following ECHR Article 2 (right to life), Article 5 (right to liberty and security) Article 8 (respect for private and family life).

The report makes a number of recommendations and conclusions. For example, it states that the government’s guidance has placed insignificant focus on role of family members. The report says that ‘[i]t was wrong to deny essential care givers the right to see their relatives, especially when they could have played a crucial role in supporting the over-stretched care home staff during the crisis.’ (**Footnote 197**). The JCHR found that the UK Department of Health and Social Care (DHSC) had not consulted widely enough when creating new guidance and that residents’ groups should have been involved to a greater extent (**footnote 198**). The report was also highly critical of the 14-day isolation rule (**footnote 199**). More generally, the JCHR concluded that:

“The Government and care home providers have had a difficult job balancing the right of residents to a family life with the need

to protect the right to life of all residents and staff. However, many providers have erred too far on the side of caution, to the significant detriment of residents and their families. Both the Government and providers should have done more to recognise the importance of quality of life for care home residents." (**footnote 200**).

The Committee concluded that the UK Government should now review the provision of infection prevention and control measures, including infection prevention and control nurses, to social care and ensure that social care providers, particularly care homes, are able to conduct regular pandemic preparedness drills. The Government should also ensure that care homes have isolation facilities and social care providers are able to provide safe visiting for family and friends of care home residents (**footnote 201**). Specific findings included the following:

**The need to protect the elderly**

The JCHR noted that COVID-19 has been 'a particular scourge of the elderly. People aged 80 and older who contracted covid were 70 times more likely to die than people aged 40 or younger. This meant that the arrangements to protect the elderly were of vast importance, especially during the first waves of the pandemic when no vaccines were available to protect such vulnerable people' (**footnote 202**).

**COVID-19 deaths of care home residents**

Between 16 March 2020 and 30 April 2021, 41,675 care home residents died of covid-19—nearly a quarter of deaths from all causes among care home residents. In the English context, this amounted to 25% of all COVID-19 related deaths over the same period of the pandemic. The JCHR noted that this was likely to be an underestimate given the lack of testing of care home residents during the early weeks of the pandemic. The number of deaths of people receiving domiciliary social care

between 10 April and 19 June 2020, meanwhile, was over 120% higher than the three-year average over the same period between 2017 and 2019, with 12.6% of the total involving a confirmed case of COVID-19. The UK was not alone in suffering significant loss of life in care homes, but the tragic scale of loss was among the worst in Europe and could have been mitigated (**footnote 203**).

### Impact of the COVID-19 pandemic on social care staff

The impact of the pandemic on the social care workforce has also been acute. Between March 2020 and August 2020 7.5% of workdays were lost to sickness absence compared to 2.7% before the pandemic.382 During the first wave of the pandemic - March and May 2020 - the Office for National Statistics recorded 760 deaths of people working in social care in England and Wales, nearly twice the average during the same period from 2014 to 2019. During the course of the pandemic, 74% of deaths recorded for social care workers had Covid-19 recorded as a cause of death. Further analysis showed that between 31 October 2020 and 5 February 2021, 26% of the total number of all covid-19 deaths occurred among care home residents, compared to 40% during the first wave of the pandemic between mid-March and mid-June 2020. The fact that many social care staff remain unvaccinated represents an ongoing challenge for the sector (**footnote 204**).

### Prioritising NHS health care over social care – discharges back to care homes

Witnesses to our inquiry suggested that the Government’s emphasis on “protecting the NHS” first and foremost caused specific practical problems for social care providers, with a view that care homes were ‘very much sidelined’ during the first part of the pandemic. The most damaging way in which the prioritisation of the NHS over social care manifested itself during the first wave of the pandemic was in the rapid discharge of people from hospital to care homes without adequate testing.

In order to free acute hospital beds in anticipation of the first wave of the pandemic, NHS providers were instructed to urgently discharge all medically fit patients as soon as it was clinically safe to do so, and care home residents were not tested on their discharge from hospital. Around 25,000 people were discharged from hospitals into care homes between 17 March and 15 April 2020, and while the total number is smaller than in the preceding year due to significantly lower admissions, during the critical weeks in early March there was a marked increase in the number of discharges to care homes compared to the previous year (**footnote 205**).

**Lack of COVID-19 testing for care home residents**

There were several factors during the early period of the pandemic which meant that it was not possible to safely discharge patients to care homes and at the same time avoid outbreaks of covid-19 within those homes. Most obviously, a lack of testing capacity meant that patients were not prioritised for testing ahead of being discharged to care homes. Guidance on testing was issued on the basis that care homes would be able to safely isolate people who were admitted from hospital. However, in reality many care homes lacked the facilities to safely isolate patients admitted from hospital. At the most basic level not every care home had the physical space to be able to effectively isolate patients being discharged from hospital (**footnote 206**).

**Lack of access to PPE for social care workforce**

The risk in care homes was further compounded by poor access to PPE during the early period of the pandemic. In March 2020, it was note that delivery of PPE to care homes was “insufficient”, “extremely erratic and difficult” and this continued until at least mid 2020. The Committee recognised that the UK Government took action to address these shortages including adding CQC registered social care providers to the Government’s PPE supply chain and providing free PPE via

personal Local Resilience Forums for other types of care provider (**footnote 207**).

**Lack of infection control in care home settings**
Efforts to carry out effective infection control in social care settings were undermined by workforce factors, including both pre-existing shortages and shortages due to covid-19, as well as a lack of access to asymptomatic staff testing. The movement of care home staff between different homes has been a particular area of focus, with the ONS's Vivaldi study of 9,081 care homes for older people (aged 65 and over) finding that care homes that regularly used bank or agency staff, or homes where employed staff regularly worked elsewhere, had higher risk of infection. The study also "found that the payment of sick pay was associated with a decreased risk of COVID-19 infections. Reliance of social care providers on agency staff reflected longstanding staffing difficulties in the social care workforce (**footnote 208**).

**Lack of pandemic preparedness in social care**
Drawing on evidence presented to the Inquiry, the JCHR noted that there were scant resources to support [infection prevention and control] in the care home sector across the UK" and further that: The regulation of IPC in care homes is poor, it is not perceived as an integral part of quality and inconsistently and inappropriately monitored […] The level of qualified IPC support to care homes on a national level is minimal and such services have been under-resourced for many years. In some areas the qualified IPC support can be as little as one Infection Control Nurse for 300 care homes (**footnote 209**).

**Longstanding problems with social care sector and workforce underlying challenges facing the care sector**
The pandemic occurred against a backdrop of issues in social care including workforce shortages, funding pressures and provider instability which successive governments have failed to

address. Even without the factors explored above, these long-term issues meant that the sector entered the pandemic in a weakened state which hampered its ability to respond to the impact of covid. Coming into the pandemic, adult social care services were already at “breaking point”. The social care workforce entered the pandemic in a weakened state. In 2019–20, there was an estimated vacancy rate of 7.3% across the year, equating to 112,000 vacant roles. The turnover rate was 30.4%, and around a quarter of the workforce (24% were employed on a zero-hours contract. While pay has increased since the introduction of the National Living Wage, care workers continue to be low paid. The pandemic served to highlight long-standing funding pressures. There were underlying structural problems in the funding and staffing of social care, both in care homes and in people’s own homes, before the pandemic. PPE costs were substantial for the care home sector and remain so. There had also been increased insurance costs due to the risks of COVID-19 outbreaks, which had been suggested as a particular barrier to care homes acting as designated sites for isolating patients discharged with COVID-19 (**footnote 210**).

On 15 July 2021, the UK Government responded to the JCHR report (**footnote 211**. It considered that it had responded well to its positive obligations under Article 2 ECHR (right to life, stating that ‘[a]s care home residents are particularly vulnerable in the event of infection with COVID-19 – the interference by way of continuing restrictions in this specific cohort is necessary and proportionate to the risks they face.’ The main goal had been to ‘protect lives’ and that ‘visiting arrangements have been available throughout the pandemic’ (e.g. window visits and visits in exceptional cases, such as in end of life, with restrictions imposed on residents being ‘proportionate and appropriate’ (**footnote 212**.

In response to the JCHR’s findings that the visiting restrictions severely interfered with Article 8 ECHR rights (right to a private

and family life), the UK government responded that '[w]e have made judgements that balance these rights to enable residents to have meaningful visits with their families and loved ones while ensuring that residents are protected, as far as possible, from infection and harm from COVID-19.' Reference was also made to the fact that the UK government had subsequently issued further guidance in mid-2020 which allowed for a significant relaxation of restrictions. This allowed care home providers to undertake individual risk assessments taking account of vaccination status, variants of concern, the rate of infection and other issues in order to make a proportionate decision on visits to individual residents.

However, it is worth noting that the guidance referred to the UK government was subsequently tightened again to restrict visits to care homes in order to control the spread of COVID-19 as the UK entered the second wave of the pandemic in the latter half of 2020 and into early 2021. Two further inquiries are underway at the time of writing which will be relevant to care homes. They include an Inquiry into the UK Government's response to COVID-19 focused on the implications of lockdown restrictions on human rights, and in particular the impact of long lockdown communities on particular communities (**footnote 213**). A further Inquiry is examining whether the human rights of care residents were respected during the COVID-19 pandemic (**footnote 214**).

## G. COVID-19 and the Health and Social Care Workforce in Scotland

### Managing workforce risks

NHS Scotland Staff Governance established an online 'hub' which collated guidance endorsed by the Scottish Government

for use by NHS Scotland NHS Scotland Staff Governance established an online ‘hub’ which collated guidance endorsed by the Scottish Government for use by NHS Scotland employers to support the workforce. The resource can also be used by social care employers, with the caveat that supplementary guidance on terms and conditions only apply to NHS Scotland staff. Guidance is updated in real time and best viewed online (**footnote 215**).

Much of the guidance is aimed at assessing risk for healthcare workers in NHS Scotland. The guidance aims to provide managers and staff with guidance on how to assess the specific risk of COVID-19 to individuals in the workplace, that considers both individual and occupational risk factors. In July 2021, Coronavirus (COVID-19): guidance on individual occupational risk assessment was published. This replaced the earlier Guidance for Health and Social Care Emergency Workers with underlying Health Conditions, which had originally been published on 30 March 2020 and the Interim Guidance for health and social care employers on staff from Black, Asian and Minority Ethnic Backgrounds, originally published on 21 May 2020. The guidance recognises that underlying health conditions and ethnicity, when viewed in isolation, do not accurately predict an individual’s vulnerability.

The risk assessment tool that is endorsed for use by all staff is based on clinical and scientific evidence and takes into account multiple personal characteristics including ethnicity, age, gender, BMI and health conditions, to assess an individual’s overall vulnerability to COVID-19. It is designed to support managers and staff to have a supportive and constructive conversation about a member of staff’s personal characteristics and how they can be enabled to work safely. There are three things which need to be considered when assessing an individual’s occupational health risk from COVID-19: workplace

risks and control measures; understanding individual risks and local prevalence of COVID-19 (**footnote 216**).

Guidance was also published which set out exemptions for health and social care staff in relation to what would follow from COVID-19 infection, time off work and then a return to work. Details are set as follow:

**Health Workforce Directorate, Director's Letter and Policy Framework on 'Isolation Exemptions for Health and Social Care Staff (DL 2021/22)**
A policy framework was published which was designed with clinical leads within the Scottish Government to enable fully vaccinated and asymptomatic health and social care staff who have been a contact of someone with a positive COVID test to be exempted from self-isolation requirements under specific circumstances. These circumstances are detailed within the framework which sets out a range of control measures to ensure that we continue to prioritise the safety of health and social care staff and patients / service users. The framework is designed to assist health and social care employers to determine the appropriate 'in extremis' conditions in which they can ask appropriate staff if they are willing to return to support service delivery. It is important to stress that nothing in the framework would make it mandatory for any self-isolating health and social care worker to return to work, even if asked (**footnote 217**).

**Scottish Government, Health Workforce Directorate, Director's Letter and Policy Framework on 'Isolation Exemptions for Health and Social Care Staff (DL 2021/24)**
From 9 August 2021 people (including health and care workers) identified as close contacts of someone who has tested positive for COVID-19 are no longer required to automatically self-isolate if they are double vaccinated with the 2nd dose of COVID-19 vaccine at least two weeks prior to exposure to the

case, have no COVID-19 cardinal symptoms and return a negative PCR test taken after exposure to the case. There is an updated policy framework outlining the clinical safeguards necessary to reduce any residual risk with close contacts returning to work within health and social care. This framework replaces the 'in extremis' Framework for the implementation of isolation exemptions for health and social care staff (DL 2021/22) (**footnote 218**).

**Scottish Government, Health Workforce Directorate, Update on Self-Isolation for Health and Social Care Staff, (DL 2022/01)**
From 17 January 2022, fully vaccinated staff (those who have had two doses and a booster 14 days prior to the last exposure to the case), identified as either household or non-household contacts will be expected to take daily LFD tests for seven days, from exposure to the case and if the LFD tests are negative and they remain well, will not have to isolate. They can also end further contact testing at the end of the ten-day period (**footnote 219**).

Other initiatives included the Scottish Government's Clinical Guidance Cell publishing detailed information on definitions of underlying health conditions to support Health and Social Care and Emergency Service Workers understand the risks associated with their health conditions. It was emphasised that the policy approach was designed to facilitate individualised decision-making, that considers a range of known risk factors, the nature of an employee's work, steps taken to reduce risk, the expectations of employees, and the prevalence of the virus (**footnote 220**).

A national wellbeing hub for health and social care workers was also established. The National Wellbeing Hub was launched on 11 May 2020. It signposts staff, unpaid carers, volunteers and their families to relevant services, and provides a range of self-

care and wellbeing resources designed to support the workforce as they respond to the impact of COVID-19. On 20 July, a new national wellbeing line for the health and social care workforce was also launched, based within NHS 24, which provided an around the clock service to those who need further psychological support, including in light of the coronavirus crisis. All health and social care workers in Scotland will now have 24/7 access to mental health support. These wellbeing initiatives were supported by separate initiatives at regional/territorial Health Board level as well (**footnote 221**). The resource can also be used by social care employers, with the caveat that supplementary guidance on terms and conditions only apply to NHS Scotland staff. Guidance is updated in real time and best viewed online (**footnote 222**).

Much of the guidance is aimed at assessing risk for healthcare workers in NHS Scotland. The guidance aims to provide managers and staff with guidance on how to assess the specific risk of COVID-19 to individuals in the workplace, that considers both individual and occupational risk factors. In July 2021, Coronavirus (COVID-19): guidance on individual occupational risk assessment was published. This replaced the earlier Guidance for Health and Social Care Emergency Workers with underlying Health Conditions, which had originally been published on 30 March 2020 and the Interim Guidance for health and social care employers on staff from Black, Asian and Minority Ethnic Backgrounds, originally published on 21 May 2020. The guidance recognises that underlying health conditions and ethnicity, when viewed in isolation, do not accurately predict an individual’s vulnerability.

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the policy approach was designed to facilitate individualised decision-making, that considers a range of known risk factors, the nature of an employee’s work, steps taken to reduce risk, the expectations of employees, and the prevalence of the virus (**footnote 223**).

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## Availability of Personal Protective Equipment (PPE)

The UK had developed a national pandemic PPE stockpile as part of the UK Pandemic Influenza Preparedness Programme (PIPP), and this was increased in size following the swine flu pandemic in 2009. PPE requirements during the Covid-19 pandemic were unprecedented and the levels held in the stockpile were not enough to meet initial demand. The Scottish Government did not fully implement improvements identified as part of preparedness exercises.

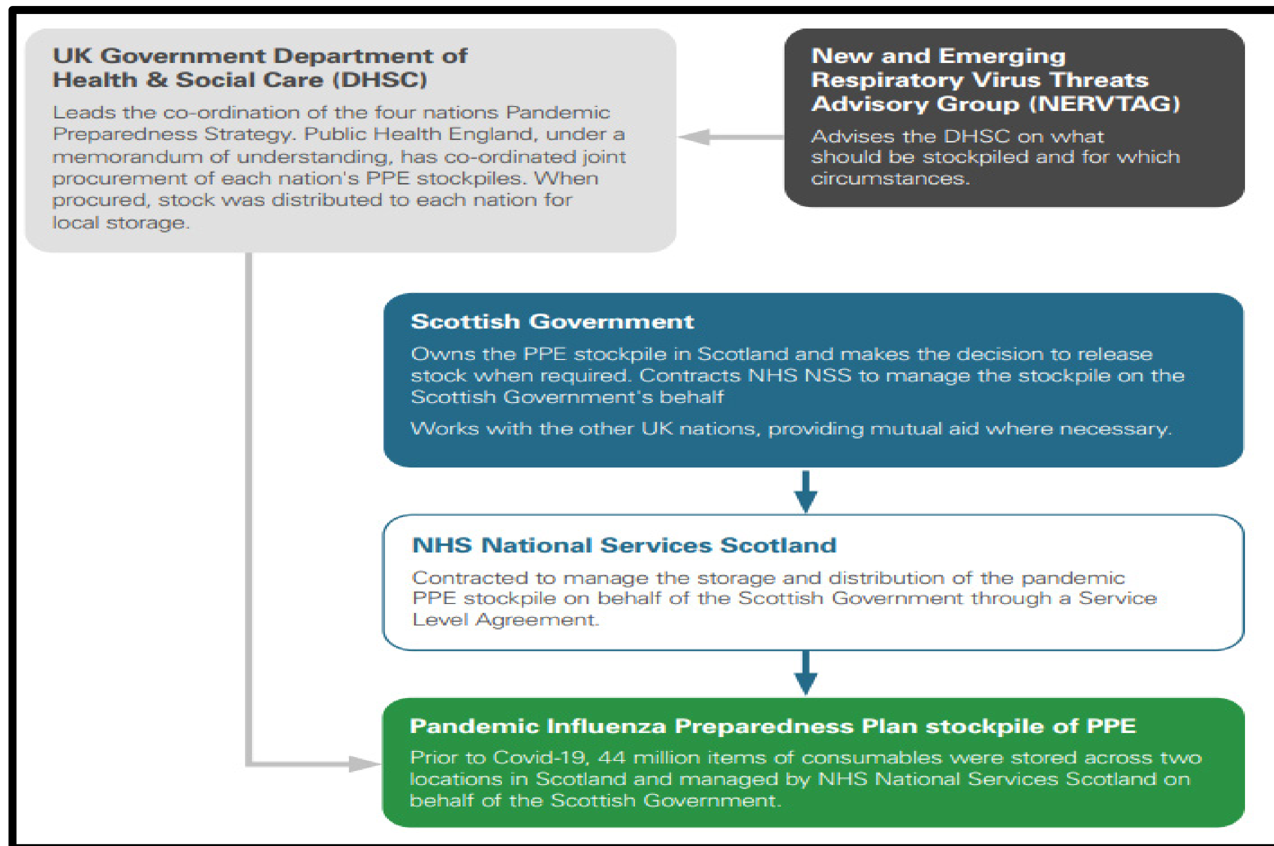
PPE stockpiles The Scottish Government conducted two pandemic preparedness exercises. Exercise Silver Swan was

held in 2015 and Exercise Iris in 2018. Both exercises identified access to, and training in the use of PPE as areas for improvement. Pre-COVID-19 pandemics, an overview of the UK PPE pandemic stockpile arrangements, including arrangements with devolved administrations, such as Scotland, is set out below.

In Scotland, National Services Scotland (NSS) is a national board forming part of NHS Scotland. Part of its role involves acting as the single national procurement service for the NHS Scotland. Prior to the emergence of the COVID-19 pandemic. NSS provided a stock and distribution service for Personal Protective Equipment (PPE) supplies for hospitals. None of the PPE stocked by the NSS was manufactured in Scotland. NHS boards would place orders which NSS supplied through its National Distribution Centre. The model for distributing PPE to NHS health boards was based on processing relatively low volumes of PPE.

In 2019/20, NSS distributed on average 5.6 million items of PPE per week across Scotland, costing £162,000. This was less than a third of the volume of average weekly shipments since the start of the pandemic. Primary care and social care providers were responsible for sourcing and buying their own PPE supplies. The processes that NSS had in place for distributing PPE were based on lower PPE usage. They were not designed to enable distribution of high volumes of PPE to urgent timescales. In early April 2020, NSS commissioned a review of PPE distribution in Scotland. The review report highlighted a range of issues, including a lack of knowledge about stock held by NHS boards and a need for a better understanding of PPE demand and usage in social care and primary care settings.

## Figure 18 - UK Management of the Pandemic Stockpile




[Figure 18 shows a flow chart with the following information. Step 1 is at the top.

Step 1
**New and emerging Respiratory Virus Threats Advisory Group (NERVTAG)**
Advises the DHSC on what should be stockpiled and for which circumstances.
[Step 1 leads to Step 2 only]

Step 2
**UK Government Department of Health and Social Care (DHSC)**
Leads the co-ordination of the four nations Pandemic Preparedness Strategy, Public Health England, under a memorandum of understanding, has co-ordinated joint

procurement of each nation's PPE stockpiles. When procured, stock was distributed to each nation for local storage.
[Step 2 leads to Step 5 only]

Step 3
**Scottish Government**
Owns the PPE stockpile in Scotland and makes the decision to release stock when required. Contracts NHS NSS to manage the stockpile on the Scottish Government's behalf.
Works with other UK nations, providing mutual aid where necessary.
[Step 3 leads to Step 4 only]

Step 4
**NHS National Services Scotland**
Contracted to manage the storage and distribution of the pandemic PPE stockpile on behalf of the Scottish Government through a Service Level Agreement.
[Step 4 leads to Step 5 only]

Step 5
**Pandemic Influenza Preparedness Plan stockpile of PPE**
Prior to Covid-19, 44 million items of consumables were stored across two locations in Scotland and managed by NHS National Services Scotland on behalf of the Scottish Government.

End of Figure 18]

At the start of the pandemic, the four UK nations jointly developed guidance which set out the type of PPE that health and social care workers should be wearing in different settings. Scotland's PPE stockpile was purchased in collaboration with the other UK nations. 78 contracts worth £340 million were awarded to companies providing PPE between March 2020 and June 2021. The Scottish Government reports that by value, 88% of PPE (excluding gloves) is now made in Scotland.

Scotland's traditional PPE supply routes, just-in-time supply model and PPE stockpiling arrangements were not sufficient once the COVID-19 pandemic emerged in early 2020. Pre-pandemic demand for PPE was significantly lower and the national pandemic stockpile was not enough to meet the unprecedented demands of the Covid-19 pandemic (**footnote 225**). The Scottish Government, together with NSS and Scottish Enterprise worked with Scottish manufacturers to produce PPE. By April 2021, the Government reported that 88% of PPE, excluding gloves, was now being manufactured in Scotland, often using Scottish raw materials. Gloves remained almost exclusively produced in Malaysia, where there is an established supply chain.

There are normally strict rules surrounding the public sector's purchase of goods and services in the UK. In normal circumstances, any contract over the threshold of £50,000 for goods and services must go through a competitive process. On 20 March 2020, the Scottish Government published procurement guidance for public bodies during the COVID-19 pandemic, to enable them to procure goods and services with extreme urgency. The main mechanism used by NSS during the pandemic was to award contracts directly to suppliers without competition (**footnote 226**). In 2020/21, NSS awarded eight contracts (10 per cent) worth £71 million (21 per cent) through its existing arrangements, but most contracts for PPE were directly awarded to suppliers.

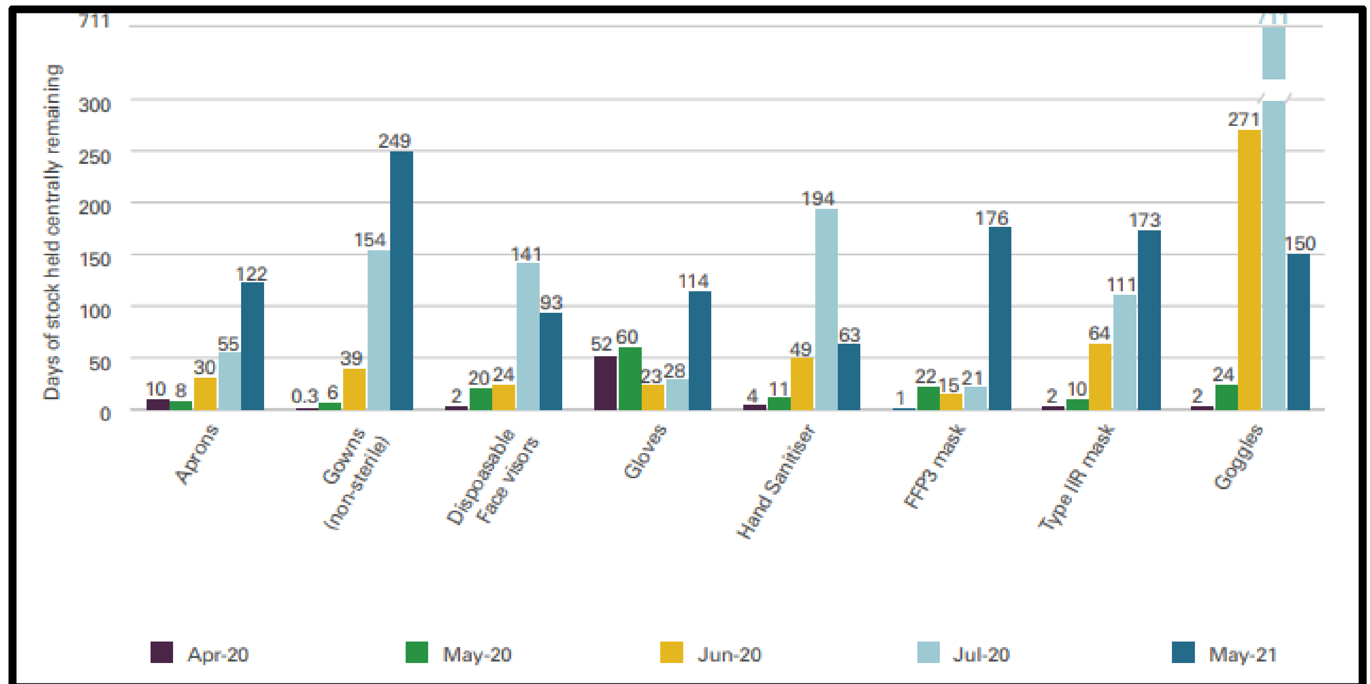
In the early stages of the pandemic, the Scottish Government set up a PPE Strategy and Governance Board. This group is responsible for overseeing the implementation of the Scottish Government's PPE Action Plan. This includes an action to improve evidence about the fit and comfort of PPE for different groups, including women and ethnic minorities. It also supports opportunities to develop a Scottish PPE supply chain and

oversees work around environmentally sustainable and reusable PPE.

There are other groups involved in decision-making around PPE. These include the PPE for Primary Care Group and the Social Care PPE Steering Group. A framework was also set up by the Scottish Government to provide PPE to all public bodies outside the NHS and regulated care sector, eligible private businesses that provided an essential public service, and all third sector organisations to obtain PPE from a private framework supplier when their traditional supply routes failed. This was brought to an end in October 2021 once supply chains stabilised.

In the initial stages of the pandemic, NSS delivered a week's supply of PPE to all care homes in Scotland. It then established 48 PPE hubs across Scotland. Care providers, including unpaid carers and personal assistants, can access up to a week's PPE from the hub. In March 2020, NHS NSS also set up the social care support centre, which has an emergency phone line for urgent requests for PPE. Calls to this number are triaged and either directed to a hub or arrangements are made for an emergency delivery to the care setting.

## Figure 19 - Number of Days of Stock held centrally by NHS, NSS (April 2020 - May 2021)




[Figure 19 shows a bar graph. Each bar on the x axis shows stock types and is split into 5 categories as follows: Apr-20; May-20; Jun-20; Jul-20 and May-21. The y axis is labelled 'Days of Stock held centrally remaining' and goes from 0 to 711. 0 to 300 is shown in increments of 50, then 711 is added at the top. The information shown is as follows:

Aprons

- Apr-20: 10
- May-20: 8
- Jun-20: 30
- Jul-20: 55
- May-21: 122

Gowns (non-sterile)

- Apr-20: 0.3
- May-20: 6
- Jun-20: 39
- Jul-20: 154
- May-21: 249

Disposable Face Visors
- Apr-20: 2
- May-20: 20
- Jun-20: 24
- Jul-20: 141
- May-21: 93

Gloves
- Apr-20: 52
- May-20: 60
- Jun-20: 23
- Jul-20: 28
- May-21: 114

Hand Sanitiser
- Apr-20: 4
- May-20: 11
- Jun-20: 49
- Jul-20: 194
- May-21: 63

FFP3 mask
- Apr-20: 1
- May-20: 22
- Jun-20: 15
- Jul-20: 21
- May-21: 176

Type IIR mask
- Apr-20: 2
- May-20: 10
- Jun-20: 64
- Jul-20: 111
- May-21: 173

Goggles

- Apr-20: 2
- May-20: 24
- Jun-20: 274
- Jul-20: 711
- May-21: 150

End of Figure 19]

Care homes and care-at-home services usually ordered their PPE from private supply chain. However, they found in the early stages of the pandemic, that their usual suppliers were unable to provide the increased levels of PPE needed. The Scottish Government then decided to expand the remit of the NSS to provide PPE to primary care providers and social care settings (including care homes and care-at-home services) which were unable to access PPE through their usual routes. When this was not possible, they used the NSS hubs.

For the social care sector, NSS provided top-up and emergency PPE free of charge from the national stock via 48 regional distribution hubs, alongside an emergency triage service for adult social care providers who had an urgent shortage of PPE. Between April and August 2020, NSS has estimated that it provided 38% of PPE requirements for Scottish care homes and 42% of care-at-home services (including for personal assistants). Unpaid carers obtained all their PPE from NHS NSS through the NSS hubs as well.

In the period March 2020 – April 2021, the Scottish Government also reimbursed an estimated £17.5 million to social care providers for costs associated with PPE and infection control through its sustainability fund. During this same period, NSS provided 1.1 billion items of PPE, worth £218 million, to health and social care across Scotland. 62% of such supplies went to

acute health care, 9% to primary care and 29% to social care and carers.

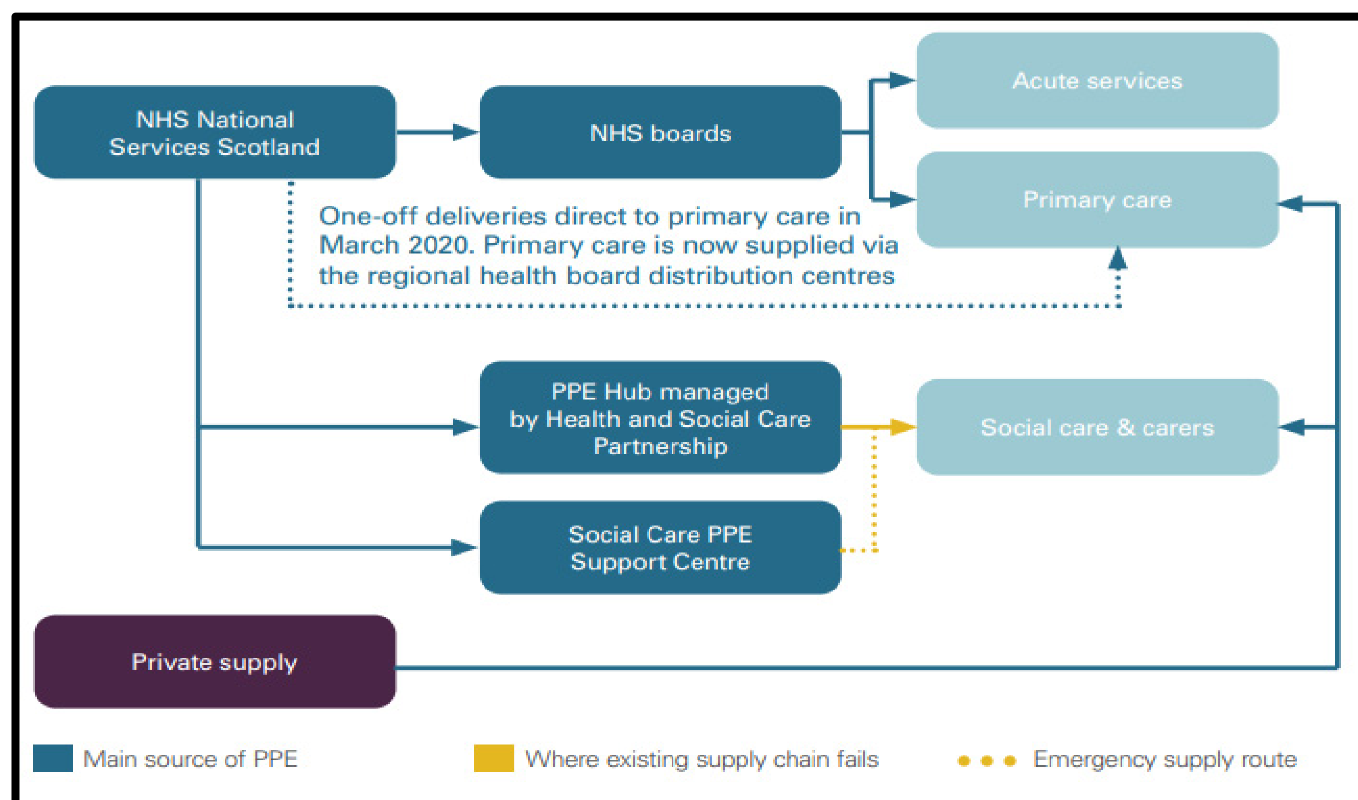
In the early stages of the pandemic, organisations representing frontline health and social care workforce raised concerns with the Scottish Government about both the availability and suitability of PPE provided to those working in health and social care. Concerns included whether the guidance on what PPE to use adequately protected healthcare professionals. In April 2020, the Royal College of Nursing (RCN) surveyed its members on the use and availability of PPE (**footnote 227**). Results from its Scottish members showed that 25% of those surveyed who worked in high-risk environment reported that they had not had their masks fit tested and 47% reported being asked to re-use single use PPE. On 26 May 2020, the Chief Nursing Officer issued a letter to all NHS health boards clarifying that single-use PPE should not be re-used.

In April 2020, the British Medical Association surveyed its Scottish members and found that 29% of those surveyed reported shortages of full-face visors and 13% reported shortages of FFP3 masks. Of those not carrying out Aerosol Generating Procedures (AGPs) and working with possible or confirmed COVID-19 patients, availability of eye protection was the main concern, with 24% reporting shortages (**footnote 228**).

Audit Scotland Report published a report in June 2021 which examined the Scottish Government's approach to PPE supply during the COVID-19 pandemic (**footnote 229**). It found that in March 2020, an increase in demand for PPE and a reduction in supply as foreign factories shut because of COVID-19 lockdowns meant that the global supply chain for PPE began to falter. This pressure resulted in difficulties procuring PPE, large cost increases and unstable supply across the world. There were particular pressures on gowns and visors at the start of

the pandemic, as these items had not been held in the UK stockpile. During summer 2020, COVID-19 cases fell, orders arrived, and NSS increased the level of centrally held PPE stock. Based on modelled demand, it now has between 3-4 months' supply of PPE. More PPE is now made in Scotland, which has stabilised the supply chain.

**Figure 20 - Routes to obtaining PPE during the pandemic in Scotland**




[Figure 20 shows a flow chart with the following information. Step 1 is on the left.

**Step 1**
Step 1 is split into
- 1a: NHS National Services Scotland (Main source of PPE)
- 1b: Private supply

[Step 1a leads to 2a, 2b and 2c with a solid line, and to 3b with a dotted line. The dotted line is labelled 'One-off deliveries

direct to primary care in March 2020. Primary care is now supplied via the regional health board distribution centres'.
Step 1b leads to 3b and 3c]

**Step 2**
Step 2 is split into
- 2a: NHS Boards (Main source of PPE)
- 2b: PPE Hub managed by Health and Social Care Partnership (Main source of PPE)
- 2c: Social Care PPE Support Centre (Main source of PPE)

[Step 2a leads to 3a and 3b.
Step 2b leads to 3c (Where existing supply chains fail)
Step 2c leads to 3c (Emergency supply route)

**Step 3**
Step 3 is split into
- 3a: Acute Services
- 3b: Primary care
- 3c: Social care and carers

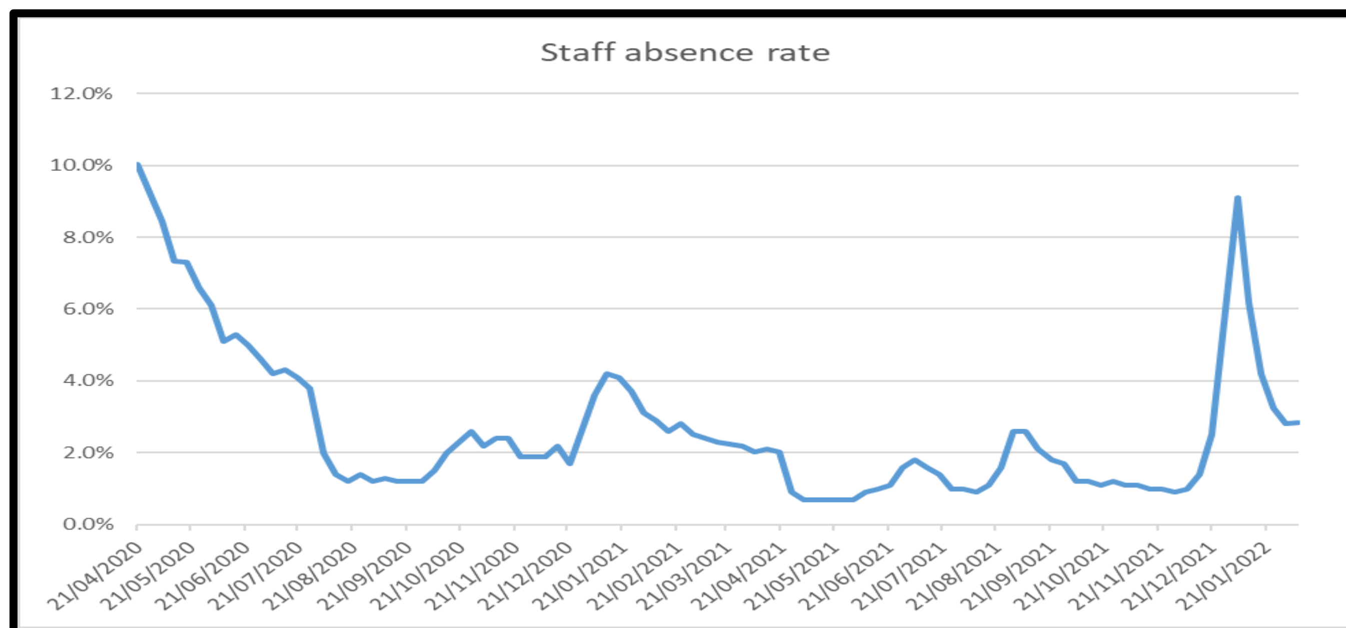
End of Figure 20]

## Rates of COVID-19 infection and deaths for health and social care workers

For the week ending 15 February 2022, on average 3,482 NHS Scotland staff, or around 1.9% of the NHS workforce, reported absent each day for a range of reasons related to COVID-19. In addition, 1,148 staff in adult care homes (including adult and older people care homes) were reported as absent due to COVID-19, based on returns received from 730 (69%) adult care homes. Staff absent due to COVID-19 represents 3.1% of all adult care home staff (36,949) for whom a return was provided (**footnote 230**). There appears to be little, if any,

published data on the impact of long Covid on health and social care staff.

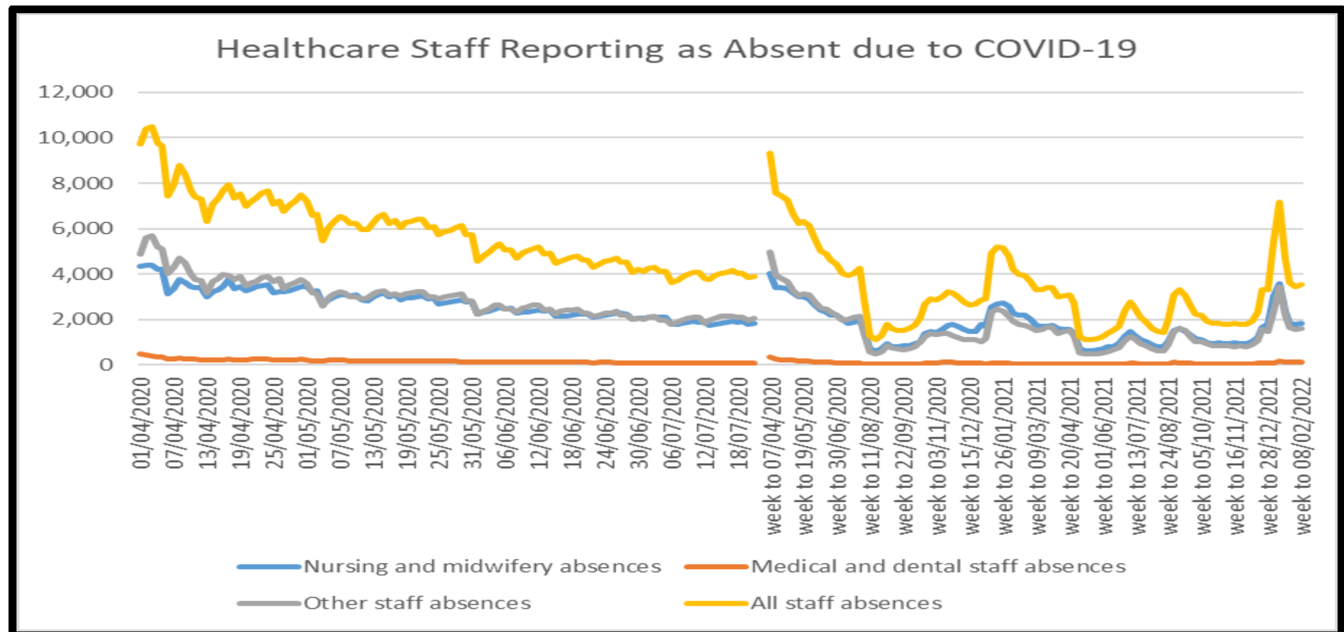
**Figure 21 - Health and Social Care Staff Absence Rates in Scotland (2020-2022)**




[Figure 21 shows a line graph labelled ‘Staff absence rate’. The x axis shows dates and goes from 21/04/2020 to 21/01/2022 in monthly increments. The y axis shows percentage and goes from 0.0% to 12.0%. Figures given are approximate. The line starts at 10% on 21/04/2020 and drops sharply to 1.25%. It fluctuates between 1% and 4% until 21/12/2021 then rises sharply to 9% in January 2021. It then immediately drops sharply again back to 2.5%.

End of Figure 21]

## Figure 22 - Health and Social Care Staff: Absence Due to COVID-19 in Scotland




[Figure 22 shows 2 line graphs labelled 'Healthcare Staff Reporting as Absent due to COVID-19'. Both graphs have 4 lines, 1 for each of the following groups: 'Nursing and midwifery absences'; 'Medical and dental staff absences'; 'Other staff absences' and 'All staff absences'. The y axis of both graphs goes from 0 to 12,000. Figures given are approximate.

The graph on the left shows data on a weekly basis from 01/04/2020 to 18/07/2020.
'Medical and dental staff absences' are shown as very low. They start at 500 in the first week, then drop and the line is almost flat to the x axis for the rest of the graph.
'Nursing and midwifery absences' start at 4200 and although they fluctuate by small amounts over time there is a general slow downward trend to 1,900 at the end of the graph.
'Other staff absences' starts at 4,800, initially increased to 5,900 then drops to 4,000 very quickly and follows a very similar pattern and curve to 'Nursing and midwifery absences'. It fluctuates by small amounts over time but there is a general slow downward trend to 2,000 at the end of the graph.

‘All staff absences’ starts at 9,900, initially increases to10,300, then drops quickly to 6,200 by 13/04/2020. It then fluctuates by small amounts over time but there is a general slow downward trend to 4,000 at the end of the graph.

The graph on the right shows data on a monthly and sometimes bi-monthly basis from ‘week to 07/04/2020’ to week to 08/02/2022’.
‘Medical and dental staff absences’ are shown as very low. They start at 500, then drop and the line is almost flat to the x axis for the rest of the graph.
‘Nursing and midwifery absences’ start at 4200. They fluctuate by small amounts over time but the general trend is as follows: they drop to 500 on the week to 11/08/2020, increase slowly to 3,000 on the week to 12/01/2021, decrease to 500 on the week to 20/04/2021, increase and fluctuate between 1,000 and 1,800 until the week to 28/12/2021. They then increase sharply to 3,900 and fall quickly back to 2,000 week to 08/02/2022.
‘Other staff absences’ starts at 4,800, then follows a very similar pattern and curve to ‘Nursing and midwifery absences’.
‘All staff absences’ starts at 9,900. They fluctuate by small amounts over time but the general trend is as follows: they drop sharply to 1,000 week to 11/08/2020, increase slowly to 5,500 on the week to 26/01/2021, decrease to 1,200 on the week to 20/04/2021, increase and fluctuate between 1,800 and 3,500 until the week to 28/12/2021. They then increase sharply to 5,500 and fall quickly back to 3,900 week to 08/02/2022.

End of Figure 22]

In a study conducted on the risks faced by healthcare workers in Scotland during the first wave of the COVID-19 pandemic, it was found that such staff and their families accounted for a sixth (17%) of hospital admissions for COVID-19 in the working age population (18-65 years), even though they represented only 11% of such population. Although hospital admission with

COVID-19 in this age group was very low overall, the risk for healthcare workers and their families was higher when compared with other working age adults. This was particularly so for those in ‘front door’ patient facing roles such as paramedics and Accident and Emergency department staff. Among healthcare workers who were admitted to hospital, 1 in 8 were admitted into critical care and six (2.5%) died. To put this into context, this corresponds to just 0.004% of deaths as a proportion of all healthcare workers (**footnote 231**).

As at 18 February 2022, the Scottish advised that it had been notified by Health Boards and/ or the Care Inspectorate of 27 deaths of healthcare workers and 34 deaths of social care workers, related to COVID-19. However, the Scottish Government was not able to confirm how many of these staff contracted COVID-19 through their work (**footnote 232**).

On 13 May 2020, the Lord Advocate announced that the following are to be reported to the Procurator-Fiscal: all COVID-19 or presumed COVID-19 deaths where the deceased may have contracted the virus in the course of their employment or occupation. This would include care home workers, frontline NHS staff, public transport employees and emergency services personnel. This ensures that all such deaths will be registered within the Crown system of death investigation, and that each of those deaths can be investigated. This is currently being undertaken by the Crown Office’s COVID Deaths Investigation Team (**footnote 233**).

# Part V: Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

## Key Points

**Cardiopulmonary Resuscitation (CPR)** is a treatment that can be given when a person stops breathing, suffers respiratory or cardiac arrest. The aim of CPR is to re-start a person's breathing and heartbeat. The success of CPR may turn on whether a person had pre-existing health problems. Empirical data reveals a success rate of around 18%, which is at odds with a public perception of success, which is closer to 50%..In the event of survival, consequences can include (significant) impairment of physical and mental functions. Very few people make a full recovery following CPR.

**Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)** means that if a person's heartbeat stops, or they stop breathing, then there will be no attempt to try and restart their heart. A DNACPR decision by a person (or their legal representative) is ordinarily recorded on a special form, known as a DNACPR form, a treatment escalation plan (TEP) or a recommended summary plan for emergency care and treatment (ReSPECT).

**Ethical principles** which should underpin DNACPR policy and practice include showing due respect for autonomy and bodily integrity, as part of upholding a person's dignity. In the healthcare context, this involves patients being provided with information and being able to make decisions about their end-of-life care. Where a person does not have capacity, then their legal representatives should be consulted in line with relevant mental capacity laws. Healthcare professionals have ethical obligations to uphold the principles of beneficence (striving to do good) and non-maleficence (do no harm) in the context of DNACPR decision-making and practice.

**Scotland's DNACPR policy** was originally published in 2010 but was updated in 2016 in light of the 'Tracey' and 'Montgomery' judgments, as well as changes to professional guidance. It also now incorporates a stronger human rights-based approach. The policy applies to all NHS Scotland staff and the care of adult patients in all health and social care settings within the remit of NHS Scotland. Independent care organisations and facilities are encouraged to make use of the policy for the benefit of individuals under their care. The policy should be used in conjunction with the revised NHS Scotland DNACPR form, decision-making framework and designated patient information leaflet.

**COVID-19 pandemic and DNACPR decision-making** concerns have been expressed about the imposition of blanket or inappropriate imposition of DNACPR decisions, particularly during the first wave of the COVID-19 pandemic between March and June 2020. This is contrary to both human rights and equality legal protections. There is some evidence available that this took place, in addition to futile or inappropriate CPR attempts, difficult and delayed conversations about DNACPR decisions and the inappropriate withholding of other treatments. Unlike the rest of the UK, Scotland had a clear and coherent policy approach to DNACPR policy although further data is needed on how this was implemented in practice during the COVID-19 pandemic.

## A. Overview

Cardiopulmonary Resuscitation (CPR) is a treatment that can be given when a person stops breathing, suffers respiratory or cardiac arrest. The aim of CPR is to get breathing and the heart starting again. CPR can involve chest compressions (pressing down hard repeatedly on the chest; using a machine known as

a defibrillator to stimulate the hear through the use of electrical shocks; using equipment to help oxygen move around the body (artificial ventilation) and giving an injection to get the heart going again (**footnote 234**).

The success of CPR may turn on a number of factors. If the person's lungs, heart and other organs already worked well and were healthy prior to the event; a person trained in CPR comes to the person's aid; and useful equipment is nearby, such as a defibrillator for example. The chances of success with CRP lessen if the person's lungs, heart or organs were not working well prior to the event. This may occur for a number of reasons and should not automatically be associated with having a disability (**footnote 235**). In the circumstances, it is understandable that references is made to Do Not **Attempt** CPR, in recognition that it may not always be successful (**footnote 236**).

Empirical data on the success or otherwise of CPR vary depending on the above factors. Of those in whom CPR is attempted, the success rate in terms of return of spontaneous circulation is around 18% (**footnote 237**). This is so, notwithstanding public perceptions that it is much higher, being closer to 50% (**footnote 238**) In the event of survival, side effects can vary from bruising, rib fractures and the puncturing of lungs, in addition to heart and/or brain damage due to the lack of oxygen. Admission to intensive care will inevitably follow cases where it was possible to restart the heart through CPR. Significantly reduced mental and physical function may follow in the longer term. Very few people will make a full recovery following CPR (**footnote 239**).

DNACPR refers to Do Not Attempt Cardiopulmonary Resuscitation. Other expressions that may be used interchangeable include Do Not Attempt Resuscitation (DNAR) and Do Not Resuscitate (DNR). What DNACPR means is if

there is a cessation of heartbeat or a person stops breathing, then the healthcare team will not try to restart the heart. The DNACPR decision is ordinarily recorded on a special form, but these forms may differ depending on locality or region. The forms may be known as a DNACPR form, a treatment escalation plan (TEP), a recommended summary plan for emergency care and treatment (ReSPECT) process.

Developed by the Resuscitation Council UK, the ReSPECT process seeks to create personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices. It recognises the importance of having conversations between a person, their family, and a clinician, which leads to the recording of a summary of such conversations on a form which belongs to the patient. The emphasis is on the process, rather than form-filling. If a person lacks capacity to contribute to the process, then this can take place between their legal proxy (if they have one) or otherwise with a close family member. All conversations and decisions must be individual to the person involved (**footnote 240**).

The DNACPR decision is usually set out in a specified form that may be kept on a patient's medical records; retained by care and residential homes if they refer to particular residents; or otherwise kept at home by individuals. It is important to keep in mind that DNACPR only refers to CPR and does not impact a range of other care and treatment that may be provided to a person.

A systematic review of the international literature regarding DNACPR identified significant variability in DNACPR decision-making and implementation. These differences ranged from who was responsible for decision-making; how and where the decision could be made, as well as how it should be communicated and implemented. Overall, there was not a

strong evidence basis for such differences, or the costs and resources involved in the use of CPR. Interestingly, differences arising out of cultural issues and approaches to clinical decision-making were 'evident and influential'. In relation to the latter, it was clear that clinicians were grappling with how best to balance respect for autonomy with their duties to provide medical benefit and…avoid harm.' (**Footnote 241**)

In the UK, a review of approaches taken to DNACPR in the National Health Services (NHS) revealed that there were also local and clinical differences and shortcomings in practice, as well as a range of unintended consequences (**footnote 242**). Key findings from the review highlighted futile or inappropriate CPR attempts; difficult and delayed conversations and decision-making in relation to DNACPR decisions; and the 'inappropriate withholding of other treatments.' (**Footnote 243**)

This is compounded by a lack of consistency and variation in the use of documentation, as well as a lack of coordination between health and social care services meaning that it may not be clear what decisions have been taken, or whether other care should be provided or withheld (**footnote 244**). A further unintended consequences is that original DNACPR decisions may be placed on patients' medical or social care records without scrutiny or regular review (**footnote 245**).

While it is recognised that the optimal approach would be for DNACPR decision-making to be included in advance end of life planning which takes place outside an emergency situation, the reality points to such decisions often being taken at the last minute, rather than through careful planning, with treating healthcare professionals often finding it difficult to have such conversations for fear of causing distress to patients and their families. It results in decision-making that is 'suboptimal', occurring in circumstances where it is often 'too late for meaningful engagement' (**footnote 246**). A further contributing

factor may be found in the fact that these are difficult conversations to have not only for the patient and their families, but also for their treating healthcare professionals. In this regard, it is recognised that it would be helpful if specialist training was provided covering ‘clinical reasoning, ethics and communication’ so as to provide them with the requisite tools for having such conversations (**footnote 247**).

CPR is an ‘invasive medical treatment that was never intended to be given to patients who are dying from an irreversible condition’ and therefore DNACPR decision-making should properly be viewed as ‘mechanism for protecting patients from harm.’ (**Footnote 248**). However, what these type of reviews, as well as other empirical data have highlighted, is that such decision-making, as well as its implementation, can be ‘complex’, turning on questions of institutional culture, social norms, clinical practice, and available resources. Such complexity also stems from the fact such decision-making not only impacts the person in question, but also their families, friends and treating healthcare professionals and institutions.

## B. Ethical Principles

A range of ethical, human rights and equality principles could be said to underpin the DNACPR policy and practice. Showing due respect for **autonomy** involves a recognition of patients as independent moral agents, with the right to choose how they wish to live their own lives. Closely linked to the notion of autonomy is showing due respect for the principle of **bodily integrity** which recognises the importance of individuals having self-determination over their own bodies (**footnote 249**).

In the healthcare context, this involves patients being provided with information and make decisions about consenting to, or

conversely refusing to consent to, medical treatment. This should also include being able to make decisions about end-of-life planning and care. This assumes that the patient has capacity. Where this is not the case, it is suggested that either supported or substituted decision-making models (or a combination of both) should be employed with respect to such decision-making in relation to the patient who lacks capacity in line with relevant legislation (**footnote 250**).

Showing due respect for a patient's **dignity** – whether they are capacitous or not – should involve a recognition on the part of treating healthcare professionals and institutions of the importance of patients and/or their legal proxies being able to receive information and participate in decision-making in relation to diagnosis, treatment and prognosis, and that would include DNACPR on its own or as part of end-of-life planning more generally (**footnote 251**). Since the turn of the millennium, there has been a growing recognition of the importance of upholding patient autonomy in healthcare settings which is captured in notions such as patient empowerment (**footnote 252**) and shared decision-making (**footnote 253**), as well as in recognition of the importance of disclosing material risks to patients so that they can make their own decisions about medical treatment recommended by their treating healthcare professionals (**footnote 254**).

This marks a shift away from long entrenched **paternalism** on the part of healthcare professionals and institutions (**footnote 255**), which is rooted in the idea that patients – including vulnerable groups of patients such as the elderly and those with a disability for example – are in need of protection in relation to the provision of healthcare (**footnote 256**). This may translate in clinical practice to a 'doctor knows best' approach to the provision of information to patients in discussions regarding medical treatment. It may also contribute to (over-) reliance on the notion of the **therapeutic exception**, in which information is

withheld on the part of the treating doctor on the basis of a reasonable belief that to disclose such information would be seriously detrimental to the patient's health (**footnote 257**).

In addition to the above, healthcare professionals have ethical obligations to uphold the principles of **beneficence** (striving to do good) and **non-maleficence** (do no harm). In the context of DNACPR, it could be said to require that treating healthcare professionals do not subject patients to CPR where they have life-limiting illness or where they have expressed a wish that no CPR be provided, or otherwise have reasonable grounds for believing that the patient's life has ceased to be of benefit to her (**footnote 258**).

Questions of **justice** may also feature strongly in relation to DNACPR decision-making and implementation. For the individual patient, questions of justice may be strongly linked into notions of autonomy and dignity in terms of being able to participate in discussions about the merits of otherwise of CPR in their particular case. More broadly, justice in the healthcare context is more usually associated with fairness in the allocation of (scarce) resources, although this does not necessarily equate with treating everyone equally (**footnote 259**).

Other principles which may be invoked in relation to the use of DNACPR may be rooted in concerns that a failure to consult or the imposition of a decision without notice on the part of a patient is a violation of their human rights, as well as equality principles. This links into a range of laws, such as the Human Rights Act 1998 and the Equality Act 2010 (**footnote 260**), of which further detail will be provided in the next section. Nevertheless, such violations can be characterised as both moral and legal. In the former, there is a broader concern about the need for a moral framework which discerns between the 'right to choose and what choices will promote human flourishing' against a background where the individuals do not

operate in isolation from their community where such choices may impact on others as well (**footnote 261**).

Many ethical principles guiding good practice on the part of healthcare professionals and institutions in relation to DNACPR are set out in professional and government guidance. Although they may be indicative of professional norms and practices, they are not legally binding rules or instructions. In both ethical and legal terms, it is important to keep in mind that guidelines only provide a basis for informing an ethically principled decision in relation to a particular patient's condition (**footnote 262**).

In the context of end-of-life decision-making and practice, mention should also be made of the concept of **futility** as potentially contributing to clinical judgment and practice in relation to the use of DNACPR decisions. As Laurie et al have pointed out, medical futility can be defined in a number of ways: (i) treatment that is either useless or ineffective; (ii) treatment fails to offer a minimum quality of life or a modicum of medical benefit; (iii) treatment cannot possibly achieve the patient's goals; and (iv) the treatment does not offer a reasonable chance of survival (**footnote 263**). They advocate for a concept of futility in relation to making decisions about medical treatment (which would include CPR for example) as involving being constituted where it could not be shown that there would be a 'minimum likelihood of quality of benefit … and is not owed to the patient as a matter of moral duty' (**footnote 264**).

In considering questions touching on futility in medical treatment, there is a need to be careful that clinical judgment involving the 'purely physiological' does not cross over into what could be considered a more subjective assessment about what constitutes a life worth living which may be better determined by the patient and/or their legal proxies (**footnote 265**). The danger that may exist when there is such cross over is that it

positions medical paternalism over the exercise of patient autonomy, in addition to raising the potential for 'disguised and arbitrary rationing of resources'. There is a need for caution on both ethical and human rights grounds in using the concept of futility as a basis for exercising clinical judgment in relation to imposing a DNACPR decision in a particular patient's circumstances without first engaging with the patient and/or their legal proxies (**footnote 266**).

## C. Case Law

DNACPR decision-making is situated in the broader context of end-of-life care. In the context of such care, healthcare professionals need to be careful that their actions in terms of treatment of their patients are legally permissible, and do not engage with the criminal law (and specifically a charge of homicide). Notwithstanding persisting unease in ethical and legal terms, the position under UK law is that the withdrawal of life-prolonging medical treatment (n the case of a person in a persistent vegetative state) is to be regarded as an omission rather than an action (**footnote 267**).

Doctors' conscientious objection to treatment withdrawal should be respected, which for many could have its roots in an unwillingness not to act deliberately to cause the death of their patients (**footnote 268**). Not starting life-sustaining treatment in the first place is an omission (**footnote 269**), and this is where DNACPR would likely be situated in legal terms.

In recent decades, there have been a series of cases which have clarified what is legally permissible on the part of healthcare professionals (in particular doctors) in relation to the provision of end-of-life care, as well as what patients are

entitled to expect in relation to such care. Key cases and their findings are highlighted below (on chronological basis):

**‘Law Hospital NHS Trust v Lord Advocate’ 1996 SLT 848**
Authority was sought by relatives of a woman in a persistent vegetative state (PVS) to discontinue feeding. It was held by the Inner House that it was not competent to issue a declarator to effect that a proposed course of action was or was not criminal; however, it did find that the **parens patriae** jurisdiction survived in Scotland. Therefore, any authority given by the court regarding withdrawal of life-saving treatment would have the same effect in law as if consent had been given by the patient. The court found that the decision to either consent to or to refuse medical treatment should be taken in the patient’s best interests. It followed that in this case, if the treatment could be of no benefit then there we no longer any best interests to be served by continuing it (**footnote 270**). Notwithstanding the judgment, some confusion remains over whether it is necessary to seek judicial approval for this course of action on each occasion which remains problematic for treating healthcare professionals given the potential criminal legal consequences (**footnote 271**).

**‘Burke v General Medical Council and Ors’ [2005] EWCA Civ 1003**
In this case, it was held by the English Court of Appeal that patients have the right to refuse but not to demand treatments in relation to end-of-life care.

**‘Aintree University Hospitals Trust v James’ [2013] UKSC 67**
The UK Supreme Court held that a patient cannot demand a particular medical treatment (per ‘Burke’). However, healthcare professionals must take account of a patient’s wishes when marking treatment decisions. As per Lady Hale:

“In considering the best interests of this particular patient at this particular time, decision-makers must look at his welfare in the widest sense, not just medical but social and psychological; they must consider the nature of the medical treatment in question, what it involves and its prospects of success; they must consider what the outcome of that treatment for the patient is likely to be; they must try and put themselves in the place of the individual patient and ask what his attitude to the treatment is or would be likely to be; and they must consult others who are looking after him or interested in his welfare, in particular for their view of what his attitude would be” (**footnote 272**).

It should also be noted reservations were expressed about the way in which the concept of futility was being used. This is against a background where treatment limitation decisions have traditionally only been considered in patients where treatment may be futile (**footnote 273**).  In the leading judgment by Lady Hale, she considered that it was ‘setting the goal too high to say that treatment is futile unless it had ‘a real prospect of curing or at least palliating the life-threatening disease or illness from which the patient is suffering.’ Instead, she stated that:

“A treatment may bring some benefit to the patient even though it has no effect upon the underlying disease or disability…where a patient is suffering from an incurable illness, disease or disability, it is not very helpful to talk of recovering a state of "good health". The patient's life may still be very well worth living. Resuming a quality of life which the patient would regard as worthwhile is more readily applicable, particularly in the case of a patient with permanent disabilities…it is not for others to say that a life which the patient would regard as worthwhile is not worth living.’” (**Footnote 274**)

**‘R (on the application of Tracey) v Cambridge NHS Foundation Trust’ [2014] EWCA Civ 822**
Janet Tracey had been diagnosed with terminal lunch cancer and was admitted to hospital with serious injuries following a car accident. As her health deteriorated, on two occasions, DNACPR notices were issued, cancelled and then reinstated before her death. She had previously expressed her wish to receive full active treatment and was not told about the first decision to include a DNACPR notice in her notes. The English Court Appeal found that her Article 8 ECHR rights had been breached in relation to the imposition of the first DNACPR decision.

In the leading judgment by Lord Dyson, he recognised that the claimant was not seeking to challenge the clinical decision to withhold CPR; rather the concern lay in the way in the procedure which led to the marking of the decision and aspects of hospital policy governing the making of DNACPR decisions (**footnote 275**). He observed that:

“A decision as to how to pass the closing days and moments of one's life and how one manages one's death touches in the most immediate and obvious way a patient's personal autonomy, integrity, dignity and quality of life.” (**footnote 276**).

In the circumstances, he went on to hold that treating healthcare professionals have a duty to consult with patients about the imposition of DNACPR decisions (**footnote 277**). Although Counsel for the Trust submitted that it was ‘inappropriate to involve the patient if the clinician forms the view that CPR would be futile even if he considers that involvement is unlikely to cause the patient harm’, this submission was rejected by Lord Dyson for two reasons:

“First, a decision to deprive the patient of potentially life-saving treatment is of a different order of significance for the patient

from a decision to deprive him or her of other kinds of treatment. It calls for particularly convincing justification. Prima facie, the patient is entitled to know that such an important clinical decision has been taken. The fact that the clinician considers that CPR will not work means that the patient cannot require him to provide it. It does not, however, mean that the patient is not entitled to know that the clinical decision has been taken. Secondly, if the patient is not told that the clinician has made a DNACPR decision, he will be deprived of the opportunity of seeking a second opinion, [although there is no legal obligation to do so]" (**footnote 278**).

**The case of 'Tracey' is seen as a key case on DNACPR decision-making and there was extensive academic and other commentary following the judgment.** While recognising the logic in the judgment in terms of recognising a patient's right to know that a decision of such significance has been taken on their behalf, commentators such as Jackson have observed that it might nevertheless be equally distressing for patients to be told about a treatment option that was not in fact going to be offered to them (**footnote 279**). For Fritz and colleagues, the ethical basis for the judgment is strong and to be welcomed. However, they recognise that clinicians who are 'concerned about the logistic implications of the judgment in terms of time and resource allocation' may then 'refrain from making resuscitation decisions at all rather than risk uncomfortable discussions or litigation'. However, they go on to point out that 'problems with DNACPR predate' the 'Tracey' judgment, and an alternative way forward is needed whereby CPR needs to be considered in the context of end-of-life planning and care (**footnote 280**).

**‘Winspear v City Hospitals Sunderland NHS Foundation Trust’ [2015] EWHC 3250 (QB)**
Before making a DNCPR decision in relation to an adult patient who lacks capacity, it is necessary to consult a person identified in s 4(7) of the Mental Capacity Act 2005 (MCA), if practicable and appropriate. Failure to do so absent a convincing reason would violate a patient’s rights under Article 8 ECHR. Under s 4(7) of the MCA such persons would be anyone engaged in caring for the person or interested in their welfare; any donee of a lasting power of attorney granted by the person, and any deputy appointed for the person by the court, as to what would be in the person's best interests (**footnote 281**).

**‘An NHS Trust and Ors v Y and Anor’ [2018] UKSC 4**
The UK Supreme Court emphasised that the fundamental question facing a treating doctor in treating a patient who lacks capacity is not whether it is lawful to withdraw or withhold medical treatment, but whether it is lawful to give it. It is only lawful to give such treatment if it is in the patient’s best interests. It was also recognised that there was a need to be wary of seeking to impose the court’s views on experienced medical teams and medical professional bodies concerning clinical decision-making regarding the survival of patients (**footnote 282**).

**‘Cambridge University Hospital NHS Foundation Trust v AH and Ors’ [2021] EWCOP 64**
The case involved a 56-year-old woman, AH, who suffered catastrophic side-effects from having been infected with COVID-19 in late 2020. She had been in intensive care and on mechanical ventilation since January 2021. In mid 2021, Cambridge University Hospital NHS Foundation Trust applied for a declaration to the Court of Protection (England and Wales) that continued mechanical ventilation was no longer in AH’s best interests under the Mental Capacity Act 2005 and extensive evidence was submitted in support of this position by

AH's treating multi-disciplinary medical team. The declaration was opposed by AH's family who considered that her neurological status would likely have improved over time and she would have been able to progress to recovery. This was combined with her religious beliefs and cultural values being such that she would wish her life to continue with the prospect of recovery. AH had a DNACPR decision in place, drawing on the ReSPECT process which had been agreed following her initial admission in late December 2020 when she still had capacity, although this was no longer the case. The family agreed with the DNACPR decision. When AH had a cardiac arrest some months after her admission, it appears that she was given CPR by her treating clinicians due to uncertainty about the ongoing status of the ReSPECT form. The court held (per Theis J):

"Having heard the evidence as a whole, and weighed the respective benefit and burdens of continuing treatment, including carefully weighing in the balance the strong presumption that it is in AH's best interest to stay alive, which would accord with her religious beliefs and is something her family strongly wish to happen, I have reached the conclusion that the very real burdens in the particular circumstances AH is in, with the prospect of no change and more probably a continued deterioration which may last many months of treatment, with the risk of an infection and dying away from her family, outweigh those very considerable benefits" (**footnote 283**).

## D. DNACPR Policy in Scotland

In 2006, NHS Lothian implemented the UK's first DNACPR policy. This was followed in 2008 by the launch of the Scottish Government's national action plan for palliative and end of life

care, which was updated in January 2011, which expressed a 'commitment; to implementing a 'cohesive, person-centred and sustainable approach to the equitable provision of high quality palliative and end of life care across Scotland (**footnote 284**). Following a review by Audit Scotland into palliative care services in 2008, it was recommended that the Scottish Government develop a consistent national integrated policy for DNACPR (**footnote 285**).

The Scottish Government's initial national DNACPR policy was published in 2010 (**footnote 286**). The policy recognises the 'necessity' of a national approach, which is stated to be underpinned by current good national practice. The policy emphasises that it should be used in conjunction with the NHS Scotland DNACPR form decision-making framework and patient information booklet, which was appended to this policy. The framework was developed to provide 'guidance and clarification for all staff working within NHS Scotland regarding the process of making and communicating DNACPR decision.' (**Footnote 287**). While the policy was stated to apply to all staff employed by NHS Scotland, as well as those involved in the care of adult patients in all care settings operating under the auspices of NHS Scotland, 'independent care organisations and facilities' were nevertheless encouraged 'to make use of this policy for the benefit of their patients.' (**Footnote 288**)

In a review of the 'Tracey' judgment published in the Law Society of Scotland Journal, it was recognised that Scottish Government DNACPR policy was now not fully aligned with the judgment. This was particularly so given the emphasis placed on the concept of futility. As emphasised in the judgment, the futility of the treatment of itself was not sufficient for the completion of the DNACPR notice. Instead, the patient was to be consulted unless they were likely to suffer harm by such consultation. To do otherwise was to risk contravening the patient's rights under Article 8 ECHR (**footnote 289**).

In a further review conducted by Scottish researchers into DNACPR decision-making published in 2015, it was found that there was a paucity of original research in the area which examined the UK context; what had been published in the international literature did not take account of cultural and other variances relevant for the UK; that discussions concerning CPR were considered acceptable by patients in the context of end of life planning; and that more research was needed into what constituted effective communication methods in relation to discussion and decision-making in this area (**footnote 290**).

The Scottish Government's national DNACPR policy was updated in 2016. This was in light of the 'Tracey' and 'Montgomery' judgments, as well as taking account of other relevant updated guidance from the General Medical Council, 'Treatment and care towards the end of life: Good practice in decision-making' (2010) and joint guidance published by the British Medical Association, Royal College of Nursing and the Resuscitation Council (UK) – 2016) (**footnote 291**).

The policy applies to all NHS Scotland Staff and the care of adult patients in all health and social care settings within the remit of NHS Scotland. Independent care organisations and facilities are encouraged to make use of this NHS Scotland policy for the benefit of their patients. The advice in this policy should be used in conjunction with the revised NHS Scotland DNACPR form, decision-making framework and patient information leaflet, are appended to the policy document. Key aspects of the updated policy include the following:

**Aims and Objectives**

The aim of the policy is to prevent inappropriate, contraindicated and/or unwanted attempts at CPR which are of no benefit and may cause significant distress to patients and families. A death managed with inappropriate CPR treatment is undignified and highly traumatic. When a patient dies at home

or in a care home, an inappropriate CPR attempt may also involve the Scottish Ambulance Service paramedics and even the police, which can add greatly to the distress of the families and be upsetting for all those involved. This policy supports the wider aim of ensuring that a person's goals of care are known and respected at the end of life irrespective of whether they are being cared for in hospital, a hospice, a care home or in their own homes (**footnote 292**).

The objectives of the policy include the need to ensure a consistent and integrated approach to CPR decision-making, documentation and communication across Scotland for all patients in all care settings (including the patient's own home or care home) in line with national good practice guidance. In addition, it is important to ensure that decisions regarding CPR are made according to whether CPR could be successful in achieving sustainable life; the clinical needs of the patient; the patient's wishes and their judgment of the overall benefit provided by CPR where it might be successful.

Relevant ethical principles and legislation should be taken into account such as the Human Rights Act (1998) and Adults with Incapacity (Scotland) Act 2000, as well as international human rights instruments such as the European Convention on Human Rights and the UN Convention on the Rights of Persons with Disabilities (**footnote 293**).

**Purpose**

The purpose of the policy is to provide guidance and clarification for all staff working within NHS Scotland regarding the process of making and communicating decisions about CPR. It is a duty of care to ensure that, as far as possible, an advance DNACPR decision is communicated in a way that rapidly informs the emergency decisions of healthcare professionals when a patient's pulse and breathing have stopped. A consistent and instantly recognisable document is

essential and the NHS Scotland DNACPR form is recommended as best practice. An advance DNACPR decision can also be indicated within the electronic Emergency Care Summary using the Key Information Summary (KIS). Services involved in the assessment of acutely unwell patients in the community or in hospitals should ensure that all frontline staff has access to, and knowledge of the KIS (**footnote 294**).

**Approach of NHS Health Boards**

A number of Health Boards are using and developing forms and templates for documenting options for emergency treatments or levels of care (e.g. "ward level care", "intensive care", etc.) that would or would not be appropriate and/or wanted in a sudden acute deterioration situation. It is recommended that the NHS Scotland DNACPR form be used to complement any locally developed Anticipatory Care Plans (AnCP), Treatment Escalation Plans (TEP) or Emergency Care and Treatment Plans (ECTP).

When no explicit decision has been made about CPR before a cardiopulmonary arrest occurs, and the express wishes of the patient are unknown, it is presumed that staff will initiate CPR. However, there will be some people for whom attempting CPR is clearly inappropriate; for example, a person in the advanced stages of a terminal illness where death is imminent and unavoidable and CPR would not be successful, but for whom no formal CPR decision has been made and recorded. It is essential to document clearly in the clinical notes a detailed account of the assessment and rationale for the clinical decision not to attempt CPR in this situation, and clinicians must be supported to do this by colleagues and line managers (**footnote 295**).

**Quality of life**

This policy supports the view that clinical decisions should be based on immediate health needs, and not on professional

opinion on a person's quality of life. This is primarily because opinions on quality of life made by health professionals are very subjective and often at variance with the views of the patient and relevant others. The UN Convention on the Rights of Persons with Disabilities sets out that discrimination on the basis of disability is a breach of the Convention. Article 25 provides that States shall 'prevent discriminatory denial of health care...on the basis of disability' (**footnote 296**).

**Advance decisions**

CPR can be difficult and can cause considerable emotional distress but, when discussed in the context of goals of care and choices about available treatment options, they can also be extremely reassuring and a huge relief for some patients. There is evidence that patients experience conversations about DNACPR as positive and empowering when they happen within the context of wider discussions about emergency care planning and end of life care goals The appropriateness of CPR should always be considered on an individual patient basis. There is never a justification for blanket policies to be in place (**footnote 297**).

**Adults who lack capacity**

If a patient does not have capacity for the CPR decision, then the principles of the Adults with Incapacity (Scotland) Act 2000 apply. Where CPR might be successful in achieving sustainable life, a decision about whether the benefit of CPR would outweigh the harms and burdens for that patient must be discussed and agreed between that healthcare team and the patient's relevant others. Where there is a legally appointed proxy decision-maker (welfare attorney or welfare guardian) they must be involved in the decision-making process. Relevant information should be shared with those close to the patient (see Appendix IV of the policy).

Care should be taken in assessing capacity, and a specialist assessment may be helpful. Where a person's communication may be impaired, they should be provided with whatever assistance may be needed to assist communication. Further guidance is available in Chapter 3 of the Mental Welfare Commission's guidance document on Consent to Treatment (**footnote 298**). Even if a person does not have capacity, attention should be paid to their past and present wishes, and proper efforts should be made to establish these (**footnote 299**).

**Review of DNACPR decisions**

The revised guidance clarifies that review of CPR decisions must be done on a clinically appropriate and individualised basis. A timeframe for review of the initial decision should reflect the variability of the patient's clinical situation. Patients, who are continuing to deteriorate with one or more irreversible conditions and with no prospect of recovery to a point where CPR might work, do not need to have the DNACPR decision reviewed.

Local clinical teams have a responsibility to ensure that CPR status is checked and clarified along with other aspects of anticipatory emergency care and treatment planning at every handover, safety huddle, ward round or multidisciplinary meeting. When the lead clinician changes due to transfer or discharge, any DNACPR decision must be reviewed as soon as is reasonably possible, but it is assumed that the existing decision will remain valid meantime. Where the team are notified of the appointment of a welfare guardian or welfare attorney after a DNACPR is in place, that person should be notified of the existence of the form, and consideration given to a review involving them (**footnote 300**).

# E. End of Life Care

It is important to situate DNACPR decision-making in the context of (anticipatory) end of life planning and care.

**Anticipatory care planning**
A person's views on CPR may also be recorded as part of an Anticipatory Care Plan (AnCP), which is a voluntary process to be taken up on an individual. Indeed, the current DNACPR policy also emphasises that this would be advantageous, where possible (**footnote 301**). It has been recognised that having such a plan in place would be particularly advantageous for individuals living in a care home; who are being proactively care managed; or who have complex, palliative or end of life care needs. Any appointed attorney or guardian would need to be included in the process, as well as members of the multidisciplinary team caring for the individual. Account would be taken of any formal Ads that exist. DNACPR decisions should be clearly recorded and communicated to all relevant members of the care team (**footnote 302**). Key details of any palliative care data or ACP, if any such details were recorded in the GP clinical system, would also be recorded as part of NHS Scotland's Emergency Care Summary (ECS) for individual patients (**footnote 303**).

**Palliative care**
The Scottish Government published a strategic framework for action plan (2016-2021) which set out a vision for the next five years, outcomes and ten commitments to support improvements in the delivery of palliative and end of life care across Scotland. The vision was to ensure that everyone in Scotland who needed palliative care would have access to such care by 2021. The Scottish Government made ten commitments to realise this vision in the framework action plan. By April 2016, the aim was for these commitments to be

reflected in implementation and improvement plans supported by a national implementation group to be reviewed annually (**footnote 304**).

The Scottish Public Health Network also produced a report in 2016 examining what would constitute a public health approach to providing palliative care at the end of life. This was on the basis that there were 'important gaps in how society and services, including health and social care services, deal with death, dying and bereavement.' The aim was to assist colleagues working with Integrated Adult Health and Social Care Boards to further develop end of life care services, whilst supporting and encouraging the development, implementation and evaluation of asset-based approaches to death, dying and loss within local communities. The aim was also to link into the recently published report by the Scottish CMO on 'Realistic Medicine'.

## F. COVID-19 and DNACPR Guidance in Scotland

**Letter from Scottish CMO to GPs re identifying high risk groups, dated 26 March 2020**

We would also like to ask for your help with the identification and proactive management of patients who are at particularly high risk of severe morbidity and mortality from COVID-19. Included with this letter at Annex C was a guide to be used with patients to check their understanding of advice they have received in the letter, to ensure that practices have up to date contact details for key carers and healthcare professionals involved in their care and to ensure that they are able to access their medications. This part of the conversation can be done by any member of the practice team (with appropriate support) and does not necessarily have to be a GP. In addition, for some patients in this group it may be appropriate to discuss their

Anticipatory Care Plan. This discussion should be done by a clinician but again it doesn't have to be a GP (**footnote 305**).

### Statements by the Scottish First Minister, 3 and 9 April 2020

The Scottish First Minister made a number of statements concerning the imposition of DNACPR decisions in the early stages of the first wave of the pandemic. During the course of a televised COVID-19 briefing on 3 April, she stated that 'no-one should sign a do not resuscitate form if they don't want to' (**footnote 306**). In response to a parliamentary question about the use of DNACPR decisions being imposed on individuals by their treating healthcare professionals and in care homes, she stated:

Let me be clear: no one should receive a DNR form out of the blue without those sensitive discussions having taken place, and absolutely nobody should feel under any pressure to complete such a form. I want to be absolutely emphatically clear about that. We must continue to give people the best care that is available for them and the care that they would think is right for them. Sometimes, that will mean respecting people's wishes about not wanting continued medical intervention, but those conversations must be held sensitively and we must always respect people's wishes (**footnote 307**).

### Letter from the Interim Scottish CMO on 19 April 2020

We recognise that DNACPR discussions are always difficult ones to have … therefore we would like to reassure clinicians that there is not specific requirement to have a DNACPR discussions as part of this ACP conversation, unless the patient raises this and wishes to discuss it, or the clinician feels strongly that they need to discuss it. Instead, just focus on supportive discussions about what matters to them should they fall ill with COVID. The Health Improvement Scotland Anticipatory Care Planning template provides a framework for

discussions, with the option to complete the DNACPR section, if this is discussed (**footnote 308**).

**Scottish Government, Coronavirus (COVID-19): guidance on critical care management of adult patients, initially published 7 October 2020**
Assessment for escalation of care to a critical care environment with invasive organ support should take a holistic approach incorporating individual assessment of frailty, comorbidity, severity of illness, and the likelihood of critical care provision leading to survival where quality of life is deemed acceptable to the patient. Where possible, decisions regarding escalation of care and quality of life should be carried out collaboratively with patients, their families and the referring clinical team, taking into account individual patient circumstances and with respect to ethical principles. For guidance on ensuring an ethical approach to decision making, please see the Scottish Government's Ethical Advice and Support Framework (**footnote 309**).

## G. DNACPR and COVID-19: Reviews and Reports

**Medico-scientific reviews**
In a recent review of DNACPR during the COVID-19 pandemic (**footnote 310**), it was found that in hospital, cardiac arrest is relatively common with COVID-19 and often resulted in poor outcomes. A recent US study identified 14% of critically ill patients with COVID-19 had in hospital cardiac arrest with 57.1% receiving CPR and only 7% surviving to hospital discharge with normal or mildly impaired neurological status (**footnote 311**). Management of cardiac arrest in this context is further complicated by concerns about infection risk associated with aerosol-generating procedures and consequent risks to staff (**footnote 312**). Reference was made to not undertaking

DNACPR so as to avoid ‘futile medical intervention’ (**footnote 313**).

The UK Pandemic Respiratory Infection Emergency System Triage (PRIEST) was established to develop and evaluate triage tools for people presenting to hospital emergency departments with suspected Covid-19. Recruited 22,484 patients, 70 EDs across 53 sites between 26 March – 28 May 2020. DNACPR decisions were recorded to facilitate evaluation of triage tools. In reviewing the results of the study, it was found that 31% of adults admitted to hospital with suspected COVID-19 had an early DNACPR decision recorded; with 59.4% surviving for 30 days and 11.6% received some form of organ support. Old age, active malignancy, chronic lung disease and lower performance status were associated with increased use of early DNACPR.

The findings confirm that potentially life-saving treatments were provided to a significant proportion of people. The use of mechanical ventilation in people with a DNACPR decision was an unexpected finding. Contact with people at the sites suggested this could be explained by the use of the ReSPECT process in discussions about resuscitation. Patient encouraged to explicitly indicate which treatments they want in a future situation where they are unable to make or express choices. This process enables people to consent to mechanical ventilation but decline CPR if its subsequently required.

**British Institute of Human Rights**

The British Institute of Human Rights (BIHR) has been working with people affected by DNAR, advocates and frontline staff on DNAR decision-making during COVID-19 and beyond (**footnote 314**). It recognises that human rights concerns arising in the context of DNACPR decision-making are not new in the UK and are long-standing. However, the COVID-19 pandemic brought these concerns into sharper focus and

revealed that the lack of human rights compliance around such decision-making in the health and social care sectors. The BIHR indicated that this involved discrimination and other improper practices primarily on the basis of age and/or disability, both of which are also protected characteristics under the Equality Act 2010 (**footnote 315**).

On 2 April 2020, the BIHR Director published a blog, which detailed her concerns about the way in which DNACPR decision-making was taking place during the first wave of the COVID-19 pandemic, observing that what was being reported to the Institute 'revealed some shocking attitudes about whose life counts and whose does not.' (**Footnote 316**). This included many instances of people with learning disabilities and older people having DNACPR orders applied to them, with little consultation. Specific examples were provided of GPs contacting such individuals to inform them that people with learning disabilities, and other complex needs, should all be DNR. There was no mention of consultation with families or best interests assessments (**footnote 317**). Care home residents in Hove, East Sussex and sought Wales were amongst those who had DNACPR notices applied to their care plans, without proper consultation with them or their families (**footnote 318**).

As part of its ongoing work in this area, the BIHR has produced a series of reports examining DNACPR decision-making during the COVID-19 pandemic, drawing on information provided by over 400 people who accessed public services including their families and those who care for them and over 950 people working in health and care services across the UK (including Scotland) (**footnote 319**). In relation to the reported experiences of health and social care staff in relation to DNACPR decision-making, over a third had experienced pressure to put DNAR orders in place without involving the person in the decision; and over three-quarters considered they

had not provided with legal training or clear information about upholding human rights law (**footnote 320**).

The reports of experiences of patients and their families with DNACPR decision-making also paints ‘a worrying picture around the rights of involvement in care and treatment decisions including DNARs… it depicts serious issues of discrimination related to disability and age, and the intersection between the two, as well as other factors.’

Key findings included the fact that there was a real need for people to have more easily accessible information about human rights; a considerable majority had not received any information about their Article 2 ECHR rights during coronavirus outbreaks in care homes, which also included having a DNACPR decision being placed on their files without their knowledge. Just under half said that such decisions were not related to end-of-life care. Key recommendations included the need for it to be made clear that DNACPR decisions about people’s legally protected human rights, and that medical (and other) staff have legal duties to uphold these rights in their decision-making as otherwise they contravene the HRA and the EA. Any review of documentation must include testing the veracity and completeness of the information provided. There should be a clear national statement on DNAR decision-making to be human rights based (**footnote 321**).

**Queen’s Nursing Institute**

The Queens’ Nursing Institute conducted a survey in May the June 2020 period to canvas the views of care home staff during the first wave of the pandemic The majority of those surveyed were female, with three quarters being over the age of 45 years. Two thirds of respondents said they always had access to appropriate PPE. A small minority said that they and not been provided with PPE and had to improvise as a result. 21% of respondents said their home accepted people discharged

from hospital who were positive for Covid-19 and substantial number (43%) said care home accepted people where their status was unknown. For many it has been very negative experience.

While the majority of respondents found it easy to access hospital care for residents, substantial minority found this very difficult. A substantial number also found it difficult to access GP and district nursing. Many indicated that they were not able to access essential training from health professionals at this time. Some respondents did raise fact that a range of NHS decision-making bodies did DNACPR decisions without speaking to residents, families and care home staff, in addition to imposing blanket DNACPR decisions on whole groups of people  (**footnote 322**).

**Compassion in Dying**

The UK-wide advocacy group, Compassion in Dying, identified that most people who contacted them about the use of DNACPR decisions during the first two waves of the COVID-19 pandemic were actually seeking support to protect themselves from CPR, as well as to be able to refuse other treatments and to ensure that it was made clear to treating healthcare professionals how they understood quality of life in their own case. It was 'undeniable' that people did place value on being able to discuss DNACPR decisions are part of advance care planning  (**footnote 323**).

The organisation also confirmed the position of the BIHR that there was nothing new about the problems with interpreting and applying DNACPR, the problems of variation in interpreting the law and of poor communication were just exacerbated during COVID.' (**Footnote 324**). While they accepted that there was a lack of public understanding of what is involved in a DNACPR decision and what their rights were but they wanted to know and were happy to discuss this further. In the

circumstances, ‘poor communication was a very big issue. When people were distressed, it was usually not because of a decision to withhold CPR but how this decision was communicated. People felt ignored and upset when they were not given any choice.’ (**Footnote 325**)

**Joint Committee on Human Rights (JCHR), The Government’s Response to Covid-19: Human Rights Implications, 21 September 2020**

The JCHR noted that it had ‘received deeply troubling evidence from numerous sources that during the COVID-19 pandemic DNACPR notices have been applied in a blanket fashion to some categories of person by some care providers without any involvement of the individuals or their families.’ The Committee confirmed that this was discriminatory and contrary to both the ECHR and the Equality Act 2010 to apply blanket notices on the basis of a particular type of impairment such as a learning disability (**footnote 326**). It further recommended that a UK-wide DNACPR policy be adopted. It stated that:

“The blanket imposition of DNACPR notices without proper patient involvement is unlawful. The evidence suggests that the use of them in the context of the Covid-19 pandemic has been widespread. The Court of Appeal held in ‘Tracey’ that there was no legal requirement for the Government to implement a national DNACPR policy. However, the evidence suggests that the absence of such a policy has, in the context of the pandemic, led to systematic violation of the rights of patients under Articles 2 and 8 ECHR. The systematic nature of this violation means that it is now arguable that the Government is under such an obligation. Such a policy should make clear, amongst other things, that DNACPR notices must never be imposed in a blanket fashion by care providers; the individuals must always be involved in the decision-making process, or where the individual does not have capacity, consultation must

take place with persons with an interest in the welfare of the patient.” (**Footnote 327**)

In response to the JCHR report, the UK government stated that: ‘the blanket application of DNACPR decisions is unacceptable and that standards and quality of care should be maintained even in pressurised circumstances.’ The UK Department of Health and Social Care has now asked the Care Quality Commission – the independent regulator of all health and social care services in England – to ‘review how DNACPR decision were used during the pandemic. In addition, NHS England is producing public facing guidance which includes information on what a DNACPR is, how it should be applied, who should be involved and what to do if an individual or loved one has concerns (**footnote 328**). However, the UK government did not agree with the JCHR’s recommendation that a new Commissioner for Art 2 compliance should be established, Instead, it indicated that their approach was to focus on ‘improving the effectiveness of existing agencies in their collation and dissemination of learning in their area. Note in the case of Finucane (**footnote 329**), UKSC held if an Art 2 compliant investigation is required but has not yet taken place ‘it is for the state to decide … what form of investigation … is required in order to meet its requirement under Art 2.

**Care Quality Commission**

Following the JCHR report (see above), the CQC undertook a review DNACPR decision-making in care and residential homes during the first and second waves of the COVID-19 pandemic (**footnote 330**). It gathered evidence on the issue between October 2020 and January 2021. The CQC heard from over 750 people about their experiences and conducted a survey about relevant practices in adult social service provision. The CQC found different DNACPR forms and approaches were used, including ReSPECT plans, local treatment escalation plans and DNACPR decisions. There was a lack of consistency in

approach impacts quality of care and providers had to cope with a huge amount of guidance about all aspects of the pandemic that lacked clarity and changed rapidly, leading to confusion.

Drawing on the findings from its survey, the CQC found that in 500 cases there had been ‘a likely breach of the individuals' human rights.’ (**Footnote 331**). There was also evidence that care homes, clinical and social care staff did not recognise the importance of a person-centred approach, or what was required in terms of current legal obligations in relation to the DNACPR decision-making. This included problems with carrying out best interests assessments in two-thirds of the care records surveyed (**footnote 332**). There was also little evidence of any further or regular reviews of DNACPR decisions once they had been made, especially if the person moved between services (**footnote 333**).

The CQC concluded that that some care home residents were wrongly subjected to DNACPR decisions in the early stages of the pandemic, leading to potentially avoidable deaths. There was an urgent need for regional health and social care systems including providers to improve how they assure themselves that people are experiencing personalised, compassionate care in relation to DNACPR decisions (**footnote 334**). The review revealed ‘a worrying picture of poor involvement, poor record keeping, and a lack of oversight and scrutiny of the decisions being made. Without these, we cannot be assured that decisions were, and are, being made on an individual basis, and in line with the person's wishes and human rights.

The CQC report revealed that while there have not been a ‘national blanket approach to DNACPR, there was undoubtedly confusion at the outset of the pandemic and a sense that some providers felt under pressure to ensure DNACPR decisions were in place.’ The report highlighted that more work is needed

to support health and care clinicians, professionals and workers in holding conversations about DNACPR decisions as part of a holistic approach to advance care planning.' (**Footnote 335**). There is a need to focus on information, training and support; a consistent national approach to advance care planning; and improved oversight and assurance (**footnote 336**).

In expert commentary provided in the wake of the CQC findings, Dr David Oliver pointed to the need to 'ensure that people in nursing and residential homes have a clear structured emergency care and treatment escalation plan can help reduce unnecessary acute admissions. In hospitals, this can stop excessive medical intervention that may worsen distress, ignore a patient's own priorities and add little value.' (**Footnote 337**)

**Age Scotland**

In the wake of the findings published in the CQC report, Age Scotland – the national charity for older people – wrote to Healthcare Improvement Scotland seeking advice and support undertaking an inquiry into the practice and use of DNACPR decisions in Scotland over the last year. This was on the basis that 'over the course of the last year we have heard of shocking examples from older people of the use and practice around DNACPR orders which run counter to the guidance'. Despite inquiries, the charity had a range of unanswered questions about DNACPR which they consider requires a proper inquiry, and which they listed in the letter. They indicated that they had also called on the Scottish Government to undertake this and had also written to the Scottish Parliament's Health and Sport Committee last year to ask the same (**footnote 338**).

**Scottish Parliament, Equalities and Human Rights Committee, Report on the impact of the COVID-19 pandemic on equalities and human rights, March 2021** (**footnote 339**)

The Committee noted that in 2020-21, people had 'all faced the challenges of a pandemic and the measures put in place to deal with it. It has been evident that whilst we are all in the same storm we are not in the same boat. The virus does not discriminate but it is crystal clear that the reality is those already facing inequality, for example due to their sex, age, disability and race or in those vulnerable situations due to poverty have been impacted to the greatest extent (**footnote 340**).

It recorded its concerns at recent information received from Age Scotland suggesting there the imposition of DNACPR forms without consultation was still taking place as recently as November 2020, noting that 'it is of great concern to the Committee that there is continued poor practice in this area (**footnote 341**). The Committee confirmed that it welcomed the Government's intention to hold a public inquiry into care homes, recommending that any such inquiry 'should take a human rights-based approach and we ask the Scottish Government to ensure the inquiry specifically gives consideration as to whether human rights standards and principles have been met (**footnote 342**).

# Appendix A: Annotated Chronology COVID-19 Pandemic in Scotland

## 2019

Date: 31 December

- Event: Chinese authorities notify the WHO of an outbreak of pneumonia in Wuhan City, which was **later classified as** a novel disease: 2019-nCoV (later referred to as COVID-19).
- Notes: WHO **Statement on the notification of an outbreak of pneumonia of unknown cause in Wuhan city, Hubei province of China**.

## 2020

Date: 22 January

- Event: Public Health England moves the risk level to the British public from 'very low' to 'low'

Date: 29 January

- Event: The first two cases of COVID-19 were confirmed in the UK

Date: 30 January

- Event: **WHO declare** the COVID-19 outbreak a 'public health emergency of international concern'
- Notes: **WHO - Statement on the second meeting of the International Health Regulations (2005) Emergency Committee regarding the outbreak of novel coronavirus (2019-nCoV)**

Date: 11 February

- Event: **WHO assigns the novel coronavirus its official name:** COVID-19

Date: 25 February

- Event: Public Health England **issue guidance** to care homes
- Notes: The guidance contains no restriction on visits, and states that, at the time, it was "very unlikely that people receiving care in a care home or the community will become infected.

Date: 1 March

- Event: First positive case of COVID-19 **confirmed** in Scotland

Date: 3 March

- Event: **Governments of the UK publish a coronavirus action plan** which sets out a collective approach to the outbreak
- Notes: It stated that the 'The UK government and the devolved administrations have been planning an initial response based on information available at the time, in a context of uncertainty, that can be scaled up and down in response to new information to ensure a flexible and proportionate response.' While noting that the emergence of COVID-19 represented a 'significant challenge for the entire world. The UK government and devolved administrations, including the health and social care system, have planned extensively over the years for an event like this. The UK is therefore well prepared to respond in a way that offers substantial protection to the public.
  New guidance was published on 13 March 2020.

Date: 3 March

- Event: GMC publishes **'Joint Statement from Healthcare Regulators: How we will continue to regulate in light of novel coronavirus (COVID-19)'**

Date: 5 March

- Event: First recorded death attributed to COVID-19 recorded

Date: 11 March

- Event: WHO **classify** the COVID-19 outbreak a global pandemic

Date: 11 March

- Event: UK Chancellor Rishi Sunak announces a **£12bn package of emergency support to help the UK**.

Date: 11 March

- Event: The **first case of community transmission in Scotland** unrelated to contact or travel is identified.

Date: 11 March

- Event: GMC publishes **'Joint statement: Supporting doctors in the event of a COVID-19 epidemic in the UK'**

Date: 11 March

- Event: **Letter issued by the Chief Planner** on the relaxation of enforcement of conditions relating to retail distribution in relation to the Coronavirus (COVID-19).

Date: 13 March

- Event: **First confirmed death of a patient in Scotland with COVID-19**.

Date: 13 March

- Event: People with symptoms of COVID-19 told to stay at home for seven days

Date: 13 March

- Event: Public Health England **issues new guidance** for reducing the risk of transmission in residential settings, including care homes
- Notes: Prior to this, care homes were represented as low-risk settings for COVID-19.
  The guidance suggests that visitors who are feeling unwell should not visit care homes and emphasises the "positive impact" of seeing friends and family. This is advisory, and places no ban on visits.
  The guidance states "to minimise the risk of transmission, care home providers are advised to review their visiting policy by asking no one to visit who has suspected COVID-19 or is generally unwell, and by emphasising good hand hygiene for visitors"
  To balance these restrictions, care home policies are advised that they "should consider the wellbeing of residents, and the positive impact of seeing friends and family".

Date: 15 March

- Event: **Letter from the Chief Medical Officer (CMO), Catherine Calderwood**, to Scottish health boards about the implications of the move to the delay phase on how to identify and manage cases.

Date: 15 March

- Event: Scottish Government advises organisers should **cancel or postpone all mass events of 500 people or more – indoors or outdoors**.

Date: 16 March

- Event: Cancellation of all mass indoor and outdoor events of 500 people or more in Scotland.

Date: 16 March

- Event: UK Government begins daily press briefings.

Date: 16 March

- Event: **Modelling by Imperial College** reveals that the current pandemic approach would overwhelm capacity to manage COVID-19 cases within the NHS

Date: 17 March

- Event: First Minister's keynote COVID-19 **speech to the Scottish Parliament** saying "life will change significantly" and emphasising the need for every citizen to reduce all non-essential social contact.

Date: 17 March

- Event: Health Secretary **Jeane Freeman told MSPs the NHS in Scotland was now on an "emergency footing."**

Date: 17 March

- Event: UK Chancellor Rishi Sunak announces the **biggest package of emergency state support for business since the 2008 financial crash**.

Date: 17 March

- Event: Patients are discharged from hospitals to care homes without mandatory testing.
- Notes: NHS England and NHS Improvement wrote to trusts telling them to "expand critical care capacity to the maximum" by freeing up beds. This was to ensure the NHS had the capacity it needed to treat Covid-19 patients in the coming weeks and months.

To that end, trusts were told to postpone all non-urgent operations and to “urgently discharge all hospital inpatients who are medically fit to leave.” This included some inpatients who would then be discharged to a care home. Discharge requirements published in greater detail on 19 March

Date: 18 March

- Event: Communities Secretary Aileen Campbell announces **£350m to support people in need**.

Date: 18 March

- Event: Scottish Government issues **guidance for social landlords**.

Date: 19 March

- Event: Coronavirus Bill introduced to the UK Parliament
- Notes: The UK government was seeking a wide range of legal powers to manage the lockdown measures, as well as to the issues that had arisen in relation to responding to the COVID-19 pandemic

Date: 19 March

- Event: In a statement to Parliament, the Scottish Government **announces the closure of schools and nurseries** by the end of the week.

Date: 19 March

- Event: Deputy First Minister and Cabinet Secretary for Education and Skills John Swinney’s **speech on managing the impacts of coronavirus on Scottish education**.

Date: 19 March

- Event: **Speech on the UK Government Coronavirus Bill** by the Cabinet Secretary for the Constitution, Europe and External Affairs Michael Russell

Date: 19 March

- Event: **Letter from the Chief Pharmaceutical Officer, Dr Rose Marie Parr appealing to pharmacists and pharmacy technicians to rejoin the General Pharmaceutical Council (GPhC) register**

Date: 19 March

- Event: Department for Health and Social Care (DHSC) and NHS England and Improvement published the **discharge requirements** for patients going to care homes.
- Notes: There was no requirement to test everyone who was discharged to see if they were infected. The document said that, where applicable, Covid-19 test results should be included in the documentation that accompanied people who were discharged.

Date: 20 March

- Event: The first death in a care home attributed to COVID-19 reported

Date: 20 March

- Event: Scottish Government published procurement guidance for public bodies during the COVID-19 pandemic

Date: 20 March

- Event: NICE **publishes guidance** on ‘Critical Care for Adults with Covid-19’
- Notes: NICE had recommended that all adults should be assessed for frailty on admission to hospital using the Clinical Frailty Scale (CFS). Concerns over the application of CFS for those with neuro-developmental conditions led NICE to amend it’s guidance on 31 March.

Date: 22 March

- Event: **First daily media briefing by the First Minister**

Date: 23 March

- Event: A proposed computer simulation of the impact of “targeted herd immunity” was contained in a planning document, used by NHSX and a technology contractor to map out the data response to the pandemic.
- Notes: While it does not appear that a herd immunity simulation took place, its inclusion in a list of possible interventions raises questions about the government’s position on the policy
  Note that on 14 March, **M Hancock denied** that this was a part of any government policy.

Date: 24 March

- Event: Lockdown commences in Scotland

Date: 24 March

- Event: Cabinet Secretary Humza Yousaf’s **speech on Justice and COVID-19 to the Scottish Parliament** where he outlines how justice agencies, front-line professionals and other staff are dealing with this emergency situation.

Date: 25 March

- Event: Coronavirus Act 2020 (Coronavirus Act) receives Royal Assent
- Notes: The Act is due to expire 2 years from this date, subject to a limited number of exceptions

Date: 25 March

- Event: **Letter sent to all registered childminders in Scotland** from Children’s Minister Maree Todd confirming that registered childminders should cease all provision besides emergency childcare for key worker families and vulnerable children

Date: 25 March

- Event: Coronavirus (COVID-19): Declaration of a serious and imminent threat to public health **Announcement of the declaration for the exercise of powers under schedule 21 and 22 of the Coronavirus Act 2020**

Date: 26 March

- Event: Scottish Government produce clinical **guidance for the management of clients accessing care at home, housing support and sheltered housing**. The guidance is aimed at local authorities, Health and Social Care Partnerships (HSCPs) and registered providers, who support and deliver care and support to people in their own homes.

Date: 26 March

- Event: Direction under Paragraph 2(2) of Schedule 14 (**Review of medical certificates of cause of death and cremations: Scotland**) of the Coronavirus Act 2020 (C.7).

Date: 26 March

- Event: Scottish Government produce updated **clinical guidance for nursing home and residential care residents**.

Date: 26 March

- Event: **Letter from the Chief Medical Officer, Chief Nursing Officer and Chief Social Work Adviser about COVID-19 clinical guidance for social care settings.**

Date: 27 March

- Event: Scottish Government **publishes rules on staying at home and away from others (social distancing)** These measures are required by law using powers from the UK Coronavirus Bill.

Date: 27 March

- Event: Scottish Government produces **advice for unpaid carers**

Date: 30 March

- Event: Scottish Government produces **advice for schools and childcare settings who are providing care to children** including information on social distancing

Date: 30 March

- Event: Scottish Government publishes Guidance for Health and Social Care Emergency Workers with underlying Health Conditions
- Notes: This was replaced in July 2021, Coronavirus (COVID-19): guidance on individual occupational risk assessment was published

Date: 30 March

- Event: British Geriatrics Society publishes **'Managing the COVID-19 Pandemic in Care Homes for Older People'**

Date: 31 March

- Event: Scottish Government introduces the Coronavirus (Scotland) Bill
- Notes: This is to make changes to some of the duties of public bodies to let them focus on work which responded to the coronavirus outbreak

Date: 31 March

- Event: Scottish Government produces **guidance setting out the childcare and learning provision for key workers and vulnerable children**

Date: 01 April

- Event: The Coronavirus (Scotland) Bill is considered by a Committee of the Whole of Parliament

Date: 01 April

- Event: **New guidance issued** jointly be the Department of Health and Social Care and other agencies on procedures for the admission and care of residents in care home
- Notes: The government reiterated in new guidance that "any [care home] resident presenting with symptoms of COVID-19 should be promptly isolated" but **specified that** "negative tests are not required prior to transfers / admissions into the care home.".
  Visits should only be made in exceptional circumstances, such as when residents are dying.
  "Family and friends should be advised not to visit care homes, except next of kin in exceptional situations such as end of life"

Date: 01 April

- Event: British Medical Association publishes **'COVID-19 - ethical issues. A guidance note'**

Date: 01 April

- Event: Guidance issued on procedures for admissions and care of residents in care homes.
- Notes: This introduced what might be called a 'light touch monitoring regime' of in-house measures. Care homes were advised to assess each resident twice a day by checking for symptoms. Only if they had 2+ symptomatic residents were they obliged to report it to the Health Protection Team. This did not guarantee a test would be forthcoming

Date: 02 April

- Event: The **global total of confirmed deaths from Covid-19 has passed 50,000**, according to the tally of official figures maintained by Johns Hopkins University

Date: 02 April

- Event: DHSC publishes **'Coronavirus (COVID-19): admission and care of people in care homes'**

Date: 03 April

- Event: Scottish Government produces clinical guidance from the Chief Medical Officer (CMO) on **treating patients with COVID-19**

Date: 03 April

- Event: Scottish Government produces **tailored advice for those who live with specific medical conditions**. Conditions include: cancer, diabetes, heart disease, IBD; chronic kidney and liver disease; dermatological, neurological, (specific) ophthalmic, respiratory and rheumatic conditions, chronic pain, and rare diseases.

Date: 06 April

- Event: Coronavirus (Scotland) Bill is passed and formally became law

Date: 06 April

- Event: Moves to direct PPE to care homes
- Notes: This did not prioritise care homes, they were included alongside other providers such as hospices, residential rehab, and community care organisations.

Date: 07 April

- Event: Scottish Government announces that **more than 12,000 returning health and social care workers and students have come forward to support the NHS** in its response to the outbreak

Date: 09 April

- Event: **Joint statement and guidance issued by the Scottish Government, COSLA and SJC Unions on PPE use in social care**

Date: 10 April

- Event: **The global death toll surpasses 100,000**.

Date: 10 April

- Event: **Cross-government plan for the delivery** of PPE to frontline workers
- Notes: Care homes were mentioned here as among the 58,000 relevant providers, alongside GP surgeries, hospices, and other community providers.

Date: 12 April

- Event: **Social care staff to receive a 3.3.% pay increase**, backdated to 1 April 2020

Date: 14 April

- Event: Several UK charities, including Age UK and the Alzheimer's Society, **express their concern that older people are being "airbrushed" out** of official figures because they focus on hospital deaths and do not include those in care homes or a person's own home

Date: 15 April

- Event: Action plan for adult social care announced, including bespoke supply routes and **specific guidance for care homes regarding PPE**. (England specific)
  UK Government finally introduces a requirement to patients to be tested before being discharged from hospital into a care homes
- Notes: The UK government recommended that before being transferred to a care home, hospital patients needed to be

tested for COVID-19. Note that the requirement for patients to be tested following discharge was not included in the earlier Coronavirus action plan published in early March 2020

Date: 18 April

- Event: A **charter flight from China carrying essential personal protective equipment (PPE) and NHS supplies has lands in Scotland**

Date: 20 April

- Event: **NHS Louisa Jordan hospital opens**

Date: 21 April

- Event: Scottish Government publishes **report on the projected impact of COVID-19 on Scotland's economy**.

Date: 21 April

- Event: **Social distancing regulations introduced in March are confirmed and extended to protect workers**
- Notes: It finally became mandatory for hospital patients to have two negative Covid tests before being discharged.

Date: 22 April

- Event: The **National Records of Scotland (NRS) releases data** up to 19 April.
- Notes: The number of deaths in Scotland was up 80% above the 5-year average. 537 deaths had been recorded in care homes, double the number of the previous week.
  Public Health Scotland's daily figures were under-counting deaths by up to 40%, as it was reporting deaths in hospitals only

Date: 23 April

- Event: **'COVID-19: A Framework for Decision-Making'** is published by the Scottish Government. The document sets out the position during lockdown and outlines the factors that must be considered as the country moves gradually to ease restrictions
- Notes: Identifies that ''We need a better understanding of the transmission of the virus in particular places - especially our hospitals and care homes – and how that may impact community transmission.'

Date: 24 April

- Event: Scottish Parliament holds its first meeting of the newly formed **COVID-19 Committee**. The Committee is established as a temporary committee for the duration of the emergency legislation which has been enacted to respond to the pandemic

Date: 26 April

- Event: Scottish Government announces that more than 22,000 returning health and social care workers and students have come forward to support the NHS in its response to the outbreak.

Date: 26 April

- Event: Health Protection Scotland publishes **'COVID-19: Information and Guidance for Care Home Settings Version 1.0'**

Date: 27 April

- Event: Scottish Government announces that **Local Hubs will distribute PPE supplies to the whole of the social care sector** where normal supply routes have not been successful

Date: 28 April

- Event: Scottish Government produce **guidance on the personal use of face coverings** during the pandemic

Date: 28 April

- Event: UK Government **extends testing** to include the testing of all care home residents.

Date: 28 April

- Event: Scottish Government announce that the 'Rapid Research in COVID-19 funding' that funds **research projects to increase the understanding of COVID-19, screen potential treatments and support clinical trials will benefit from almost £5 million of funding**

Date: 01 May

- Event: The Scottish Government announces a **further expansion of testing** as it was confirmed that the target to reach capacity for 3,500 tests a day across NHS labs has been exceeded

Date: 03 May

- Event: Two specialist organisations to receive **additional funding to support 47,000 autistic people across Scotland** during the pandemic

Date: 03 May

- Event: Scottish Government announces **key mental health services supporting families, young people and autistic people are to receive more than £1 million additional funding**

Date: 05 May

- Event: Government published **'Coronavirus (COVID-19): framework for decision making – further information'**

Date: 06 May

- Event: The National Records of Scotland records the first weekly reduction of registered deaths (for the week ending 3 May) since the first COVID-19 death was registered in the week beginning 16 March

Date: 06 May

- Event: Scottish Government proposes that as part of the next emergency coronavirus legislation, an additional £19.2 million investment in Carer's Allowance Supplement will enable **a special one-off Coronavirus Carer's Allowance Supplement in June**

Date: 09 May

- Event: Scottish Government announces more **Personal Protective Equipment (PPE) will be manufactured in Scotland** following the establishment of a new NHS Scotland supply chain

Date: 11 May

- Event: Scottish Government announces the advice on how often people can venture outdoors has changed.
- Notes: As of 11 May, people can go outside more than once a day to exercise. This activity should continue to be undertaken close to home. Those going out to exercise should either go alone or with members of their household. The UK government has set out its plan to return life to as near normal and has published new rules for **staying safe outside your home**. These new rules will take effect on Wednesday 13 May 2020.

Date: 11 May

- Event: A second **Coronavirus (Scotland) Bill** is introduced to the Scottish Parliament. It includes emergency measures to protect people facing financial hardship and allow public services to operate effectively in response to the pandemic.

Date: 11 May

- Event: **National Wellbeing Hub** is launched
- Notes: The Hub is a new partnership between national, local and professional bodies looking after the emotional and psychological wellbeing of Scotland's health and social services workers

Date: 12 May

- Event: Scottish Government confirms an initial **£50 million to help the social care sector deal** with the financial implications of the pandemic

Date: 12 May

- Event: UK Government publishes **'Our plan to rebuild: The UK Government's COVID-19 recovery strategy'**: a roadmap for how and when the UK will adjust its response to the COVID-19 crisis

Date: 12 May

- Event: **Figures released by the Office for National Statistics** and the devolved administrations indicate the death toll from COVID-19 exceeds 40,000 – including almost 11,000 care home residents

Date: 18 May

- Event: Scottish Government announces that **testing for coronavirus (COVID-19) is to be opened out to everyone who is symptomatic over the age of five**

Date: 18 May

- Event: UK Government announces that **everyone in England, Scotland, Wales and Northern Ireland with coronavirus (COVID-19) symptoms is now eligible to book a test**, ahead of the rollout of the test and trace service

Date: 18 May

- Event: Scottish Government publishes **Coronavirus (Covid 19) – enhanced professional clinical and care oversight of care homes**
- Notes: The new arrangements strengthen oversight of Scotland's care homes

Date: 20 May

- Event: Scottish Parliament has unanimously supported new emergency measures in the **Coronavirus (Scotland) (No.2) Bill**

Date: 21 May

- Event: Scottish Government publishes a COVID-19 **Routemap** to take Scotland through and out of the COVID-19 pandemic

Date: 21 May

- Event: Scottish Government publishes Interim Guidance for health and social care employers on staff from Black, Asian and Minority Ethnic Backgrounds

Date: 24 May

- Event: Scottish Government announces that **extra financial support will be given to social care workers** in Scotland during the Coronavirus emergency
- Notes: Plans for death in service cover and enhancements to statutory sick pay

Date: 26 May

- Event: Chief Nursing Officer issued a letter to all NHS health boards clarifying that single-use PPE should not be re-used.

Date: 28 May

- Event: First Minister Nicola Sturgeon **announces the move to Phase 1 of the route map out of lockdown**, beginning on Friday 29 May

Date: 28 May

- Event: NHS Scotland's Test and Protect scheme is rolled-out across Scotland

Date: 04 June

- Event: Scottish Government publish a report on Personal Protective Equipment supplies.

Date: 07 June

- Event: Scottish Government announce **new public health measures** will come into force on 8 June to help suppress coronavirus (COVID-19) and prevent new cases being brought into Scotland

Date: 09 June

- Event: Scottish Government publish **the first two-monthly report to Scottish Parliament on the use of the emergency powers contained within the Coronavirus Act 2020 and Coronavirus (Scotland) Act 2020**

Date: 09 June

- Event: Scottish Government establish **a new expert group to assess the impact of the virus on minority ethnic communities**

Date: 10 June

- Event: Scottish Government publish **initial Test and Protect data**.

Date: 15 June

- Event: Health Secretary Jeane Freeman says an **Independent Review into the Queen Elizabeth University Hospital** in Glasgow has found that while it now offers a high quality healthcare setting, the initial design didn't adequately take into account the needs of some vulnerable patients.
- Notes: The report was commissioned by the Health Secretary after some patients contracted severe infections linked to issues with water quality and ventilation systems. The independent review team found that patients, staff and visitors with compromised immune systems were exposed to risks which could have been lower if the correct design, build and commissioning had taken place.

Date: 18 June

- Event: First Minister Nicola Sturgeon announces the **move to Phase 2 of the Route Map out of lockdown**, with a staged introduction of changes commencing on 19 June.

Date: 19 June

- Event: Move to Phase 2 of the route map out of lockdown.

Date: 22 June

- Event: Visitors were **permitted to visit** relatives in England, but this could only include one visitor per resident
- Notes: See DHSC, 'Visiting care homes during coronavirus' and UK Government, 'Care homes: Visiting restrictions during the covid-19 pandemic'

Date: 23 June

- Event: Scottish Government announce that **routine testing of health and social care staff is to be extended** as more services resume

Date: 24 June

- Event: Scottish Government publish an **updated route map with indicative dates for Phase 2 and early Phase 3 measures**

Date: 24 June

- Event: Scottish Government publish an **assessment of the health and social impacts of COVID-19 on particular groups**

Date: 25 June

- Event: Scottish Government publish **guidance for care homes on phasing in the re-introduction of visiting**.

Date: 29 June

- Event: Scottish Government establish a new advisory group which meets for the first time on Monday 29 June. The **Mobilisation Recovery Group**, led by Health Secretary Jeane Freeman, will work to balance the safe resumption of some health care services that were paused during the initial response to the coronavirus (COVID-19).

Date: 29 June

- Event: Scottish Government publish **Coronavirus (COVID-19): UK fiscal path – a new approach**. The report calls for a UK-wide £80 billion stimulus package to regenerate the economy and reduce inequalities following the coronavirus (COVID-19) pandemic.

Date: 30 June

- Event: Scottish Government publish **guidance for hospitals on safely phasing in the reintroduction of visitors**.

Date: 02 July

- Event: Due to a spike in cases in Dumfries and Galloway, the Scottish Government implements the first localised delay in the relaxation of restrictions. Other areas would be impacted in a similar way as the pandemic continued.

Date: 09 July

- Event: First Minister Nicola Sturgeon announces **the move to Phase 3 of the Scottish Government's route map out of lockdown**.

Date: 10 July

- Event: Move to Phase 3 of the route map out of lockdown

Date: 14 July

- Event: Scottish Government publishes **'COVID-19 Ethical advice and support framework: Fairer Scotland Duty Summary'**

Date: 20 July

- Event: Scottish Government announce **additional mental health support for health and social care staff**.

Date: 30 July

- Event: Advice on self-isolation changed from 7 to 10 days

Date: 30 July

- Event: Scottish Government publishes 'Coronavirus (COVID-19): guidance on individual occupational risk assessment'

Date: 31 July

- Event: Scottish Government announce a **new contact tracing app** to support NHS Scotland's Test and Protect system is now in development.

Date: 31 July

- Event: Scottish Government publishes **'Coronavirus (COVID-19): Clinical Guidance and Ethical Advice and Support Framework - Impact Assessment'**

Date: 03 August

- Event: Scottish Government announce the **social care sector will receive up to £50 million further additional funding** to help meet additional costs related to coronavirus (COVID-19).

Date: 09 August

- Event: Scottish Ministers announce a **relaxing of rules for care home visits** from the following day that allows three outdoor visitors per person from two separate households

Date: 09 August

- Event: Scottish Government published **'Update on isolation exemptions for health and social care staff'**

Date: 16 August

- Event: A **Sunday Post investigation** reveals that at least 37 COVID patients have been transferred to care homes following a diagnosis in hospital in Scotland

Date: 20 August

- Event: Scottish Government announce that **Scotland is to remain in Phase 3** of the route map, as COVID-19 remains a significant threat to public health. The Government publish an **updated route map** setting out dates for further changes.

Date: 26 August

- Event: Scottish Government announce that NHS Scotland has agreed a £6.76 million deal to purchase new machines capable of turning around coronavirus (COVID-19) **tests in 12 minutes**. UK-based life sciences company LumiraDx will supply 300 rapid testing machines as well as a minimum of 500,000 tests.

Date: 01 September

- Event: Scottish Government announce **restrictions on indoor gatherings and limits to hospital and care home visiting in East Renfrewshire, Glasgow and West Dunbartonshire**, from midnight on Tuesday 1 September

Date: 03 September

- Event: Scottish Government announce the **resumption of health and wellbeing visits to care homes from 07 September**
- Notes: The new guidance recommends that enhanced visiting is only resumed in care homes where there are no active cases, have been free of COVID-19 for 28 days, and are actively participating in the care home worker testing programme

Date: 10 September

- Event: Scottish Government publish an **updated route map**, limiting indoor and outdoor gatherings to six people from two households, as Scotland remains in Phase 3

Date: 21 September

- Event: The UK Chief Medical Officers issue a **joint statement recommending that the UK COVID-19 alert level move from level 3 to level 4**.

Date: 24 September

- Event: Scottish Government publish the **Autumn Budget Revision for 2020-21**, outlining further funding allocations

Date: 02 October

- Event: Scottish Government publish the **Coronavirus (COVID-19): mental health needs of hospitalised patients – report**
- Notes: Dr Nadine Cossette was commissioned to examine mental health needs of patients hospitalised due to COVID-19. Her report contains analysis of need and recommendations for action to support recovery

Date: 08 October

- Event: Scottish Government publish the **Mental Health – Transition and Recovery plan**, outlining the Government's response to the mental health impacts of COVID-19

Date: 12 October

- Event: The rules for care home visits in Scotland are relaxed, with visiting time limits expanded from 30 minutes to four hours

Date: 23 October

- Event: Scottish Government publish the **five-level Strategic Framework**, which indicates different levels of protection that might be needed based on different levels of transmission for the virus
- Notes: Levels to come into force on 2 November

Date: 28 October

- Event: Public Health Scotland publish its **report on discharges from NHS hospitals to care homes in Scotland**

- Notes: The report exposes that **over 113 patients were discharged into care homes in Scotland after having tested positive for COVID-19**

Date: 28 October

- Event: Scottish Government announce a **NHS Winter Preparedness Plan to support health and care services** over the Winter

Date: 29 October

- Event: New local authority protection measures announces
- Notes: These came into force on 02 November 2020.

Date: 02 November

- Event: Scottish Government announce a **£15 million funding package to respond to children and young people's mental health issues**, with a focus on those brought about by the pandemic

Date: 03 November

- Event: Scottish Government publish the **Care Home Review (A rapid review of factors relevant to the management of COVID-19 in the care home environment in Scotland)**

Date: 03 November

- Event: Scottish Government publish the **Adult Social Care Winter Preparedness Plan**, backed by £112 million investment to support the sector over winter

Date: 16 November

- Event: Scottish Government publishes **'Coronavirus (COVID-19): Ethical Advice and Support Framework'**

Date: 16 November

- Event: Scottish Government announce **£1 million funding for digital devices to keep care home residents connected**

Date: 19 November

- Event: Scottish Government outlines **plans for the delivery of COVID-19 vaccines**
- Notes: Health and social care workers, older care home residents and the over 80s first to be vaccinated

Date: 22 November

- Event: **Opposition parties in Scotland call for** a complete ban on discharging hospital patients to care homes unless they have received two negative COVID tests after reports the practice continues

Date: 25 November

- Event: Health Secretary Jeane Freeman announces plans for an **expansion in testing for hospital patients, health and social care staff, and communities in Level 4 areas**

Date: 30 November

- Event: Scottish Government announce a one-off **£500 payment for health and social care staff**

Date: 02 December

- Event: UK Government announce that **the vaccine developed by Pfizer and BioNTech has been authorised by the medicines regulator for use in the UK**
- Notes: The Pfizer/BioNTech vaccine was approved by the MHRA under Regulation 174 of the Human Medicine Regulations 2012 (2012 Regulations).

Date: 03 December

- Event: Scottish Government announce **changes to the way patients access emergency hospital treatment**. Anyone with a non-life threatening condition who would usually go to A&E should now call NHS 24 on 111 first, day or night, to be directed to the right NHS service

Date: 08 December

- Event: Scottish Government announce the **first vaccinations against coronavirus (COVID-19) have been given in Scotland** to those who will be carrying out the vaccination programme

Date: 14 December

- Event: Scottish Government announce the **first vaccinations in care homes in Scotland have taken place**

Date: 19 December

- Event: First Minister Nicola Sturgeon announces the **tightening of COVID-19 restrictions around the festive period**.

Date: 30 December

- Event: Medicines and Healthcare products Regulatory Agency (MHRA) **approves the Oxford AstraZeneca vaccine for use in the UK**
- Notes: The AZ vaccine was also approved under the 2012 Regulations.

Date: 30 December

- Event: The UK Chief Medical Officers issue a **statement on the prioritisation of first doses of the coronavirus vaccines**

## 2021

Date: 04 January

- Event: Scottish Government announce **mainland Scotland is to go into lockdown from 5 January 2021** with a new legal requirement forbidding anyone from leaving their home except for essential purposes

Date: 04 January

- Event: Scottish Government announce **mainland Scotland is to go into lockdown from 5 January 2021** with a new legal requirement forbidding anyone from leaving their home except for essential purposes

Date: 04 January

- Event: Scottish Government announce the **roll-out of the Astrazeneca vaccine**.

Date: 05 January

- Event: Mainland Scotland goes into lockdown.

Date: 07 January

- Event: **First Minister Nicola Sturgeon announces** that medical staff are "well over half way through" vaccinating care home residents in Scotland

Date: 08 January

- Event: The Moderna vaccine, another mRNA vaccine, was approved by the MHRA.

Date: 21 January

- Event: It is **reported** that a special Crown Office unit established in May 2020 to investigate COVID-related deaths is probing deaths at 474 care homes in Scotland

Date: 01 February

- Event: **NHS confirms** COVID vaccination now offered at every eligible care home in England

Date: 01 February

- Event: **First Minister Nicola Sturgeon confirms** that 98% of elderly care home residents have been offered their first COVID vaccination, together with 80% of those aged over 80 in the wider community

Date: 04 February

- Event: UK Government publishes **COVID-19: Government procurement and supply of Personal Protective Equipment**

Date: 20 February

- Event: Scottish Government announce **routine indoor visiting of care home residents** will resume from early March with care providers supporting residents to have up to two designated visitors each and one visit a week for each visitor.

Date: 23 February

- Event: Scottish Government publish the **updated Strategic Framework**, setting out the broad order of priority for re-opening and the conditions that need to be met to start lifting restrictions

Date: 24 February

- Event: Scottish Government publish **'Open with Care - supporting meaningful contact in care homes: guidance'**
- Notes: This provides guidance to support the resumption of meaningful contact between care home residents and their loved ones.

Date: 25 February

- Event: The UK Chief Medical Officers issue a **joint statement recommending that the UK COVID-19 alert level move from level 5 to level 4**

Date: 26 February

- Event: Scottish Government launch the **Workforce Specialist Service**, which offers confidential mental health assessment and treatment to health and social care professionals

Date: 26 February

- Event: Joint Committee on Vaccination and Immunisation (JCVI) issues **interim advice on Phase 2 of COVID-19 vaccination programme rollout**.
- Notes: Evidence suggests an age-based approach remains the most effective way of reducing death and hospitalisation from COVID-19

Date: 01 March

- Event: Scottish **visiting restrictions on care homes are relaxed**, allowing residents to choose two visitors who can visit them once a week

Date: 08 March

- Event: Scottish Government published **'COVID-19 Vaccination Programme Priority List: FOI Release'**

Date: 16 March

- Event: Scottish Government publish a **timetable for easing restrictions**

Date: 18 March

- Event: Scottish Government announce the **closure of NHS Louisa Jordan**. The hospital, which was set up to support Scotland's response to the COVID-19 pandemic is to close on 31 March, with the mass vaccination centre relocating to The SSE Hydro

Date: 31 March

- Event: Scottish Government publishes **Coronavirus (Covid-19): social distancing in education and childcare settings**

Date: 18 April

- Event: **A full breakdown of COVID-19 related deaths** in every Scottish care home is published by the Crown Office

Date: 20 April

- Event: Scottish Government announce all parts of the country will move to Level 3 from Monday 26 April.

Date: 21 April

- Event: **Public Health Scotland says it "cannot rule out"** a link between the discharge of patients from hospital and care home deaths from COVID-19

Date: 14 May

- Event: Scottish Government announce most of mainland Scotland (with the exception of Moray) will **move to level 2 from Monday 17 May**

Date: 28 May

- Event: Medicines and Healthcare products Regulatory Agency (MHRA) **approves the one-dose Janssen Covid-19 vaccine for use in the UK**

Date: 4 June

- Event: Medicines and Healthcare products Regulatory Agency (MHRA) **approves the Pfizer/BioNTech vaccine for use in 12- to 15-year-olds**

Date: 4 June

- Event: Scottish Government announce Professor Julie Fitzpatrick OBE is appointed as the **Scottish Government's next Chief Scientific Adviser (CSA)**

Date: 24 June

- Event: The Coronavirus (Extension and Expiry) (Scotland) Bill is **passed by the Scottish Parliament at Stage 3**
- Notes: The Parliament agreed for the Bill to be treated as an Emergency Bill, with Stages 1-3 running on consecutive days from 22 June to 24 June. SPICe has published an **extended blog providing an overview the Bill and it's impact**.

Date: 27 June

- Event: Scottish Government announce **£8 million funding package for health and social care workforce wellbeing**

Date: 30 June

- Event: Scottish Government announce **social care Personal Assistants will receive £500 payment**

Date: 02 July

- Event: Scottish Government announce **£380 million additional funding to help Health Boards with pandemic costs**

Date: 03 July

- Event: Scottish Government announce **Test and Protect will prioritise high risk cases**

Date: 13 July

- Event: First Minister Nicola Sturgeon announces **all of Scotland will move to protection level 0 on Monday 19 July**

Date: 29 July

- Event: Scottish Government announce **£11.5 million funding to help reduce waiting times** as part of NHS remobilisation efforts

Date: 29 July

- Event: Scottish Government announce nine projects supporting carers and disabled people will share **£1 million to tackle loneliness and isolation** as a result of the pandemic

Date: 03 August

- Event: First Minister Nicola Sturgeon announces **Scotland to move beyond level 0 on 9 August**, when the legal requirement for physical distancing and limits on gatherings will be removed

Date: 07 August

- Event: Scottish Government announce two metre physical distancing will **remain in place at health care settings across Scotland** from 9 August when COVID-19 restrictions are lifted elsewhere in the country

Date: 17 August

- Event: Scottish Government launches its **consultation on Scotland's recovery**, which sets out a range of proposals, including whether some temporary provisions made under Scottish and UK coronavirus legislation and due to expire in March 2022 should be maintained

Date: 25 August

- Event: Scottish Government publish the **NHS Recovery Plan**, setting out key actions for the next five years to help address backlogs in healthcare and increase capacity by at least 10%.

Date: 07 September

- Event: Scottish Government publish **Programme for Government 2021-22**

Date: 09 September

- Event: Scottish Government launch £10 million **Long COVID Support Fund** to help health boards respond to the condition

Date: 15 September

- Event: Scottish Government **publishes interim guidance**, aligned to Open with Care

Date: 17 September

- Event: UK Government announce **Ronapreve** will be rolled out to vulnerable hospital patients. Ronapreve becomes the first neutralising antibody medicine specifically designed to treat COVID-19 to be authorised by MHRA for use in the UK

Date: 21 September

- Event: Scottish Government announce **additional funding of £20 million for the Scottish Ambulance Service** (SAS) to help improve response times, alleviate pressures and improve staff wellbeing

Date: 24 September

- Event: Scottish Government launch a five-week consultation on introducing **Anne's Law** – to ensure people who live in adult care homes have rights to be able to have direct contact with people who are important to them in order to support their health and wellbeing

Date: 30 September

- Event: Scottish Government publish an **updated 2021 vaccination strategy**, including plans for COVID-19 and seasonal influenza (flu) vaccinations in autumn and winter 2021 to 2022 in Scotland

Date: 30 September

- Event: Scottish Government announce **Invitations for coronavirus (COVID-19) booster injections** are issued to people aged 70 and over and those aged 16 and over who are at highest risk, with appointments scheduled from the week beginning 4 October

Date: 01 October

- Event: Data obtained by the BBC indicates that **more than half of elderly patients discharged from hospital in Scotland to 200 care homes** were not tested for COVID beforehand

Date: 05 October

- Event: Scottish Government publish **Covid Recovery Strategy: for a fairer future**

Date: 05 October

- Event: Scottish Government announce **£300 million NHS and Care Winter Package**.

Date: 15 October

- Event: Scottish Government launch the £15 million **Communities Mental Health and Wellbeing Fund**.

Date: 22 October

- Event: Scottish Government publish the adult social care **Winter Preparedness Plan 2021-22**

Date: 31 October

- Event: Scottish Government announce **£32 million for 139 additional trainee doctors**

Date: 02 November

- Event: Scottish Government announce an additional **£10 million winter funding for NHS health boards** to improve A&E waiting times

Date: 03 November

- Event: Scottish Government issue **new guidance for A&E departments**, in response to a request from NHS Boards to support hospitals to refer people to the most appropriate place for treatment, if they do not need emergency care

Date: 16 November

- Event: Scottish Government publish an **update to Scotland's Strategic Framework**, setting out the latest approach to managing the pandemic

Date: 29 November

- Event: Scottish Government announce **£30 million funding for GP practices** to help support more face-to-face appointments

Date: 02 December

- Event: Health and social care professionals were **advised** that updated guidance from that issued in April 2021 was being provided

Date: 09 December

- Event: An **inquiry into the cause of increased excess deaths in Scotland since the start of the pandemic** has been launched by the Scottish Parliament's COVID-19 Recovery Committee

Date: 09 December

- Event: Scottish Government publish the **2022-2023 Scottish Budget**, aiming to restore public services and to respond to the pressures created by the pandemic

Date: 10 December

- Event: Scottish Government publishes **'Coronavirus (COVID-19): minimising the risk over winter and updated protective measures for Omicron variant'**

Date: 10 December

- Event: Scottish Government updates its care home guidance

Date: 12 December

- Event: UK Government announce the **UK coronavirus (COVID-19) alert level will be increased from Level 3 to Level 4**

Date: 17 December

- Event: Scottish Government publish updated **guidance on visiting care homes and hospitals**.
- Notes: Adult care homes and hospitals should continue to support visits for residents and patients, however new recommendations set out that visits should be in line with the rules for the general public brought in to control the spread of the Omicron variant of Covid-19

Date: 21 December

- Event: UK Government publishes **'COVID-19 Guidance for First Responders'**

Date: 29 December

- Event: Scottish Government announce that **priority for PCR test site slots will be given to essential workers, those at highest risk and anyone eligible for new Covid treatments**.

## 2022

Date: 05 January

- Event: Scottish Government announce **changes to self-isolation and testing**.
- Notes: From 6 January, new cases can end self-isolation if they don't have a fever and test negative on a LFD on Day 6 and again at least 24 hours later. Anyone who tests positive on a LFD will no longer be asked to take a PCR test to confirm the result.

Date: 14 January

- Event: **Number of people in Scotland who have died within 28 days of testing positive for Covid passes 10,000**

Date: 17 January

- Event: Scottish Government publish **Update on Self-Isolation for Health and Social Care Staff**

Date: 20 January

- Event: Scottish Government issue **new guidance for care home operators**, reducing and removing isolation periods for care home residents

Date: 24 January

- Event: Scottish Government **removed** the guidance asking people to limit indoor gatherings to three-households

Date: 27 January

- Event: Public Health Scotland publishes Covid-19-Information and Guidance for Care Home Settings (Adults and Older People), Version 2.7

# Footnotes

1. UK Parliament, House of Lords, The Union and Devolution, paras 18-20.
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3. S Greer, ‘Devolution and Health in the UK: Policy and its Lessons Since 1998’ (2016) 118(1) ‘British Medical Bulletin 16’.
4. Ibid.
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6. Scottish Government, ‘After Brexit: The UK Internal Market and Devolution’ (8 March 2021) **https://www.gov.scot/publications/brexit-uk-internal-market-act-devolution/**.
7. See S Katikreddi et al, ‘Devolution of Power, Revolution in Public Health’ (2017) 39(2) ‘Journal of Public Health’ 241.
8. Greer, (n 3) 17.
9. NHS Scotland, ‘Organisations’ (2021) **https://www.scot.nhs.uk/organisations/**
10. Scottish Government, ‘Organisations’ (Gov.Scot, 2022) **https://www.mygov.scot/organisations#scottish-local-authority**.
11. Ibid, 19. In 2019-20, for example, the application of the formula resulted in an allocation of £32bn to Scotland, before adjustments to account for tax devolution), see Institute for Government, ‘The Barnett Formula’ (25 November 2020) **https://www.instituteforgovernment.org.uk/explainers/barnett-formula**.
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13. Greer, 2016 (n 3) 19.
14. Scottish Government, 'Scottish Budget' (Gov.Scot, December 2021) **https://www.gov.scot/budget/**.
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16. Scottish Government, 'Health and Social Care: Medium Term Financial Framework' (Gov.Scot, Oct 2018) **https://www.gov.scot/publications/scottish-government-medium-term-health-social-care-financial-framework/pages/2/**.
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19. Care Quality Commission, 'Annual Report and Accounts 2011/12', HC 482 Session 2012-2013.
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21. Daily Record, 'Number of NHS Patients Sent for Private Care at Public Expense Doubles in a Year' (2015) **http://www.dailyrecord.co.uk/news/health/number-nhs-patients-sent-private-6242541**.
22. NHS Scotland, 'Data – Equality and Diversity' (2020) **https://turasdata.nes.nhs.scot/media/lbmlffwy/equality_and_diversity_m2020_revision_mar2021.xlsx**.

23. Note that the data collection and analysis functions for the NHS Scotland healthcare workforce were moved to NES in 2019. The full report for 2020/21 is not yet available, but we provide an overview for 2020/21 in the infographic, see **https://turasdata.nes.nhs.scot/media/fqwkaw1e/quarterly-update-dec21.pdf**).
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29. For an overview, see Audit Scotland which publishes Annual Reports on local, Government and NHS Scotland finances. In addition, the Scottish Government publishes quarterly consolidated financial reports for integration authorities, local authorities, and health boards in respect of integrated services.
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