Scottish Covid-19 Inquiry

Day 29

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(9.30 am)

THE CHAIR: Good morning, Mr Gale. Good morning, Mr Macaskill.

MR GALE: Good morning, my Lord.

THE CHAIR: When you're ready, Mr Gale.

MR GALE: Thank you, my Lord. We have two witnesses today. Both are representatives of the organisation Scottish Care Limited. The first is Dr Donald Macaskill. I will be leading Dr Macaskill. The second is Ms Hedge and my colleague Mr Dunlop will be leading her.

THE CHAIR: Thank you.

MR GALE: The reference of Dr Macaskill's statement is SCI WT0189 000001.

DR DONALD MACASKILL (called)

Questions by MR GALE

MR GALE: Dr Macaskill, your full name, please?

A. Donald Macaskill.

Q. Your details are known to the Inquiry, your contact details, and you provided the Inquiry with a detailed statement. You've also provided the Inquiry with other documents which the Inquiry has regard to and, as I understand it, you are happy that the statement that you've provided, together with the evidence that you

give today, will constitute at this stage your evidence to the Inquiry in relation to impacts in the health and social care sector, and you're particularly interested, obviously, in the social care sector.

A. Yeah.

Q. For the avoidance of doubt, you have already given evidence to the UK Inquiry, when it sat in Edinburgh on 18 January of this year, and the relevant transcript is, for that date, from pages 106 to 172. Just for completion, my Lord and Dr Macaskill, obviously we have an agreement with the UKI to share information and not to duplicate matters, so we have regard to what you said both in your statement to the UKI and your oral evidence to the UKI, so we will have regard to all of that.

Against that background, can I ask you a little bit about your personal background? You are the chief executive of Scottish Care?

A. I am.

Q. How long have you been in that position?

A. Seven years.

Q. Yes. In regard to your evidence in this section of the Inquiry, you are dealing specifically with the care home sector, if I can put it that way?

A. I shall.

Q. Yes, and your colleague, Ms Hedge, will be dealing with

care in the community, if I can put it again in that way?

A. She will.

Q. Now, could you just tell us a little bit about Scottish Care, what it is, what it does, who it represents?

A. Scottish Care is the national representative body for social care providers, mainly for older people and adults, and our membership constitutes the majority of care home providers in the term that we use is "the independent sector". That means the charitable, not for profit, employee owned and private sector; in other words, all care homes who are not run by the state. And it also, in our membership, includes the majority of providers of care at home, housing support for individuals living in their own home, again, not provided by local authorities or the state.

So as an organisation we have existed over a number of years to engage in policy and seeking to influence. Our basis is that we are concerned with the improvement of the quality and the delivery of care and that the social care sector is better understood and valued within wider Scottish society. We do that through various mechanisms, such as policy, influence, contributing to Scottish Government and local authority

and other partnerships' development.

Q. Something I think you will come on to later, but you mention the care sector being properly regarded in Scottish society. I can ask this at this stage and I will ask you to develop it later: has the pandemic had a negative effect on the way in which the care sector has been regarded?

A. Before the pandemic, the social care sector in Scotland was not sufficiently understood or regarded and the pandemic has only served to worsen and deepen that ignorance, lack of priority and understanding of the value of social care in Scotland.

Q. From your perspective, as the head of Scottish Care, what steps are you presently and have you been taking to counteract that negative impression?

A. I think virtually every time I open my mouth, certainly publicly, it is to underline the value that should be given to the women and men who work in social care and, even more importantly, the women and men who receive social care support, regardless of their age, status or any designation of any condition. So I think I and all my colleagues are about enhancing the understanding of social care as an intrinsic part of Scottish society. The language that is often used about social care is about how much it costs us, how much it's a drain on

society and, as an organisation and as a membership body, we are about emphasising how intrinsic to the nature of Scotland as a community the delivery of social care is and how we need to value the women and men who work in the sector and how we importantly need to better value the women and men who use social care support. So it's a constant battle and it's probably sadly one which was made worse by the pandemic.

Q. Yes. Can I put it bluntly? Is there and has there been, in your view, an unfair criticism and an unfair comparison of the Scottish Care sector as compared to the NHS?

A. I think there's always been a lack of understanding about the intimate relationship that exists between health and social care provision. Historically it's always been easier to understand the NHS as an entity in itself. It's always been a challenge to convince and this includes clinicians and advisers who should know better about the value of social care.

The way in which I often communicate it is that, if I break my leg and I end up in A&E and am admitted into a hospital, then the nature of the support I get is going to be very, very different to what I need should I then have, as a result of that incident, to spend the rest of my life receiving care and support in the

community or in a residential setting. We're not talking about the same entities or institutions or organisations or skills but we are talking about a deeply connected set of relationships between the NHS and social care.

And I think all of us, whether working with children, those living with the addiction or mental health issues or, in my context, adults and older people, bemoan the lack of understanding in the general public and perhaps more concerningly amongst our political leadership of all parties about the nature of social care. We are not the NHS, we're not better or worse than the NHS, but we are essential to the fabric of health and well being in Scotland.

Q. And something we'll come to, Dr Macaskill. But you mention there that this perhaps lack of understanding is something that permeates through to political figures. In the course of the pandemic, did you encounter difficulties in your dealings and we'll come to discuss your dealings with various ministers and officials in due course but did you encounter instances where there was not a proper appreciation on the part of politicians as to the significance of and the difference from the NHS?

A. I think, with very few exceptions, the understanding of

social care amongst parliamentarians, whether at Westminster or in Holyrood, is not where it needs to be. When one considers not only the contribution of social care to our national economy, this is a sector that contributes the fourth largest economic contribution of any sector in the country, but much more importantly, given the fact that thousands tens of thousands of individuals today are using social care supports, which massively dwarfs the 17,000, for instance, who are in a hospital today, that lack of understanding of the reality of social care delivery is very concerning.

What I found is that there were some who were open to learning, to listening and to understanding about the nature of social care, and we might want to talk about some of those, but there were others who swallowed assumptions, followed stereotypes and, to be truthful, were not that interested in a perspective that didn't have the NHS badge attached to it.

Q. Right. We'll come to some specifics in due course. A little about your own personal background. You have a doctorate. Can you tell us what that doctorate is in, please?

A. So it's a multi disciplinary doctorate in sociology, theology and in psychology. I explored and examined the nature of occupational burnout and the degree to which

vocational roles impacted on your sense of identity and what happened if those were diminished and burnout resulted. And, sadly, it was an academic study which became much more resonant in my professional life, not least during the pandemic and since.

Q. Right. You also have, if I can put it in generality, a human rights background and interest. Again, can you tell us about that, please?

A. Yeah, when I was primarily working in academia, I was very much involved in the whole field of equality, diversity, inclusion and human rights, and when I left that world, I established a human rights and equality consultancy and led that for about 13 years, working with public bodies predominantly across the United Kingdom and internationally, and latterly focused predominantly on the human rights of older people and what that meant in practice. And I was privileged to work with bodies such as the Scottish Human Rights Commission in developing practice around the human rights of older adults in different settings, including in the care setting.

Q. Again, if I can put it bluntly, is it the case that very frequently the human rights of the elderly are ignored?

A. I think it is almost to be taken for granted that the community and a group of people who we describe as

"older" are least protected in terms of our human rights frameworks. There has been and I've been part of it a growing clamour for the United Nations to develop a convention on the rights of older people and there has been a growing desire for communities and nations to develop commissioners for older people.

I was privileged during the pandemic to work closely with the Older People's Commissioner for Northern Ireland and for Wales. Scotland does not have that role and neither has England. I think the valuing of older people and their distinctive human rights is one which, whilst in rhetoric we talk a lot about in Scotland, in practice and the pandemic certainly for me personally underpinned the reality in practice we pay lip service to the rights of older people.

Q. Right, thank you. Again, something we'll develop in a little. I think you then go back to the nature of Scottish Care. You set this out at paragraph 7 and following of your statement, and I think we can see that Scottish Care has 350 members which cover, as you put it, approximately 900 services. It seems in terms of services, it seems an awful lot. Can you explain how that number was arrived at?

A. So one of our members may, for instance, have 60 care homes or 50 care homes or 30 care homes and, obviously,

that's a distinct service per number, and so that's the differential between the number of members and the number of services delivered. I would have to say that the 85% or 86% it changes of all care home delivery in Scotland is undertaken by the independent, charitable, private, not for profit sector, and the vast majority of those are members of Scottish Care. So our membership does constitute one of the largest social care representative bodies in Europe.

Q. You give an indication in paragraph 10 of the nature of the various varying types and sizes of the organisations and, obviously, that ranges from a single individual care home and I think you've emphasised on a number of occasions, certainly in conversation with me, that a lot of these are family provided. They're family run, family operated.

A. Yes, and when I first got involved in the sector, I supposed I had the image that many others have, which is that care homes are run by large groups and multiple organisations within a group. Now, that is true to some extent, but in Scotland we're very different or have been historically different compared to the rest of the United Kingdom in that the vast majority, historically, of care homes are run by individuals or by families and constitute either single care homes or units of no more

than two or three care homes in a group. And that's always added a particular colour to the Scottish context, but it's also added a particular challenge and, sadly, both before and since the pandemic we are seeing more of those family run organisations not being able to meet the challenges of sustainability.

There were huge pressures, particularly for these small care homes, in dealing with a pandemic, not least in the fiscal challenge of getting hold of PPE, which is much easier if you're a group of 50 or 60 care homes than if you're a care home a single care home in a remote part of Scotland. So the nature of social care provision in Scotland is changing and, sadly, from my perspective, we are losing some of the colour and the locality of businesses and organisations which were set up by families. And in the same way, we are losing at a really disturbing rate our charitable care homes, which, when I started this role, constituted around about 19% to 20% of our membership and now are closer to 10.

Q. 10%, right. Again, a point that you will come to later in your statement, in your evidence, I think one of the difficulties that care homes experienced during and as the pandemic progressed was the obtaining of necessary insurance. I take it that would be more difficult for

the smaller

A. Yeah.

Q. independent care homes than the larger more corporate care homes?

A. Yeah. Of necessity, if you are a larger corporate group, you have an ability to negotiate and to identify insurance cover which is much larger than a smaller provider. And I can remember one instance in the middle of the summer of 2020, this single care home operator in the north of Scotland, who was absolutely at wits' end on a Friday her insurance cover, despite months of activity, was due to finish at 5.30 that evening and she ended up, literally because of a lack of choice ended up paying approximately four times the amount of money that she had previously paid for insurance, and that nearly put her out of business, in her own words, though she is still in business. It was virtually the straw that nearly broke the camel's back. So it's extremely and was and to be frank, still is a considerable challenge for smaller providers to identify insurance who are prepared to insure single entities.

Q. Right, thank you. One point I'm sorry, I'm slightly going back one point I forgot to ask you about. You have a particular interest in the care of those with

dementia.
A. Yeah.
Q. And I think you were you chaired the Scottish Government's Care Home and Dementia Group and also the Dementia Advisory Group. Can you tell me how your interest in that particular area developed and what your role was in those various groups?
A. I suspect, like many people in this room, my interest in dementia is a very personal one in that my own mother had dementia and died from and with dementia. My grandmother had dementia and my great grandmother had what we would now define as dementia. From an early age, my understanding of older age was very much connected to neurological decline and disease, and that did deeply influence, probably with retrospect, much more of my professional life than I then understood.
I considered it a privilege to chair the Scottish Government's dementia working group in care homes, and I did that I think for six years before I resigned from the post in the middle of the pandemic. And the purpose of that role was to learn the lessons of what good dementia care needed to look like within the care sector because supporting an individual, particularly with advanced dementia and the majority of individuals in a care home are living with a degree

of neurological decline to support that individual is I think the essence of good care and support and it requires the skill, aptitude, compassion and ability of a very dedicated staff.
I said earlier this week in a talk that working with somebody [sic] like dementia was necessitates you in relearning a language; learning how to communicate, for instance; learning to be sensitive to what can sometimes be the very challenging changes in behaviour and in manner of somebody living with dementia. I am always and remain in amazing admiration for the women and men who support others living with dementia, and doing a small part by chairing a group, by improving practice, was the least I could do and it's something that remains very important to me.
Q. In the context of and we will, as an Inquiry, be looking at preparations for the pandemic as a specific subject but with your background and particularly your background on these groups that you've mentioned, presumably one would assume that, in preparing for a pandemic of the sort that we encountered with COVID, one would need to be aware of the impact on certainly the most vulnerable in society, and including within that category one would have regard to those with dementia. Just from your perspective, did you feel that

there was planning put in place to cope with a pandemic directed towards those with dementia?
A. My statement makes this quite clear, that I was astonished and now am appalled about the fact that preparation for a pandemic did not include social care and, by "social care", I don't mean policymakers who knew about social care or think they know about social care, I don't mean those who necessarily commission and contract social care delivery, I mean those who are actually doing the job. And that's not people like me but those at the front line with the knowledge and awareness of what it means to manage a pandemic, not least with individuals who might be most vulnerable and not least with people living with dementia.
There was a complete and utter lack of inclusion of social care providers and voice in the planning of the pandemic, and sadly what I find all the more inexcusable and astonishing is that the current Scottish Government's pandemic preparatory body, looking to the future, still does not include any representatives from the agencies that I've just described. So we are walking into the potential of a future pandemic having completely failed to learn the lesson that, unless you have those at the table who know instinctively and at first hand what it means to manage

a pandemic response in different settings, then you are destined to make the same errors again.
Q. Yes. Now, I listened carefully to your evidence to the UKI, I listened to the evidence of other witnesses to the UKI, and I think one of the points that was made by you and by others was that, at the table when the pandemic began, the early months of 2020 there was nobody at that table who could represent the care sector. Whether it be care homes or whether it be care in the community, there was nobody approximating to the role of the Chief Medical Officer or the Chief Nursing Officer. There was nobody who could be, as it were, the Chief Officer for Social Care. Is that something that you see as a serious deficit in the way in which this was carried out?
A. Yeah, I think it's fair and I was on record before the pandemic as saying the lack of a social care voice at the heart of Government was a misstep. I think now it is a dangerous failure not to have a social care voice. We have a professional advisor in terms of the Chief Social Work Advisor, but we're not talking about the same disciplines or professions or entities. I think the fact that we had a chief medical officer, a national clinical director, but that we did not have in Government somebody with knowledge of the social care

sector was a real failure and it meant, I think throughout the pandemic, a clinicalisation or medicalisation of decisions and behaviours which failed to understand the particularity of the care sector becauseyou do not know what you do not know and, sadly, the social care sector has had experienceof presumption, which is the presumptive knowledge of those who come from an overt clinical background that they really understand social care. But, as I said at the beginning, social care is not clinical care. It's complementary to but distinct from.

Q. Yes, thank you. We're obviously looking, at this stage in the Inquiry's investigations, at impacts, and it may be perhaps a slightly unfair question to ask you, but I'm going to anyway. Do you feel that the absenceof that level of preparednesshad an impact on the cohort of people within the social care sector, both staff and residents and patients?

A. It had a profound impact and, on staff, for them, it made it feel as if, "Nobody understands us, nobody is listening to us, nobody is recognising us", and I think for those who were receiving social care supports, whether in the community or in care homes I think somebodyput it well to me, "If you've never been in a care home, if you've never lived and worked amongst

people with dementia, then you could possibly have developedthe sort of guidance and the sort of systems which we had to experienceduring the pandemic. But if you had, you would at least have had the humility to recognise that you do not know everything and that you neededto ask, consult, engage and involve".

And I'm not saying this and I've thought very carefully about what I'm about to say I'm absolutely convinced that the lack of engagement and involvement in planning at an early stage of the social care sector in anything other than presence becauseit's different simply being in the room; it's very different having those who are making decisionslisten to you, respect you, trust you and act upon that that lack did and sadly cost many people their lives, both staff and those who were residents in care homes and citizens in our community.

Q. Thank you. Can I go on to ask you a little bit about your engagement with key stakeholders? Now, clearly you are here as the chief executive of Scottish Care and you have, of necessity, the interests of your organisation and your members at the heart of what you say. Can I ask you and again if I may be blunt has that in any way disguisedin your mind some of the deficiencies that there may exist and the criticisms that there may

be about the care home sector?

A. I don't think it's disguised in any sense. I have always been very honest with my colleaguesand my members in saying that the social care sector, whether care home or home care, exists for the primary purpose of supporting and caring for those who require care and support and can only achieve that by the valuing and the affirmation of those who work in the sector, and those too have always been for me dominant. I took this job and I said at my interviewing panel that it is very much my intention that Scottish Care and the work that it did should be a human rights based organisation. Now, that's not always been possible to achieve and we're still a distance from achieving the destination that I would want the organisation to achieve, but I can assure you and this did not always and has not always made me popular for me the human rights of those who receive support, who deliver support, are paramount in the work that we do as an organisation.

Q. Well, you won't be surprised to know, I think, Dr Macaskill, that this Inquiry has a similar human rights based approach which we have expressedin documents which are available online, so we are aware of that sort of approach that is necessary. In terms, how do you utilise the human rights based approach in the

way in which you run Scottish Care?

A. On a very basic level, when I came in, we sought funding and were successfulin establishing a distinctive human rights project, which was working with care homes and community organisations to embed human rights practice in their delivery. I note in my statement that I was part of the group that developedthe Care about Rights project, with the Scottish Human Rights Commission and other partners, so we were very robust in encouraging our members to think about what human rights really meant. I would have to say there is a multiplicity of commentary around what does human rights mean in the care setting, and I don't think you'll find many politician, policymaker or pundit, who would not be comfortable talking about human rights.

But the reality of what it means in practice is challenging. So in an environment where somebody living with dementia wants to take a particular action which may place them at a point of unsafety and the staff member wants to, to a degree, prevent that person from taking that action, where does human rights interplay in that regard? So what we've been trying to do was to give staff and managers and owners the confidence of thinking, "How do you look at a situation through a human rights lens?". And there are elements of that

examination which alter your practice, which enable a different understanding of risk, which encourage you to include a diversity of those who contribute to a decision and, ultimately, which alters your practice.

So I think and we're still not there and we've some distance to go. I have very little interest in the rhetoric about human rights. I think our pandemic response is an example of a human rights failure and at the same time I know that we have had loads of commentary about how we are working in a human rights basis.

Before the pandemic I spoke at the Irish Human Rights Commission about the difference between rhetoric and reality and the degree to which so many of us in a broader human rights community were becoming despondent about the way in which human rights language just falls off the tongue but, when push comes to shove, we don't implement human rights processes and practices. And sadly and we may go on to talk about this I think the pandemic and the Government's response to the pandemic and to an extent the sector's response to the pandemic underlined the difference between the rhetoric and the reality of human rights.

Q. As an organisation, how do you or did you or do you get across the human rights approach and basis to your

members, because I suppose it's a question of getting it across to the care home providers but also assuming or making provision whereby that also gets across to the individual carers.

A. Yeah.

Q. So how does the organisation go about doing that?

A. I think probably the way in which I try to go about doing it and with respect to you, Mr Gale, and other distinguished members of the legal profession in this room, for me, human rights and in the care setting human rights is not about legality. It's not about knowing which article might be engaged in a particular context, though that is important. It is about, for me, primarily relationship. And I ask and say to people, "What do human rights mean to me? They mean how do I relate to you; how do I relate to the person who might not be able to communicate verbally, might not understand because of capacity issues what's happening to them; how do I relate to a circumstance where the answer is not always black and white but is a very challenging answer where we have to arrive at together". So, for me, human rights is ultimately about the treating of one another with and in the manner in which dignity is upheld and that, for me, is what social care should all be about and, sadly, often human rights are

left at the door in the delivery and in the commissioning and the politicising of care.

Q. Thank you very much. Now, can I ask you a little about guidance?

A. Yeah.

Q. And I should say, Dr Macaskill, that in the time that we have available today, I will not be touching on all aspects of your statement. Some of them I'm going to just simply take as read, but there are certain matters that I would like to explore with you in a little more detail. I'd like to discuss the question of guidance because I think it does cut across many other matters that you touch upon, so visiting, PPE and others.

You, as an organisation, I think put out very early in the pandemic I think it's dated 24 February 2020 guidance to your members, and I think that was based on Public Health England advice, wasn't it? What was the nature of that guidance? What were you attempting to do at that very early stage?

A. It was essentially an information or briefing paper. It didn't have the connotation of guidance, which later we might want to talk about the understanding of guidance as being, simply because we had members asking us, "Can you give us some help?", because at that time, by the time we published that document, there was no official

guidance from, at that stage, Health Protection Scotland. The only guidance which existed was guidance explicitly dealing with COVID which had been developed by Public Health England and, in its early stages, it talked about the importance of developing a resilience plan, it talked about the importance of undertaking a PPE audit, of understanding the nature of PPE that was necessary, it talked about what you need to do to support families and individuals to understand what may be happening. This was in the context, you may remember, that travel was being highlighted as a particular issue and, at that time, Public Health England had instigated a concern about people coming from particular countries.

So it was very much a collation of material that was available to try to support our members, who, from probably the end of January/beginning of February, were beginning to ask us, "What do you think this is going to mean for us?", and, like everybody else, we were aware of what we were seeing on our television screens from Italy, Spain, France, and I, because of being a director of the Global Ageing Network, tied into colleagues in different parts of the world, was hearing from them the early steps and measures that they were taking in aged care facilities.

So we wanted, in the absence of anything, to say something, and indeed I do believe it was used by other organisations as an early tool until more formal guidance came out from Scottish Government on 12 and 13 March.

Q. Thank you. You do mention it's at paragraph 58 of your statement. You don't need to look at it but you do mention that guidance, as one progressed to guidance, was issued by a number of organisations, ranging from the Scottish Government, Public Health Scotland, COSLA and the Care Inspectorate. Now, in your experience, did the fact that guidance came from a variety of sources cause any difficulties ?

A. Yes, very much so.

Q. And what were they?

A. There was a difficulty of uncertainty over status, for instance, of what status the guidance had because of who was issuing it . There was an uncertainty particularly in instances where there might be conflicting guidance or statements which could be read in different ways. So the you know, at one stage somebody said to me, "If our pandemic response was based solely on the amount of guidance and the changes to guidance and the amount of paper and trees that were produced were wasted, then our pandemic response would have been exemplary". But

actually the multiplicity of guidance, sometimes four changes to guidance in a week, added real confusion because, in the end of the day, the women and men at the front line, their primary focus was keeping people alive, and sometimes, I think with the benefit of distance, we've lost a sense of the fear, the anxiety and, in some parts, the terror . And I had people on the phone not sure that they could go into work because they were paralysed by the uncertainty and the fear of working in an environment, particularly in care homes, which they did not understand, because nobody knew about this pandemic other than what we saw on the television screens, and they tended to be scenes of ICU, with staff dressed from head to foot in protection, and that's not what was happening in the social care sector.

So in that context guidance added an extra burden rather than what it should have done, which was to give assurance, certainty and support. And, for me, the word "guidance" has a counselling element to it, in which you guide somebody to make them more confident and assured in their practice, whereas, unfortunately, the way in which guidance became understood was more restrictive and limiting rather than something enabling.

THE CHAIR: You say "more restrictive". In what way more restrictive ?

A. I think one of the challenges, your Lordship, is that the status of the guidance was unknown. So care providers have been used to dealing with statutory guidance in which it's very clear, "You do that and, if you don't do that, then trouble might ensue", but they've also been used to dealing with guidance which doesn't have that statutory association or connotation and for that there has always been a flexibility in its interpretation and in its application . I think that's important because at times I heard from some of our members saying, you know, if they would just mandate this and say, "Right, you have to do this", that would make matters much easier because we could then say to people, "Listen, we have no alternative". But that actually I think might have been a very real weakness and challenge because, if guidance is properly understood, it should have a flexibility in it to allow for local interpretation and adoption because no, for instance, care home is exactly the same. The environment is different , the people who are being supported are different , the needs and the acuity of individuals are different .

So if guidance is and it had been before the pandemic written in a way which is guiding, permissive, but affirmatory at the same time, then

people can work with that. I think the challenge of the pandemic was that the more guidance began to be used as a tool against which to scrutinise, inspect and hold to account, that flexibility in interpretation at local level, to be sensitive to local needs, went out the window, and it was exacerbated by actions elsewhere which gave to guidance a role and a status which I think was unhelpful and which meant that those who deliberately went against the guidance were a minority and did so with a very real sense of fear about consequence.

THE CHAIR: I happen to agree with virtually everything you just said and indeed have been critical in the judicial capacity of guidance. But looking at it this is something the Inquiry has to do from the perspective of those making decisions which are capable of being enforceable, ie a government, what then and I'm asking you the question are they to do in a very difficult situation such as a pandemic? I agree with you, the only way they can make something mandatory is to make it either a statute or a regulation with no doubt penalties for failure to comply. On the other hand, as you quite eloquently explain, guidance can be itself helpful, informative and of considerable utility . But how does Government make that decision and, more

importantly, how do they give an indication of how guidance should be interpreted? I think you've hinted at the answer by suggesting and presumably they'd have to build this into any guidance they issued some further guidance as to how it should be interpreted and applied, for example, perhaps allowing for regional differences. But do you first of all accept it's rather a difficult position for Government and how do you think they should approach it in the future?

A. So I absolutely accept that it's a difficult position, particularly in emergency circumstances, but I think there are both lessons that we can learn now, but, even more importantly, knowledge that we had before about what makes guidance easier to apply. The first element of that is the formation and the development of that guidance, who is involved and engaged, which gives that guidance an authenticity and a sense that there is verifiable truthfulness around the guidance. And if I can use so we're talking about different guidance, I suppose, in the Inquiry. If I can use guidance which relates to infection prevention and control as an example, I think one of the reasons that the sector really struggled with the application of infection prevention control measures in guidance was that that was developed by individuals who were completely

ignorant and I'm not using that word lightly who were ignorant and insensitive to the different contexts in which that guidance was ultimately going to be used.

The guidance produced was exemplary and often international standard for an acute hospital secondary care setting, but the application of similar principles and approaches to infection prevention and control within a care setting, which is singularly different because you're dealing with people who are living in congregated environments, who and you're dealing with an environment which is not the same as the rather sterile, cold existence, with respect to my colleagues, in acute and secondary hospital settings, and when you're working with people who have fluctuating capacity and live with conditions such as dementia, that's a very different context.

So had the guidance had an authorship and a sense of veracity about it which spoke the story of that environment, then its adoption and application would have been much easier. So I think that's the first ask, whenever you're developing guidance, is: make sure you know what you're talking about, you have people who understand the context of its application and you're sufficiently responsive after its application to any changes that need to be made to make it more

appropriate.

We were, all of us, to some extent with COVID, learning as we went. I think some and I would equate here the social care sector was more open to listening to others than some, not least those who developed infection prevention and control guidance, were open to listening to the insights of the sector. So I think guidance succeeds if there is proper ownership, a sense of application and a real sense of being able to adjust to meet changing needs. All of those did not get achieved in terms of those IPC guidance.

THE CHAIR: Now, again I understand that, but formulating guidance in the way you have just described it is something which I would imagine is going to be taking time and would be very difficult to do in the very short periods of time that the Government was facing in March of 2020. Do I take it, then, that you would favour an approach that guidance, which incidentally would have to cover all sorts of settings, as you already indicated, but also all sorts of different viruses that might create pandemics that sort of guidance should be developed in a plan in advance of any future pandemic

A. Yeah.

THE CHAIR: and indeed modified on a regular basis?

A. Yeah, certainly. And I think one of the intrinsic elements of planning for any event is that you've already built an understanding of the context, which was singularly missing because of the lack of inclusion, and that you've already started to form trust based relationships, because you're right that it guidance will only work if there's a sense of trust that the people who developed the guidance knew what they were about. I think the singular lack of involvement in the planning for the pandemic of the social care sector made when the guidance first came out, especially the first elements of the guidance, it gave a sense of despair.

We held a surgery two or three days after the first set of guidance came out, at which I think there were 240 of our members present, and the sense of despondency was absolutely you know, you could cut it with a knife because people said, "Do they know what they're talking about?". So guidance which said to isolate individuals in their own room, how do you do that when you've got people living with dementia to fail to understand that communal, collective, shared environment was intrinsic to the way in which people managed their dementia, for whom contact and relationship and physical touch was really important in terms of assurance and neurological confidence.

Now, had people who knew what it was like in a care home been involved, and not just involved but listened to, at an early stage in March, then it would have been very different. Now, as things got on, it improved. However, I would have to say that I still today have fundamental concerns that ARHAI and our professional infection prevention control experts are still insensitive to a context which is not an acute secondary hospital context, and I don't think we've learned those lessons

So, yes, you are absolutely, I think, right, your Lordship, in saying that there needed to be urgent guidance delivered, but into the future we need to be more responsive to what we already know and we could have been more responsive in March and into April to what the sector and other stakeholders were saying to quote the experts, who and I used the phrase in April that we were witnessing an "IPC fundamentalism", and I used that deliberately because it presumed that the science was certain and set in stone, whereas, as we've all become aware of, the science for COVID, as much as the science for IPC, is not certain. There is a diversity of approach and, importantly, should we consider human rights, sometimes the desired outcome of an IPC guidance may be at odds with the human rights and

the individual rights of individuals in a setting to make decisions and to exercise risk which may contravene IPC but may be most appropriate for that individual or person.

THE CHAIR: Thank you. I'm sorry, Mr Gale

MR GALE: Not at all, my Lord.

THE CHAIR: I've taken you out of order, and jumped ahead, but it was interesting.

MR GALE: Indeed.

Really just to take I suppose that point a little further, we've heard in this Inquiry of various care homes operating within the same within the structure of the same guidance but taking different approaches, some and I'm talking really about visiting talking about certain care homes having a more liberal approach to visiting; others simply saying that the guidance is such that there is no visiting, there must be no visiting. Was that a problem for Scottish Care when you had different care home operators, possibly within the same geographic area, operating different policies on visiting?

A. It was, and, you know, I had conversations with the founders of Care Home Relatives Scotland, some of whom would email me and say "Care home X is allowing visiting but care home Y is not. Can you intervene?". We tried

in our seminars with members I was involved in the group that developed the first stage guidance and I think my statement makes clear my despair that it took so long after myself and others had developed that initial guidance for clinicians at Government level to actually act upon what we asked. It took over five weeks from what we considered to be the completion of guidance to a decision to be taken about its potential implementation and then a distance of time before it was implemented.

So we were very aware that there was a diversity of approaches to guidance around visiting. I think both myself and Ms Hedge and our management a senior manager around membership did all that we could to try to influence organisations to be as flexible and as liberal, to use your phrase. But I do remember phoning one operator and saying, you know, "What can you do to be more liberal in interpreting the guidance?", and being told, "You're not going to be held culpable or responsible. If I do this ..." not least this was after Operation Koper started "If I do this, will you stand in front of a judge and take culpability for the fact that ten people might die?", and in a very direct way saying, "Will you speak to my insurance provider and say that you have invalidated the protection of other

people?". And equally the person said, "Will you tell the relatives who have told me that they will come", quote, "and absolutely get me if I let somebody into the care home?".

So I think we forget that at the time we were, all of us, wanting to change and to open up care homes, but there were strong voices who were arguing, "Open up immediately", and there were other strong voices saying, "We can't and don't you dare". As an organisation, I hope Scottish Care tried to positively encourage a more liberal approach but at the same time I'm not going to be held responsible or culpable for particular acts, and, Mr Gale, you might go on to talk about Operation Koper. Operation Koper was a deadening of flexibility and, from my experience, was the singular event which caused harm during the summer months to the care home sector.

Q. Well, we will go on to Operation Koper in a moment.

We've heard very eloquently from Care Home Relatives Scotland their argument for a more liberal I'll just use that word liberal approach to access to relatives in care homes and we've heard, obviously, about the campaign in favour of Anne's Law, and I'll ask you about Anne's Law in a little, but I think interestingly you have indicated that there was a contrary view being

expressed to both members of your organisation and through those members to you. Was that coming also from people who had relatives in care homes?

A. Yeah, I think things changed over time. So at the beginning of the pandemic and when care homes went into lockdown, I personally believed that lockdown was an entirely proportionate and reasonable action to take in order to preserve life, given the knowledge that we had about a virus which we knew little about at the time. And I think, to be fair, the overwhelming majority of family members understood that action, primarily because they had been used to lockdowns before because of norovirus, but they had only lasted, those lockdowns, two or at a maximum three weeks, so there was always an end in sight.

In April people like me began to question the appropriateness of lockdown which we could see no end in sight to and certainly into the early months of the summer we were seeing that this is causing more harm to individuals, both families and to individual residents, and our members were saying people were deteriorating, clinically deteriorating, because of the absence of family and normal activity. So I think in that context there was a desire to try to open up as quickly as possible but, over and against that, there was a very

real concern that there were risks in doing so. And I heard of a number of incidences where care homes had virtual meetings with residents and families' groups and where there were very strong views on both sides, saying, wholly understandably, "I really want and I need to see my husband/my wife/my partner/my daughter", but equally, on the other side, especially in the early stage, "Please don't open up. This is going to run rife through".

Now, I think, knowing what we know now, we absolutely should have opened up care homes significantly earlier and the process of that opening up should have been more local, it should have been more trust based and it should have been more respectful of the professionalism of the staff, who had been used to dealing with infectious diseases in the past. But there were singular distinctions. One was Operation Koper, the second was an inspection and scrutiny regime, not least by oversight teams, against which the managers and the staff of care homes were being held to account. So this wasn't norovirus. This was something which they followed in some instances the letter of the guidance very conservatively, but I know that was because of fear and anxiety. It wasn't because of a desire to keep people out. I really don't recognise that at that

stage.

Q. You speak very quickly, Dr Macaskill.

A. Apologies.

Q. It's not a criticism. It's just that we have to be mindful of the stenographers and we have to give them a break, so I'm going to ask for a break in a few moments. But I would like to just pick up one point that you made in that last answer, and that was "trust based". You said that the opening up of care homes to visiting had to, amongst other things, be trust based. The trust of whom? Who would you be trusting?

A. I think the trust of all engaged. The care sector felt as if it had been done to. The multiplicity of guidance, the fact this guidance was frequently changed on a Friday to be adopted as immediately as possible, the continual negativity of media and political leadership was all about holding the care home sector in particular in a light of negativity. And in such an environment, distrust and a lack of trust is seeded. So people become more conservative and more risk averse.

Had we been in a context where, instead of being instructed, there had been a more collaborative, consensual, collegiate approach to shaping guidance, to developing flexibility around visiting, to listening to

families and to staff at the front line, then, for instance, in relation to visiting, we would have opened up earlier. I have no doubt about that.

And, you know, I have heard as much from my members in March and April and May the words, "This is against the human rights of residents", as I did from any other commentator, but nobody else was hearing that statement from my members except ourselves. And so part of our role in developing guidance was to encourage those outside the sector, particularly clinical advisers and CMOs and IPC experts, to actually listen and trust the sector.

These are professional skilled nurses and staff at the front line. You would not have treated ICU consultants or specialists in the way in which we negated, ignored and marginalised the voice and contribution of our front line staff. If we'd trusted them to do the right thing, then this pandemic in our care home sector could have been dealt with extremely humanely rather than the way in which it was, which was not.

MR GALE: My Lord, perhaps we can take just a few minutes for the stenographers at this stage.

THE CHAIR: We'll take 15?

MR GALE: 15 would be fine, my Lord.

THE CHAIR: The clocks seem to be all over the place. Does anyone actually know what the time is? Let me check my computer. 10.38. So if we come back at about five to the hour, something like that.
MR GALE: Thank you.
THE CHAIR: Very good. Thank you very much indeed.
(10.38 am)
(A short break)
(11.01 am)
THE CHAIR: Yes, when you're ready, Mr Gale.
MR GALE: Thank you, my Lord.
Before we do recommence with the evidence, I think we are aware we have a time constraint today and we also have Ms Hedge to hear. What I propose to do is to continue with Dr Macaskill until 11.45 and then, at that point and hopefully it will be at an obvious break in a certain part of the evidence ask Dr Macaskill if he will come back and assist us at a further date. He's indicated generally that he would be willing to do that. I'm very grateful to him.
THE CHAIR: I'm very grateful to Dr Macaskill. That's sensible.
MR GALE: Dr Macaskill, I'd like to ask you about the content of paragraph 60 of your statement, where you make reference to a statement made by the then

Cabinet Secretary, Jeane Freeman, on 5 May 2020, which was following a number of outbreaks and I'm sure we all remember those outbreaks in care homes, where she was concerned that the guidance was not being followed by care homes. And what she said in her statement was that the guidance for care home providers was "really clear" and that the "private care home providers have not, in some instances, appeared to follow the guidance that we require them to follow". Can I have your comment on that, please?
A. The comment today would be the comment I made directly to Ms Freeman after she made the comment in Parliament, that I thought it was both inaccurate and unhelpful. The provision of care homes across the country is not just in the private sector. It includes the charitable, it includes the not for profit and it includes the public sector. And to that period of time, we had equal challenges with infectious outbreaks and, sadly, deaths in other elements of the sector, and I felt and said to her that this was an unhelpful politicisation of a reality which was very, very challenging.
I also said to her and I said at the time and subsequently that the guidance was far from clear. So, for instance, the guidance issued on the 12th and the 13th gave the presumption that you should not

transfer somebody who developed COVID in a care home to hospital. Now, clinically, that's understandable. If somebody is not going to benefit from an intervention from ICU or otherwise, then they should be enabled and supported on a palliative and end of life pathway to make their last few days as comfortable as possible. That was not always the case. And I was dismayed and distressed at the time to hear from our members that people had phoned ambulances and ambulances refused to take people to hospital, that people had been taken to hospital and consultants had refused to admit an individual because they had come from a care home, and numerous such examples, that people were being prevented as citizens from exercising their right to receive clinical care and support simply because they had come from a hospital [sic]. Now that was one piece of the guidance which we robustly hit back at and was changed by the time the guidance was reissued on 26 April, though sadly that practice of denying people their clinical rights, should they require transfer to hospital, continued. Indeed I had an incidence of such later that year and, perversely and coincidentally, yesterday had an incident in which a provider, who has made this public, contacted me to say that somebody had had an injury in the care home and then the ambulance

refused to transfer them to hospital. So we had then a real challenge where guidance was uncertain. That's one issue.
The rest of the guidance, the stuff about isolating individuals, of not having people use communal space, the insensitivity of much of that was not clear and it certainly wasn't easily transferable by our members. So I disputed with Ms Freeman at the time and, as I think I've said in the UK Inquiry, we had a very honest relationship, which I respected, but it was not helpful for the front line staff of the sector to be the object of speculation and pillorying in the manner in which that statement and the subsequent debate in Parliament ensued.
THE CHAIR: Might I also suggest, probably from a lawyer's perspective, that the use of the word "require" at the end of the sentence is actually wholly inappropriate. The Cabinet Secretary I beg your pardon yes, the Cabinet Secretary cannot require someone to do something that is merely guidance.
Do you agree with that?
A. Sorry, my Lordship, I wasn't aware you were asking a question. Yes, I do.
MR GALE: Just another point on that quotation, "some instances", was that expanded beyond "some" to "many"?

A. I think the sentiment was expanding from "some" to "many". I think throughout the pandemic it didn't really matter whether your care home was run by a private individual family group or a large corporate or a local authority or many of our charitable members. The care, the concern, the fear, the anxiety, the desire to do what was best for people, was consonant. Nobody comes into care with other than the best resolve, and certainly during the pandemic the front line women and men did everything they could, and it was singularly unfortunate that this debate started a process of victimisation of many care home staff.

I had one colleague share with me the fact that their nurse in a rural part of Scotland had to change her shopping habits because she couldn't go into the village shop because people were saying, "Oh, you work in that death home", and those sort of assaults, verbally bullying on front line care staff or nursing staff who were trying their hardest, were sadly far too commonplace to respect any accidental intervention.

Q. You go on to talk about the constantly changing guidance in relation to care homes and the effect that that had on managers of care homes. One of the things we've heard in the evidence thus far in the Inquiry is that there seemed to be an unfortunate habit of issuing

a change of guidance late on a Friday afternoon or an evening. Was that something you were aware of?

A. We were painfully aware of it because the implication of that meant that staff, particularly management and supervisory staff, had to look at that new guidance in the early stages, and for some considerable time there wasn't a direct reference to what had changed and then, even when that happened, there were inconsistencies. So, anyway, managers and supervisors just had to read everything anyway and that meant that they had to spend in some instances, if they could, the weekend to interpret what that actually meant.

Now, most staff working at the front line probably did not see the full guidance because their managers and supervisors and seniors translated the full guidance into something that was meaningful for a front line carer or a senior carer or a nurse. So that process of translation of guidance to application in the context took time and it was hugely annoying. And we made representations to our colleagues in Public Health Scotland and through CPAG. There was an understanding that this needed to change, but it didn't.

Q. Right. Do you know why there was the habit of issuing guidance at the end of a week?

A. I think you from memory, I think you in deference

I think you would probably have to ask those who developed the guidance, but my memory

Q. Yes, but your impression.

A. My memory was that the process was required to be as late as possible because it needed to go through sign off processes, with the Chief Medical Officer, with ministers and then with Public Health and then with ARHAI specialists, and then it had to get publication, so I would imagine that's Governmental publication unit, before it came out to the sector.

We pleaded the care home managers who were on the Clinical and Professional Advisory Group pleaded to ask, "Can this stop? Please stop issuing guidance on the Friday". And I do mean pleaded because these were women and men who were working 70 hour weeks and, you know, who weren't being able to spend time with their family, who you know, some of our colleagues were isolating so they weren't in contact with their family. I know one manager who, for nine months, lived in a caravan outside their house so they didn't bring the virus into the care home or indeed bring the virus into their own family home. So these were people who were massively stretched, who were at their literal wits' end, and then you got dumped upon on a Friday afternoon or early evening and it started all over again.

Q. I think you've hinted at this, Dr Macaskill. One would need to know what the pre existing position was in the guidance

A. Yeah.

Q. then note what the change was, if any, in the guidance and be able to then translate that I suppose, trickle it down to the workers themselves within the care homes?

A. Yeah. And, you know, we used the language, you know, "The guidance changed". It wasn't a sentence here and a paragraph there. 18 months into the pandemic, a colleague a social worker in Glasgow said to me, "Do you realise we're up at 2,900?". I said, "What do you mean?". She said, "This is 2,900 actual changes in this guidance since the start".

Now, that's not 2,900 documents, that's 2,900 changes, and I hesitate to think of what the number is by the time we came to the latest ARHAI guidance. It required managers, supervisors and team leaders to make that sensible for front line staff.

Q. Yes. Operation Koper, you've mentioned this already and I think you've been very clear in your opinion of it. I'd like to ask you a little bit more about it. You talk about it in paragraph 62 of your statement and, just to give context, it was an announcement by the then

Lord Advocate in May 2020 that the death of any care home resident due to COVID or presumed COVID was to be reported to the Procurator Fiscal. You go on to talk about the investigations associated with these reports came to be known as "Operation Koper". I don't know whether that's the correct pronunciation. I think probably some people pronounce it differently.

The effect on your members and staff, can you just explain what that was at the time and continues to be?

A. I think the effect was devastating at the time and remains traumatic for hundreds, thousands, of front line staff. I think we've got to put this into context. The first context is that the Lord Advocate at the time had previously decided, because we were in an emergency situation, that the routine process of reporting deaths which were unexplained or which happened as a result of an infectious disease which was notifiable would be suspended, and that, at the beginning of the pandemic, was what occurred across the board, both in the NHS and social care.

Now, care homes were perfectly used to working with the Procurator Fiscal locally if there was a death which was unexplained or needed further explanation and examination, and that has always been the nature of provision. What singularly changed with the

announcement was that all deaths would then be would require to be reported. Now, had that been a technical reality, that would have been wholly acceptable. What then resulted was the process of investigation of all deaths, and I think many of us at the time and I spoke to the team and have had we have had regular engagement with the team at the Crown Office since what would have been entirely appropriate would have been a proportionate response; in other words, were there information or additional complaints or evidence which would have suggested that there is merit in further investigation of this death or that care home, then that is entirely appropriate, and Scottish Care's position has always been that those who have lost loved ones deserve to know if there were instances of inappropriate practice, following of guidance or error, and that is an understandable right and intrinsically important to the grieving process.

However, what we now have is, four years on, we have thousands of staff whose professionalism has been called into question, over whom there is a weight of suspicion and a cloud hanging over and, sadly, that has resulted in individuals feeling they can't continue in their role and making a decision to leave the sector and, tragically, it has resulted in individuals and

whereas there is never one reason for somebody to take measures to harm themselves, I know personally that there have been a number of individuals for whom investigation as part of Operation Koper, even having to fill out the 27 questions per death for each resident that you supported when you maybe lost ten residents in the space of a week even that process has broken them.

So there is a complete imbalance and I think, you know, personally it is a real stain on the justice system in Scotland that this disproportionate action still remains against a workforce who, by vast majority, all they did was to try to do their best.

Q. You mention later in your statement and I will come to it either later today or when you return it is about the impacts on health and well being of staff and also you have a separate section on staff morale. Operation Koper, was that a particular aspect that you have in mind when you're talking about that?

A. There was a huge amount, and I've said in my statement that I had the privilege of being appointed one of the UK Bereavement Commissioners and, as a result of that, I took evidence in that commission and read evidence of hundreds of care workers. And undoubtedly the major reason for trauma for front line staff was, in a care

home, witnessing the deaths of people who you knew, who weren't just patients you got to know one week ago, but residents whose story had become part of your story over a long period of time. And to go as somebody said to me a few weeks ago indeed, how she went on one shift from one room to the next, to the next, to the next and lose four people in a shift, that scars and traumatises and results in technically what we could call "prolonged grief syndrome", but, in reality, what we were left with was a broken group of people.

And Operation Koper has added to the inability to heal those wounds because it's not going to change the reality that these are front line staff who experienced, in some instances, really traumatic experiences of somebody dying, who tried to be there when family were shut out and not able to be present, who tried to be the person so that nobody died alone. And these individuals have, in many instances, really struggled, as that nurse who spoke to me a few weeks ago has struggled. Even though she's away from a direct care role now, she still struggles, and she said to me, "I wake up at least once a week thinking about that week where I lost so many people".

I think our responses as a nation and as a society and certainly as a judicial system should have been

primarily pastoral rather than what appears to be a disproportionate seeking for blame and guilt. Yes, by all means identify culpability, mistake, accident, but let's do it in a manner which respects individuals.

Q. You've used the wording of "human rights" on a number of occasions in what you've been saying to us and the word "proportionate". Do I take it that you are of the view, if one is applying that term, that what has happened with Operation Koper, which we know is continuing I don't think there's been any prosecutions as yet was not proportionate?

A. I think it is wholly and utterly disproportionate. Proportionality is and I'm not trying to teach grannies to suck eggs

Q. You can teach me about it. I'm very happy to learn.

A. Yeah, but proportionality is such a key concept, not just in human rights law but in the practice of human rights in the community, and, for me, one of the descriptions which was used by one of Scotland's Scotland's first Human Rights Commissioner, Professor Alan Miller, was, you know, "You don't use a sledgehammer to crack a nut". And I cannot think of any other description for Operation Koper, but, in truth, I cannot think of any other description for an awful lot of things that we failed to do during the

pandemic response. We certainly did not embed human rights and we are not embedding human rights in an ongoing Operation Koper exercise.

Q. I suppose also that, for many people who have been questioned in the context of Operation Koper, both personally and within their communities, there will be the shadow of suspicion lying over them. Would that be correct?

A. Yeah, that would be I was interviewed myself by the officers of Police Scotland as part of Operation Koper and that was the first time I have ever had a police interview. You know, it might not be an unusual experience to some in this room, but it is extremely I'm not suggesting criminality on the part of those in the room, I hasten to add, but professional.

Q. We've read about it!

A. Yeah. But it brings it back upon yourself, you know, it is an uncomfortable experience, and that's what loads of front line staff who, when asked to be interviewed and I'm not by any means criticising the officers involved, who are merely carrying out their duty and who are doing so, from everything I hear, with a real sensitivity to the exercise but it really has frightened front line workers, nurses, managers, because of the uncertainty and the unknowability.

One of my I've written this week indeed to the Crown Office to ask for yet another meeting. One of my hopes would be that we can get to a stage at which these investigations can end and the thousands of staff who are out there today thinking, "I don't know what that might mean to me tomorrow", can have a degree of assurance. And what really upsets, apart from that, is this similar exercise is not happening for our colleagues and nor do I think it should happen for our colleagues in the NHS, where sadly more people died than did in care homes.

Q. Right. You conclude that section of your statement at paragraph 64 by saying that care home managers feel that they had been abandoned by the Scottish Government. Can you explain why you've come to that view and say that to the Inquiry?

A. I think this is a direct reference to how long it was taking to get announcements from Government about different stages of opening up to visiting, and I don't think it was just managers. I know from speaking to family members that there was a sense in which, every time there was a lessening in restrictions or an opening up, that care homes were never mentioned. So I and others sat watching the daily briefings from the First Minister and other clinical advisers, waiting to

hear when are we going to get mention of care homes, and from my perspective it was even more frustrating in that I know we had done the work, we had done what was required to make opening up possible, and yet it was delayed and it wasn't published.

And I'm not saying people were deliberate. I think there was a fear that the real harm and the loss that we all experienced in March and April, at the height of the pandemic, would be revisited upon us after the summer. But, you know, there was a perverse irony that, by the time we really began to open up, we were shutting down again with the arrival of Omicron in December 2020, whereas we could have had a summer of much more flexible engagement and, you know, garden visits should only have lasted a week. We could have moved from garden visits to a much more person to person response if appropriate PPE had been allocated to family members and others. But we were keeping people distant when all they wanted and needed was to be in touch.

Q. Right. Thank you. One further matter I'd like to ask you about, and this, again, concerns the early part of the pandemic and your interaction with the Scottish Government. The Inquiry heard earlier this week from representatives of the Royal College of Nursing, and I think you are aware of their evidence

either in specific or general terms. One area of controversy that they identified as between them and the Government in the early days of the pandemic was the Government's adherence to the view that COVID was a virus spread by droplet and not by aerosol or, put another way, airborne transmission. Were you aware of that controversy?

A. Yeah, very much aware because we were in complete agreement with the RCN, from the perspective of this is what we were hearing from our managers and members, so I mentioned the surgeries or webinars we changed the name interchangeably that we held with members. So there were two things that really struck me and, you know, I've watched these again in the early months. One was that our members were seeing the classic signs at which people are presenting themselves as potentially COVID positive were not being mirrored explicitly in a population in our care homes. There was additionality.

The second was and I remember we had clinicians present from Government saying that, you know, you were safe outwith a 2 metre area and as long as you did not have contact within that period for 50 minutes, which, at the time, was the advice that this was a disease that was transmitted by droplets and by cough and that mask

protection was, for instance, not necessary in that room beyond 2 metres or indeed was not necessary elsewhere.

We were very aware and probably myself especially aware because of contact with international colleagues, and I participated in some of the World Health Organisation sessions that there was a growing sense from our sector that, "Oh, come on, this is not the case. This is much more virulent. This is airborne", and that we needed to increase protection, which is why Scottish Care, in a media statement, called in April for the mandatory wearing of sorry, slightly later in the mandatory wearing of masks. And it took about six weeks before that became the recommended guidance because front line staff were saying, "This is presenting in extremely different ways from what we're being told".

Q. We've heard from members of the RCN that they made this point in discussion with Scottish Government officials.

A. Yeah.

Q. Were you present when they were made? Did you agree with them?

A. I completely agreed with the RCN representations. We weren't present all the times that RCN directly met with Government, but Ms McKenna, who gave evidence on Wednesday afternoon, and I were both part of the

Clinical and Professional Advisory Group

Q. CPAG.

A. CPAG, sorry.

Q. No, not at all.

A. and quite frequently we were with one voice, together with care home managers, saying, "You know, we need to look at beyond what we're being told".

And again, throughout the pandemic's early stages, there was a degree of balancing what you were hearing from the trusted experts, the scientists, with what you were being told by, from my perspective, the experts by experience, who were on the ground telling a different story and experiencing a different pandemic. And I'm afraid increasingly I was trusting one voice over and against another, which would certainly be what RCN staff experience was telling them in both hospital and care home.

Q. I think we also know that well, you mention that you were aware of what considerations were being given by the World Health Organisation. I think eventually the World Health Organisation confirmed that the method of transmission was by aerosol, by airborne transmission. That was obviously on the basis of a level of scientific advice and scientific knowledge as well as being supplemented by the information that came from your own

individual members. Now, in discussions with Scottish Government, there was clearly a push back against that at an early stage at least. Was the push back against that being explained to you or were you I'll ask you directly did you feel you were being dismissed on that matter?

A. So personally I'm not a clinician, I'm not an epidemiologist. I'm conveying the experience of people on the front line to those who are, and certainly one has to trust. And their argument was, "That's not what ..." whether it be SAGE UK level "That's not what our expert advisory group is saying. That's not what international experts are saying". And, to be frank, I think those of us in some degree of leadership in the care sector were avaricious about trying to get information online, linking in with groups everywhere we could in order to get as broad an understanding of what was happening as possible.

But we trusted that what we were told, and I remember hearing somebody say, of seniority a clinician of seniority say, "This is what happens and you're okay in X situation". I had no reason not to listen and nor did most of us, to be honest. But as it became increasingly clear that there were different sides to the truth, I think we began to question, and

when we did so, the responsewas, "This is the evidence that we have". And I you know, we, as an organisation, don't have scientists enabled to do the sort of robust research that's required in a very short timeframe in order to counter those arguments, and the RCN stated this work that they undertook internationally which provided them with that evidence, and certainly bodies like ourselves and others utilised that to argue the point.

Q. Again, I asked this of Mrs McKenna of the RCN and I'll ask it of you: did you get the impression that you were a lone voice in adopting this position?

A. I think CPAG it was an interesting group because myself and one colleague, Ms Hedge, and three other providers were present in probably a virtual room of 40 to 50 people that was the social care presence together with colleagues from the Coalition of Care Providers Scotland, who were very much focused on adults and children and younger people.

The vast majority of quote "expertise" in that room was clinical and governmental. You know, I'm probably not backward in coming forward, but even in that environment it is difficult to challenge, particularly virtually. And I know I was a proverbial pain in the derrière and probably made life

uncomfortable for both of the chairs becausemy role there was to say what we were being told and to advocate as robustly as possible, but I think the care sector was tolerated on that group rather than respected. And I'm not saying that's an individual position becausel've spoken to the other group members who came from the social care perspective. I think, when push came to shove, the view of the NHS and clinical guidance at Government dominated over any experienceor any contribution that we might have made, even with regards to visiting.

Q. Can I go back to guidance just briefly, Dr Macaskill?

A. Yeah.

Q. These questions emerge out of some questions I've been asked to pose to you. Can we understand from you what steps Scottish Care took to ensure that all your members were aware of the guidance that was current at the time and then to changesin guidance when they took place?

A. If we're talking specifically about guidance in relation to visiting

Q. Let's talk about visiting, yes. I'm sorry, I should have phrased it in that way.

A. If we're talking about visiting guidance, we were obviously and particularly myself very closely involved in developing both the initial guidance and the

subsequentguidance. We held weekly surgeries at which our members attended, at which I was able to, with Ms Hedge, engage in a question and answer and to explain the guidance and to encourage and to try to reassure within some of the parameters that I spoke about earlier. We also invited our clinical colleagues from Government and senior civil servants who had been involved in developing the guidance, so there was that ongoing effort. We also engaged in meetings with stakeholders, such as the Cabinet Secretary. We attempted to work at local level through our local staff, our independent sector leads, to give support to providers who were trying to embed best practice.

I think one of the ongoing challengesthat we had around guidance and its implementation was the role of sign off by local incident management teams and Public Health teams. So particularly in the early stages, a risk assessmenthad to be carried out by the care home which had to be particular to that care home and then it had to be signed off by the local team, and you could only then have people admitted as visitors once it had been signed off. That was torturous. And I remember probably losing it a bit where, 24 hours before we were due to start another phase of admission of visitors, half the Public Health teams in Scotland

had not even looked at, never mind signed off, the guidance.

So that gate keeping, that lack of trust in the professional ability of local teams, that necessity to have external experts tick the box, was an example of the way in which, despite the desire at local level, there were obstacles and where there was a fear that only added to the mechanism and the barriers to prevent opening up.

Q. Right. One thing that we are aware of from the Care Home Relatives group is that they conducted a survey after the change to guidance in October 2020, which I think was to make it more liberal, using my expression, and that 90% of those who respondedwithin the group to that survey had not noticed any change in visiting. Now, were you aware of that survey?

A. I was aware of the survey. I had conversations with Care Home Relatives or the senior group of people at the time. We were aware that there were issuesof timing. I've just expressedwhat some of the concerns were at local level. I shared with them then the sort of concerns I've shared with you today, about Operation Koper, about insurance, about fear and anxiety, and I said to them then and I hope I've been true to this that I would personally do everything

I could to make sure that would change as speedily as possible. And thankfully, by the time we got to December, things were beginning to change significantly, sadly only for things to go backwards in terms of the closing down of care homes. So, you know, I we worked, hopefully constructively, with Care Home Relatives to try to persuade our members to be as liberal as possible but at the same time, as I said earlier, understanding why there was reserve and fear.

Q. And was the reserve and fear engendered by the localisation, I suppose, of advice being given to care home operators?

A. To some extent. So it's difficult if you're a national care home group and you're doing something in one area but it's not replicated in another and that sign off happens in one area and it's not replicated in another. That's difficult. I do think it's really important that, in the future, if we have a future pandemic, that we bestow more trust to a local level, but intrinsic to that is the necessity of prior relationship. So if you were to ask me before the pandemic, "Where is there likely to be constructive, mutual regard and professional relationship between the social care sector, Public Health or Health Protection Scotland and indeed health and social care partners and the NHS?",

I could have told you where those areas were, and they, not surprisingly, were the areas where we had least challenge or difficulty because they had been areas of developed relationship and professional regard. That, sadly, was not and is not the case across Scotland, where there is still a fracture of relationship and regard and respect between social care and our colleagues in the NHS and Public Health.

Q. I'm mindful of the time, Dr Macaskill, and I'm very grateful to you for agreeing to come back and I think we can I hesitate to use "compartmentalise" certain parts of your evidence, but there is just one other thing and I think we can deal with it probably relatively briefly. It's something that we perhaps haven't discussed a great deal in the Inquiry, though we have had it referred to. It's what you say at paragraphs 83 to 87 of your statement and it relates to the restriction on medical care of care home residents. Now, as I say, we have heard something about it. Obviously you're looking at it from the point of view, principally, I suppose, from your members' point of view but also from the point of view of the residents within care homes. What was your view about restrictions that were imposed on the medical care into care homes during the pandemic?

A. I thought it was deplorable and I would still have that position now because, if you move into a care home, you don't give up your rights as a citizen of the community and the country in which you reside. It's a location which is there to support and care for you and, if with dementia, to enable you to live as fulfilling a life as possible.

I understand fully at the start of the pandemic when things were closing down that general practitioners in particular were concerned about the risk of seeing patients and bringing the virus into care homes, but what I struggle to understand is those instances and examples where people managers were phoned up and told, "We're not going to be back in", or where there was a Jiffy bag of DNACPR forms put through the door or another Jiffy bag in another care home in another location where death certificates were put through the door, and I could go on.

Q. To be completed, presumably?

A. To be completed. And I could go on and evidence, as I think the Inquiry will no doubt hear from other front line practitioners, that all culminated to a real sense of feeling alone, that actually we looked for support and it's not there, except it is there virtually, at a distance. And people were upset and

they were frightened and, with the passage of time, that turned to anger and hurt, that those who you looked to care for you and support you at your time of need are not there.

Now, by no means is that descriptive of all primary care practitioners. There are glorious, honourable examples of sacrificial dedicated professionalism, but there are too many instances of a sense of abandonment. And when I was invited to speak at a virtual conference of the Royal College of GPs, I was honest a couple of months later in saying, "This is what people are feeling. They're feeling that where before there was a relatively positive relationship, now they're on their own, and they're on their own at a time with an unknown disease which is causing terror and whose nature actually you being there just to listen, just to do a ward round", which wasn't a virtual ward round, to use the term used locally, "would have made a huge difference", because front line staff would not have felt alone, families would not have felt that their relative was somehow or other being considered as being of lesser worth and it would have made a difference.

Q. You talk about a perception among the care home sector that there was a presumption that had emerged amongst medical professionals that no external clinical visits

should take place.
A. Yeah.
Q. Was that a widespread perception?
A. It was very widespread. I've given instances of transfer from care home to hospital. I think there are it was you know, one nurse described to me that it was impossible to get an allied health practitioner to come into the care home. It was impossible to get somebody who was a dentist or part of a dentistry team to come in, an ophthalmologist.
Now, I accept that for the rest of society there was a real drawing back of those services as well, but in extremis it was possible to access all of those services and to get the professional input that was necessary. This is a population with multiple comorbidities, this is a population who were at the greatest risk of this disease in particular, and even if they were unfortunate enough, as many, many thousands were, to contract and to survive, the least we owed them was the ability to have their other health conditions maintained, whether that was cancer or COPD or any other respiratory condition. It was really challenging and that's why staff felt, "Gosh, we're alone here".
Q. You say at paragraph 86:
"This restriction of clinical care was hugely

damaging to residents with ongoing and developing clinical conditions and resulted in marked deterioration in the health and wellbeing of residents. It also increased the strain on care home staff who could not obtain appropriate medical care for residents."
That tends to suggest that this was a very considerable impact on residents and indeed on staff, that such clinical visits were denied to them. Do you agree?
A. Yeah. It pushed people back on their own resources and actually it astonished me throughout the pandemic in its early stages that hardly anybody left a care home by resignation or by a desire to go somewhere else. Staff stayed, they supported, they sacrificed time, they gave of themselves to an astonishing degree, they were exemplary, and I'm continually humbled by the humanity of our front line social care staff in the care home and community. But it would have been inordinately beneficial to the residents of our care homes had those professional staff not had to rely as much as they did rely on themselves and on their team and on their knowledge because, expert though they are in older people's care and support and clinically in the care and support of dementia, they are insightful enough to know that they don't have all the answers. But, sadly, when

they asked the question, there was nobody there from primary care and other colleagues all the time when they were needed to answer that question.
MR GALE: Dr Macaskill, I'm going to pause there, if I may, and we will invite you back to complete your evidence in as short a period of time as we can, but with that, my Lord, can we take a short break?
THE CHAIR: Yes, thank you. Thank you, Dr Macaskill. I'm sorry your evidence isn't completed in one session, but thank you for agreeing to come back.
A. Thank you.
THE CHAIR: Now, we were scheduled to start at 12.30, but I suspect you'd like to start a little bit earlier.
MR GALE: Well, it's
THE CHAIR: In other words, allow you half an hour.
MR GALE: So vicariously I can say on behalf of Mr Dunlop, if he's in the building, he will start
THE CHAIR: So we'll start I also notice that that clock is wrong. I've checked my computer. I think it's five or six minutes we'll try and get that sorted, but I think that means that, if we go by my computer, which says 11.52, we should be back at about 20 past or just after 20 past 12, if that's okay. Very good. Thank you all.
(11.53 am)

(The short adjournment)
(12.20 pm)
THE CHAIR: Good afternoon, Mr Dunlop.
MR DUNLOP: Good afternoon, my Lord.
MS KAREN HEDGE (called)
THE CHAIR: Good afternoon, Ms Hedge.
MR DUNLOP: My Lord, we have one witness this afternoon, Ms Hedge. For the benefit of your Lordship and the transcript, the organisational statement provided by Ms Hedge is referenced SCI WT0159 000001.
THE CHAIR: Thank you.
MR DUNLOP: Thank you.
Questions by MR DUNLOP
MR DUNLOP: Good afternoon, Ms Hedge.
A. Good afternoon.
Q. I wonder if you could provide us with your full name.
A. It's Karen Louise Hedge.
Q. Thank you. You've provided us with a statement. That's correct, isn't it?
A. That's correct.
Q. Before I move on to any of the substantive questions, is there anything within the statement that you would like to correct?
A. Yes, there is. I note, unfortunately, after submission, that the organisation or the title of the organisation

at which I previously worked at is wrong. It should be the Prince of Wales Foundation, not the Prince's Trust.
Q. I think we find that do we find that in paragraph 2 in the last three lines? I think the statement should be before you.
A. Yes.
Q. We see a sentence:
"Whilst based in Washington DC, I was the Director of Finance, Governance, and Compliance at the Prince's Trust ... "
And should we score out "Trust" and put in "Foundation", is that it?
A. Prince of Wales Foundation.
Q. And having read through the statement, is that the only error that you've identified?
A. Absolutely. I was forensic about the stuff pertaining to the pandemic and missed my own background.
Q. Not at all, not at all. These things happen. We've heard evidence this morning from your colleague, Dr Macaskill, in relation to I didn't hear the evidence but I understand it was in relation to care homes. Am I correct that your evidence today before the Inquiry considers care at home services and what you refer to in your statement as "housing support services"? Is that correct?

A. That's correct, and some day care services as well, who are also our members.
Q. Thank you. Just for our benefit, when we talk about "care at home", it might seem self explanatory, but "housing support services" may not. Could you just explain briefly what you mean by those terms?
A. Absolutely, and actually it's difficult to describe because there's a myriad of different ways that it could present, but effectively it's where you have housing with additional support. So someone would come in to where somebody lives, in their own home, to provide them support. It could be personal care, it could be less than that. It just depends on what individuals need at that point in time.
Q. Is there any minimum or maximum number of hours or services or can it just vary from person to person?
A. It varies from person to person, yes.
Q. If we can look forward to paragraphs 9 and 11 of your statement, and at that point you're talking about it's under the chapter "Scottish Care's engagement with members during the pandemic", and you highlight that there were regular meetings every fortnight for members who were delivering care at home. You also state that there were concerns about the guidance and changes in the operating arrangements, such as banning agency staff

working in care homes. Was that the particular concern with the guidance or were there other concerns about the guidance that members were expressing?
A. Many and several. The biggest challenge with the guidance was the rate and the speed at which it was changing, so the ability for providers to keep on top of that was difficult. We heard some of that in Dr Macaskill's statement this morning, about the impact that had on the staff then trying to enact that, and that was no different for care at home organisations as it was for care homes.
Q. Were members expressing that to you directly or and what did Scottish Care do in relation to that, when it became aware that there was an issue with the speed at which it was changing?
A. So one of the things that we do very well as a membership organisation is engaging with our members to find out, you know, how are they experiencing things on the ground, trying to get as much evidence as we can behind that to present that to the organisations that were making the decisions. Principally that would have been Scottish Government or ARHAI, but also organisations such as the Care Inspectorate and local health and social care partnerships.
Q. Sorry, immediately after "Scottish Government" you said

a word which didn't immediately spring to my knowledge.
A. Yeah, it's part of Public Health.
Q. And what did you describe it as?
A. ARHAI, A R H A I, and pleased don't ask me to tell you what they stand for.
Q. I won't then.
A. But it's where the infection prevention control guidance came from.
Q. Okay. Thank you. You said there that the speed at which guidance was changing was a concern to members. What about the interpretation of the guidance? Was that an issue or was it clear it was just an issue of speed that was a problem?
A. So because the guidance was wide ranging, sometimes it was clear, sometimes it wasn't, sometimes it was interpreted differently locally than it was nationally and sometimes it was interpreted differently between different organisations. And I don't mean our members when I'm referencing that. I mean between, for instance, the Care Inspectorate and individuals in Public Health. And that caused challenge for our members on the ground, knowing what was expected from them in that instance.
Q. And if it wasn't clear and, as you say, caused a challenge, was Scottish Care doing anything to address

that or the members? What was being done?
A. So the surgeries that we set up were particularly useful in that instance because it gave us a very quick ability to respond to what was happening in real time and then feed that into Government meetings. So we specifically timed the surgeries to be earlier in the week so that, when we went to the Government meetings, which were usually on a Wednesday and a Thursday, then we were doing that in a timely manner.

We also have a branch structure, which comprises of volunteer members, and it roughly matches health and social care partnerships' area, but there are some which duplicate, just for ease. We have some staff which are funded by health and social care partnerships but hosted by Scottish Care and employed by Scottish Care who were also really integral in raising issues and concerns in the local areas as well and enabling sort of constructive collaboration where possible.
Q. Thank you. Just to go back and touch on it, you mentioned that there were surgeries which were held before the meetings, which were normally on a Wednesday and Thursday. Can I take it from that, then, that there was weekly surgeries?
A. Yes. So actually, in the very early days, there were twice weekly, and then, when things became more stable,

we reduced the number.
Q. Can you tell us, when you say "surgeries", what did that involve? Were they held remotely? Who was invited? Can you tell us a little bit more about them?
A. Yeah, so the surgeries specifically were a Q&A session, so members could come and talk about their experiences and they could ask questions and ask to seek clarifications on things like the interpretation of the guidance and equally ask us to raise issues into, for instance, Scottish Government.

Alongside that we also hosted webinars, and the webinars were where we invited other experts to come and speak to our members as well. It was mostly we would close the surgeries to our members only though to give them a safe space where they could also experience some peer support.
Q. And who was providing the answers at these surgeries? Was that yourself or ...?
A. And Dr Macaskill, yes, and occasionally we would have other members of the team who might have specific expertise.
Q. And were they well attended?
A. Extremely well attended. We had to increase our licensing to enable more people to attend, and I think Dr Macaskill this morning referenced one meeting with

240 of our members present. To clarify, we have about 350 members.
Q. In terms of you mentioned other bodies earlier in your evidence. If your members had any concerns about your guidance or issues with other bodies, did you have a mechanism of contacting those other bodies? You've talked about the Wednesday and Thursday meetings. Were those other bodies at those meetings?
A. Yes in the main, yes, they were, though there was some distance in the early days with Public Health, which would have been Health Protection Scotland at that point in time.

Other challenges that we had actually was that the method for getting in contact with the individuals responsible for different portfolios changed throughout the pandemic, so not only was the guidance changing, not only were the meetings that we went to changing, but actually the persons responsible was changing frequently as well. So sometimes it was a case of just finally finding the person with responsibility for it and holding on to their email address for dear life and other times, you know, you were redirected through a central mailbox system, which was then siphoned off. So that made it particularly difficult in when you consider the pace at which things were changing,

actually finding ways to navigate the system and to get into the system and to find the relevant person to speak to was difficult also.
Q. Okay. But let's you've talked to us obviously there's a line of communication and you're feeding back and you're at these meetings with the Scottish Government. Were they listening to the members' concerns and acting upon them or not?
A. Again I'm going to give you a varied response. So there were experiences which were extremely supportive and extremely helpful, so examples I would give there would be around about PPE, which in the early days was difficult, but then, very quickly, through NSS, Scottish Government stepped up to support the sector through the creation of hubs and access to the right quality and standard of PPE.

And there were other areas where it felt as though our presence was tokenistic and that rarely were changes made to the guidance when we were raising the issues and the concerns of providers, and in relation to you know, more examples in the space for care homes than I have for care at home, but one of the big issues I would raise would be about the oversight arrangements that existed at the time.
Q. And by "oversight arrangements", is that

Care Inspectorate are you talking about or what do you mean by ...?
A. No, it's not. So during the pandemic oversight arrangements were stepped up, where they had individuals from Public Health who reported to the local director of nursing, who would go into care homes and effectively undertake what which was a sort of inspection, looking at infection prevention control but also straying beyond that into areas which the Care Inspectorate were responsible for. That caused huge confusion in the front line
Q. Okay.
A. and did not recognise the pre existing skill set of staff in the sector.
Q. I won't go into care homes too much with you. I appreciate that Dr Macaskill's evidence has been part heard and I hope continued at some point later in this Inquiry.
A. There is it may be helpful to talk about another piece of guidance where we did manage to get change. So initially there were recommendations made for staff not to car share, but we managed to give feedback from the sector to relevant persons at Government to make change there, though it did take a couple of weeks.
The reasons that that would not have been

appropriate for this sector is because actually many people who work in care at home don't have a car. It is although a highly skilled role, it is a lowly paid role, so we had to recognise that many of them don't have a car, many of them work part time, so car sharing was a significant part of how they would undertake their job. The alternative to not sharing a car would be to travel on a bus, which would potentially put them at greater risk because they would be travelling with more people in an enclosed space as opposed to their known colleagues, which is who they would be travelling with in a car, so the same people they would be going into people's homes with.
Q. Am I correct in assuming that a lot of people who need care at home require two carers at one time?
A. Yeah, that can be the case, particularly if people need support to use a hoist, maybe for showering purposes, things like that, yeah.
Q. In your statement at paragraph 18, under the chapter "The key issues and impacts: care at home", you say at paragraph 18 that the way care could be provided to individuals at home was severely affected by the pandemic. I just wonder if you can give me some examples of how it was affected.
A. So actually we know that there were significant staff

shortages at the time and we know that some people had their care packages limited by local authorities to respond to some of that. We also know that some people chose to reduce the care packages that they had to be able to ease the impact on the social care workforce. Even a colleague of ours was written to by the local authority asking if they would reduce the care and support for their mother at that time. We also know there was significant backlog in social work assessments being undertaken which then resulted in significant delays to people in the community getting the care and support that they would otherwise have been able to access far more quickly.
Q. Okay. Can I maybe just pick you up on a couple of those points? You said there were staff shortages. I wonder what the reason for those staff shortages were.
A. Yeah, we were in a pandemic. You know, many staff also experienced, you know, catching COVID and had to take time off for that. There were also instances where some COVID tests, you know, would have given a false positive reading as well.
Q. And were some of those carers shielding?
A. Some of the social care workforce as in paid carers?
Q. Yes.
A. Sorry, I just wanted to distinguish.

Q. Yes, of course.
A. So, yes, some paid carers would be shielding. In those instances, it would the first step would be to see if they could find some other work within the organisation. Maybe they could work remotely from home doing rostering or, you know, support to front line carers over the phone. But actually, if you needed to shield, then you may have to take time out of work.
Q. And you also said that care was the local authorities sought to limit care, and you gave an example of one person, and please don't name any names
A. No, no.
Q. but one person being asked to reduce the care services that they were receiving. Why were local authorities doing that if there were people that were prepared to go out and provide that care?
A. So just to clarify, it wasn't just one person. So we have letters from quite a few partnerships or local authorities who wrote blanket to everyone that was accessing care and support in that particular local authority area, so it was a fairly common practice in some areas at that point in time. And the reason was, you know, to reduce the burden upon the local authority. That's what they wrote in the letter. But we also know that that had a significant impact on some individuals,

who reduced their care with the intent of helping the system but putting the system before themselves as a human being and their needs.

Q. It may be that we ask if these letters can be produced

A. Yeah.

Q. but in terms of reducing the burden, was that a financial burden, was it the burden of assessing what care was required? Do you know what was meant by "burden"?

A. So I don't have you know, that would need to be a question to those who made that, but I do know that conversations that were had with local authority areas at that point in time described the delays to social work assessments and they described workforce shortages. So it may have been a combination of those things. There may well have been other things as well contributing to that decision.

Q. Thank you. Moving on to paragraph 20, you discuss guidance and we've had a chat about guidance already. I just wonder if you can tell me, in terms of the guidance, was the guidance sufficient in terms of advising your members what should be worn in terms of PPE?

A. So I think first of all it's important to note that it

took a very long time to get guidance for care at home in comparison to other parts of the health and social care system, so that in itself was a worry and a concern. And then, when it did come, there was confusion or the requirement of a lesser amount of PPE to be worn than in other parts of the system.

So what we saw was people living in their own homes in the communities and care at home workers not having to wear PPE unless they thought that individual had COVID. So they were walking into a home you know, one person gave an example of walking into a home at which point a community nurse was leaving that person's home and the community nurse was wearing, you know, full gown, mask, gloves, and yet the individual working in care at home, provision to the social care worker was not entitled to that same protection and nor was that individual living in their own home. The assessment was done based upon where you worked, not upon who was coming into your home and who was at risk.

Q. There's a couple of points I wonder if I can ask you about. You said it took some time for guidance to come out. Am I correct that, before lockdown, Scottish Care and I think you deal with this in your statement Scottish Care produced its own guidance due to a failure by the Scottish Government to provide

guidance? Is that correct?

A. That's correct, yes.

Q. And I think you deal with that in your statement at paragraph 14.

A. Yeah.

Q. Sorry, I was just going to ask, is there a reason that you're aware of why the Scottish Government couldn't have provided guidance, firstly just generally at an earlier stage, and why it took well, I'll ask you the first question first. I'll ask you in two parts why the Scottish Government couldn't have produced guidance at an earlier stage?

A. I don't know the reasoning why Scottish Government did not provide anything sooner. However, having been involved with the EU exit preparation planning of the Scottish Government, I sat in a room and listened to a 20 minute presentation by an NHS consultant on what social care was, so I have a belief that there was a misunderstanding and misrecognition of what social care is and does and has the potential to do. So I think that lack of understanding and recognition may well have caused the delays.

Q. What led you to conclude that there was a lack of understanding? Can you give me some examples?

A. So the failure to understand, for instance, the

description that I gave earlier about who a front line care worker is in care at home, you know, the constraints that they face; also the remarkable skill set they already have existing in infection prevention control because they're already managing things like norovirus, flu, in the communities as well and preventing that.

So it came through for me in the way that the guidance was published and produced and it was done particularly and I will make particular reference here to care homes but I think there was a particular failing in that space around about not recognising that it's an individual's home, that they bring their personal effects with them into a care home because it is their home. It's where they live. And for care at home, they didn't necessarily recognise that a care worker is going into someone's home over which they have no control over the environment. So the guidance didn't recognise, for instance, that there could be other family members present in that home and what to do in that instance, should they wear PPE, should they not. It didn't make reference to what the environment could be, was there windows, was there ventilation, things like that as well. So because these idiosyncrasies you know, this real detailed stuff was not there or not

recognised, then that for me is that failure to understand.

Q. Thank you. We saw that Scottish Care produced guidance before the lockdown in relation to for the benefit of your members. Can you remember you said it took a long time for the Scottish Government to issue guidance which was specifically directed at care at home services. Do you remember when roughly that was produced?

A. It was right in front of me on the screen. I think it was 26 March. It was on the section that was up earlier. So I know that only feels like a few weeks after we published our guidance, but I think it was so long ago now we forget how scared we were at that point in time, you know, what the uncertainties were. We didn't truly understand the nature of the virus, we didn't truly understand the spread nor did we understand in that context what we could do to protect people and ourselves and our workforce. So although it was only a matter of weeks, it felt, you know, like a matter of years out there. People worrying, "Am I going into this person's house? Will I infect them with the pandemic? How do I carry that with me for the rest of my career?", so basically crying out for guidance and support.

Q. In terms of we know that the Scottish Government is

relatively well resourced. In terms of Scottish Care producing guidance, what resources did you have to produce that guidance? I don't know what size the organisation is and my apologies if that came out this morning in evidence, but were there a lot of staff or ...?

A. We are a small charity. We have sort of circulate around about 40, but over half of our team work part time, so, as with many other organisations during the pandemic, it was very much an all hands on deck situation and scenario. So many people in our team, as in many other organisations, went above and beyond.

Q. Thank you. In your evidence there you gave an example of a community nurse coming out who was obviously more fully equipped with PPE than some of your members' staff. Particularly at the beginning of the pandemic, in late March and early April 2020, did your members have difficulties sourcing (a) sufficient quantities and (b) suitable PPE to go into homes?

A. Absolutely, yes. Particularly smaller organisations found it difficult because they didn't necessarily have the same purchasing power as the larger organisations or possibly even the storage capabilities that larger organisations might have had to just have that number of masks or gloves stored somewhere in any eventuality.

Scottish Care at that point in time worked closely with suppliers and a colleague was enlisted in contacting all the various suppliers and issuing every week every Monday morning in fact a list of, "Here is where you can get gloves, here is the prices. Here's where you can get masks, here's the prices". So, you know, we did as much as we possibly could to access that. Another colleague supported a group of providers to come together so that they could bulk purchase together, but, unfortunately, we still heard occurrences when, you know, shipments of PPE came in to the UK but they then didn't get to the provider who had purchased them.

Q. Why was that?

A. So we heard stories that they were being commandeered for the use of the NHS, though we have no evidence. But that's what we were told.

Q. And in terms of the smaller organisations who were having difficulties, as you identified, securing PPE, in terms of the prices of PPE I think it's probably within judicial knowledge that that had gone up did that have an impact on the ability of your members to purchase PPE?

A. Absolutely, and for all our members. So, you know, you could add a couple of zeros on the end of what things

had previously cost.

Q. You also discussed earlier that your members' staff from your member organisations could be going into homes where the community nurse had come out fully kitted. Did that cause any concerns to your particular members, that they didn't have the same level of kit, if you like, as others and what type of concerns was it causing?

A. Huge concern because it was such a time of uncertainty. Nobody knew, you know, what the impact of the pandemic was going to be at that point in time and how to mitigate that risk. So they were seeing people coming out looking as though they were very well protected and they felt like they were second class citizens. They felt like they were you know, there was an acceptance that they could be put at risk, whereas members of, for instance, the NHS could not be put at risk. So they felt like there was a hierarchy in their relevance as persons and as individuals.

And I'll give an example of a front line worker who I spoke to at the time, who described coming in from their shift, calling to the members of their household not to come into the hall. They then stripped their clothing off, ran from their front door to their washing machine, put the washing on and then ran up to the

shower because they were so scared and terrified that they were going to pass anything on to their children in particular.

Q. And some of those individuals, would they perhaps have had people who were shielding in the property?

A. They may well have done, but I know that many staff made arrangements to live elsewhere or to compartmentalise their homes in those instances.

Q. Moving on to testing, which you deal with starting at paragraph 33 of your statement, you tell us that testing was extended to staff and residents working in care homes but not staff or service users providing care at home. What impact did that have on your members who were providing care at home services?

A. So, again, it made them feel as though the decision making was not done in the bounds of risk but upon where you worked, the location of where you worked. So it reinforced that feeling of being a second class citizen and reinforced the worry that, you know, they could be passing on the pandemic unknowingly.

Q. Was that issue raised with the Scottish Government?

A. Yes, it was.

Q. Can you tell us when it was raised and with who?

A. I couldn't tell you a date at this point in time, but it would have been raised through one of the weekly groups

that we attended, most likely CPAG.

Q. And, as a result of raising it, was an explanation given for the difference in treatment?

A. So at one point in time I was told there was difficulty of access to a sufficient number of tests so decisions had to be made about who got access when.

Q. And did anything change as a result of Scottish Care having raised its concerns with Scottish Government?

A. So whether it was as a result of that or whether it was as a result of access to more tests, I'm not sure. I couldn't tell you that. But, you know, access was made available to care at home staff eventually, although, again, there was confusion about the type of test because in some areas there was access to PCRs and in some areas it was LFTs.

Q. At paragraphs 37 to 40 you describe the effect of isolation on persons receiving care at home. Do you know of any evidence, perhaps anecdotally from what you've been told, whether that was affecting the mental health of service users?

A. Yes, because if you were shielding in your own home, you're still not connecting with your local community. You know, each of us in this room had to some extent an experience of lockdown, but that would have been for a prolonged period and we know that loneliness has

a significant effect on people's mental health. That also had a significant effect on the workers going in to those people's homes because they wanted to be able to spend more time with them because they saw the impact that it was having.

Q. You say they wanted to spend more time and I think you deal with that at paragraph 40 of your statement. You say that a local authority has the power to increase the length of visits. Were there applications being made to extend the length of visits?

A. So one of the things which front line care workers are skilled at doing is completing care notes and within that they will assess how that individuals is at that point in time, and those notes will show changes over time in a person's well being, behaviour, health, and that would be used as evidence to argue for changes to the package that the provider is commissioned to deliver.

Q. Were there administrative difficulties in increasing the hours?

A. Because there were also staffing shortages within local authorities, because, like our members, there were staff absences during the pandemic, there were backlogs in having these assessments seen to, yes.

Q. Okay. With the benefit of hindsight, are you or can you

offer an opinion on whether there would have been a way round that essentially?

A. Yes, and in some areas this happened, and particularly where the Self directed Support Act is implemented effectively, then there is the ability to change the care and support that's delivered in real time much more fluidly. So if the Self directed Support Act had truly been implemented in Scotland before the pandemic, then there would have been much more flexibility in the moment.

Q. Would that have relaxed the assessment criteria or what would that have done?

A. It gives tolerances to respond to. So an individual can request changes to their care packages, to increase, to decrease, to do something different with it, to use a different service in their community, not just a care worker. And the same with care workers themselves, you know, they can make they can make the decisions and make changes to that in those times day to day as well and say, "Well, actually, I can spend a bit longer with you here but what we'll do is reduce time over here" or instead of "What I'll do is I'll come in and we can spend time maybe reading or doing something more social, but instead of coming in and cooking you dinner, we could get you a takeaway or something like that". So

you can be much more flexible to the needs of the individual at that point in time, upping care at some points, reducing care at other points, just depending what the individual needs there and then. But if you don't have that relationship with your local authority and you don't have self directed support really implemented in the correct person led way, then you're back to, you know, 15 minute commissioned visits.

Q. Okay. Did the local authorities have discretion to do that?

A. Yes, they do. They do.

Q. Did some local authorities exercise that discretion and others not or did any of them?

A. Some not in response to the pandemic some did already have those arrangements in place.

Q. Most or a few?

A. A few.

Q. Okay, thank you. At paragraph 45 of your statement you raise the issue of care staff not being recognised as key workers and you give the example of the police essentially I think stopping them when they're in cars and Scottish Care having to get involved. Was that due to poorly drafted guidance or is that due to another reason?

A. Actually it's partly about identification. So if you're

wearing a NHS uniform, you're visible and people know and see that you're a key worker. You know, it's clearly understood. But there's such a richness and variety of care providers, and that's a really good thing because what it does is it offers choice and control to individuals so they can choose who they want to deliver their care and support but because there's such a variety in that, they were not always visible to the police if they were a care worker because, you know, it could look similar to a hairdresser's uniform or other service professionals and individuals. So we had to work with providers on, you know, what would be a suitable identification and to educate the police that that would be the case and that they should be accepting that care workers were key workers.

Q. I want to just ask you a couple of questions about Long COVID now. You talked about a worker coming back and stripping off and jumping into the shower to ensure that no members of the family contracted COVID. As far as you're aware, were your members if somebody did contract COVID occupationally, was that being recorded in the member's personnel files?

A. Yes, and they had to report to Government and to the local authority on staff who were absent with COVID at any point in time. Some were required to do that daily,

some were required to do it weekly, some were required to do it to the local authority and the Care Inspectorate and the Government, some were required just to do it to one of those organisations, so there was a lot of duplication on demand of data provision at that point in time as well.

Q. Can I ask obviously we don't have crystal balls so if someone catches COVID, we don't know if it's going to develop into Long COVID, but if it did develop into Long COVID, would that be recognised in the employer's records? You might not know the answer to that, but ...

A. I don't know the answer to that, that's correct.

Q. Moving on to paragraph 48, you identify that social care workers experienced trauma and that there was inadequate support in place. Can you maybe just tell us what you mean by "trauma" and what support you expected to be in place or hoped would be in place?

A. Yeah. So Dr Macaskill spoke eloquently on this for care home workers this morning and it would be no different for people providing care at home in the community. You build a relationship up with those individuals you know, it's a job which I used to do many, many years ago and I have I couldn't tell you the dates, the times, this, that and the next thing, but I could tell you, you know, that one of the people I worked with, when they

were stressed, the noise of the hoover calmed them down. I can tell you that another individual liked me to sit beside them and they would hold my hand while we watched old movies. That's the sort of relationships that people had with these individuals. And it wasn't just last week, it's when I was at uni, so I still remember that. I remember how that felt at that point in time.

So it's part of your life, a hugely significant part of your life. So when you see the experience that they have when they have COVID and when there's loss and when people die as a result of COVID, you know, you're losing that relationship too. You are a part a de facto part of their family, and through that they experience trauma. You know, they've experienced significant loss over a prolonged period of time. We know that some NHS boards were offering psychological support to NHS staff whereas that wasn't available to the same extent for social care workers. There was well being support but not psychological.

Q. And is that when you say "support", is that what you're suggesting should have been available?

A. Yeah.

Q. Okay. At paragraph 51 you tell us that day care services were advised not to fully re open until October 2022. Just a few questions about that.

I suppose firstly : who advised them, are you aware?
A. So that would have been guidance that came from the Government.
Q. Okay. Do you know if you don't know the answer, please just tell me but do you know why they were advised not to fully re open until October 2022?
A. I don't know, but I assume it would be connected to infection prevention control.
Q. And I may be reading too much into it, but are you criticising are you being critical of that decision and, if so, why?
A. So, yes, I'm being critical of that decision because this was a significant time after everyone else in the community had gone back to you know, closer to our normal pre pandemic behaviour. So people living in their own homes who would have previously had access to the social support that day care services provided, the stimulation that they had there was not available to them for a very long period of time and that exacerbated their feelings of loneliness, which had other consequences on their mental health and well being.
Q. In your opinion, perhaps with appropriate measures put in place, wearing masks, social distancing, whatever that might be, could they have re opened at an earlier stage?

A. Yes.
Q. And not to pin you down to a date, but do you have a view on how much earlier they could have re opened?
A. I don't. I would need to go back through what was happening at that point in time to do that
Q. I appreciate that.
A. I suppose specifically the science around about what we knew about the virus at that point in time to give that advice.
Q. I suppose just so that we appreciate the impact, how important were those services to the people that used them?
A. Yeah, so they performed a variety of tasks. It wasn't just a social aspect. They would also provide personal care, provide a warm meal for individuals as well, so if that was something that you were used to accessing day to day and then suddenly you didn't get that for, you know, a couple of years really, then it certainly exacerbated feelings of loneliness and put additional pressure on potentially family members, who were having to step in to deliver that care and support instead.
Q. I was going to say that. I appreciate you're not speaking we will hear evidence in relation to unpaid carers during the Inquiry. But in terms of respite, from your experience, do these types of service offer

a respite?
A. Yeah. Yeah, they did.
Q. Moving on to paragraphs 69 and 70, you discuss the issue of data requests and you indicate that the sector was under pressure from the Scottish Government, local authorities and the Care Inspectorate in relation to data requests. I suppose I'm just not clear, what kind of data was being requested by those bodies?
A. Yeah. I think it's important that I say that data collection was an important part of pandemic response, so I'm not saying that it shouldn't have happened, I'm saying that data collection was important, but it was the manner in which it was requested and the duplication was the biggest issue here. So at a time when we really needed our social care workforce supporting individuals, many of them were pulled away to do administrative duties around about data request. So it was more prevalent for care homes than it was for care at home, although in some local authority areas they asked for the same data in care at home as they did for care homes. So the sorts of things that were requested were number of people accessing care home support, number of residents, number of those who had COVID, workforce, workforce vacancies and things like that. But it was the requirement to do that on different forms for

each agency that was requesting it and the requirement to do that on a daily basis in some instances, so at a time when we really needed people concentrating on delivering the care and reducing the risk, they were spent having to fill in forms.
Q. Is your evidence essentially that there could have been a more joined up approach where there was one form filled that could have been sent to all the various agencies? Is that essentially
A. Yes. And now, you know, one of the things that's happened as a result of the pandemic is it's accelerated the uptake in use of technology and digital, so there are other ways that we can consider going forward to do that on an automated basis that would completely remove the burden altogether if we were coherent in that.
Q. Thank you. I have some questions but you seem to have answered them.
Before I ask you if there's anything further you want to add, there's some questions that have been provided to the Inquiry by core participants, so I wonder if you can help us with these. So I'll be moving back to the beginning of your statement. At paragraph 4, you say that you sat on the Ministerial Advisory Group for Health and Social Care. Do you know if that involved any planning for a pandemic?

A. Not at the time when I attended that group, no.
Q. And what time was it that you attended?
A. So most often it would have been Dr Macaskill and our chair that attended, but I would step in for either of those when one of them couldn't make it, and it was certainly not discussed at any of the meetings that I went to.
Q. And moving forward to paragraphs 49 to 52, at these paragraphs you discuss the impact on day care services. Do you know if the issue of closure and re opening of day care services was discussed at the Scottish Government groups that the Scottish Care attended?
A. It was because we raised it, as did some representatives there from unpaid carers' organisations.
Q. And what was discussed?
A. The impact that it was having on the individuals not being able to access it and also, from Scottish Care's perspective, there were significant fiscal implications for those organisations which might have prevented them from being able to open again at all.
Q. And in relation to any potential future pandemic, did the Scottish Government indicate what should happen in relation to day care services?
A. No.

Q. Moving forward to paragraphs 73.2 and 74, you mention the Clinical Practice Advisory Group for Care Homes CPAG meetings. Do you know if minutes were taken of those meetings?
A. Yes, there are, yes.
Q. And to the best of your knowledge, at any of those meetings, did any attendee call for a human rights impact assessment in relation to restrictions of visits to care homes?
A. Yes, my colleague Dr Macaskill did.
Q. And what was my apologies if this was dealt with this morning what was the outcome of that?
A. So the response given at that time was there wasn't capacity to do that.
Q. And finally at paragraph 80 you discuss Health Protection Scotland guidance. Did Scottish Care provide its members with advice on how guidance would operate in practice?
A. Actually it was in many respects the other way around. So what we are very good at is bringing our members together to find a way through this, to navigate the guidance together and to make sense of that. So one of the things that had to be done was to translate the guidance into a way that would be accessible to front line care workers, so we found that some of our

managers were working together to do that. I don't mean Scottish Care managers; I mean the managers within our membership organisations.
Q. And just in relation to the final question, I appreciate there may be a degree of separation between Scottish Care and the family members, but did Scottish Care provide any advice in relation to family members who were providing care at home?
A. No.
Q. Simply before I thank you for your time, is there anything that you wish to say that hasn't cropped up in our discussions today or that is omitted from your statement?
A. So I guess I want to recognise those that I had the privilege to walk alongside during this experience in the pandemic and thank them for their support in supporting the sector through what has been a very challenging experience. I also know that many of them and many others experienced loss and trauma, so I would wish to express my condolences.
MR DUNLOP: Thank you. I just take this opportunity to thank you for your time today and also the considerable time and effort that you've put into providing an organisational statement for the Inquiry. It's much appreciated.

A. Thank you.
THE CHAIR: Yes, thank you. Thank you, Ms Hedge. I'm very grateful.
A. Thank you, my Lord.
THE CHAIR: Good.
MR DUNLOP: There are no further witnesses for this afternoon.
THE CHAIR: I knew that. 9.45 on Tuesday morning.
MR DUNLOP: Yes.
THE CHAIR: Very good, thank you.
(1.10 pm)
(The hearing adjourned until Tuesday, 26 March 2024 at 9.45 am)

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