**OPENING STATEMENT BY THE CHURCH OF SCOTLAND SOCIAL CARE COUNCIL**

**Hearing on the impacts of Health and Social Care commencing on 24 October 2023**

The Church of Scotland Social Care Council, which operates under the name of CrossReach, offers care to people of all ages across a wide range of different needs, with locations all over Scotland. It is one of the largest voluntary sector care providers in Scotland, with services including homelessness, mental health, learning disabilities, criminal justice, substance abuse, residential care for older people, day care and care and education for children and young people. At this Inquiry, it seeks to speak both for those people who were supported by its services and the staff who delivered that support.

CrossReach believes that it is important to understand the context in which the health and social care voluntary sector was operating even before the start of the pandemic. This sector was already significantly under-resourced due to years of under-investment, about which discussion with the Scottish Government had started by the end of 2019. It was into this already fragile situation that the pandemic hit.

CrossReach recognises that all citizens of Scotland faced significant disruption during the pandemic and all were impacted by the advice and guidance issued by Scottish Government. However, they believe that there was a particular impact on social care due to a fundamental lack of understanding about its nature and scope that led to guidance being issued which swung between being non-existent for some services and misguided and heavy handed for others and ultimately led to those it was supposed to protect being opened to wider harms.

I will refer briefly to a number of the key impacts experienced by CrossReach:

- Difficulties with guidance
- Rules on self-isolation
- PPE shortages
- The requirement to meet clinical setting care standards
- Financial pressures
- Vulnerability of service managers

First, **difficulties created by the guidance issued by the Scottish Government**. It took a significant effort to interpret and implement guidance which came thick and fast, was often unclear, sometimes unhelpful and came with short implementation windows. Sector representatives CCPS and Scottish Care had to intervene to stop critical guidance from being issued by the Scottish Government late on a Friday, with impossibly short lead-in times, often the following Monday morning. The guidance changed too frequently to allow staff on the frontline to keep up with it. As a result, much effort was expended by the organisation in issuing regular updates and supporting implementation before it all changed again. It was also clear that guidance was mandatory, as it was enforced by the regulator via inspection. The guidance was applied across the board and failed to properly recognise the controls which care homes had in place, which were not replicated in community settings.

This all created additional stress at a time when the focus needed to be on supporting individuals with additional needs, some of whom had suffered trauma, many of whom were bereft of family and friends as a result of the treatment of visitors to residential homes.

Second, in relation to the **rules on self-isolation**, CrossReach staff were identified as keyworkers and it was critically important that these rules were followed to reduce the risk of outbreaks in services. The rules disallowed staff from attending work if someone in their household had tested positive or had symptoms of Covid. This was a sensible move however it fell outwith the circumstances which allowed this time off to be paid. The guidance referred to allowing claims only if staff tested positive. CrossReach put in place a system whereby staff could elect to mitigate the loss of pay by using holidays and if they did so CrossReach would match those used. In effect the member of staff and employer each paid for half of the time off. It wasn't until the Social Care Fund was announced in June 2020 that the situation was rectified. In terms of lessons learned for the future, in similar circumstances, where self-isolation is mandated, and there is reliance on the goodwill of staff to do the right thing for others, it is essential to ensure that financial pressure to attend work is avoided for keyworkers.

Third, **the supply, distribution and use of Personal Protective Equipment** was hugely problematic**.** The supply of PPE, initially at least, was a matter for care services to deal with under their normal purchasing arrangements. The procurement and use of PPE was not new to care homes who were used to taking infection control measures and dealing with infectious diseases on a routine basis. However, because of the unprecedented quantity of PPE needed, much early effort was directed by CrossReach towards sourcing and distributing good quality PPE. While residential care settings were eventually prioritised by the Government, housing support and day support services felt relegated. These services in particular experienced difficulties obtaining PPE, even in situations where there was a confirmed outbreak

From early April 2020, the NHS PPE helpline was operating a triage system to ration the distribution of emergency PPE. The questions involved in this process placed adult care services behind residential care settings, making it almost impossible for these services to obtain PPE. There were problems getting access to PPE due to some services not having a unique identifier, as they were linked to a single Care Service Number.

The PPE shortage was a risk to the lives of service users and staff and CrossReach believe that that there was an inequality in the support given to health services as against social care providers, particularly in terms of PPE. By 22 May 2020 the Scottish Government had still not opened their PPE procurement site. This void created uncertainty.

PPE shortages caused significant price increases. Some companies would supply only to the NHS but where it was available for purchase it was bought from private providers at a significant uplift, with some companies charging up to seven times the normal rate.

Fourth, as guidance was issued to social care settings by the Scottish Government, there was a **failure to distinguish between distinct types of care setting**. Recommendations which made sense from a Covid infection control perspective, and were appropriate in an "ordinary" setting, did not work where other risks to health or wellbeing specific to the context, were overlooked. There was a significant lack of understanding of the context of social care. Residential care homes, for example, which had previously been inspected against care

standards to ensure that they were as homely as possible started to be assessed against the same clinical standards as hospitals.

Not consulting with the representative bodies for social care providers or with providers directly at an early stage meant that opportunities were lost to ensure that the guidance issued allowed the significant expertise of those working in social care to be harnessed rather than disempowered.

Social care operators work in different settings to hospitals and other clinical care settings. Care settings require greater comfort, with space for living, anchoring and nourishing; capable of catering for the full range of 'life'. They have soft furnishings, places to congregate, communal spaces to eat – they are 'home'. They are not short-term, high-level, clinical settings. There appeared to be a mistaken belief that care services were akin, or capable of being akin to, clinical settings. This resulted in infection control and hygiene requirements that were either overly onerous or impossible to achieve. It also resulted in an expectation that care settings could provide high-level and critical clinical care that was not realistic to achieve in terms of staffing, setting and equipment.

The guidance to separate those with Covid symptoms from other care home residents, whilst understandable on paper, took no account of the practicalities and fundamentally misunderstood the impacts on the people using the service, particularly people with dementia whose quality of life depends on having familiar routines and surroundings. The general public were not asked to move home when they were infected and yet one set of guidance suggested that all infected residents should be kept in one part of the building with infection-free residents being cared for in another, which would have necessitated uprooting them from their familiar rooms. This should not have been expected of vulnerable people in care. Also, the separation expected within care settings posed additional practical, physical, difficulties.

In substance misuse residential services, vulnerable residents, living chaotic lifestyles and sometimes suffering mental health difficulties, were simply unable to comply with the guidelines. In adult care services, whilst one harm was prevented often another was created, seemingly without any balancing exercise being done to determine which was the greater

risk, or whether both could be mitigated. The guidance for children's services was almost non-existent in the early stages of the pandemic and when it was issued the rights of children were not upheld, because a risk-assessment approach was not adopted. Some children in care were prevented from seeing their family members and at one point the self-isolation guidance could have led to a whole team of staff having to isolate, leaving children with no familiar adults whatsoever. This would not have been tolerated in a 'normal' family setting and should not have been thought appropriate in a children's care setting. Whilst a "bubble" model for looking after children was eventually agreed with the Scottish Government it was never adopted into the Public Health Scotland guidance.

The fundamental impossibility of applying the mandated infection control practices in services was left to managers and staff to grapple with. Residents without capacity could not be kept in their rooms and asked to self-isolate without experiencing significant distress. They could not abide by physical distancing requirements when in communal areas and many could not remember even simple instructions issued by staff about what they could and could not do. Inspection standards imposed on care settings were too clinically driven. Care inspection evaluations which had previously focussed on the quality of care and the outcomes for individuals became too prescriptive and were almost entirely based around infection, protection and control using clinical standards, and care providers were found wanting because they could not react quickly enough and meet the standard. Where a care home was found wanting in this regard their deficit was reported directly and openly to Scottish Government which allowed for public shaming through the press to occur. This was not the same for hospitals or other settings.

Fifth, there were **significant financial pressures**. CrossReach experienced income shortfalls and incurred extra costs not adequately covered by payments from the Scottish Government. There was a significant difference to sustainability payments by various Local Authorities and official guidance was inconsistently applied. The 'light touch' approach promised, was often ignored. Financial difficulties were evident in all aspects of CrossReach's work and cash-flow difficulties were experienced.

There was a rise in insurance premiums and major difficulties in renewing cover, which eventually led to the withdrawal of cover for COVID-19 harms. This was due to the police investigations into COVID-19 deaths, and the level of loss of society awards seen in Scotland, as against lower, fixed bereavement awards in England & Wales. This effectively forced CrossReach into 'self-insurance' in this respect. The sector called for the same indemnity as was offered to the NHS in these circumstances, but this was denied.

Public sector day centres closed without considering alternative ways of providing support. This affected CrossReach services. As these day centres closed, people supported by CrossReach for part of their care and support packages had to be entirely supported by CrossReach staff 24/7. CrossReach had to increase staffing hours as a result. Often this was only possible with agency staff. This was eventually recoverable from COVID funding but it took resources to evidence the extra costs and there was a significant delay in costs being reimbursed under the sustainability payments, which led to cash flow pressures.

Reference has already been made to financial pressures caused by large uplifts in the cost of PPE.

Sixth, there was a considerable impact flowing from **the transfer of residents to or from homes, and restrictions on visiting.** There was, at times, a breakdown in the necessary movement of people from the community, to care to clinical settings. When people were transferring from the community to care homes there was a lack of clarity on responsibility for testing prior to admission.

Those who would ordinarily have required hospital treatment were 'stuck' in care homes. At one stage there was a resistance to provide health care to these individuals, even in acute situations. Key healthcare supports, particularly GPs and CPNs, suddenly became very difficult to access, even on a remote basis. A greater challenge was advocating for reviews of prescribed medication.

One further area of difficulty in care homes was the complete cessation of visits. Managers were besieged by complaints from relatives and having to manage some very emotional

conversations. There was no discretion given to managers in the early stages of the pandemic in terms of being able to balance the risks to health and wellbeing caused by the potential of catching Covid-19 against that of being isolated from family and friends. Managers could see significant deterioration in some residents, particularly with dementia, which might have been ameliorated should the guidance have taken this into consideration. CrossReach supported essential visits to the dying, wherever possible, throughout the pandemic, but the tardiness of the guidance in care home settings in terms of allowing social interaction compared to that in the community did become a significant point of tension and could be seen to directly disadvantage a significant proportion of the population.

The pre-Christmas 2020 last-minute reversal of a decision to allow care home festive visiting was hugely disappointing and distressing for residents and their relatives given that much thought had been given to how to manage visits safely over this period. Pressures on staff were significant, with relatives resistant to the new situation seeing the care home as the barrier to allowing them to visit their loved ones.

Finally, **there was a huge impact on staff within the sector.** In whatever area of support they worked they were required to turn customary practice on its head and deliver care, often of the most personal and intimate kind, in a situation where they themselves were at risk.

Only those in the most vulnerable category were furloughed. The majority of the workforce at CrossReach turned themselves inside out to provide care and support in new ways to supported people. Even where face to face services had to close, staff were keen to find ways of keeping people connected and making sure that their needs were being met. This was particularly important in the mental health and addictions services where the risks associated with services being withdrawn could have catastrophic consequences for those relying on them.

The school at Erskine Waterfront Campus remained open for most of its children, who would all qualify as vulnerable by nature of their placement at the school. Where there was capacity the school kitchen became a food distribution centre, delivering food parcels and educational materials to vulnerable families known to them or referred by others.

Prisons also stopped visits with no regard to families who were often sick with worry about their loved ones. The Prison Visitors Centres became a bridge between the prison and families providing support and information as appropriate.

Care homes were effectively requisitioned by the Scottish Government, but without the Scottish Government taking any responsibility, at the time, for the consequences of the guidance being applied. The Cabinet Secretary communicated that it was not advised that residents in long-term care facilities be admitted to hospital. This was backed up by some local GP services stating that they would not admit people from care homes with Covid-19 to hospitals. The expectation was that they would stay and be treated in the care home. This put pressure on care homes without the resources, protection or status of the NHS; and there was a feeling of abandonment. This principle was adopted without understanding that care home provision is very distinct from nursing care or cottage hospital settings, with neither the clinical skills nor equipment to administer the treatment that may have been necessary to treat patients with Covid.

Deaths in social care services were referred to the Crown Office, and are being investigated by the police. Some managers continue to have the prospect of potential prosecution hanging over them. This was not replicated in the NHS where the majority of Covid deaths actually occurred and where all of the infrastructure to support the critically ill was in place. This was particularly difficult, given the pressures on care homes, because the infrastructure to deal with the pandemic simply was not there, and the guidance at the time was that older people in care homes who were suspected to have Covid should not be hospitalised, despite the fact that some people who were untested were being moved from hospitals to care homes and thus increasing the risk there. The NHS was given priority and protection, leaving care services to fend for themselves in these initial days of the pandemic, and we still face the consequences today.

Additionally, there was inadequate protection from the virus when following Health Protection Scotland guidance up until the Chief Nursing Officer guidance of July 2020. Thereafter delays in the testing infrastructure created vulnerability and risk.

In the beginning care staff were applauded along with NHS workers and valued as key workers, however at some point, when the care home deaths toll began to be reported there was a public perception that NHS staff should continue to be applauded, but that care home staff were doing something wrong and could not keep people safe. This was a perception exacerbated by media reporting on care home deaths. This has had a significant long-term impact on managers in CrossReach which continues today. Managers worked incredibly hard. They feel blamed and shamed for COVID deaths in their homes. They made a Herculean effort to continue these key services, to do so in compliance with the guidance and to keep all those in their care safe. A great deal of damage has been done to the perception of care as a career choice.

During the course of the pandemic staff wellbeing was included as a significant risk on CrossReach's risk register and resources were ploughed in to support staff to stay resilient and to access support for themselves while they supported others. It has only recently been downgraded as a risk, but senior management believe that the wellbeing of the workforce remains fragile and continue to monitor this.

We believe that the strain of the pandemic on staff coupled with the negative perceptions of social care in some settings due to its treatment by Government and regulators has exacerbated the recruitment and retention issues now prevalent across the sector, and we welcome the opportunity provided by this Inquiry to learn lessons from the strategic response to the pandemic in Scotland and to make recommendations for the future.