Report in Relation to Impacts of COVID-19 and Health and Social Care in Scotland

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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.

Executive Summary

Hospital Discharge

The need to ensure that there were sufficient beds available for Covid patients led to an approach being taken to facilitate rapid discharge of patients from hospitals in the early stages of the Pandemic. It subsequently emerged that in some instances patients were discharged without adequate testing being undertaken. Evidence suggests that where certain Covid positive patients were discharged into care homes this was related to subsequent spread of the virus within the care home.

The Mental Welfare Commission has also stated that there were a number of moves of patients who lacked mental capacity from hospitals into care homes during the Pandemic which were unlawful. There was also evidence of poor practice.

Deaths of Care Home Residents during the Pandemic

Serious concerns arose in relation to the numbers of care home deaths of residents which were related to Covid during the Pandemic including specific clusters of deaths within certain care homes. These include the discharge of patients who had contracted Covid to care homes and the lack of appropriate testing. Covid related deaths in care homes are currently the subject of a Crown Office investigation known as “Operation Koper.” The Covid-19 Deaths Investigation Team (CDIT) Unit is examining deaths in Scottish Care Homes.

Treatment and Care of Care Home Residents

Restrictions on visitors to care homes introduced for infection control purposes has been a source of major controversy during the Pandemic. It has been argued that the absence of visiting has had a deleterious impact on the health and well-being of residents and also a consequent adverse impact on family and those close to them. While Article 8 of the European Convention on Human Rights safeguards the right to home and family life this right itself is a qualified right enabling further considerations such as the broader public interest in relation to safeguarding health to be taken into account. Following the campaign for "Anne's Law" the Scottish Government has committed to the introduction of legislation to establish visiting rights in relation to care homes however to date such legislation has not yet been introduced.

Effectiveness of Guidance for Care Homes

There was proliferation of various guidance documents to care homes during the early stage of the Pandemic. This it is suggested raised the prospect of confusion in implementation.

Inspections of care homes during the Pandemic

Concern was raised that the pausing of inspections by Care Inspectorate Scotland and Healthcare Improvement Scotland during the first period of the Pandemic may have had serious impacts including loss of life. Subsequent inspections revealed some findings of serious concern. There was some criticism of the way in which the Care Inspectorate had operated during the Pandemic. Some joint inspections were undertaken between Care Inspectorate Scotland and Healthcare Improvement

Scotland. Subsequent review of these inspections highlighted some differences in approaches between the two bodies which it was recommended needed to be addressed

The Impact of the Pandemic on Social Care

Concerns as to the ability of social care provision to withstand the impact of a Pandemic were noted in relation to Pandemic planning before 2020. As in England and Wales provisions to "ease" the application of existing statutory provisions concerning social care were incorporated in the Coronavirus Act 2020 Sections 16 and 17 of the Coronavirus Act 2020 enabled local authorities in Scotland to depart from certain existing statutory provisions during the Pandemic. The provisions were later withdrawn in November 2020. It was reported that in practice there were substantial adverse impacts of withdrawal of care services experienced by service users such as older persons and those with disabilities. Some reports have suggested that while financial support was provided by the Scottish government that this had in some instances not translated to effective support at local level. Concerns also remain as to access to day centre provision.

Impact on the delivery of primary medical care.

Primary care provision utilised triage processes through the operation of Community hubs and Assessment Centres for patients with Covid-19 symptoms. Availability and appropriateness of face to face GP appointments in the later period of the Pandemic remains a matter of discussion

Triage decision making choices concerning critical care treatment and consequent application of professional guidelines where this occurred

The potential for utilisation of difficult rationing tools in relation to critical care treatment was highlighted from the start of the Covid Pandemic. These are particularly sensitive issues to resolve in relation to respect for the fundamental human right to life under Article 2 of the European Convention of Human Rights. The Scottish Government made provision for the establishment of ethical advice and support groups in each Health Board along with the establishment of a National Ethics Advice and Support Group. It remains unclear as to how effective these bodies have been in practice.

The process of re-starting NHS Care

In the early months of the pandemic there was a prioritisation of NHS services towards delivery of Covid related care with various other services being paused or reduced. A strategy was introduced in May 2020 to restore NHS service provision. Audit Scotland in its report NHS in 2021 indicated that data on waiting time targets had been requested but had still not been provided. In relation to the recovery of cancer care research suggests the full impact may not be known for several years. Evidence indicates that some choices of maternity care were limited during the Pandemic period. It is unclear as to what was the full impact on matters of choice over the course of the Pandemic. There was also a pause regarding access to fertility treatment in late 2021-2 for persons who were not fully vaccinated in relation to which consequent implications for individuals' human rights were raised.

Changes to mode of delivery of healthcare during the Pandemic

The move to implement social distancing during the Pandemic drove the increased use of digital technologies such as telemedicine. Existing schemes such vCreate" and "Near Me" were rapidly expanded. Advantages were seen for some in terms of easier access to for example secondary care consultations without need to travel considerable distances. Concerns were raised in relation to the problems of digital exclusion and lack of privacy in relation to consultations if individuals were living in crowded accommodation. Use was made in relation to telemedicine in relation to the provision of early medical abortion services from the early stages of the Pandemic. Continued use of various forms of digital technology is envisaged post Pandemic however concerns still remain in relation to the impacts of digital exclusion.

The impacts on staffing in primary and secondary care

Notable staffing and workforce pressures in primary and secondary care were indicated during the Pandemic. NHS staff suffered Covid illness and some sadly died as a result of the infection. Other strains on staff physical and mental health were reported during this period. Workforce pressures were linked to by professional bodies to existing staffing shortages, adverse staff wellbeing, health inequalities and demand on healthcare provision etc. which pre-dated and were exacerbated by the Pandemic impact. Attempts were made to alleviate this through measures such as the NHS Wellbeing Hub and helpline. Tensions though have been highlighted between drives to increase service provision going forward and staff wellbeing.

Equality and diversity issues

Respect for equality and protection from discrimination is enshrined in domestic law and in international statements of human rights and should be a core value for all. The Pandemic has exacerbated existing inequalities in relation to health. Throughout the Pandemic there have been concerns as to the disproportionate impacts of Covid upon certain groups in the community including minority ethnic individuals and/or those suffering from socio-economic deprivation. The Scottish Government measures included the establishment of a new Health Inequalities Unit.

Use of Do Not Attempt Cardio-Pulmonary Resuscitation Orders During the Pandemic

The application of Do Not Attempt Cardio-Pulmonary Resuscitation Orders has been of notable controversy. This is an area which engages fundamental human rights in the form of Articles 2 the right to life and Article 8 – the right to privacy of home and family life contained in the European Convention of Human Rights. It has been claimed that these were applied in relation to some individuals without their knowledge or in the case of persons lacking mental capacity, without the knowledge of their relatives.

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I. Care and Nursing Homes: Strategic Elements of Handling the Pandemic

1.1 Hospital Discharge Processes

Key Issues

The need to ensure that there were sufficient beds available for Covid patients led to an approach being taken to facilitate rapid discharge of patients from hospitals in the early stages of the Pandemic. It subsequently emerged that in some instances patients were discharged without adequate testing being undertaken. Evidence suggests that where certain Covid positive patients were discharged into care homes this was related to subsequent spread of the virus within the care home.

In the early stage of the Pandemic steps were rapidly taken to discharge patients from hospitals into care homes to facilitate spare capacity for the expected surge of Covid patients. Concerns were subsequently raised regarding to what extent this rapid discharge had resulted in the spread of Covid into care homes themselves with a consequent serious adverse effect on the health and lives of those residents transferred and those of others already resident in the care home to which they were moved.

Effective and timely discharge from hospital can be seen as appropriate healthcare policy. There have been concerns prior to Covid as to the potential harms to patients if they remain in hospital for an unduly long period both in terms of mobility and of the risk that they may contract illnesses while in hospital itself (**footnote 1**). Research and reflection on facilitating discharge has been undertaken by Health and Social Care Scotland

working with the Scottish Government (**footnote 2**). This can be seen as part of a movement to a "discharge to assess" approach which is being adopted in England where detailed social care needs assessments are only undertaken after hospital discharge (**footnote 3**). In October 2021 two new programmes Interface Care and Discharge without Delay were introduced with the aim of facilitating rapid discharge and also enabling NHS boards to organise care for patients without them requiring hospital admission (**footnote 4**).

Audit Scotland in their report "The NHS in Scotland in 2021 "published in February 2022 commented that

"In its health and social care winter overview, the Scottish Government committed to providing £62 million, to increase the capacity for providing care at home, and funding of £40 million, to move people delayed in hospital into care homes on a short-term basis. This aimed to free up capacity in hospitals over the winter. By December 2021 there had been a small decrease in the average daily bed days occupied by delayed discharges …... The measures to reduce delayed discharges, particularly during the first wave of the pandemic, were effective in the short term but a longer-term, more sustainable solution is needed." (**Footnote 5**)

A major concern in relation to the decision for discharge to care homes in the early stages of the Pandemic was that this was at a point when testing was not being comprehensively undertaken with the prospect of consequent serious adverse impacts to patients and care homes. The Cabinet Secretary for Health and Sport announced on 21st April 2020 that prior to admission to care homes persons should have a negative Covid-19 test. However this was subject to the provision that admission could be undertaken where

“In the clinical interest of the patient to be moved, and then only after a full risk assessment. Where a patient has tested positive for Covid two negative tests are required.” (**Footnote 6**)

Subsequently in evidence to the Health and Sport Committee on 4th June 2020 Jean Freeman the Cabinet Secretary for Health and Sport stated that

“However the guidance that we issued on 13th March was very clear. We asked care homes to undertake screening for symptoms as part of the Health Protection Scotland guidance. We said that transitions from hospital should be screened clinically to ensure that people were not transferred inappropriately, that communal activity should be reduced by 75 per cent, with residents remaining in their rooms as soon as possible and that only essential visitors should be allowed, with particular exemptions for end of life care and residents with dementia. There was also clear guidance on the use of PPE.” (**Footnote 7**)

Furthermore she commented that

“Assessing the clinical appropriateness of discharge should be undertaken in the hospital setting and the received in the setting to which the patient is being discharged. That applies whether the patient is returning to the care home or entering it for the first time.” (**Footnote 8**)

Later in the evidence session on 4th June 2020 the following exchange occurred.

“**The Convener:** Is it the case that those assessments at both end of the discharge process did not automatically include testing for Covid-19?

Jeane Freeman: During the early period of the outbreak they did not." (**Footnote 9**)

Subsequently in the same hearing there was the following exchange:

"**Miles Briggs**:…Will the cabinet secretary confirm that no one who has tested positive for Covid-19 is now being discharged from hospital?

Jeane Freeman {Cabinet Secretary for Health and Sport}: I confirm that no one should be discharged from hospital who has a positive test for Covid-19. If they are in hospital and have tested positive for Covid-19, they should remain there and be treated for the virus." (**Footnote 10**)

The First Minister stated in April 2021 that the discharge of Covid patients was a "mistake" and subsequently tweeted that

"What I said is that with the benefit of knowledge we have now (but did not have then), it was a mistake. But too many people in care homes died and we must be candid about that. I hope that the other UK govts {sic} will join me in committing to a full public inquiry starting later this year." (**Footnote 11**)

The consequences of this discharge policy in relation to allegations made concerning deaths of care home residents are discussed below at paras 2.1.1 and 2.1.2.

1.2 Legality of Discharge of Patients Lacking Mental Capacity to Care Homes

Key Issues

The Mental Welfare Commission has stated that there were a number of moves of patients who lacked mental capacity from hospitals into care homes during the Pandemic which were unlawful. There was also evidence of poor practice.

The legality of the discharge of certain patients lacking mental capacity to care homes in the early stages of the Pandemic has also been questioned. As Audit Scotland noted in their report "The NHS in 2020"

"Legal experts, human rights groups and others had concerns that people who lacked capacity may have been discharged from hospital or moved without due legal process and without their consent. This may have been a breach of their human rights." (**Footnote 12**)

The Equality and Human Rights Commission and the Mental Welfare Commission were involved in judicial review proceedings in 2020 concerning unlawful detention of patients (**footnote 13**). The actions were brought against NHS Greater Glasgow and Clyde (NHSGGC) and HC One Oval Ltd a company which owns a care home chain. The judicial review was brought on the basis that

"patients who were medically fit to be discharged from hospital but who lacked capacity to make decisions about their personal welfare were being transferred into and held in two care homes in Glasgow without consent or lawful authority. These people were kept in homes for periods ranging between a few weeks and a year, pending the appointment of a welfare guardian. The

EHRC argued this practice was unlawful, discriminatory and contrary to the United Nations Convention on the Rights of Persons with Disabilities and the European Convention on Human Rights." (**Footnote 14**)

The judicial review action was finally dismissed when the NHSGGC agreed to end the practice and the patients were no longer unlawfully detained and the company agreed that they would not receive any further patients in this manner (**footnote 15**).

Subsequently in their Report "Authority to discharge – report into decision making for people in hospital who lack capacity" published in May 2021 the Mental Welfare Commission examined 457 discharges from hospital to care home in Scotland in the period March until May 2020 (**footnote 16**). Under section 13ZA (1) of the Social Work (Scotland) Act 1968 a local authority has power to make significant community care arrangements where that person lacks mental capacity. However this power cannot be exercised if the local authority is aware either that a guardian or welfare attorney already has powers regarding these steps, or an intervention order has been granted regarding those steps or in a situation in which there has been an application for an intervention order or a guardianship order but this issue has not yet been determined (**footnote 17**). As the Mental Welfare Commission Report stated

"Intervention under s.13ZA may be appropriate where an adult does not indicate disagreement with the proposed action, either verbally or through their behaviour/actions, and it appears that they are likely to accept the care arrangements. All interested parties, including professionals and the person's family/carer must agree with the care intervention proposed." (**Footnote 18**)

Under the Coronavirus (Scotland) Act 2020 schedule 3 para 11(1), as the Explanatory Notes to the legislation state (**footnote 19**):

“91. When local authorities are carrying out their functions under section 13ZA they are obliged to follow the principles in section 1 of the Adults with Incapacity (Scotland) Act 2000 (“the 2000 Act “). Subparagraph (1) (a) limits the application of the principles to those set out in subsections (2) and (3) of section 1 of the 2000 Act. It removes the requirement for the local authority to apply the principles in section 1(4) of the 2000 Act, which are to take into account the present and past wishes and feelings of the adult and the views of other interested parties described in the subsection.

92. Subparagraph (1) (b) disapplies section 13ZA (4) of the 1968 Act. This therefore allows local authorities to take steps to provide a community care service to an incapacitated adult despite them having a guardian, welfare attorney or an intervener with powers relating to the proposed steps, or there being an application in process in relation to an intervention order or a guardianship order under the 2000 Act.” (**Footnote 20**)

However these powers were never enacted. The provision was expired under the Coronavirus (Scotland) Acts (Early Expiry of Provisions) Regulations 2020. The Scottish Government had noted that

“Even at the height of the pandemic the fine balance between the right to life and the right to be consulted was not such that the provisions should be brought into force.

Following stakeholder consultation, Ministers concluded that there would be no conditions that are likely to exist which would

lead to the provisions being required in the future." (**Footnote 21**)

Nonetheless there appeared to be some misunderstanding in relation to that position at local level. The Mental Welfare Commission Report commented that

"Some of our findings were specifically related to the pandemic. For example, we found some evidence that there had been an interpretation that easement of s.13ZA had been enacted as a result of the Coronavirus (Scotland) Act 2020 when in fact this legislation was never activated and indeed removed in September 2020. Although Highland HSCP did not provide us with information requested within timescale to fully inform this report, they did advise that they introduced an alternative to application for an AWI order, making decisions 'internally' rather than recourse to the courts, the critical safeguard for individuals. This particular practice started in response to the pandemic and ended in August 2020.

The Commission's significant concern is that, in these cases, this may present as not only lacking in clear legal authority but also as an Article 5 deprivation of liberty and a possible breach of ECHR. The Commission does not provide legal advice so we asked whether legal advice had been sought in relation to both of these practices; confirmation was given that legal advice had been sought and given." (**Footnote 22**)

The Mental Welfare Commission Report went onto note that

"We took further steps to assure legal rights were respected and protected beyond the 20 unlawful moves reported and found that those working in the field of hospital discharge were 33 not always fully sighted on the powers held by attorneys or guardians or indeed whether the attorney's powers had been activated or guardianship orders granted. It is our view that

such assumptions, rather than evidence based decision making, had the potential to render additional moves as unlawful and also as an Article 5 deprivation of liberty and a possible breach of ECHR." (**Footnote 23**)

While the sample size was small the Report concluded that:

"Twenty unlawful moves, across eleven Health and Social Care Partnership areas, were reported directly to us. Further analysis suggested that there may have been more unlawful moves than reported. For example, within Health and Social Care Partnerships we found a general lack of understanding of the law used to provide legal authority to facilitate moves from hospital to care homes. We also found assumptions were made about whether legal powers were in fact in place.

When we set out to undertake this report we intended to make inquiries in relation to how the law was used to protect the most vulnerable adults in our community during the significant challenges of the pandemic period. During the course of this work we found examples of poor practice and a lack of knowledge of the law that were presented as more longstanding and endemic." (**Footnote 24**)

Thus there is evidence in the Report of the Mental Welfare Commission of lack of understanding of the applicable law concerning discharge to care homes of persons lacking mental capacity, with the Commission asserting that there may have been consequent violation of Article 5 of the European Convention of Human Rights.

2.1 Treatment and Care of Residents

2.1.1 Deaths of care homes residents related to the Pandemic

Key Issues

Serious concerns arose in relation to the numbers of care home deaths of residents which were related to Covid during the Pandemic including specific clusters of deaths within certain care homes. These include the discharge of patients who had contracted Covid to care homes and the lack of appropriate testing. Covid related deaths in care homes are currently the subject of a Crown Office investigation known as "Operation Koper." The Covid-19 Deaths Investigation Team (CDIT) Unit is examining deaths in Scottish Care Homes.

Serious concerns have been expressed in relation to the number of care home deaths due to Covid during the Pandemic and the extent to which these deaths could have been avoided had alternative decision making processes concerning discharge into care homes and infection control in the care homes themselves had been undertaken. Also of concern are those deaths of care home residents during the Pandemic not due to Covid but where their death might have otherwise been preventable had standard health care provision been operational. The Audit Scotland Report the "NHS in 2020" noted that

"The Scottish Government acknowledged there was a lack of oversight of the care home sector and stepped in to provide an enhanced system of assurance during the pandemic. In April 2020, the Scottish Government announced that NHS directors

of public health in NHS territorial boards would provide oversight and clinical support to care homes across Scotland." (**Footnote 25**)

Statutory duties to make daily reports of care home deaths from coronavirus, deaths attributable to coronavirus or other deaths, to the Care Inspectorate were placed on care home owners under the Coronavirus (Scotland) (No2) Act 2020 (**footnote 26**). The Care Inspectorate was also placed under a duty under the 2020 Act to make a report of such deaths every seven days to the Scottish Government (**footnote 27**).

A report by Public Health Scotland in 2020, which was revised in 2021, confirmed that patients who had tested positive for Covid-19 had been discharged into care homes (**footnote 28**) and that a link between discharge an outbreak "could not be ruled out." (**footnote 29**) It was noted that more than half of older patients discharged to care homes had not been tested prior to discharge. A report by the University of Sterling published in August 2020 stated that there was a higher proportion of deaths in Scottish Care Homes linked to Covid-19 and also a higher number of infections as compared with other parts of the UK (**footnote 30**). On 4th February 2021, ITV news reported that the death of "dozens of care home residents in the South of Scotland" were being investigated by the Crown Office (**footnote 31**). A freedom of information request submitted by ITV Border to NHS Borders and NHS Dumfries and Galloway also revealed that although on 21st of April 2020, the Scottish Government had decided all patients had to have two negative tests before discharge, in relation to NHS Borders 4 patients had been discharged to a care home between 22 April and 31st May who had not been tested. Of 55 persons who were tested 7 had been found to have Covid (**footnote 32**). Of these 5 patients had then been re-tested and were subsequently moved to the care home after they had received a negative test result. In relation to 2 patients these had been transferred to a care home despite the fact that they did not

have a negative test. The report stated that “The health board says this was in their best interests and only after careful clinical guidance.” (**footnote 33**) In relation to NHS Dumfries and Galloway 3 patients who had not been tested were moved to a care home. A further 61 patients were tested and 3 found to be positive. In relation to those patients they then tested negative prior to discharge (**footnote 34**).

Subsequently in October 2021 the BBC published data from Public Health Scotland (**footnote 35**) which concerned hospital discharges between March and May 2020 and which stated the proportion of persons discharged who were positive or who had not been tested for Covid (**footnote 36**). This stated between 1st March and 21st April 2020 of the 3595 patients who were discharged some 82% were not tested.

In July 2020 the Scottish Human Rights Commission produced a briefing “Care Homes and Human Rights. It noted the obligations placed on the state under Article 2 of the European Convention of Human Rights, the right to life (**footnote 37**). The briefing went onto state that

“The Commission considers this obligation requires an appropriate regulatory and administrative response to the threat posed by coronavirus in care homes. This could include, for example, clear guidance and regulation on PPE requirements and access to PPE; appropriate clinical guidance around access to treatment; and clear procedures around the movement of staff and residents between care homes, or from hospitals to care homes.” (**Footnote 38**)

Infection control issues were in July 2020 by the Care Inspectorate in reviews of 5 care homes including concerns regarding access to PPE (**footnote 39**). In October 2020 Burton et al in an article in the medical journal, “The Lancet” warned that if community incidence of Covid-19 rose then care home

residents would be at risk and that it was important to shield such residents from risks of infection and for action to be taken rapidly to minimise outbreaks where these occurred (**footnote 40**). Care home deaths however still continued into the second wave (**footnote 41**). It should be noted that in England Dr Gardner, whose father died in a Care Home of Covid-19 is currently bringing judicial review proceedings claiming that the Westminster Government policies "failed to take into account the vulnerability of care home residents and staff to infection and death, the inadequacy of testing and PPE availability." (**footnote 42**) Her action is supported by the Equality and Human Rights Commission. In contrast Eskgreen Care home in Musselburgh, where the decision was taken to lockdown on 13th March- well before the original official lockdown it was reported in June 2020 that there had been no Covid cases amongst staff or patients, although the long lockdown did raise challenges in relation to mental health due to lack of direct contact with family and friends (**footnote 43**).

In relation to Thornlea nursing home in Loanhead, Midlothian which was inspected by the Care Inspectorate in December 2020 15 residents had died of Covid (**footnote 44**). On inspection it was revealed that those resident had "experienced unnecessary harm and suffering." This care home subsequently closed and the firm operating it went into liquidation.

In December 2020 an independent report "Care Home Review: A rapid review of factors relevant to the management of COVID-19 in the care home environment in Scotland" commissioned by the Cabinet Secretary for Health and Sport and authored by Jacqui Reilly, David Crawford, Donna O'Boyle was published (**footnote 45**). Recommendations included recognising vulnerabilities to the virus raising awareness in care homes of the symptoms on older people; need for active measures to reduce introduction of Covid into care homes; need for connected information management systems for

information sharing within and between Health Boards; further of development of early warning systems; parity of access to testing for staff and urgency in receiving test results back; need for organisations to ensure emotional well-being of staff; care home specific visiting guidance and a "visiting champion"; extension of whistleblowing service to staff in both health and care (**footnote 46**).

The use and effectiveness of lateral flow tests in general (**footnote 47**) and in the context of care homes has been a matter of some discussion during the Pandemic (**footnote 48**). Guidance in relation to adult care home lateral flow guidance was published in January 2021. Issues remain as to the extent to which care home staff themselves were also vectors for transmission in care homes. Responses from care homes to the Health and Sport Committee in 2020 also claimed that earlier testing of staff and residents along with earlier supply and use of PPE would have protected both residents and staff (**footnote 49**).

2.1.2 Operation Koper

The deaths of 10 residents at Home Farm Care Home in Skye led to a Care Inspectorate Investigation Report published on 18th May 2020 which raised major concerns in relation to infection control in care homes (**footnote 51**). In September 2020 the legal representative of relatives of those who died at the Care Home wrote to the Lord Advocate (**footnote 52**). What is known as "Operation Koper" is currently underway. This was established in May 2020 under the Lord Advocate's Direction (**footnote 53**). A team from the Crown Office and Procurator Fiscal Service, the Covid-19 Deaths Investigation Team (CDIT) Unit is examining deaths in Scottish Care Homes, reported to be some 3,491 by the end of September 2021. Scottish Care

expressed considerable reservations regarding this investigation

“The operation from the Lord Advocate’s instructed Crown Office investigation has both in its timing, extent and unequal treatment of the care home sector caused considerable distress. Whilst it is of course critical and essential that assurance is given to families and the wider community that everything that could be done was done to protect their loved ones, the balance between accountability and intrusive investigation has not, we believe, been one which the Crown Office has achieved. We very much regret the Lord Advocate chose to treat the care home sector with this degree of disproportionate focus which has done little to enhance community assurance or indeed professional confidence.” (**Footnote 54**)

It should however be noted that the Unit has also received complaints in relation to deaths in hospitals (**footnote 55**).

As the Pandemic progressed it appeared it appeared that one consequence of the high level of care home deaths was that the confidence of some patients regarding their discharge into hospitals had been damaged. In December 2021 news reports stated that Humza Yousaf (Cabinet Secretary for Health and Social Care since 2021) said that there were some 1500 patients in hospital who could be safely discharged elsewhere but that that some hospital patients refused to be discharged to care homes (**footnote 56**). It was reported that the Chief Executive of Scottish Care, Donald Macaskill suggested that one of the reasons for care home discharge being refused by patients and families were what was said to be a “machine of negativity” regarding care homes (**footnote 57**). Macaskill went on to state that “We have heard of people being very reticent about going into a care home” and also stated that “I think that this is in a sense us reaping the way in which care

homes have been treated in the last 20 months." He went onto say that

"When I talk to colleagues elsewhere in the United Kingdom we are not seeing the same negativity towards care homes. But in Scotland we have seen, uniquely in the United Kingdom, every single death in a care home being investigated by the Crown Office. That hasn't happened anywhere else. And what that has done is to create a toxic environment which has led to staff leaving the sector. Nurses in particular of real experience, feel as if they are being victimised and it has fed into the narrative that care homes are places which are unsafe. (**Footnote 58**)

As noted above the question of care home deaths remains at the time of writing under formal investigation and the result of Operation Koper inquiries is awaited.

2.2 Restrictions on Visiting and Impact on Health Outcomes

Restrictions on visitors to care homes introduced for infection control purposes has been a source of major controversy during the Pandemic. It has been argued that the absence of visiting has had a deleterious impact on the health and well-being of residents and also a consequent adverse impact on family and those close to them. While Article 8 of the European Convention on Human Rights safeguards the right to home and family life this right itself is a qualified right enabling further considerations such as the broader public interest in relation to safeguarding health to be taken into account. Following the campaign for "Anne's Law" the Scottish Government has committed to the introduction of legislation to establish visiting rights

in relation to care homes however to date such legislation has not yet been introduced.

From March 2020 onwards restrictions were placed upon visitors to hospitals and care homes to restrict the spread of the virus. Particular concerns were expressed as to the limitations on care home during the Pandemic and its adverse impact on the health of residents including those lacking mental capacity due to for example, dementia and also the adverse impact on family members estranged from them due to the restrictions (**footnote 59**). Questions were raised as the extent to which visiting restrictions could be seen as proportionate (**footnote 60**) and in line with respect for principles of fundamental human rights (**footnote 61**). Article 8 of the European Convention of Human Rights protects the right to privacy of home and family life. The Scottish Human Rights Commission writing in July 2020 stated that

"The ECtHR has held that reduction in levels of care contrary to the wishes of the person concerned engages Article 8. .. So, too, would restrictions on a person's movement. For example, the inability of care home residents to receive visitors is undoubtedly an interference with Article 8. However, as Article 8 is a qualified right the proportionality of any interferences must be considered. To do so, an examination of the stated legitimate aim being pursued (such as for the protection of health) and the reasons provided by public authorities to justify those interferences would be required." (**Footnote 62**)

In December 2020 it was stated by the Scottish Government that

"We are actively monitoring the adoption of Stage 3 visiting across Scotland and will work with partners to ensure the consistent adoption of guidance. Essential visits where they will benefit the resident's health and wellbeing, or allow families and

friends important time with loved ones in circumstances approaching end of life should be generously and sympathetically accommodated at all-time throughout the pandemic. Visiting arrangements to care homes are updated on the basis of evidence." (**Footnote 63**)

On 24th February 2021 the Scottish Government produced the guidance "Open with care: resuming meaningful contact with care home residents" (**footnote 64**). This had the effect of enabling at first "two designated visitors" twice each week initially and as a "minimum starting point" (**footnote 65**). It was noted that consideration should be given to "increasing the numbers 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." It was stated that there was to be an approach which was based on principles such as responsibility placed on all to follow requisite guidance to stay safe, focus on maintaining wellbeing and "supporting meaningful contact to happen safely wherever possible to protect and restore well-being of residents and their loved ones and in line with residents' care needs" (**footnote 66**). Other principles where those of "safely balancing risks of harm", taking an "individualised approach" with all persons having an individualised visiting plan, "equality and choice"- such that individual residents "and/or representative decision makers) have the right to choose their designated visitors. Also included are the need for flexibility at local level and professional judgment and finally it stated that

"local visiting policies would take account of the European Convention of Human Rights (ECHR) and in particular Article 8 which provides a right to respect for private and family life." (**Footnote 67**)

Guidance was updated subsequently to reflect developments in the pandemic but the principle regarding visiting remained in

place. Nonetheless some restrictions on visiting were reported as continuing beyond this point for example, Alzheimer Scotland stated that that they had reports of inconsistencies in the approach taken by care homes to visiting restrictions despite Government Guidance during the Omicron wave (**footnote 68**). It was announced on 17th December that care home visiting could continue but that there should be

“in line with the recommendation for the general public to limit the number of households meeting indoors to three, we recommend that there should be no more than two households meeting with a resident at one time inside the care home” (**Footnote 69**)

In addition the Guidance stated that those visiting care homes should also take a lateral flow test prior to visiting and wear a fluid resistant mask” (**footnote 70**). The Guidance also went onto say that

“For adult care homes with a COVID-19 outbreak, care homes can support residents to choose a named visitor who may visit the resident in their private room if the local Health Protection Team has agreed this can happen .” (**Footnote 71**)
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2.2.1 Campaign for “Anne’s Law”

Concerns around the impact of limitations on access to care homes by relatives led to the establishment of a campaigning group, Care Home Relatives Scotland (**footnote 72**). There was also campaigning for what was known as “Anne’s Law.” The campaign was inspired by Anne Duke who had entered a care home after developing Alzheimer’s at the age of 55 years old. She died at the age of 63 during the pandemic after having been separated from her husband and family during the

Pandemic (**footnote 73**). The aim of this campaign has been for designated visitors who were complying with infection control rules to be given legal visiting rights to enter care homes. The First Minister committed to legislation in the SNP's manifesto for the May 2021 elections (**footnote 74**). She was criticised for not acting sufficiently swiftly (**footnote 75**). A five week Government public consultation closed on the 5th November 2021 (**footnote 76**) and the consultation responses have been published online (**footnote 77**). To date legislation has not been brought forward. This has been the subject of criticism by campaigners in February 2022 (**footnote 78**). However on 2nd March 2022 the Scottish Government published the results of an independent consultation on responses to proposals for Anne's Law which were stated to have received "'almost unanimous' support for care home visit rights" (**footnote 79**).

2.3 Effectiveness of Guidance for Care Homes

Key Issues

There was proliferation of various guidance documents to care homes during the early stage of the Pandemic. This it is suggested raised the prospect of confusion in implementation.

During the Pandemic a range of specific guidance was first issued to care homes by the Scottish Government on 13th March 2020 and it was subsequently up dated. Concern was raised as to clarity in relation to advice given to Care Homes and also the implications of the proliferation of guidance from different bodies during the Pandemic at the hearing of the Health and Sport Committee on 4th June 2020 (**footnote 80**). The following exchange was noted in the Report of the proceedings:

“**Brian Whittle:** One comment in the evidence was that there is ‘a lack of clarity around the government advice’

Advice is also coming from local health and social care partnerships, Health Protection Scotland and the NHS. Should a single body be responsible for providing the care sector with appropriate and informed public health guidance?”

Jeane Freeman: There might be a case for that. Certainly, the guidance that should be issued in the current circumstances is from Government. That clinical and practice guidance is signed off or cleared, if you like, by our chief nursing officer and our chief medical officer, and then by me, before it is published. Of course, HPS, in its very particular role, also issues guidance. I am aware of at least one instance—there may have been more—where it appears that the local health and social care partnership issued additional guidance that did not help to clarify matters and created a degree of confusion.” (**Footnote 81**)

The question of a multiplicity of guidance which may result in confusion in practice is it is suggested something which is worthy of consideration in relation to developing effective Pandemic practice going forward.

3. Inspections of care homes during the Pandemic

Key Issues

Concern was raised that the pausing of inspections by Care Inspectorate Scotland and Healthcare Improvement Scotland during the first period of the Pandemic may have had serious impacts including loss of life. Subsequent inspections revealed some findings of serious concern. There was some criticism of the way in which the Care Inspectorate had operated during the Pandemic. Some joint inspections were undertaken between Care Inspectorate Scotland and Healthcare Improvement Scotland. Subsequent review of these inspections highlighted some differences in approaches between the two bodies which it was recommended needed to be addressed

The Care Inspectorate Scotland regulates services including care homes for older people, adults and children and also care at home (**footnote 82**). Specific duties were placed on the inspectorate in the Coronavirus (Scotland) (No 2) Act 2020 in relation to the reporting of care home deaths (**footnote 83**). A Covid assessment tool was introduced from 30th July 2020 (**footnote 84**). One factor common across the UK was that of the cessation of regulatory inspections in the early period of the Pandemic something it was argued cost lives (**footnote 85**). As Audit Scotland Committee Report noted

“The Care Inspectorate had stopped on-site inspections early in the pandemic to reduce the risk of spreading Covid-19. From May, the Care Inspectorate resumed on-site inspections of care homes that were deemed to be high risk. The findings of these inspections are currently reported to the Scottish Parliament every two weeks. From 4 May to 31 July, 134 visits had been

carried out. These visits resulted in 16 letters of serious concern, one improvement notice and one application for cancellation of registration." (**Footnote 86**)

The operation of the Care Inspectorate in the early stage of the Pandemic came under criticism. Press reports in May 2020 stated that

"It is understood the Care Inspectorate's systems are struggling to deal with complaints made over the phone, with the body redirecting complainers to its website or offering a 24-hour call back service.

A member of staff at the Scottish Social Services Council, who did not wish to be named, said they had been receiving calls from people unable to reach the Care Inspectorate with requests for help." (**Footnote 87**)

These criticisms were rejected by the Care Inspectorate which commented that

"A spokesman for the Care Inspectorate said they are "not aware" of any issues in regards to be people contacting it for support and call backs are currently taking place "within 24 hours". (**Footnote 88**)

"Our focus is and always has been the safety and wellbeing of people experiencing care. In response to the pandemic, we adopted a different approach to ensure we continue to carry out our scrutiny role while minimising risk of infection transmission."

He said the body's inspectors make nearly 3,000 contacts with services across Scotland every week.

"This contact includes video consultation and observation that includes examination of the service's environment, systems and

processes. We continue to act on the concerns and complaints people raise with us.

“The Care Inspectorate has been working closely with local health and social care partnerships, directors of public health, local infection prevention and control teams, and other clinical specialists to provide an enhanced system of assurance around each care home in Scotland as requested by Scottish Government.” (**Footnote 89**)

Healthcare Improvement Scotland’s role is that of regulating NHS hospitals (**footnote 90**) and also regulates independent hospitals and clinics (**footnote 91**). In the first wave Lockdown Healthcare Improvement Scotland stopped inspections in relation to cleanliness of hospitals, care of older people, of independent clinics, hospitals and hospices. It subsequently undertook “COVID-focused inspections” which were adapted from “previous ‘safe and clean’ inspections” (**footnote 92**). It has been noted that subsequently, following the rise of Covid care home deaths, Healthcare Improvement Scotland worked with the Care Inspectorate in relation to the conduct of care home inspections (**footnote 93**). This ceased from July 2021 (**footnote 94**). A review of joint inspections published in December 2020 highlighted some differences in approaches in investigations between the two bodies which it was recommended needed to be addressed “to ensure a truly integrated approach to inspection in care homes is in place” (**footnote 95**). Further adaptations of inspections followed in November 2021 on approval from the Cabinet Secretary for Health and Social Care (**footnote 96**).

Concerns however continued to be expressed as to the effectiveness of the operation of the Care Inspectorate during the Pandemic into 2022 criticisms which were also rebutted by the Care Inspectorate (**footnote 97**).

4.0 The impact of the Pandemic on the provision of social care services

Key Issues

Concerns as to the ability of social care provision to withstand the impact of a Pandemic were noted in relation to Pandemic planning before 2020. As in England and Wales provisions to "ease" the application of existing statutory provisions concerning social care were incorporated in the Coronavirus Act 2020 Sections 16 and 17 of the Coronavirus Act 2020 enabled local authorities in Scotland to depart from certain existing statutory provisions during the Pandemic. These provisions were later withdrawn in November 2020. It was reported that in practice there were substantial adverse impacts of withdrawal of care services experienced by service users such as older persons and those with disabilities. Some reports have suggested that while financial support was provided by the Scottish government that this had in some instances not translated to effective support at local level. Concerns also remain as to access to day centre provision.

Provisions to "ease" the application of existing statutory provisions concerning social care were incorporated in the Coronavirus Act 2020. Sections 16 and 17 of the Coronavirus Act 2020 enabled local authorities to depart from some of the existing statutory provisions (**footnote 98**). These were statutory assessment of needs of adults (section 12A of the Social Work (Scotland) Act, 1968) and for children and young persons (sections 22, 23 and 29 of the Children (Scotland) Act, 1995) and assessment of charging for needs. It also altered certain existing requirements in relation to support plans for adult carers and young carers statements (sections 6 and 12 of

the Carers (Scotland) Act, 2016). Here the focus of the discussion is on adult social care provision.

It was reported that some 6 Scottish local authorities made use of the new powers did so in the period between 5 April 2020 until 16 May 2020 (**footnote 99**). In relation to the period 17 May to 8th November 2020 some 4 authorities were using them (**footnote 100**). It was stated in relation to the 2nd Report on the Coronavirus legislation by the Scottish Government to the Scottish Parliament.

“Some are using the powers across the whole authority area and all services, while others are using the powers in a more targeted way, for example, on particular services only.” (**Footnote 101**)

It was decided that in relation to adult social care powers that these were to be withdrawn but that those concerning children would remain active (**footnote 102**).

The provisions under section 16 of the Act concerning adult social care and adult carers were finally suspended from the 30th November 2020 through the Coronavirus Act 2020 (Suspension: Adult Social Care) (Scotland) Regulations 2020 (**footnote 103**). The policy note which accompanied these regulations indicated that they could be brought back into force at a later date (**footnote 104**). In December 2020 the Scottish Human Rights Commission in December 2020 asked the Scottish Government to publish information as to the Health and Social Care Partnerships and councils which used the coronavirus legislation or what they are planning to use them (**footnote 105**).

While the changes to adult social care provision applied only to certain local authorities it appears that changes to provision may have had in practice a broader impact across Scotland. The Equality and Human Rights Commission stated that

“Older and disabled people have experienced difficulties in accessing care due to reductions in the availability of formal care” (**Footnote 106**)

Inclusion Scotland which undertook a survey of the experience of disabled persons during April 2020 found that

“Around 30% of respondents said that the social care support that they receive was either stopped completely or reduced, sometimes overnight and without warning. People were left in desperate situations as a result. Survey respondents told us they were forced to sleep in their wheelchair or left unable to get out of bed. Others told us they were unable to wash and dress themselves and keep up with basic household chores.” (**Footnote 107**)

Similarly Age Scotland in evidence to the Equalities and Human Rights Committee stated that they were

“ extremely concerned that from mid-March care at home packages were removed or severely reduced almost overnight from older people across Scotland”…. They recognised social care providers faced challenging decisions, however, they believed providers did not sufficiently consider whether families could provide the care that was being withdrawn.” (**Footnote 108**)

Research undertaken by University of Glasgow along with the London School of Hygiene and Tropical Medicine in the lives of disabled persons and their families during Covid found that

“social care assessments had been suspended for up to 4 months in some areas, leaving those with newly acquired impairments or where support needs increased, without the help they required.” (**Footnote 109**)

Concerns were expressed that although a package of financial support was announced by the Scottish government that this had not translated to support for service users (**footnote 110**).

The impact of Covid-19 on those receiving care and support at home was examined by the Health and Sport Committee of the Scottish Parliament (**footnote 111**). The Committee undertake an online survey as to responses of those who provide and those who receive care and support at home. This survey involved 723 participants, some of whom indicated that they were willing to be involved in online video focus groups which were also undertaken (**footnote 112**). Themes which emerged was as to the reduction of care and how both families and their neighbours needed to "step in" providing care/support (**footnote 113**). For example, it was reported that some 54% commented that care that they had received at home had either entirely ceased – as reported by 33% or had been reduced – some 21%. It was also stated that some 12% of respondents had been obtaining care and support in other ways (**footnote 114**). Day and respite centre care had been closed (**footnote 115**). Telephone support seen as minimal by some respondents though others were more positive (**footnote 116**). Some 61% of staff indicated that care packages had changed and service providers also noted

"'prioritisation'" of care packages "to identify those that required low and moderate support that could be provided in an alternative way" meaning that 'some (care packages) were suspended, some required different delivery and some carried on as normal." (**Footnote 117**)

Suggestions were made that it had been anticipated by care providers that following cancellations of services "unpaid carers 'will pick up the slack' (**footnote 118**). Reasons for change in service provision included staff safety and staff illness (**footnote 119**), or because family members who e.g. were furloughed

had taken on care provision (**footnote 120**). Staff working for service providers nonetheless identified greater work load including issues such as training in infection control, increased meetings, increased risk assessment and development of recovery plans" (**footnote 121**).

There were some safety concerns raised regarding access and use of PPE by care staff and the testing and training of care staff (**footnote 122**). Issues with accessing PPE at the beginning of the Pandemic were also highlighted by the Learning from Reducing Delays and Admissions and Hospital Admissions Report (**footnote 123**). Concerns also were raised as to ensuring the same designated carers entering homes rather than a revolving staff. Employers raised issues concerning staff absence, shielding and requirements regarding self-isolation. The "Lessons Learned from Reducing Delays and Admissions and Hospital Admissions Report" also noted that delivery of home care was sustained through

"the use of redeployed staff from closed services or use of fast track recruitment to provide additional capacity on both the front line and administrative support. Some partnerships undertook initial modelling at the start of the crisis in an attempt to predict levels of sickness absence." (**Footnote 124**)

The role of other care support such as third sector, neighbours and faith groups was also highlighted in the Scottish Parliament Report. Staff raised the fact that their workloads had grown including training needs, greater paperwork and increased meetings. Managers highlighted the adverse impact of home working on work-life balance (**footnote 125**). It was indicated that while information and guidance from the Scottish Government received praise from respondents there was need for improvement as to communication between service providers and service users (**footnote 126**). Well-being and mental health concerns were raised including in relation to

isolation (**footnote 127**). In additional the survey noted the need for greater recognition of unpaid carers (**footnote 128**). Also raised were issues such as the need for flexible spending of “Self Directed Support” (SDS) (**footnote 129**).

During the early stage of the Pandemic Day Centres which can be a critically important service for those who may be isolated and/or have disabilities were closed across Scotland and it was announced that these would be re-opened, with local agreement, from 3rd August 2020 (**footnote 130**). This was followed with guidance from the Scottish Government (**footnote 131**) and also from the Care Inspectorate (**footnote 132**). It was recognised that risk assessments were appropriate but that also these were services of value to service users (**footnote 133**). Concern has been expressed as to the adverse impact of change of service provision during the Pandemic including impacts of day care centre closure on service users such as those with disability (**footnote 134**). In 2022 the BBC highlighted concerns in relation to day centre closures in Scotland and how service users had been “forgotten” (**footnote 135**). It was reported that the BBC had contacted the 32 councils in Scotland in relation to day care provision which was available. Only 18 had responded to the query and of those the Report stated that” none could tell us categorically that their day-care services have yet returned to pre-pandemic levels” (**footnote 136**).

II. Health Care Services: Strategic Elements of Handling of the Pandemic

5.0 Impact on the delivery of primary medical care.

Key Issues

Primary care provision utilised triage processes through the operation of Community hubs and Assessment Centres for patients with Covid-19 symptoms. Availability and appropriateness of face to face GP appointments in the later period of the Pandemic remains a matter of discussion

A triage process was utilised in primary care during the Pandemic for patients with Covid-19 symptoms. Community Hubs were operational from 23rd March 2020 (**footnote 137**). As the Audit Scotland Report "NHS in 2020 commented

"Covid-19 community hubs and assessment centres were established. These hubs assess patients presenting with Covid-19 symptoms in the community, relieving pressure on GP surgeries. Between March 2020 and January 2021, over 250,000 consultations for advice or assessment were conducted through these hubs and centres." (**Footnote 138**)

Hubs were established in the majority of Health Boards. In relation to Orkney, Shetland and the Western Islands the Community Hub was provided by NHS Highland. If at the Community Hub it was determined that a patient should be seen by a doctor a referral was made to a local Assessment Centre. Each Health Board area established at least one such

centre. The clinicians at the Assessment Centre provided face to face care. It was noted that

“Forty two Assessment Centres were operating as at 16th June. Between the 23 March and 14 June 2020 74,312 people had a total of 89,443 consultations with COVID-19 Community Hubs and Assessment Centres. (NHS Grampian data included from 01 May 2020 onwards). More recently the Assessment Centres have been used for community testing too. The Community pathway model was based largely on the existing OOH model and was delivered and supported by OOH teams. In some areas this meant the consolidation of OOH centres as these were designated as COVID-19 red zones.” (**Footnote 139**)

Provision of in person primary care services to Care Homes during the Pandemic was raised as a matter of concern. In person provision in the early period of the Pandemic raised the prospect of risk of transmission of the virus. In evidence to the Health and Support Committee at their meeting on 4th June 2020 the issue of provision of care by GP’s to care homes discussed. The then Cabinet Secretary Jeanne Freeman commented that

“The guidance that was issued to care homes on 17 April was from the chief medical officer, and there has been subsequent engagement with GPs by the British Medical Association, the Royal College of General Practitioners and the chief medical officer around care and support for residents of care homes. As for the question of managers carrying out clinical procedures, as I said, many care homes employ nursing staff, who will have the skills to carry out clinical procedures in certain circumstances. However, where that is not possible, care home staff should expect to receive the right level of care from their local primary care practice. As I said, residents in care homes are in their home. Just as people living in their home elsewhere expect to get primary care and support from their GP or others

in the primary care practice, residents in care homes should expect that, too." (**Footnote 140**)

On 3rd September 2020 it was announced that from the 7th September in person "face to face" care provided by "a wide range of health and social care professionals, including podiatrists, physiotherapists, optometrists, dentists, social workers and mental health and disability specialists" would be able to resume (**footnote 141**). This was to be undertaken subject to risk assessments and visits were to take place in "indoor communal areas" (**footnote 142**). It was also recommended that such visiting should only occur where the care home had first, no active cases, second, had been free of Covid in the last 28 days and third, that the care home was an active participant in the testing programme for care workers. On 14th April 2021 the Minister for Mental Wellbeing and Social Care, the Interim Chief Nursing Officer, the National Clinical Director, the Chief Medical Officer and the Director of Mental Health and Social Care wrote to care home providers regarding the updating of guidance concerning the visiting of health, social care and other professionals and services to care homes. The guidance proposed a "levels based approach" to return of services.

On 2nd December 2021 care homes providers were again contacted regarding the visiting of health, social care and other professionals and services to care and were informed that there was now a move away from a" levels based approach." It was stated that "visiting professionals should visit adult care homes if required to do so unless otherwise advised by the care home/ or local Health Protection Team" (**footnote 143**).

Generally access to primary care services was addressed in the NHS Recovery Plan in August 2021 which stated that.

“Through this Recovery Plan we will increase wider primary care capacity and urgently seek to fully restore face to face consultations in GP surgeries and other primary care services as a priority. To support this Public Health Scotland will imminently publish updated guidance for primary care settings covering key issues such as physical distancing requirements, access for patients and infection prevention control.” (**Footnote 144**)

Access to in-person GP appointments during the Pandemic remains a matter of debate. A letter was sent to general practitioners by Humza Yousaf, the Cabinet Secretary for Health and Social Care and the British Medical Association on the 5th October 2021 (**footnote 145**). This stated that

“Just as they have for many years now, in person face-to-face appointments form part of a hybrid model of options that you offer your patients including video consultations, telephone consultations and in person face-to-face appointments. The pandemic changed the balance between these appointment types and while we all aspire to return to a greater availability of face-to-face appointments, we are both clear that for a number of patients they will wish to continue with telephone or video consultations. The type of appointment offered should be agreed through shared decision making, balancing patient choice and autonomy, and practice circumstances/capacity and clinical judgement.” (**Footnote 146**)

This however did not mandate a total return to face to face appointments with discretion being given to individual practitioners. In response to questions at the Scottish Parliament Covid-19 Recovery Committee on 7th October 2021 Humza Yousaf stated that:

“As for face-to-face GP appointments, I note that Mr Rowley referenced my joint communication with the British Medical

Association. First of all, we want a hybrid model to continue, because it works for a lot of people. In August, when I had an eczema flare-up, I was able to phone the doctor in between meetings and get the prescription for the ointment that I needed sent to the pharmacist, to be picked up later in the afternoon. That meant that I did not have to take any time out for a face to-face appointment. For some people, therefore, the hybrid model works well, because they want a telephone appointment or video consultation.

However, what I say very clearly and in black and white in the joint communication with Dr Buist is that, given the changes in guidance that were recently published by Public Health Scotland, I expect an increase in the number of face-to-face appointments. That is the desire of the Government, but we also have to take into account a clinician's own decision, because neither I nor Mr Rowley should determine when a patient should be seen face to face. That said, I agree with his premise that an individual who requires a face-to-face appointment should get one." (**Footnote 147**)

Concerns regarding access to GP appointments in Fife were raised in November 2021 (**footnote 148**). There was further controversy in relation to access to face to face appointments in December 2021 (**footnote 149**). Plans were announced to move away from the triage approach which had been undertaken in assessment hubs for suspected Covid-19 patients. The intention was to operate respiratory and non-respiratory pathways. The Guidance stated that patients would be screened via 9 questions from GP receptionists either in the surgery or on the phone. This was resisted by GP's who argued that this additional time commitment would impact on the time available for in-person care. It was also stated by Dr Andrew Buist, chairman of BMA Scotland GP committee, that "Patients with Covid symptoms will be forced to go to the GP and will be

sitting only a few metres apart from people with other medical problems" (**footnote 150**).

In December 2021 the First Minister indicated that the NHS pressure would be “inevitable” due to the rise of cases consequent upon the Omicron wave (**footnote 151**). In Lanarkshire it was reported in mid-January 2022 that for the next month due to the impact of Covid and of increased demand GP’s would only be attending the most urgent cases (**footnote 152**). The Scottish Government and British Medical Association see a hybrid model involving virtual and in person services as effective treatment delivery, some concerns though have been raised as to its operation in practice- see also below re discussion in relation to digital modes of healthcare delivery.

The question of access to GP’s appointments was however still the subject of discussion in January 2022 (**footnote 153**).

6. Triage decision making choices re critical care treatment and consequent application of professional guidelines where this occurred

Key Issues

The potential for utilisation of difficult rationing tools in relation to critical care treatment was highlighted from the start of the Covid Pandemic. These are particularly sensitive issues to resolve in relation to respect for the fundamental human right to life under Article 2 of the European Convention of Human Rights. The Scottish Government made provision for the establishment of ethical advice and support groups in each Health Board along with the establishment of a National Ethics Advice and Support Group. It remains unclear as to how effective these bodies have been in practice.

The experience of jurisdictions such as Italy in the early months of 2020 indicated that the UK might be faced with difficult decisions in relation to the rationing of treatment such as the decision in relation to admission to intensive care beds and that of the allocation of ventilators. In relation to whether one person should be removed from a ventilator and replaced with a person who was judged to have a greater likelihood of survival on 15th April 2020 the Medical Defence Union advised that in such a situation doctors should take such an issue to the courts for determination (**footnote 154**). During 2021 it emerged that the UK Government's Moral and Ethical Advisory Group (**footnote 155**) had been asked by Professor Sir Chris Whitty, the Chief Medical Officer in England in had been asked to draw up guidance in Spring 2020 regarding resource allocation concerning Covid-19 treatment. It was not however ultimately adopted by the Department of Health and Social Care in England. However the guidelines were circulated and used by some in the medical profession (**footnote 156**). It is unclear as

to whether that included Scotland. An Intensive Care Society Clinical Guideline was also produced in 2020 but again it is not clear as to the extent to which this was used nationally (**footnote 157**).

In Scotland documents produced were the Scottish Government "Clinical Advice" document (**footnote 158**) and the "Ethical Advice and Support Framework" (**footnote 159**). The Ethical Advice and Support framework was first published on 3rd April 2020. Concerns in relation to original versions of the document were raised regarding human rights and equality, disability and age discrimination with reference to the provisions of the European Convention of Human Rights and United Nations Convention on the Rights of Persons with Disability were made by Professor Jill Stavert, Professor Colin McKay and Professor Alison Britton (**footnote 160**) and by the Scottish Human Rights Commission in relation to the Clinical Advice document (**footnote 161**) and comments from the clinical community. An Equality Impacts Assessment (EQIA) was undertaken in relation to both these documents in meetings on 29 April and 25 June 2020 and the documents were then amended in the light of this (**footnote 162**).

The Covid-19 Ethical Advice and Support framework provides for the establishment of ethical advice and support groups in each Health Board. The aim being to "deliver useful, timely and pragmatic ethical support for complex cases" (**footnote 163**). The Groups were to include

"lay representation
experienced clinical and public health input
multi-disciplinary perspective
social care input
member of the Spiritual Care Team" (**footnote 164**)

They were intended to work flexibly in relation to the provision of guidance (**footnote 165**). They would report to the Health

Board through the Chief Executive “or a delegated responsible officer” (**footnote 166**). It was anticipated that such groups would only deal with a small number of cases (**footnote 167**). Areas where it was anticipated that the Groups might be involved “might include,”

“Complex decisions around withdrawal of care

- Situations where clinical decision makers feel moral distress regarding the application of national guidance
- Challenging decisions around escalation planning and ceilings of care
- Complex decisions related to patient discharge due to high clinical demand.
- Challenges related to reduced ability to provide normal standards of care due to competing need for resource.” (**Footnote 168**)

In addition a National Ethical Advice and Support Group was to be established. The intention was that this would “offer advice and support to local groups, as well as to consider national ethical issues and offer advice” (**footnote 169**). This was to meet on a regular basis. It would report to the Scottish Chief Medical Officer “or to a delegated responsible officer” (**footnote 170**). The body was to be an interdisciplinary group including “healthcare professionals, academics, legal professionals, a representative of all faiths and none, social care professionals, and lay representation” (**footnote 171**). Its role was to be

“a point for escalation for the Board level groups. This group will meet to review system based challenges or complex individual cases that have already been discussed at the local level, to review the common challenges that are being encountered and to consider whether review of or additional guidance would be useful. The group should be guided by a principle based approach and an awareness of the equality and human rights obligations.” (**Footnote 172**)

The Framework stated that

“3. Mutual aid agreements will offer access to immediate support, where the Health Board ethical advice and support group is unable to offer advice in a clinically useful time frame. This may be delivered through existing clinical networks or expert groups, or through local agreements. This will allow access to independent advice around complex clinical, ethical and logistical challenges as they arise.” (**Footnote 173**)

Reference was also made to the need to act within the law, including that relating to decision making capacity (**footnote 174**) and also to respect for the Equality Act 2010 and the Human Rights Act 1998 (**footnote 175**). It made reference to the ethical framework which had originally been published by the Committee on Ethical Aspect of Pandemic Influenza in 2007 and revised in 2017 by the Department of Health and Social Care (**footnote 176**). The Scottish Framework built on these statement and set out criteria such that “the principles of equity, respect and fairness are upheld across Scotland throughout this Pandemic” (**footnote 177**). Criteria set out were those of respect, fairness, minimising harm. This provided that

- “Where there is a decision that a treatment is not clinically appropriate, there is not an obligation to provide it, but the reasons should be explained to the patient, or their attorney or guardian where appropriate, in a way that they are able to understand, and other options explored in accordance with the patient’s wishes…

- No active steps should be taken to shorten or end the life of an individual, however the appropriate clinical decision may be to withdraw life prolonging or life sustaining treatment, or change management to deliver end of life care. Clinicians are already familiar with the need to make ethically-based decisions where further treatment simply will not deliver

medical benefit to the patient, and/or it runs the risk of being inhumane, degrading or violating fundamental human dignity

- Where a treatment is likely to cause significant harm or have a limited chance of benefit, clinicians, in discussion with patients and those closest to them, may decide that this treatment or course of action is not in the patient's best interests. This could include deciding against transfer to hospital or admission to intensive care or may reflect a decision to a withdraw life prolonging or life sustaining treatment. In all circumstances, patients should continue to be provided with the best possible care, as close to their wishes as possible." (**Footnote 178**)

There was also reference to "working together"- meaning that persons "should be actively involved in decisions about their health and well-being, with the assistance of full and accessible information" (**footnote 179**). They also included the criteria of flexibility-such that criteria should be kept under review and

"All individuals have the right to change their minds about the care and treatments that they would choose, for example, patients may wish to review advanced decisions or care plans in light of new treatment options." (**Footnote 180**)

A further criteria was that of "reciprocity" which here refers

"Wherever clinicians are expected or asked to take increased risks, they must be supported in doing so, for example there must be adequate supplies of appropriate PPE.

- Where there are resource constraints, patients should receive the best care possible within those constraints and making use of the maximum available resources." (**Footnote 181**)

On 7th October 2020 the document “Coronavirus (COVID-19): guidance on critical care management of adult patients” was published by the Scottish Government (**footnote 182**). The Guidance stated that

“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 principle.” (**Footnote 183**)

At local level it is clear that certain Ethical Advisory groups were established. For example in the case of NHS Grampian the body which was established also produced its own distinct ethical guidelines (**footnote 184**). Ethical guidance for front-line Pandemic staff was also produced by the Royal College of Physicians in 2021 (**footnote 185**) and was endorsed by other Royal Colleges including the Royal College of Physicians of Edinburgh, Royal College of Physicians and Surgeons of Glasgow (**footnote 186**). It appears unclear as to how all these groups at Health Board and at national level have operated in practice. There is also potential for a divergent approach to clinical advice if development of separate guidance at local level was commonplace.

7.0 The process of restarting standard NHS care

Key Issues

In the early months of the pandemic there was a prioritisation of NHS services towards delivery of Covid related care with various other services being paused or reduced. A strategy was introduced in May 2020 to restore NHS service provision. Audit Scotland in its NHS in Scotland 2021 indicated that data on waiting time target had been requested but had still not been provided. In relation to the recovery of cancer care research suggests the full impact may not be known for several years. It is unclear as to what was the impact on matters of choice in maternity care. There was also a pause regarding access to fertility treatment in late 2021-2 for persons who were not fully vaccinated in relation to which consequent implications for individuals' human rights were raised.

One result of the prioritisation of Covid-19 care has been the consequent impact on the provision of other NHS services. The prospect of resultant adverse impacts was raised in July 2020 in a letter sent by Theo Huxtable QC, Peter Walsh of Action against Medical Accidents (AvMA) and a number of other lawyers, clinicians and persons working in the area of patient safety to the Prime Minister and the First Ministers of all the devolved jurisdictions (**footnote 187**). This recognised the need for initial prioritisation of Covid care but

"We believe there is a legal duty, but more importantly, a moral duty, upon government to ensure all patients have access to the urgent diagnostics and medical treatment they need." (**Footnote 188**)

The article discussing this letter published in July 2021 notes responses from the First Ministers of Northern Ireland and of Wales but at the time the article was written the article's author did not have responses from the Prime Minister nor from the First Minister of Scotland.

From early in the Pandemic there were concerns as to the long term health impacts of pausing some forms of standard healthcare services. The interim Chief Medical Officer, Dr Gregor Smith was reported as saying on 20th April 2020 (**footnote 189**) that there had been a "72% reduction in urgent suspected cancer referrals by doctors" (**footnote 190**). Concerns were expressed by GP's in "deep end" practices (practices in socially disadvantaged areas) in Glasgow and Edinburgh in a Report published by Glasgow University in June 2020 as to the adverse impact of Covid on health care (**footnote 191**). Issues raised included delay in staff Covid testing, too much NHS work being "put on hold" and consequent backlog. In addition individuals with illnesses may be missed. There was concern in relation to remote consultations being insufficient for patients with multi-morbidities or unable to access technology. The safeguarding role of general practice was limited due to practice constraints. There was a perceived rise of mental health problems impacting on practice including in relation to women and children where there was a growth of women at home due to lockdown. Other concerns related to homeless persons and others subject to socio-economic deprivation.

On the 31st May 2020 Jeane Freeman, MSP, the Cabinet Secretary for Health and Sport, published the document "Re-mobilise, Recover, Re-design: the Framework for NHS Scotland" (**footnote 192**). This stated that

"The Framework for NHS Mobilisation sets out how Health Boards will safely and incrementally prioritise the resumption of

some paused services, while maintaining COVID-19 capacity and resilience." (**Footnote 193**)

A Framework for Mobilisation Recovery Group was also established which was chaired by the Cabinet Secretary for Health and Sport (**footnote 194**). The Health and Social Care Route map was as follows:

Phase 1: As with previous phase but with the following changes:

Beginning to safely restart NHS services, covering primary, and community services including mental health.

Phased resumption of some GP services supported by an increase in digital consultations.

Roll out the NHS Pharmacy First Scotland service in community pharmacies.

Increase care offered at emergency dental hubs as practices prepare to open.

Restart, where possible, urgent electives previously paused.

Resumption of NHS IVF treatment has now been approved in Scotland and we are working with the 4 centres to resume services quickly and safely.

Increase provision of emergency eye care in the community.

We will consider the introduction of designated visitors to care homes

Phase 2: As with previous phase but with the following changes:

Remobilisation plans implemented by Health Boards and Integrated Joint Boards to increase provision for pent up demand, urgent referrals and triage of routine services.

Reintroduce some chronic disease management which could include pain services, diabetic services.
All dental practices open to see patients with urgent care needs. Urgent care centres provide urgent aerosol generating procedures.

Prioritise referrals to secondary care begin.

Increase number of home visits to shielded patients.

Continue to plan with COSLA and Scottish Care to support and, where needed, review of social care and care home services.

Phased resumption of some screening services.

Expand range of GP services.

Phased safe resumption of essential optometry/ ophthalmology services.

Phased resumption of visiting to care homes by family members in a managed way where it is clinically safe to do so.

Phase 3 As with previous phase but with the following changes:

Emergency and planned care services delivered.

Expansion of screening services.

Adult flu vaccinations including in care homes and care at home.

All dental practices begin to see registered patients for non-aerosol routine care. Urgent care centres to provide aerosol generating procedures.

All community optometry reopens with social distancing safeguards.

Some communal living experience can be-restarted when it is clinically safe to do so.

Phase 4 As with previous phase but with the following changes:

Full range of health and social care services provided and greater use of technology to provide improved services to citizens."

A prioritisation plan for elective care was published in November 2020 (**footnote 195**). As the Audit Scotland Report "The NHS in 2021" commented

"This approach means that patients in most urgent need should be seen first and those of lower clinical priority will need to wait longer. Patients are categorised in priority levels as follows:

- Level 1a emergency – operation needed within 24 hours
- Level 1b urgent – operation needed within 72 hours
- Level 2 surgery – scheduled within four weeks
- Level 3 surgery – scheduled within 12 weeks
- Level 4 surgery – may be safely scheduled after 12 weeks." (**Footnote 196**)

The Report noted that in the previous Audit Scotland Report in 2021 they had recommended that

"data on waiting times based on the categories in the clinical prioritisation framework should be published. This will enable transparency and scrutiny of how NHS boards are managing their waiting lists. Public Health Scotland and NHS boards continue to progress this recommendation and the Scottish Government should work with them to publish this information as soon as possible." (**Footnote 197**)

To date however this does not appear to have been done. Here we consider the impacts of ceasing and the process of re-starting service provision in relation to a number of key areas: cancer care, fertility services and maternity services and dentistry.

7.1 Impacts in relation to Cancer Care

Cancer was one area where there was a prospect that deaths would arise amongst those where normally this could have been prevented due to delays in treatment. As a consequence the need to address this area was seen as a priority matter. On 11th March 2020 instructions were given to NHS Boards that "vital cancer services should remain open" (**footnote 198**). On 18th March 2020 The Scottish Government convened the National Cancer Treatment Response Group (**footnote 199**). This body was given the task of developing national clinical

consensus on cancer treatments for all cancer types while the NHS is on an emergency footing, and during its following recovery phase" (**footnote 200**). On the 24th April a campaign "the NHS is open" was launched to encourage people to seek treatment (**footnote 201**). Clinical guidance regarding cancer treatment during the Pandemic was published on the 28 April 2020 (**footnote 202**). A National Cancer Recovery Group was subsequently established with its first meeting on 5th June 2020 (**footnote 203**). On the 20th June 2020 the Scottish Government announced "Guidelines For Cancer Treatment During COVID-19 Pandemic" and that cancer treatment should be discussed with individual patients (**footnote 204**). Cervical screening restarted from the 29th June 2020. On the 13th July 2020 it was announced that Breast Screening programmes which had been postponed would restart from 3rd August (**footnote 205**). On the 25th August 2020 a Framework for the Recovery of Cancer Services was published (**footnote 206**). Bowel screening restarted on 12th October. This was followed on the 9th December 2020 with the "Recovery and redesign: cancer services - action plan" (**footnote 207**).

In relation to the impact on cancer screening Macmillan Cancer Support Report "The forgotten C? The Impact of Covid-19 on Cancer Care October 2020 (**footnote 208**) stated

"When the Scottish Government paused screening programmes, they estimated the numbers that would be affected every quarter-year based on the most recent information available. These estimates stated that within a three-month period, 248,177 patients would receive bowel screening, of which 220 would be diagnosed with cancer; 46,596 patients would receive breast screening, of which 291 would be diagnosed with cancer; and 101,963 patients would receive cervical screening, of which 341 would be diagnosed with invasive cancer.

Following an understanding that cervical and breast screening were both paused for a minimum of three months, and that bowel screening was paused for a minimum of six months, this would mean at least 644,793 people would have missed out on screening over the period the programmes were paused. It is likely to be higher as breast and cervical screening were not both fully operational from the 1 July." (**Footnote 209**)

In relation to cancer screening in Scotland Campbell et al commented that

"One of the many concerns around the impact of the pandemic was how screening participation may be affected. Breast and cervical screening require physical attendance at a healthcare facility, as does a positive test result in bowel screening. Clearly, such appointments have the potential to raise a person's risk of COVID-19 infection via attendance at and/or travel to and from such a setting (although risks were minimised due to infection control measures and PPE). There were therefore concerns that this would discourage attendance and that a reduced level of uptake could become a feature of programmes until the pandemic had abated. Fortunately, early data from the Scottish cancer screening programmes suggest that this may not be the case." (**Footnote 210**)

Nonetheless as they noted the full impact of the Pandemic "would not be known for years to come" (**footnote 211**). In relation to some of the challenges involved in re-starting screening Campbell at al commented that

"In particular, the COVID-19 pandemic has highlighted the inadequate colonoscopy capacity in Scotland, and variation in waiting times between health boards that jeopardise patient care. There is now a dedicated programme recovery board that will give recommendations to the Scottish Screening Committee

on ways of mitigating colonoscopy capacity at the national level". (**Footnote 212**)

In terms of positives identified Campbell et al stated that

"Unanticipated benefits have however been seen during the management of this pandemic. Colleagues report better interaction between primary and secondary care, with GPs and hospital specialists liaising directly for advice on referral, safety-netting guidance, seeking continuity of care, and avoiding bottlenecks in referral pathways: there is a need for this better communication to be continued post-pandemic. Governance structures and internal and external communication strategies within the Screening Programmes have been strengthened, as has more rapid information governance decisions, provision of IT and reporting systems and availability of data to inform decision-making within Public Health Scotland". (**Footnote 213**)

The Macmillan Cancer Support Report "The forgotten C? The Impact of Covid-19 on Cancer Care October 2020 (**footnote 214**) stated that in relation to the cancer backlog

"Scotland does not publish data on referrals for suspected cancer, but only on referrals that translate to diagnoses and starting treatment as part of the 62-day week standard. It is therefore not possible for us to estimate the backlog of people in Scotland who need to access diagnostic services." (**Footnote 215**)

The Scottish Government "Recovery and redesign: cancer services - action plan" document stated that

"Near the beginning of lockdown, referrals with an urgent suspicion of cancer (USC) dropped significantly to a low of 27% of pre-COVID levels. We delivered the 'NHS is Open' campaign encouraging people to continue to present to their GP practice

or hospital should they have worrying or urgent symptoms. Overall, referrals have since returned to above normal anticipated levels." (**Footnote 216**)

However it noted that

"The number of people starting treatment in Scotland was 23% behind 2019 levels between April and June, with a backlog of 1500 fewer people. … In actual numbers, this meant 5056 people had their first cancer treatment between April and June of 2020, compared to 6582 in the same period the previous year." (**Footnote 217**)

"We have therefore published, and require compliance with, a surgical framework to ensure a standardised clinical prioritisation of cancer patients for surgery across Scotland. This means that patients are receiving the earliest available appointments. Additionally, we purchased added capacity from the independent sector in order to continue to deliver cancer surgery safely." (**Footnote 218**)

"Our National Cancer Medicines Advisory Group (NCMAG) was rapidly convened and at the time of this publication has provided advice to offer 17 new treatment options for cancer patients. The introduction of these new interim cancer medicines allow for greater flexibility and ensure patients have additional treatment options throughout this pandemic. Other innovations have reduced the need for patients to attend hospital thereby reducing their COVID-19 risks. New guidance on remote consent for Systemic AntiCancer Treatment (SACT), means safe prescribing can continue remotely. Community hubs have been used for pre-treatment blood tests. More Systemic AntiCancer Treatment has been delivered orally, and closer to home." (**Footnote 219**)

Further information in relation to cancer treatment was published by Public Health Scotland in 2021. This stated that

“During the nine months of the pandemic in 2020 (April-December), there were 2,681 patients diagnosed with breast cancer, 1,958 patients diagnosed with colorectal cancer and 3,287 patients diagnosed with lung cancer. These numbers are 19% (breast), 25% (colorectal) and 9% (lung) lower than would have been expected in this period had COVID-19 not happened.

The fall in numbers in 2020 Q2 is due to the initial lockdown. In the remaining months of 2020, numbers of people diagnosed with breast and lung cancer started to return to pre-pandemic levels, although colorectal figures remain well below previous years

For breast cancer, there were large falls numbers in stages 1 and 2 (35% and 15% respectively). In contrast, there were small increases in stages 3 and 4 (5% and 7%), with the biggest increase seen for those of unknown stage (34%).

For Colorectal Cancer, there were substantial drops (30% and more) in the numbers diagnosed with stages 1, 2 or 3 colorectal cancer; whereas there was only a 4% drop for metastatic colorectal cancer.

For Lung Cancer, there were falls 11%-13% for stages 1, 2 and 3; but only a fall of 4% for stage 4 diagnoses, which was only lower than expected in April 2020.” (**Footnote 220**)

In February 2021 the charity Cancer Support Scotland said that they were starting to see the effects of the delay in cancer treatment (**footnote 221**). In January 2022 there were reports of emergency cancer referrals being the highest in four year period (**footnote 222**). Jason Leitch in evidence to the Covid-19

Recovery Committee of the Scottish Parliament was reported as saying that

“Globally, cancer is presenting later, for two principal reasons. One is that people were staying away because they were either told to stay away or worried about coming to hospitals.

“Second is because of capacity issues. Most cancer patients don’t have cancer on their referral letter. Most cancer patients are found because of some other symptom for which they are sent to hospital, and then after tests they are discovered to have cancer. Some of those people are on waiting lists. (**Footnote 223**)

While there is notable evidence from the initial statistics published of the Pandemic upon cancer treatment in Scotland further analysis information will be needed to determine the precise effect going forward in relation to areas such as cancer screening as data becomes available.

7.2 Impact on the delivery of fertility and maternity services

All new Fertility treatments were paused on 17th March 2020 and existing fertility treatments ended on 15th April 2020 (**footnote 224**). UK based research of those undertaking treatment during this period when treatment was paused illustrated the psychological impacts such as feeling powerless, frustrated and anxious as to the prospect of being able to effectively re-start treatment (**footnote 225**).Treatment was re-started from 17th May 2020 (**footnote 226**). In order to re-open the clinics providing fertility treatment had to comply with the criteria of the national regulator – the Human Fertilisation and Embryology Authority (**footnote 227**), and also have authorisation from the Scottish Government. The document “A

Covid-19 and Fertility Treatment in Scotland Plans for Restarting Treatment –A Framework" was published in June 2020 (**footnote 228**).

In October 2021 the Scottish Intensive Care Society Audit Group Report was published (**footnote 229**). This highlighted the risks of pregnancy to women who were not vaccinated. Following the rapid spread of Omicron fertility treatment was paused on 23rd December 2021 in relation to NHS treatment and from 7th January 2022 in relation to private treatment in relation to women who were not fully vaccinated (**footnote 230**). The Chief Medical Officer wrote to Health Boards in relation to treatment being temporarily deferred for those patients who were not fully vaccinated stating that the rationale for this recommendation was that

"This recommendation was made in light of:

- representations made by the lead Clinicians in the four NHS Assisted Conception Units in Scotland,
- evidence of increased levels of morbidity and risk of severe illness from COVID-19 amongst unvaccinated pregnant women,
- increased incidence of pregnancy complications in women with COVID-19,
- ongoing uncertainty around the high transmissibility and unknown impact of the Omicron variant on pregnant women,
- and the high and increasing incidence of the virus in Scotland." (**Footnote 231**)

This led to patient concerns being expressed in the media (**footnote 232**). In addition Dr Mary Neal, Reader in Law at the School of Law, University of Strathclyde commented that persons refused fertility treatment may claim discrimination or that their Article 8 right under the European Convention of Human Rights had been infringed (**footnote 233**).

It was suggested that in the early stage of the Pandemic Covid-19 measures had only limited impact on health impacts of births in Scotland though as the authors noted there was need for further wider research in relation to impacts of Covid-19 on child and maternal health (**footnote 234**). Some UK wide research indicated that Covid-19 did have considerable impact on maternity services overall (**footnote 235**) and maternal experiences of them (**footnote 236**). This can be particularly seen to be the case in relation to maternal choice. Information from NHS Inform Scotland indicates that

"During the early stages of the coronavirus outbreak, some choices such as home birth were unavailable due to staff and patient safety concerns. These restrictions are now changing and you should speak to your midwife or maternity team who'll provide you with up to date information the options in your area." (**Footnote 237**)

Concerns have been expressed as to the impact of the Pandemic on home birthing services across the UK (**footnote 238**). In the early stage of the Pandemic home births were unavailable It has been suggested that home birthing is something which can be seen as protected under Article 8 of the ECHR- the right to private and family life (**footnote 239**). Further research would assist in determining the extent to which this impacted in practice on maternity choices in Scotland during the Pandemic.

7.4 Impact on related NHS dental services

Access to dental treatment in the early stages of the Pandemic was very limited. Urgent dental care centres were established on the first day of Lockdown by NHS Health Boards and by June 2020, 69 such centres were operating (**footnote 240**). Guidance stated that NHS dentists could resume seeing

patients for urgent treatment and undertake procedures not creating aerosols from 20th June (**footnote 241**). On the 30th July 2020 it was announced that the provision of services would be extended further to enable standard dental practices to undertake aerosol generating procedures such as use of drills, and this would be accompanied by the provision of enhanced PPE from 13th August 2020 for urgent treatment (**footnote 242**). From 1st November 2020 they were able to provide the full range of care. Regarding the provision of NHS General Dental Services (GDS) the figures for 2020/1 were reported as follows

"Children (under 18)

- In 2020/21, the number of GDS courses of treatment given to children in Scotland was just over 113,000, a decrease of over 357,000 (75.9%) from 2019/20. This decrease is due to the COVID-19 pandemic.
- Half (49.5%) of the claimable dental treatments provided to children were for triage activity. This includes initial telephone calling, and provision of a non-aerosol generated procedure.

Adults (18 and over)

- In 2020/21 the number of courses of treatment authorised was just over 966,000, a decrease of over 3 million (76.5%) from 2019/20.
- Half (50.7%) of adult treatments authorised were for triage activity." (**Footnote 243**)

It was raised in discussion at the Covid-19 Recovery Committee of the Scottish Parliament as to whether private practice dentistry had been prioritised at the expense of NHS dentistry and in response David Morrison from the British Dental Association (Scotland) commented (**footnote 244**)

"Prior to the pandemic, a small proportion of a dental practice's work might be carried out privately, which would help to

subsidise the practice. Each business has to function, just as a hospital or care home has to function. It just so happens that the work is mixed in the one building. When that private revenue was cut off, there was only the NHS support, and those practices became almost unviable. To build strength back into the sector, we need to continue working in a mixed fashion to allow those practices to run or they will fail. There has been a funding package, which has helped the dentists, but we would say that there are winners and losers. Certain practices have had larger payments and are doing better, while others are now doing worse, and we are trying to work our way through that." (**Footnote 245**)

Media reports in 2022 evidenced the concern of dentists as to the large backlog of treatments which remained (**footnote 246**). David McColl the chair of the Scottish Dental Practice Committee was reported as stating to the BBC in February 2022 that

"We are still having to prioritise emergency, urgent care and we are still having to follow government guidelines on infection control. That means we just cannot see the same volume of people that we did pre-pandemic.

"We need to have the government be honest with the public and not pretend that everything is back to normal because healthcare is not back to normal. We are still having to maintain 2m social distancing within the practice and that cuts down on the number of people we can have flow through the practice." (**Footnote 247**)

7.5 Overall reflection on current situation regarding impact to services

Concerns have continued to be raised regarding the effectiveness of provision of services since the restarting of standard NHS provision paused during the Pandemic. The first "Key message" of the Audit Scotland Report "The NHS in 2021" published in February 2022 and reflecting the position as of January 2022 stated that "The NHS in Scotland is operating on an emergency footing and remains under severe pressure" (**footnote 248**). This concerns pressures from emergency admission and ambulance services through to, as noted above, waiting lists for secondary care provision. Also there remain are additional challenges through patients suffering from Long Covid (**footnote 249**) and the mental health impacts of the Pandemic which remain to be fully determined (**footnote 250**). By January 2022 there were reports of high waiting lists and also long waiting times in A & E. departments in Scotland (**footnote 251**). In terms of the overall impacts Audit Scotland in their Report the "NHS in 2021" commented that

"Clearly the pandemic is having an impact on people's health beyond the direct effects of Covid-19. The scale of delayed diagnosis and treatment and what this means for NHS services and patients is not yet known. The Scottish Government does not yet have an overall strategy for monitoring the wider health impact of Covid-19. Public Health Scotland is monitoring some specific areas, such as the number of undiagnosed cancer cases. But a cohesive strategy is needed to better understand what the wider health impact of Covid-19 will be on NHS services and inform future service provision. (**Footnote 252**)

8.0 Use of digital technology in NHS services during the Pandemic

Key Issues

The move to implement social distancing during the Pandemic drove the increased use of digital technologies such as telemedicine. Existing schemes such vCreate" and "Near Me" were rapidly expanded. Advantages were seen for some in terms of easier access to for example secondary care consultations without need to travel considerable distances. Concerns were raised in relation to the problems of digital exclusion and lack of privacy in relation to consultations if individuals were living in crowded accommodation. Use was made in relation to telemedicine in relation to the provision of early medical abortion services from the early stages of the Pandemic. Continued use of various forms of digital technology is envisaged post Pandemic however concerns still remain in relation to the impacts of digital exclusion.

One feature of the Pandemic has been that of the acceleration of the use of technology in healthcare. There was already a "vCreate" secure video service. This had been initially developed at the Royal Hospital For Children, Neonatal Intensive Care Unit at Queen Elizabeth University Hospital Glasgow (**footnote 253**). It was then expanded to be used across all the adult and neonatal ICU Units in Scotland with the aim of enabling contact between patients and families (**footnote 254**). It has been stated that "Patients and families report reduced anxiety as well as improved staff morale. Videos also provide an important memory for patients and families" (**footnote 255**). Covid-19 accelerated the use of a Virtual Hospice in the context of children's hospice care by the

Children's Hospices Across Scotland (CHAS) organisation (**footnote 256**).

"Near Me" video consultations were also expanded. "Near Me" is a secure interface for video consulting which has been approved by NHS Scotland and by the Scottish Government (**footnote 257**). The initial aim of this programme was to facilitate care for those who could find it difficult to travel to obtain treatment. Prior to the Pandemic the use of these consultations were stated to be approximately 300 per week, whereas it was reported that by the start of July this was approximately 17,000 per week (**footnote 258**). This figure comprised some 13,800 video calls in secondary care, some 2900 in relation to general practice and some additional 3rd sector calls (**footnote 259**). An evaluation of the operation of "Near Me" during the Pandemic was undertaken by Dr Joseph Wherton and Professor Trisha Greenhalgh of the University of Oxford (**footnote 260**). This examined the initial months of its use in 2020. Responses were positive in relation to the Pandemic reducing infection risk and more generally meaning that e.g. removing the need to travel to consultations. A survey undertaken by the TEC programme which was noted in this study highlighted some concerns related to digital access and health inequalities (**footnote 261**). Issues raised related to poor connectivity, cost of mobile phone data and access to relevant technology and privacy concerns consequent upon undertaking such consultations in the home. A subsequent paper by Greenhalgh indicated that

"The technology was generally considered dependable and easy to use. In most cases (14,677/18,817, 78%), patients reported no technical problems during their post consultation survey." (**Footnote 262**)

In January 2022 it was also announced that steps would be taken to facilitate treatment of patients at home through use of

remote monitoring measures and that there would be expansion of other services such as “Hospital at home” (**footnote 263**). This latter measure can be seen as an effective use of technology and may alleviate pressures at the same time concerns in relation to digital exclusion remain.

8.1 Remote access to abortion services

Telemedicine was also utilised in relation to early stage abortion services. This was introduced in March 2020 (**footnote 264**). Women would have a consultation by video or telephone with a doctor or a nurse. They could then collect the necessary medication from a pharmacy, a clinic or this could be delivered to them. Both pills required to undertake the abortion would then be taken at home. This was not expressly stated as being temporary but subsequently in 2020 there was consultation as to whether this should be continued (**footnote 265**). Respondents gave differing views (**footnote 266**). Some see telemedicine problematic for reasons including ethical concerns, others see it as an effective clinical approach (**footnote 267**). As a result of this the Scottish Government commissioned an independent evaluation the results of which were published in June 2021 (**footnote 268**). The results of this evaluation demonstrated disagreements between respondents as to what should be the response post Pandemic, some from a right to life perspective who wanted a move to a tighter regime than pre-pandemic, those who wished to retain the pandemic approach and others opting for “hybrid” models (**footnote 269**). It remains unclear as to whether this form of delivery of early-stage abortion will be continued in the post Pandemic period (**footnote 270**).

8.2 Use of Digital Technology in Care Homes

Work was undertaken during the Pandemic period in relation to use of digital technology in Care Homes. A Digital Approaches in Care Homes group was set up on 28th May 2020. The "Lessons Learned From Reducing Delayed Discharges and Hospital Admissions" Report commented that

"Helping care home residents to stay in touch with their families during lockdown has been a concern. Some areas noted that they had provided iPads/tablets to Care Homes so that family members could see and speak with their loved ones by video call. Other areas have expressed an interest or intention to do this. The main challenge reported through the June conversations was around care home residents not being able to see their families/loved ones in person. Although there is a lot of virtual contact through video calls, this remains a point of difficulty, especially for residents with dementia and associated challenging behaviour." (**Footnote 271**)

Moreover it was suggested that technology could be seen as facilitating decision making. The Report goes onto say that

"Technology has helped people to make their care home choices. During the lockdown, homes in some areas have been able to provide virtual tours, to help people and their families choose their preferred care home, once a place becomes available for an appropriate move." (**Footnote 272**)

The document "Connecting People Connecting Services Digital Approaches in Care Homes Action Plan" was also published in December 2020 (**footnote 273**). This was to be read alongside the "Adult social care - winter preparedness plan: 2020 to 2021" which was also published in December 2020 (**footnote 274**). The intention was for all care homes to become "digitally

enabled" (**footnote 275**). This involved issues including digital connectivity (**footnote 276**), digital care planning (**footnote 277**) and sharing of information and use and where relevant adoption of existing platforms such as "Near Me" (**footnote 278**), along with for example measures to facilitate social connections for patients and staff well-being" (**footnote 279**). Funding was committed for this purpose. In November 2021 the Scottish Government commented that

"Sector uptake – 76% of all Scottish Care homes (1,056) = 91% of care home residents (ca. 31,500 people).

Continued to deliver a £1.5 million programme of work, which to date has dispatched 1,961 iPad devices to 1,056 care homes (746 mifi devices).

Developed and assessed options to address the connectivity challenges. The work has identified 132 homes with no devices (approx. 9% of all homes) which is impacting 3,500 residents (approx. 10% of resident population).

The numbers of staff and residents using the devices has grown gradually. The team continue to raise awareness and establish a care home learning community for care home staff and enhanced the range of services available to staff and residents." (**Footnote 280**)

As time goes forward it is likely that digital access in care homes will be inevitably the norm and can facilitate communication effectively for example, with family members in another part of the country or in another jurisdiction. In a care home context the issues of privacy in relation to digital communication may be at times problematic. In addition digital technology may not be appropriate for certain groups of residents and thus this is inevitably a supplement to the availability of face to face visits as discussed earlier.

8.3 Digital Strategy Going Forward

In October 2021 the Scottish Government published a refreshed Digital Health Strategy building on the experience of the Pandemic which recognised the potential of technologies and also problems which can result from digital exclusion (**footnote 281**). It remains unclear as to how effectively at least in the short term all the concerns regarding digital exclusion can be addressed. As the Audit Scotland Report on the "NHS in Scotland in 2021" comments

"Adopting digital technologies will be crucial to the transformation needed to make sure NHS services are sustainable in the future. But this cannot be done in isolation. It must be part of wider overall service redesign plans that are built around the needs of patients and staff." (**Footnote 282**)

9.0 Impact on Staffing in primary and secondary care.

Key Issues

Notable staffing and workforce pressures in primary and secondary care were indicated during the Pandemic. NHS staff suffered Covid illness and some sadly died as a result of the infection. Other strains on staff physical and mental health were reported during this period. Workforce pressures were linked to by professional bodies to existing staffing shortages, adverse staff wellbeing, health inequalities and demand on healthcare provision etc which pre-dated and were exacerbated by the Pandemic impact. Attempts were made to alleviate this through measures such as the NHS Wellbeing Hub and helpline. Tensions though have been highlighted between drives to increase service provision going forward and staff wellbeing.

There have been reports of notable staffing and workforce pressures during the Pandemic. This related to issues directly arising from Covid-19 including staff falling ill and isolating. It is also the case that very sadly some NHS staff died as a result of contracting Covid-19 (**footnote 283**). Some immediate measures were put in place to try and address workforce shortages. From early in the Pandemic guidance was issued in relation to the deployment of student health care professionals which included the early provisional registration of medical students so that they could take up their Foundation Year 1 year posts (**footnote 284**). Audit Scotland noted in their report "NHS in Scotland 2020" that

"NHS workforce capacity was increased, which enhanced NHS resilience. During the first wave of Covid-19, 4,880 nursing students were deployed, registration dates for 575 junior

doctors were brought forward and recently retired NHS staff were invited to return to work. An accelerated recruitment portal was also launched, which received 16,000 expressions of interest." (**Footnote 285**)

In 2021 it was reported that hospitals across Scotland including NHS Greater Glasgow and Clyde had been employing student nurses to assist in "healthcare positions" prior to them having completed their registrations with their professional body (**footnote 286**). In January 2022 it was reported that some 10,000 nursing and midwifery students would be deployed during January and February 2022 and some 1,500 allied health professional students and 500 paramedic students to be deployed in February 2022 in Scotland (**footnote 287**).

Staffing pressures have however been a re-occurring theme during the Pandemic. It was clear from the Royal College of Physicians and Surgeons of Glasgow Report in April 2021 that pressures on healthcare staff in Scotland were still very real. This Report commented that

"The need for workforce recovery and the remobilisation and renewal of services are inextricably linked and should be seen as intersecting areas. However, the work streams and initiatives are currently largely being treated independently by Scottish Government, Health Boards, and political parties. Action to address workforce recovery must begin immediately, to support remobilisation, and to allow capacity for renewal and transformation through innovation. Only then will we be able to create the sustainable healthcare service that patients in Scotland will need for the future." (**Footnote 288**)

In July 2021 BMA raised concerns of workforce pressures in Scotland related to Covid -19 (**footnote 289**). Raigmore hospital which is the largest NHS hospital in the Highlands had reached capacity "Code Black" on Tuesday 6th July 2021 and

had as a consequence made the decision to cancel all non-urgent surgery and outpatient activity (**footnote 290**). The hospital had been suffering from staff shortages resulting from the growth in Covid cases and the numbers of staff members who needed to self-isolate. There were other press reports indicating severe pressure on Lothian Hospital and University Hospital Monklands but these did not specifically mention Covid.

The First Minister claimed in September 2021 that a "driving reason" for staff pressures was due to Brexit (**footnote 291**) however this was subject to criticism by Opposition parties (**footnote 292**). The Audit Scotland Report the "NHS in 2021" in February 2022 commented that

"We have highlighted in previous reports that the NHS has struggled to recruit enough people with the right skills to certain positions, and that the UK's departure from the EU could further reduce the pool of workers available in future years… We also highlighted a lack of robust and reliable workforce data in our NHS workforce planning … particularly in relation to primary care…..We are yet to see evidence that this has improved, and there is a risk that it inhibits effective workforce planning. It will also make it difficult to monitor progress in achieving workforce objectives." (**Footnote 293**)

The impacts of Long Covid on NHS staff in Scotland are currently the subject of a two-year research study which is being led by Senior Research Fellows Dr Aileen Grant and Dr Nicola Torrance at Robert Gordon University in Aberdeen in collaboration with colleagues at the University of Aberdeen and St Andrews University (**footnote 294**). It has also been argued that the notable Covid pressures on staffing have exacerbated existing pressures in health care which existed prior to the Pandemic itself. A report, "Recovering the healthcare workforce and service for our patients" produced by Royal

College of Physicians and Surgeons of Glasgow in partnership with the Academy of Medical Royal Colleges and Faculties in Scotland and BMA Scotland stated that (**footnote 295**)

“The Covid pandemic has magnified a number of problems that already existed in our health service. These include workforce shortages,

- high levels of stress and burnout,
- poor staff wellbeing,
- health inequalities, and
- demand that outstripped capacity, resulting in increased waiting times for patients.” (**Footnote 296**)

The Audit Scotland “The NHS in 2020” Report noted that

“The Scottish Government worked to improve the support available for the health and social care workforce during the pandemic. It established a workforce senior leadership group, bringing together partners, staff and regulators from across health and social care, to respond to issues quickly. The group has met frequently throughout the pandemic and provides strategic guidance and oversight on areas such as staff wellbeing, Covid-19-related absences and guidance for staff needing to shield.” (**Footnote 297**)

The Scottish Government established an online “National Wellbeing Hub” (**footnote 298**) on the 11th May 2020. The hub was to

“enable staff, carers, volunteers and their families to access relevant support when they need it, and provides a range of self-care and wellbeing resources designed to aid resilience as the whole workforce responds to the impact of coronavirus (COVID-19)”. (**Footnote 299**)

Audit Scotland's Report "The NHS in Scotland in 2020" stated that

"Demand for the Scottish Government's National Wellbeing Hub website has been high. By December 2020, there had been over 50,000 visits to the website…. It was developed by NHS Greater Glasgow and Clyde's Anchor Service and NHS Lothian's Rivers Centre and was launched in May 2020. It gives staff, carers, volunteers and their families access to a range of resources to help them look after their physical and mental health. A helpline and a wellbeing champions network were also launched. In addition, practical staff support was put in place including assistance with accommodation and transport, and the creation of rest areas within NHS hospitals for staff to use." (**Footnote 300**)

A National Wellbeing helpline was also established in 2020 (**footnote 301**). Subsequently in their Report "The NHS in Scotland 2021" Audit Scotland noted

"The Scottish Government has reviewed the first 100 service users of the Workforce Specialist Service, usage of the National Wellbeing Helpline and examined analytics of the National Wellbeing Hub. Feedback has suggested that they have had a positive impact on wellbeing, although the National Wellbeing Helpline has had low call volumes. The Scottish Government will continue to evaluate the staff support measures it has introduced." (**Footnote 302**)

In September 2020 risk assessment guidance in relation to NHS staff was changed because

"We now know that underlying health conditions and ethnicity, when viewed in isolation, do not accurately predict an individual's vulnerability. The risk assessment tool that we endorse for use by all staff is based on clinical and scientific

evidence that takes into account multiple personal characteristics including ethnicity, age, gender, BMI and health conditions, to assess an individual's overall vulnerability to COVID-19." (**Footnote 303**)

In March 2021 the BMA in their Report "Rest, recover, restore: Getting UK health services back on track" which included a wide- ranging series of recommendations which were seen as needed for patient safety (**footnote 304**) stressed the need for health care professionals across the UK to be able to take leave, access to a safe working environment including access to occupational health and safety assessments, " up to date health and psychological risk assessments" and "Move away from the use or appearance of the politically-charged word "resilience" across NHS organisations – it is offensive to staff and is not conducive to a good working culture" (**footnote 305**).

The adverse impact of the Pandemic on the wellbeing of nursing professionals was noted in a survey by RCN Scotland reported in "The Scotsman" in January 2022 which indicated of those surveyed more than 2/3rds were considering leaving their existing role due to pressures including pressures, shortages of staff, pay and also "feeling undervalued" (**footnote 306**). These ongoing pressures are noted in the Audit Scotland Report published in February 2022,

"The Scottish Government told us that there is not a culture of seeking help in the health and social care sector. Support needs to be improved, for example by ensuring that wellbeing is part of conversations between staff and their managers. Achieving this will take time and involve managing the tension between the competing demands of staff wellbeing, the pandemic response, and remobilisation." (**Footnote 307**)

Such conversations would also need to be seen as part of a broader approach to address the range of underlying factors

which give rise to staff themselves seeking help in such situations. The Audit Scotland Report “The NHS in 2021” published in February 2022 stated that

“The Scottish Government recognises that the risks relating to workforce capacity and wellbeing are significant. This has been reflected throughout the year in the Scottish Government’s Health and Social Care Risk Register. The Scottish Government has introduced a range of controls to mitigate the risks. For example, it developed a recruitment plan to address winter pressures and winter disease. It also set up a Sustainable Vaccination Workforce Group to ensure that delivering the vaccination programme did not put further pressure on the wider healthcare system. It is too early to tell how effective these measures have been.” (**Footnote 308**)

In relation to workforce strategy going forward the Audit Scotland Report “The NHS in 2021” stated that

“The Scottish Government, in conjunction with the Convention of Scottish Local Authorities (COSLA), aims to publish a new national workforce strategy for health and social care in early 2022. This will include high level objectives, an action plan covering the short, medium and long term, and projections for anticipated workforce growth. It is crucial that this strategy is aligned with the NHS recovery plan and leads to a more integrated approach to workforce, service and financial planning. Recovery ambitions cannot be met if the right people with the right skills are not in place. We plan to carry out further audit work on this in due course.” (**Footnote 309**)

At the same time, the Audit Scotland Report emphasised that

“There is clear commitment at Scottish Government and NHS board level to support staff wellbeing, and it features prominently in the NHS recovery plan. However, the plan also

outlines significant additional demands on NHS staff that could negatively impact their wellbeing. The ambition to significantly increase activity could undermine the desire to improve staff wellbeing (**footnote 310**).

It will be important for the Scottish Government and health and social care bodies to work together to monitor the progress and evaluate the effectiveness of the new staff wellbeing measures (paragraph 22), and to better understand and provide for staff support needs." (**Footnote 311**)

Overall Audit Scotland stated that "The Scottish Government and NHS boards worked quickly to support staff wellbeing, but it is too soon to assess the effectiveness of the measures put in place" (**footnote 312**).

10.0 Equality and diversity issues

Respect for equality and protection from discrimination is enshrined in domestic law and in international statements of human rights should be a core value for all. The Pandemic has exacerbated existing inequalities in relation to health. Throughout the Pandemic there have been concerns as to the disproportionate impacts of Covid upon certain groups in the community including minority ethnic individuals and/or those suffering from socio-economic deprivation. The Scottish Government measures included the establishment of a new Health Inequalities Unit.

Respect for equality and protection from discrimination is enshrined in domestic law through the Equality Act 2010 and in international statements of fundamental human rights. Moreover non-discrimination is a core value in terms of health care delivery in the Scottish Charter of Patients' Rights and Responsibilities (**footnote 313**). The Pandemic has given rise to a range of issues concerning equality and diversity as highlighted by the Scottish Parliament Equalities and Human Rights Commission Report "Report on the impact of the COVID-19 pandemic on equalities and human rights" published in March 2021 (**footnote 314**). It has been argued that Covid has had disproportionate impacts on certain groups in society (**footnote 315**). A number of the equality and diversity issues arising from Covid were highlighted in the research report "The Impacts of Covid-19 on Equality in Scotland" produced by the Scottish Government in 2020 (**footnote 316**). It has long been recognised that socio- -economic disadvantage impacts on health outcomes (**footnote 317**). The 2020 Report commented that

"While there is no evidence of an overall trend by deprivation, the highest proportion of confirmed cases (24%) was

accounted for by those living in the 20% most deprived areas." (**Footnote 318**)

Subsequently the Audit Scotland NHS in its 2020 Report published in February 2021 stated that

- "the death rate from Covid-19 is more than twice as high in the most deprived areas (183 per 100,000 population) than in the least deprived areas (79 per 100,000 population)." (**Footnote 319**)

Research led by Professor Sir Michael Marmot has also suggested that existing socio-economic deprivation is correlated with worse Covid-19 outcomes (**footnote 320**).

Racial disparity in relation to Covid was also highlighted by the Audit Scotland Report the NHS in Scotland in 2020 which stated that

- "there is around a twofold increase in risk of admission to critical care or death from Covid-19 among people of South Asian origin. There is also evidence of an increased risk of hospitalisation arising from Covid-19 among those of Caribbean or black ethnicity." (**Footnote 321**)

Following the adverse impacts of Covid-19 upon those from minority ethnic groups the Scottish Government established an Expert Reference Group on COVID-19 and Ethnicity (**footnote 322**). It divided into subgroups- the first group had the task of producing "advice and recommendations by the Scottish Government in relation to data, evidence, risk and systemic issues" recommended the need for improved data collection (**footnote 323**). The second sub-group examined systemic issues (**footnote 324**). This Group commented that

“Scottish Government recognise the fundamental relationship of systemic issues to inequalities: “COVID-19 has exposed and highlighted the deep-rooted health and socioeconomic inequalities that minority ethnic communities face, and the systemic failures to address these issues. The Government recognises that we have an opportunity to make fundamental and lasting changes to address these inequalities.” (**Footnote 325**)

Recommendation 3 of the Group “Test and Protect and future health measures” stated that

“26. There must be Minority Ethnic participation at all levels of the COVID response. It is also important to ensure that communication with individuals from minority ethnic communities by Test and Protect teams is effective and that Test and Protect teams have incorporated processes and expertise which reflect the diversity of the communities they serve and the intersectional framing of their experiences.

27. Further, as other health policies, such as shielding and vaccinations, are being developed the Scottish Government must ensure that the needs of minority ethnic communities are considered and acted upon. There is a risk of undermining the broader zero COVID-19 community transmission approach if this is not done.

28. Culturally competent health promotion and disease prevention programmes, relating to issues such as the higher risk of diabetes and Cardio-Vascular Disease among South Asians, is well known but efforts to tackle it may have diminished recently and it is important that such efforts are reinvigorated. Further, the Independent Race Equality Framework Advisor had previously made a recommendation involving funding the implementation of a low cost community intervention project with the aim of bringing about lifestyle

changes that would a) prevent and b) improve management, of these diseases." (**Footnote 326**)

It appears unclear to date as to how effective such measures have yet been.

Mental health impacts of the Pandemic on vulnerable groups in Scotland have been highlighted by the Mental Health Foundation and the University of Strathclyde (**footnote 327**). Concerns have also been expressed in "The Impacts of Covid-19 on Equality in Scotland" Report in 2020 as to the impact on children's and women's mental health (**footnote 328**). Particular notable were higher death rates amongst older persons and those with disabilities (**footnote 329**). In relation to minority ethnic communities it was commented that

"Deaths amongst people in the South Asian ethnic group in Scotland have been almost twice as likely to involve COVID-19 as deaths in the White ethnic group." (**Footnote 330**)

In relation to men the Report noted that

"Men were twice as likely as women to have been admitted into the ICU with confirmed COVID-19 as of the end of June 2020, and age-standardised death rates (which are adjusted for the age-structure of the population) were 45% higher for men than for women." (**Footnote 331**)

There is evidence to suggest that the condition "Long-Covid" is proportionally more likely to be experienced by women than by men (**footnote 332**). This was followed in 2021 by research commissioned by the Scottish Government from the JRS Consortium (**footnote 333**) which looked at well-being in relation to Covid (**footnote 334**) and focused on 5 " key population sub- groups" (**footnote 335**) persons with disability, individuals "whose job security had been threatened by Covid-

19", women, young adults and persons "living in Scotland's most deprived communities (defined as those living in the lowest quintile SIMD communities (Scottish Index of Multiple Deprivation - SIMD 1)" The impact of Covid-19 on rural communities has also been highlighted (**footnote 336**). These may be particularly adversely affected by location inhibiting full access to services delivered digitally. Covid-19 restrictions in relation to mental health have been seen as particularly notable in relation to group's younger age groups in rural populations who may be marginalised as highlighted by Thomson and Lejac in their study of LGBT+; young carers and refugee and asylum seekers (**footnote 337**).

To address some concerns the Audit Scotland Report noted that

"In December 2020, the Scottish Government established the new Health Inequalities Unit (HIU) within its Population Health Directorate. The HIU aims to embed equity and human rights in the response to the pandemic and across wider healthcare services.

The HIU is developing a single health equity vision. This aims to provide NHS boards with clear priorities, but this work is at a very early stage. The HIU includes a fair health team that focuses on the social and economic drivers of health inequality, such as low income, inadequate housing and poverty. The team will work with other government departments including education, social justice and housing, to bring a cross-government approach.

The work of the HIU will be crucial to building a sustained approach to reducing health inequalities. Such work should focus on cross government initiatives and emphasise tackling the wider factors contributing to inequality. The fair health team will have a role in driving this work forward." (**Footnote 340**)

In 2022 it was announced that the Health Foundation would undertake an independent review into health inequalities in Scotland (**footnote 341**).

Covid-19 also, as noted earlier, gave rise to a range of ethically challenging issues for clinical practice. In relation to the proposed National Ethical Advisory and Support group there was to be representation from a range of faith groups and also at local ethical advice and support groups these were to include members of the “Spiritual Care Team (**footnote 342**).

The Covid Pandemic has graphically illustrated the importance of solidarity in community to address the challenges of the virus and demonstrates the importance in addressing underlying health inequalities and inequalities which impact on health going. It will be important to review the work of the Health Inequalities Unit going forward.

III. Delivery of End of Life Care

11. Advance Care Planning

Advance care planning can be seen as an important part of clinical practice, enabling an individual's effective anticipatory wishes in relation to future treatment to be determined (**footnote 343**). In relation to advance care planning the relevant law concerning treatment of adults who lack mental incapacity is the Adults with Incapacity (Scotland) Act 2000. In contrast to the position in England and Wales advance decisions to refuse treatment so called "living wills" do not have explicit statutory provision in Scotland (**footnote 344**). However when decisions are made concerning persons who lack mental capacity there is the requirement to take into account their past or present wishes (**footnote 345**). A specific tool kit for advance care planning during the Pandemic was produced for health care professionals (**footnote 346**). This was released by the Scottish Government in April 2020 (**footnote 347**). It was suggested that this was effective in reducing admissions and was also seen as a consequent cost saving measures (**footnote 348**). Guidance issued to Care homes in May 2020 by the Scottish Government also stated that (**footnote 349**)

"Anticipatory Care Plans (ACPs) should be in place for as many residents as possible. This allows the needs and wishes of residents and families to be taken into account in the event of changing circumstances. In many cases the care home staff will already have these in place for residents or are able to start these conversations with involvement of families and community healthcare teams. (**Footnote 350**)

However concerns were expressed by the Marie Curie organisation in evidence to the Health and Sport Committee as

to the effectiveness of such advance care planning strategies in practice.

“Due to the rapidly evolving and unpredictable nature of Coronavirus and demands in clinical/acute settings, clinicians did not always manage to discuss ACPs (and DNACPRs (**footnote 351**)) with patients in care homes or at home. As a result, this responsibility repeatedly fell to social care staff who were not always appropriately trained to have difficult conversations, quickly, with patients and their families about their care. This caused severe distress among many social care workers and when combined with unusually high numbers of patient deaths in community settings, we have heard of some staff experiencing trauma or PTSD.” (**Footnote 352**)

Do Not Attempt Cardio- Pulmonary Resuscitation (DNACPR) orders may be considered as part of effective Advance Care Planning, however due to the circumstances in which it has been alleged that certain forms of use of them was made in the context of the Pandemic these are explored below.

12.1 Visiting patients and End of Life Care

As noted above in the discussion in relation to care home visits such visits by family members and of close friends may be both therapeutic to the individual and the family and also can be seen as something which falls within the protection given by Article 8 of the European Convention of Human Rights, the right to home and family life 2021 (**footnote 353**).

In September 2020 Marie Curie, Royal College of Physicians of Edinburgh, Academy of Medical Royal Colleges and Faculties in Scotland and Scottish Care issued a document "Patients and family of patient at the End of Life" (**footnote 354**). This stated

"When patients are judged to be dying within hours or days, the presence of family at their side for short visits, or longer stays, is vital to palliative and end of life care and a timeless part of the human experience of life and death. It provides comfort not only to the dying patient, but also to those present, and the inability to be present is a source of anxiety, distress and moral injury that may be long-lasting." (**Footnote 355**)

This noted that

"Limiting travel in the wider community has been an equally important aspect of Scotland's effort to reduce deaths from COVID-19 and so enabling visiting, even when limited to the end of life, sat at odds with that risk reduction measure. Although the national updated principles on visiting noted end of life visiting as essential, Government guidance for the public on travel from home did not explicitly specify visits to a dying family member as permissible. As a consequence, inconsistent interpretations of this guidance mean that variable policies are in place." (**Footnote 356**)

They advanced an ethical framework and practical principles which they suggested should govern visiting including that

“1. All patients who are judged to be dying from COVID-19 or other conditions within hours or days are entitled to receive visitors. That entitlement is however qualified by the following.

2. Visiting arrangements will aim to best serve the needs of patients and their families, but may need to change at short notice in light of local or national changes in COVID-19 related restrictions.” (**Footnote 357**)

In hospitals as well as in care homes during the Pandemic visiting was banned or severely restricted with the aim of curtailing the spread of Covid. However some visits were allowed in limited circumstances such as where an individual was reaching the end of their life. These general restrictions were lifted in April 2021 but subsequently individual hospitals imposed restrictions where necessary to stop disease transmission and this continued into 2022 (**footnote 358**).

13. Palliative Care provision

The provision of palliative care during the Pandemic was seen as a matter of concern. Palliative care may be given at home or in a hospital setting. The correct provision of palliative care in the community setting is something which can be seen as of particular importance given the increased deaths of persons at home during the first twelve months of the pandemic (**footnote 359**). The Scottish Government published the Palliative Care Toolkit in April 2020 (**footnote 360**). This set out contingency plans for palliative care, management of supply of medicines (**footnote 361**). Health care Improvement Scotland and NHS Scotland also issued other guidance in March 2020 including specific additional temporary Guidance to the Scottish Palliative Care Guideline (**footnote 362**). The algorithm produced by NHS Forth Valley "Guidance for Prescribing and Administering PRN medication when a Person is Imminently Dying from COVID-19 Lung Disease" (**footnote 363**) was also made available.

It has been claimed that palliative care services were adversely impacted during the Pandemic. The "Better End of Life Care" Report in 2021 (**footnote 364**) highlighted shortages in PPE including in Scotland (**footnote 365**), and some evidence of shortage of equipment (**footnote 366**). 11-20% of services in Scotland also reported shortages of medication (**footnote 367**). Staff shortages in Scotland which were reported at were less than in certain other parts of the UK (**footnote 368**). Concerns were also highlighted in relation to the specific experience of bereavement during Covid-19 and the need for improved bereavement support (**footnote 369**).

IV. Use of Do Not Attempt Cardio-Pulmonary Resuscitation Orders During the Pandemic.

Key Issues

The application of Do Not Attempt Cardio-Pulmonary Resuscitation Orders has been of notable controversy. This is an area which engages fundamental human rights in the form of Articles 2 the right to life and Article 8 – the right to privacy of home and family life contained in the European Convention of Human Rights. It has been claimed that these were applied in relation to some individuals without their knowledge or in the case of persons lacking mental capacity, without the knowledge of their relatives.

Do Not Attempt Cardio-Pulmonary Resuscitation Orders (DNACPR) orders are, as their name suggests, orders placed on patients as instructions that should a cardiac arrest occur the patient should not be resuscitated (**footnote 370**). While CPR may be successful on some patients on others for example due to acute frailty it is unlikely to be appropriate. The decision to impose such an order is a clinical decision and they can be imposed despite the opposition of the patient and their relatives (**footnote 371**). However cases in courts in England and Wales have held that before such orders are issued in order to comply with Article 8 of the European Convention of Human Rights the patient themselves, if they possess decision making capacity or in a situation in which they lack decision making capacity, their relatives must be consulted (**footnote 372**). The use of DNACPR orders during the Pandemic has been a matter of controversy in the UK. While in the past discussion of use of DNACPR orders may be seen as being very much a matter for

Advance Care Planning, particularly in the context of those nearer the end of their lives in relation to the Pandemic controversy was caused by claims of the widespread use of DNACPR orders in Scotland in 2020 and in 2021. Reports appeared claiming inappropriate use as early as March 2020, though these allegations were strongly denied by the relevant NHS body (**footnote 373**). In the Covid-19 Guidance: Clinical Advice which was published on the 3rd April 2020. Letters were sent to GP's in Scotland in April 2020 regarding advice and support in relation to care planning and these included use of DNACPR orders (**footnote 374**).

The Report of the Equalities and Human Rights Committee of the Scottish Parliament stated that

"In April 2020, Age Scotland advised it was "inundated" with calls from older people saying that their GP practices were asking them to consent to a DNACPR…..Adam Stachura (Age Scotland) told the Committee his organisation was still hearing that "family members are leaving hospital with a DNAR form slipped into their discharge notes. Those people who leave hospital do not have their own capacity—they might have dementia—and their power of attorney is not consulted"… He explained that people "thought that it meant that they would not be given medical treatment and that they would be left to die if they got the virus". He was also worried that "administrative staff have been calling older people with dementia, who have agreed to something on the phone." (**Footnote 375**)

In relation to the reasons for this the Equalities and Human Rights Committee wrote to the Scottish Government and were informed that

"The Committee wrote to the Scottish Government on 4 June 2020 about the relevant guidance and received a response from the Scottish Government on 23 June 2020. This stated

decisions regarding CPR are made according to current ethical principles, legislation 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 376**)

Also in April 2020 the First Minister stressed that no one should be "pushed into signing" a DNACPR form (**footnote 377**). It should be noted in fact a signature by itself does not impact on the legality of the decision not to undertake CPR itself rather it is simply evidence that patients have been consulted on the issue (**footnote 378**). This response followed claims from a family that their 86 year old woman had been phoned by a locum doctor about the DNACPR order and then sent a form (**footnote 379**). The woman's daughter was reported as saying that her mother would have been "happy to take a phone call from anyone", but would rarely remember the discussion (**footnote 380**). In June 2020 the organisation Deaf Action noted that a deaf man in his 60's living in supported accommodation for deaf adults in Edinburgh had been given a DNACPR order without his knowledge or consent (**footnote 381**). In evidence to the Equality and Human Rights Committee in Holyrood in June 2020 in the light of reports that people had been "pushed" into accepting DNACPR orders Christina McCelvey, the Equalities Minister was reported as saying that

"I think the honest answer is we don't know. Our guidance didn't change, our guidance to GPs and other health professionals didn't change." (**Footnote 382**)

In November 2020 Age Scotland expressed their concern regarding the use of DNACPR orders in hospitals (**footnote 383**). Following the report of the Care Quality Commission in England in April 2021 which was highly critical of the use of DNACPR orders (**footnote 384**), Age Scotland called for an

Inquiry nto their use in Scotland (**footnote 385**). In April 2021 the Scottish Secretary Alister Jack supported calls for a national review of DNACPR decisions from the start of the Pandemic (**footnote 386**).

Footnotes

1. See for example, A. Rojas-García, S. Turner, E. Pizzo, E. Hudson, J. Thomas, R. Raine "Impact and experiences of delayed discharge: A mixed-studies systematic review" (2018) Health Expectations **https://onlinelibrary.wiley.com/doi/epdf/10.1111/hex.12619**
2. 'Lessons Learned From Reducing Delayed Discharges and Hospital Admissions **https://hscscotland.scot/couch/uploads/file/resources/covid19-reports/lessons-learned-report-final.pdf**' **https://hscscotland.scot/couch/uploads/file/resources/covid19-reports/lessons-learned-report-final.pdf**
3. **https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf**
4. News "Delivering the right care in the right setting", **https://www.gov.scot/news/delivering-the-right-care-in-the-right-setting/**
5. Audit Scotland NHS in Scotland in 2021, at para 15, **https://www.audit-scotland.gov.uk/uploads/docs/report/2022/nr_220224_nhs_overview.pdf**
6. Freedom of information request: 'COVID 19 Transfer of elderly patients to care homes: FOI release' Published: 8 Jun 2021, Directorate: Mental Health and Social Care Directorate, Part of: Coronavirus in Scotland, Health and social care, Public sector Information request and response under the Freedom of Information (Scotland) Act 2002; COVID 19 Transfer of elderly patients to care homes: FOI release; FOI reference: FOI/202100195150: Date received: 19 Apr 2021: Date responded: 20 May 2021.
7. Health and Sport Committee Official Report, Thursday 4th June 2020, Session 5, The Scottish Parliament.
8. Ibid at column 4.

9. Ibid at column 4.
10. Health and Sport Committee Official Report, Thursday 4th June 2020, Session 5, The Scottish Parliament, at Column 18.
11. G. Campbell “Covid in Scotland: 'Mistake' to discharge Covid patients says Sturgeon” 18th April 2021, **https://www.bbc.co.uk/news/uk-scotland-56791600**
12. Audit Scotland **“NHS in Scotland” 2020** **https://www.audit-scotland.gov.uk/uploads/docs/report/2021/nr_210117_nhs_overview.pdf** at para 32.
13. **https://www.equalityhumanrights.com/en/our-work/news/equality-and-human-rights-commission-reaches-settlement-ending-unlawful-detention**
14. “Equality and Human Rights Commission reaches settlement on ending unlawful detention of adults with incapacity by NHS Greater Glasgow and Clyde,” 20th November 2020, **https://www.equalityhumanrights.com/en/our-work/news/equality-and-human-rights-commission-reaches-settlement-ending-unlawful-detention**
15. Ibid.
16. Mental Welfare Commission ‘Authority to discharge – report into decision making for people in hospital who lack capacity’ May 2021 **https://www.mwcscot.org.uk/sites/default/files/2021-05/AuthorityToDischarge-Report_May2021.pdf**
17. Section 13 ZA (4).
18. Mental Welfare Commission ‘Authority to discharge – report into decision making for people in hospital who lack capacity’ May 2021 **https://www.mwcscot.org.uk/sites/default/files/2021-05/AuthorityToDischarge-Report_May2021.pdf**, at page 26.
19. Coronavirus (Scotland) Act 2020 Explanatory Notes. **https://www.legislation.gov.uk/asp/2020/7/notes/data.pdf**
20. Ibid

21. “Coronavirus (COVID-19): adults with incapacity.” **https://www.gov.scot/publications/coronavirus-covid-19-adults-with-incapacity-guidance/**
22. Mental Welfare Commission ‘Authority to discharge – report into decision making for people in hospital who lack capacity’ May 2021 **https://www.mwcscot.org.uk/sites/default/files/2021-05/AuthorityToDischarge-Report_May2021.pdf** at page 32.
23. Ibid at pages 32-33.
24. Ibid at page 35.
25. Audit Scotland ‘the NHS in Scotland 2020’ at para 34. **https://www.audit-scotland.gov.uk/publications/nhs-in-scotland-2020** at para 30.
26. Inserting a new section 79A (1) “Reporting on coronavirus deaths in care homes” into the Public Sector Reform Act 2010.
27. Inserting a new section 79 A (2) into the Public Sector Reform Act 2010.
28. “Discharges from NHS Scotland hospitals to care homes. Between 1 March and 31 May 2020” **https://publichealthscotland.scot/media/7313/2021-04-21-discharges-from-nhsscotland-hospitals-to-care-homes-between-1-march-and-31-may-2020.pdf**
29. See “Covid in Scotland: Discharge link to outbreaks 'cannot' be ruled out,” 21st April 2021. **https://www.bbc.co.uk/news/uk-scotland-56834412**
30. For examination of deaths in Care homes in Scotland see D. Bell, D. Henderson and E. Lemmon “Deaths in Scottish Care Homes and Covid-19” LTCcovid.org, International Long-Term Care Policy Network, CPEC-LSE, 17th May 2020.

31. These were reported as being 7 deaths in Saltgreens in Eyemouth, one death at Dean field in Hawick, 8 deaths at Charnwood Lodge in Dumfries, 11 deaths at Thorney Croft in Stranraer, 8 deaths at Alma McFadyen Care Centre in Dalbeattie, and 5 deaths at Fleet Valley Care Home in Gateshouse of Fleet. Deaths **https://www.itv.com/news/border/2021-02-04/crown-office-investigates-south-of-scotland-care-home-deaths**
32. Ibid.
33. Ibid.
34. Ibid.
35. Public Health Scotland " FOI Further Information: Discharges from hospitals to care homes" 28th September 2021 **https://publichealthscotland.scot/news/2021/september/foi-further-information-discharges-from-hospitals-to-care-homes/**
36. M. Ellison "Nearly 200 Scottish care homes took in mainly untested patients" **https://www.bbc.co.uk/news/uk-scotland-58738972** and for the detailed table see **https://public.tableau.com/app/profile/marc.ellison8696/viz/Discharged/DischargedWhichhomeswerehospitalpatientssentto**
37. The Scottish Human Rights Commission 'COVID-19: Care homes and human Rights' 14 July 2020, **https://www.scottishhumanrights.com/media/2054/coronavirus-care-homes-briefing-140720_vfinaldocx.pdf**. They make reference to the ECHR case of 'Lopes de Sousa Fernandes v Portugal' Grand Chamber Strasbourg 19TH December 2017 **https://hudoc.echr.coe.int/eng#{%22itemid%22:[%22001-179556%22]}**
38. Ibid
39. P. Hutcheon "Five Scots care homes pulled up for failings during the coronavirus pandemic", 3rd July 2020 **https://www.dailyrecord.co.uk/news/politics/five-scots-care-homes-pulled-22284507**

40. J.K. Burton, G .Bayen, C .Evans, F. Garbe, D .Gorman, N. Honhold, D .McCormick, R. Othieno, J.E. Stevenson, S. Swietlik, K .E. Templeton, M. Tranter, L. Willcocks and B. Guthrie. “Evolution and effects of Covid-19 outbreaks in care homes: a population analysis in 189 care homes in one geographical region of the UK” (2020) 1 ‘The Lancet Health’ Longev. E21-31.
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