SCOTTISH COVID-19 INQUIRY

SECOND ORGANISATIONAL IMPACT STATEMENT OF SCOTTISH CARE

I, Karen Hedge, Deputy Chief Executive Officer of Scottish Care, Personal Data Personal Data Personal Data will say as follows on behalf of Scottish Care:

I wish to begin by saying that in my role at Scottish Care, I had the privilege to walk alongside those who worked in social care during the pandemic. I know that many have experienced trauma and loss as a result. I would also wish to express my condolences and support to them and to all who were affected by the impact of the pandemic.

Introduction

1 I am currently the Deputy Chief Executive Officer ("Deputy CEO") of Scottish Care. Scottish Care is a registered charity and membership organisation representing independent social care services in Scotland. Members of Scottish Care include organisations delivering residential care, nursing care, day care and care at home and housing support services. They include private, not for profit, employee-owned and charitable organisations. I understand that my colleague Dr Donald Macaskill, the Chief Executive of Scottish Care, has provided information to the Inquiry in relation to Scottish Care's structure, purposes and membership, which I will not repeat within this statement.

2 I have worked in social care and related fields for the majority of my career, I have a Masters degree in sociology and whilst I was at University I worked in a care home for young adults with profound and multiple disabilities. I completed a postgraduate degree in social work in 2006 and then worked as a social worker in an inner London borough. I then moved to commission social care services for a local authority in England. In this role I worked on the 'Aiming High for Disabled Children' programme, part of a national effort to improve local service delivery. I became a trustee of a care home group in the south west of England in 2011 before moving overseas in 2013. Whilst based in Washington DC, I was the Director of Finance, Governance, and Compliance at the Prince's Trust, before taking on the role of Head of Commercial Partnerships for the International Department of Trade for a short period. I returned to the United Kingdom in 2017, at which time I joined Scottish Care.

3 Initially my job title was National Director however this changed to Deputy CEO in or around March 2022 as this better reflected the role I was performing. A key part of Scottish Care's, and hence my role's, remit is providing membership support. This can take the form of receiving queries or requests for advice from members or proactively contacting members to gather evidence about what is happening in the social care sector and the factors that are affecting it. The information that I and

others in the team receive from members helps Scottish Care to understand how the social care sector is changing and what support it may need to respond to external pressures and challenges.

4 Scottish Care aims to help shape the future of social care and advocates for the social care sector. Therefore, my role also involves working with regulators, the Scottish Government and non-departmental public bodies such as Public Health Scotland ("PHS") and the Care Inspectorate. I meet with the Convention of Scottish Local Authorities ("COSLA") and local government in relation to a range of issues affecting the sector and that includes attending the Charging for Residential Accommodation Guidance Group ("CRAG"). Prior to the pandemic I sat on a Ministerial Advisory Group for Health and Social Care, chaired by the Cabinet Secretary for Health, Wellbeing and Sport, which looked at data and trends within these sectors and the Scottish Government's Reform of Adult Social Care Group. I currently sit on the Scottish Government's Fair Work in Social Care Group.

5 The delivery of all forms of social care was impacted by the COVID-19 pandemic but in this statement I predominantly focus on the impacts experienced by care at home providers. Scottish Care's members who provide care at home services include employee owned organisations, smaller family run organisations as well as larger organisations. Some of our members provide care at home within one local authority area and whereas others operate across several health and social care partnerships.

6 I have touched upon the impacts on residential care however I am aware that Dr Macaskill is providing a statement to the Inquiry which will cover these in detail.

Scottish Care's engagement with members during the pandemic

7 During the pandemic, Scottish Care sought to support its members with the extremely challenging circumstances with which they were faced and to represent its members and the wider social care sector, which included attending meetings and working groups convened by the Scottish Government.

8 Scottish Care began running online meetings on COVID-19 twice a week from 17 March 2020 to provide a forum in which members could ask Scottish Care questions and share information. These sessions were hosted by Dr Macaskill and me. Scottish Care also hosted a number of webinars with guest speakers, some of which were made available to non-members. The majority of these early meetings/webinars covered a range of issues relating to COVID-19. The session on 14 April 2020 was dedicated to PPE and on 24 April, 5 May and 14 May 2020 Scottish Care hosted the Care Inspectorate, PHS and Professor Graham Ellis (who was at that time the National Clinical Adviser for Ageing and Health) respectively as guest speakers. A number of meetings provided support to interpret and follow guidance issued by the Scottish Government and PHS which was being updated frequently.

9 From 9 June 2020 the meetings took place once a week and from 11 May 2021, the meetings changed from being directed to all members to alternating weekly between sessions for care home members

and members delivering care at home. They continued on this basis throughout 2021 and into summer 2022. From 28 June 2022, these weekly meetings reduced to fortnightly - there was one session per month for care home members and one for members providing care at home. This schedule reverted to weekly sessions for all members on 25 October 2022 due to the challenges that the care sector faced as winter approached.

10 Throughout the pandemic Scottish Care was trying to capture what was being experienced by those within the social care sector without putting the burden on providers and their staff. Scottish Care wanted to make evidence-based decisions but it was not feasible to ask members to complete surveys to gather such evidence given the other demands upon them at this time. The meetings with its members provided Scottish Care with the opportunity to obtain feedback in relation to what was happening in the social care sector in different parts of the country – often over 100 members dialled in. This feedback supplemented the daily intelligence that Scottish Care was receiving from its national and regional teams based throughout Scotland. This helped Scottish Care to ensure it could advocate on behalf of its members facing challenges specific to particular regions in addition to the national challenges being faced by the social care sector.

11 Scottish Care's meetings were helpful for identifying issues that members were encountering with frequently changing guidance and concerns members had about changes to operating arrangements that were being proposed by the Scottish Government or other bodies. For example, when there were discussions about banning agency staff working in care homes (because such staff may work in more than one home), members discussed the severe practical impacts that would have on the people they support, due to staff shortages and sickness. Scottish Care was then able to feed this back to stakeholder groups and such guidance was not put in place.

Initial awareness of Covid-19 pandemic and guidance for the social care sector

12 Scottish Care became aware of the existence of COVID-19 prior to Christmas 2019. The significant impact it would have on the social care sector became increasingly apparent when we started to hear reports of what was happening in care homes in Italy and Spain in March 2020 (such as reports of the Spanish army finding residents abandoned in care homes). At this time, Scottish Care raised its concerns about the potential impacts on the social care sector and those who receive social care with relevant organisations such as the Scottish Government and Health Protection Scotland ("HPS") which was the predecessor of PHS (which was formed on 1 April 2020).

13 Dr Macaskill and I met with Scottish Care's Executive Committee in February 2020 – this was a pre-arranged meeting but the timing aligned with the heightened awareness of the impact of Covid-19. At this meeting we discussed what was happening in other countries and the conversations that Scottish Care had had with the Scottish Government at that time. By this time, Scottish Care had been in discussions with HPS about the need to create guidance for care homes, but Scottish Care was concerned about the time that it was taking for such guidance to be produced. Therefore, Scottish Care decided that it would produce its own guidance in the interim.

14 Scottish Care first published guidance for its members in relation to COVID-19 on 24 February 2020. That guidance contained general information about the virus which was based on Public Health England advice which had been published at that time as well as guidance which was based on the procedures for norovirus and flu outbreaks in care settings. It contained specific information for social care providers in relation to the development of standard operating procedures, personal protective equipment ("PPE") and resilience planning. This was the first guidance in relation to COVID-19 developed specifically for the social care sector in Scotland and was amongst the first in Europe for the sector.

15 After this initial publication, Scottish Care did not produce any further guidance during the pandemic and instead directed its members to guidance produced by the Scottish Government, PHS, COSLA and the Care Inspectorate.

16 Once those in the care sector were aware of what was happening to the provision of social care outside of the UK, Scottish Care stepped up the conversations it was having with members and with the Scottish Government about how to keep people in the social care sector safe.

17 Those delivering care at home services were concerned about the impact COVID-19 would have on those to whom they provided care, as well as on those who worked in social care. They were asking questions about what would happen if those individuals got sick and needed more support and possibly even equipment such as PPE, and what the risks for staff were in going into people's homes.

The key issues and impacts: care at home

18 There has been much attention given to what was happening in care homes during the pandemic but a significant proportion of social care is delivered to individuals living at home, either on their own or with family. The way such care could be provided was also severely affected by the pandemic.

19 Care and support at home services experienced disruption, but as a sector, services continued throughout the pandemic – there was never a time at which they stopped because of guidance. However, many service users nevertheless experienced a reduction or cessation of their packages of care and support. This was sometimes through choice and sometimes as a result of local authority intervention and it was a way to manage staffing shortages by reducing demand on the sector. Some of our members reported that many of those receiving care were asked if they wanted their care to continue as early as 25 March 2020. Some people accessing care and support chose to have family members take over their caring needs in order to reduce footfall in their homes.

Guidance

20 There was no guidance issued by the Scottish Government for care at home until 26 March 2020. This guidance was titled "*Clinical Guidance for the Management of Clients Accessing Care at Home, Housing Support and Sheltered Housing in relation to COVID-19*" and it cross referred to HPS guidance for "*COVID-19: Information and Guidance for Social or Community Care & Residential*

Settings". This HPS guidance focussed on residential care settings, such as care homes and nursing homes, and contained only one section about care at home.

21 The guidance for care homes was not applicable to the provision of care at home – for the latter, carers enter people's homes and do not have control over that environment for the purposes of implementing infection prevention and control measures. Care workers are essentially visitors to people's homes for the duration of the time they deliver support. There was therefore uncertainty for those providing care at home services and also for those receiving those services about how the delivery of care at home should be adapted.

22 There was an impression created that infection prevention and control in clinical settings such as a hospital ward was easier to navigate because such settings are controlled by the NHS or others delivering health care. A hospital ward is very different to the individualistic nature of care and support delivered in someone's own home, and this factor may have been a reason why it took longer for guidance for care at home to be produced.

23 The guidance for care at home services published on 26 March 2020 also provided guidance for housing support services. Housing support services support people to live independently in a wide range of supported housing. Scottish Care heard from one of its members who provides housing support services who expressed their concern over the delay in appropriate guidance for housing support services being published.

PPE

24 In the early stages of the pandemic due to the lack of guidance for care at home, there was a lot of uncertainty about what PPE should be worn by carers. Initially there was no general requirement for those providing care at home to wear PPE which had an impact on care at home providers' ability to source PPE. There were shortages of PPE across the country and, as there was no guidance mandating the use of PPE for care at home, providers did not have priority access to the PPE supplies that were available. As at 26 March 2020, HPS guidance for care at home was that PPE was to be worn by those providing care at home only if the person receiving care was suspected of having Covid-19 or had tested positive for Covid-19.

25 As part of their role, those providing care and support at home are required to travel between different houses. Many of our members said they were concerned about the risk of transmitting COVID-19 between those they cared for and also the risk of taking COVID-19 home to their families. These fears had an impact on the mental wellbeing of those providing care at home services.

26 At this time, social care workers were regularly seeing healthcare workers wearing full PPE. In the event that a district nurse or other health care professional came to a service user's home, they would be wearing full PPE. This made those providing care at home feel like second class citizens by

comparison as they were expected to attend homes and provide personal care, which often involves close contact with those for whom they care, without or with a lesser degree of PPE.

27 The trade unions representing social care workers called for care at home staff to have access to PPE.

28 Guidance mandating that social care staff, including care at home staff, should wear face masks was first introduced on 29 April 2020. However, at this time social care providers faced limited access to PPE due to market supply issues. To support members in navigating this complex landscape, a member of Scottish Care's staff was tasked with sourcing PPE and it became their full-time job. Other members of Scottish Care staff were delivering available PPE to care providers in their local areas. Scottish Care also supported members to enter into a consortium to order PPE from abroad and worked with local distilleries who diverted production of their alcohol to make hand gel. However, one of the orders placed through this consortium was not delivered to those who had ordered it as it was requisitioned by the UK Government for use by NHS. Priority was given to the NHS and social care staff questioned why their health or the health of the people they were supporting did not seem to be considered to be as important. This took an emotional toll on social care staff.

29 NHS National Services Scotland ("NSS") took on the role of procuring PPE for the social care sector. However, its experience was of procuring PPE for use in hospital wards for which PPE was allocated based on the number of staff and the number of 'sessions' for which PPE was required. A session was defined as a two-hour period. Social care visits were (and are) often scheduled to last only 15 minutes. Social care staff needed to change PPE after contact with each individual to whom care was being provided, or more often depending on the nature of the care being provided. This resulted in shortages in the amount of PPE being allocated to social care providers. Scottish Care worked with NSS who quickly resolved these issues and discussed the calculations that needed to be carried out to ensure staff had sufficient PPE in April 2020.

30 Care at home staff were sometimes attending homes in which there were other people living with the individual receiving care. This meant the potential for close contacts for staff was not limited to those receiving care. This caused additional concerns for staff and, when PPE became available and staff were being told that they had to wear it, often no one else in the house they were in would be wearing PPE. This made some staff feel unsafe.

31 Some providers raised concerns that although their staff had procedures to follow for the disposal of PPE, it appeared (as a result of discovering PPE in the general waste) that these procedures were not being followed by others visiting the home.

32 When it became a requirement for care at home staff to wear PPE it was at times difficult to find a balance between the use of PPE for protection and the impact it had on some people receiving care. When wearing PPE people cannot see their carer's facial expressions and it often makes understanding what is being said more difficult for those who have hearing loss. More than 70% of those over the age of 70 have hearing loss, therefore this issue is likely to have affected a significant

number of people receiving care at home. This caused communication barriers, uncertainty and fear, which in some instances caused people to communicate their feelings in a non-verbal manner that put the care worker at risk.

Testing

33 Scottish Care advocated for social care staff to be given the same priority access to testing as health care staff. In April 2020, it was announced that care home staff and residents would be given enhanced testing access, however, this was not extended to homecare staff.

34 At this time, homecare staff were experiencing high levels of anxiety and distress associated with the fear of carrying COVID-19 unknowingly between the homes of the vulnerable people they were supporting. Scottish Care made representations to the Scottish Government that testing could help to reduce such fears as well as help to ensure critical homecare workers were off work for shorter periods of time when they or a family member were suspected of having COVID-19 but testing proved that they did not.

35 Inconsistencies between testing for care home and care at home staff persisted and Scottish Care was still calling for homecare staff to be able to access testing on the same basis as care home staff in September 2020.

36 When PCR tests were required, accessing testing sites was difficult as it often required individuals to travel which proved to be a barrier for those homecare workers who did not drive. In care homes staff would test in the home, but there was no consideration of how those providing care at home could access testing. It took a number of months for care at home staff to be granted enhanced access to testing and it was not until January 2021 that priority post boxes were designated for care staff to post their PCR tests without having to travel to a testing facility.

Impact of the isolation of those receiving care

37 Many individuals receiving care at home were also shielding and not going outside because of the potential risk of COVID-19. Care at home staff reported the impact that continued isolation was having on those for whom they were providing care such as low mood, reduced appetite and changes in behaviour. These were implications of lockdown that were not widely recognised at that time.

38 Staff reported feeling like they were put in a difficult position in such circumstances. Staff often did not want to leave a person's home because they were acutely aware that the individual was lonely and they knew that they would be the only contact that individual would have all day. This was in contrast to the position prior to the pandemic where the person receiving care at home would have had access to services such as social activities and day care services and may also have had visits from family and friends. Staff did not have the capacity to stay beyond their allocated time and in many areas were

(and are) required to clock in and clock out for each home visit. If they did stay beyond their allocated time, in some areas of Scotland the company for which they worked would be penalised by the local authority for not complying with the agreed service levels.

39 This was a conflict that staff had to come to terms with during the pandemic. Many individuals choose to work in the social care sector because they are caring individuals but they had to put an emotional barrier in place and leave the home despite wanting to do more to help. I recall a care at home worker speaking about the coldness they felt they had to bring to their role, which did not align with their reasons for working in the social care sector. That individual no longer works in the sector.

40 For the length of a visit to be extended, a social work assessment is required and during the pandemic there was a huge backlog of requests for social work assessments as it wasn't clear from the available guidance how such assessments were to be performed.

Emotional impact and impact on staff morale

41 The pandemic took a huge emotional toll on Scottish Care's care at home members, providers and employees. Initially there were similarities in the concerns being raised by care at home and care home staff and during Scottish Care's online meetings with its members, both were expressing fear and uncertainty.

42 However, during the course of the pandemic, Scottish Care started to see a divergence in the concerns being raised by those providing care at home and care home providers. Care at home staff felt invisible and this understandably had an impact on morale. This partially stemmed from the lack of (and later limited) specific guidance for care at home, reduced access to PPE and lack of enhanced access to testing as outlined above.

43 Care at home and day care services did not feature in conversations which were taking place on the national stage in the same way that care homes did. Care at home providers and workers often felt as if they were an afterthought. There also did not seem to be the same level of concern for vulnerable people receiving care at home as there was for those within care homes.

44 There was an impression that those writing the guidance did not fully know or understand the role, purpose and experience of delivering care and support at home. This made it harder for them to conceptualise the real and practical challenges that were being faced by providers and staff. For instance, there was a point at which care at home staff were told not to car share with each other when traveling to work or undertaking home visits. The reality is that many care at home staff car share because they do not have a car of their own or access to one which they can use for work. This showed a lack of understanding of the sector. The reality is that staff often have to be physically close to each other when they are working, for example to help lift or manoeuvre a person to whom they are providing care. Staff also raised concerns about the increased risk to themselves and the people to whom they

were providing care if they did not car share as the alternative was to take a bus which would put them in an enclosed space with lots of other people.

45 Staff spoke of instances where they were stopped by the police because there was more than one person in the car and there was a lack of recognition of care at home staff as key workers. In March 2020 there were instances of care workers being fined by the police when travelling in vehicles together. Scottish Care had to speak to the police in March 2020 to help them understand that although those providing care at home were not NHS staff, this did not mean they were not key workers. The fines were removed, information was put out across Police Scotland to better understand the situation, and guidance was given to care workers that should they get stopped, they should identify themselves as key workers.

46 Staff were also afraid of the possibility of taking COVID-19 home to their families. Many care workers have dual caring responsibilities – being both their employment and something they do in their personal life as carers, for example for parents. I recall one care at home worker describing that when they came home from their shift, as soon as they came in the front door they would shout at everyone in the house to stay away from the hall, strip off their uniform and put it straight into the washing machine and then run to the shower. They did this because they did not know if they were carrying the virus on them and were concerned for their children and loved ones' safety. That level of fear is uncompromising and it is also an undignified position for someone to be in.

47 In terms of staff shortages within the wider social care sector, these issues existed before the pandemic with the Scottish Social Services Council reporting that 62% of care at home providers in Scotland had reported vacancies in 2019 (and 63% of care homes for older people doing so). Staff in the social care sector are undervalued, under-recognised and underpaid. However, these issues were exacerbated during the pandemic and staff shortages increased and some members of social care staff left the sector due to burn out.

48 The Scottish Government funded a national mental health wellbeing helpline to support health and social care workers – this was set up in July 2020. However, the support for social care workers in relation to the trauma they suffered during the pandemic was insufficient and did not adequately address the trauma being experienced by social care workers.

Impact on day care services

49 Day care services are varied in their provision, but their purpose is to provide support to people with additional support needs in their local communities. Some are attached to existing community buildings, some exist in their own right as day care centres, some are attached to care homes and some involve taking individuals on outings such as to the cinema or the shops. Day care services can include providing social opportunities and entertainment, provision of meals and personal care.

50 Day care services were stopped in March 2020. Many of those who accessed daycare also received care and support at home. Overall, those individuals experienced a reduction in their support, as they were only getting their existing care at home package. Care at home services were not commissioned to fill this gap in care packages. Where care providers raised the need to increase a care package there were often delays in the assessment process to achieve this. This caused concerns in relation to increased isolation and people not getting meals that they would usually get from day care services.

51 Day care services were often overlooked or forgotten about during the pandemic and were not advised to fully reopen until October 2022. Providers did not have access to financial support during the pandemic and a lot of day care services have never reopened. This has reduced the opportunities that older people have to socialise with others and increases their risk of loneliness and isolation.

52 Scottish Care members have told us that local authorities have said that day care services are an old-fashioned way to provide care and support to older people and that people should instead access support through their own community, which I understand to mean that people who previously had access to day care services should make use of the services generally available in their own community, for example those provided by libraries, churches etc. However, the system is not set up for that type of support and community services will generally not provide personal care or the same level of support provided by care workers at day care services. As a result, those who previously had access to day care services do not currently have access to a replacement for that care.

Impacts of increased costs and administration

53 In Scotland there are many more smaller providers than there are large providers. You can count the number of large providers on one hand. Scottish Care has over 350 members which gives an indication of the number of smaller organisations operating in the social care sector in Scotland. Some of Scottish Care's members are charities which operate on a not-for-profit basis. Scottish Care also has members who came into the social care sector because they were unable to find care for their own parents and wished to have a positive impact on their community.

54 There is often a presumption that private social care providers, particularly those that operate care homes, make significant profits. However, this is often not the case. An industry report produced by IBISWorld in July 2023 stated that the average profit margin for care homes (which the report refers to as 'retirement homes') in the UK is 1.8% and the average profit margin for care homes with nursing is 2%. For care at home, referred to as domiciliary care, the average profit margin is 3.4%. It is worth noting that these profits are often reinvested in the services such as for staff training and building improvements.

55 Most care homes in Scotland are funded through the National Care Home Contract which sets the rates which local authorities pay care providers for residential care. The National Care Home Contract, when it was introduced, provided stability for organisations which operate residential and nursing homes, continuity for local authorities which act as commissioners and purchase care home places,

and transparency for those who are residents. However, it is based upon a cost model which is now outdated and is not financially viable. This model is based on each home having 50 beds and 100% occupancy and with a cap on profit at 4%. Care homes do not operate consistently at 100% occupancy because of the need to provide respite options and end of life support and many smaller homes, particularly in rural areas, do not have as many as 50 beds. Occupancy rates were lower than average during the pandemic as care homes were generally not getting many new residents, partially due to the way in which care homes were being portrayed in the media during this time.

56 The pandemic had a significant impact on the operating costs of care home providers. At the beginning of the pandemic PPE became 100% more expensive due to the demand for it and its scarcity. Scottish Care members reported that there were times when there were food shortages, which increased the cost of food.

57 Care homes had to increase the use of agency staff to make sure they had a sufficient number of staff when staff were off with COVID-19 or self-isolating and there are higher costs associated with agency staff. Care workers, including agency staff, must have relevant qualifications and be registered with the Scottish Social Services Council, the regulatory body for those working in social work, social care and services for children and young people. Care workers have a period of time from commencing their role to achieve registration, however, given the complexity of the services often required by service users including the use of hoists to assist with mobility and transfers and completing stoma care, training is required. Providing social care and support is a career where you can make a difference every day, and that requires a certain demeanour. Therefore, care providers could not easily replace frontline staff with other types of temporary workers. This was a difficult time for care providers. Scottish Care worked with COSLA and the Scottish Government to put financial sustainability arrangements in place.

58 However, there was a difference between the process by which care homes could access financial support and what other small businesses received by way of financial support. Other small businesses could access a lump sum grant to help them withstand the impact of the pandemic. These were payable in anticipation of the business suffering a financial impact – the business did not have to produce their accounts to show their increased operating costs or their downturn in profits. Social care providers were not eligible to apply for these funds and a separate funding process was developed by the Health and Social Care Directorate within the Scottish Government specifically for social care providers.

59 Social care providers could apply for funding for the additional costs that they incurred as a direct result of the pandemic. Payments were referred to as sustainability payments and they covered a range of costs which were inflated or new because of pandemic response, or in cases of under-occupancy in care homes as a direct result of the pandemic e.g. the repurposing of a bedroom into a covid test room, additional cleaning staff, inflated PPE costs.

60 Local authorities were tasked with receiving and assessing applications for sustainability payments from the care sector and distributing the relevant funds.

61 The applications for sustainability payments had to be made retroactively and required to be heavily evidenced – social care providers had to provide extracts of their ledgers or their management accounts showing the increase in their operating costs for the period for which they were seeking payment. At times providers had to undergo an open book exercise in order for sustainability payments to be granted.

62 Care providers were already under considerable pressure and this increased administrative burden added to that pressure. The time required to complete these tasks took time away from the other roles that they had to perform to keep the care home running and to support staff and residents. Some of Scottish Care's members felt the pressure of carrying the legacy of a family business and caring for people they knew in their community. The stress of potential financial liabilities compounded the emotional stress such members felt due to that community responsibility.

63 As increased operating costs had to be claimed retrospectively, care providers had to cope with a high level of uncertainty as to whether funds they expended would be recovered. There were inconsistencies in the approach being taken by local authorities to applications for payments. For example, one care home was permitted to recover the costs for hiring a portacabin to put in their car park so that staff could carry out testing outside of the care home itself to make it safer. In one part of Scotland that was deemed acceptable and in another part of Scotland it was not. In the earlier stages of the pandemic, it was acceptable for providers to claim for the costs of laptops, e.g. so that staff who were not directly providing care to residents could work from home, thus reducing footfall. However, there were instances in which a provider had not claimed for a laptop in their first application for financial support, because it did not know it could make that type of claim, and the claim was denied when submitted in a subsequent application.

65 Members could not plan ahead to try to ensure financial sustainability because of the short-term nature of funding support and decision-making, with agreement to extend support happening often on the day it was set to expire. Some smaller providers had to have conversations with banks about how they could make themselves viable or sustainable going forward. I am also aware of some providers who wanted to pay their staff more during the pandemic, but they did not know whether they would have the finances available. The financial instability also made it hard for care providers to reinvest in their businesses and so there was a hiatus on any investment or development of the care homes, which ultimately impacts residents and staff.

66 Scottish Care worked with COSLA and the Scottish Government via the Financial Support for Social Care Providers Working Group to produce guidance on the costs providers could seek to recover. The strategic working group was effective, also acting as a 'trouble-shooting' group for strategic issues. However, there were significant delays in accessing this funding on the ground. Local authorities did not have sufficient resources to process the applications and at times did not explain why applications

were refused or partially granted. Scottish Care knows of some care providers that waited months and others over a year to receive the funding they had applied for. This delay is difficult for any business but particularly so for a smaller organisation. Scottish Care knows of one care provider which is now being asked to pay back some of the funds it received, because the local authority does not agree with what it spent the funds on. This resulted in Scottish Care acting as a 'go-between' providers and local government where a resolution could not be sought nationally.

67 Scottish Care liaised with COSLA to highlight the pressures that the sector was under and the challenges that applicants were having when attempting to access sustainability funds. Scottish Care also ran joint webinars with Chief Finance Officers of local authorities to help them to navigate the social care sector and understand the challenges that it faced. Scottish Care also directly supported its members to navigate the systems of funding that were potentially available to them. It collated opportunities for funding and highlighted these on its website and hosted webinars to support members with the processes for obtaining funding.

Social Care Staff Support Fund

68 The Social Care Staff Support Fund was established by the Scottish Government in June 2020 in an attempt to ensure that social care workers would not face financial hardship as a result of testing positive for COVID-19 and having to isolate. In such circumstances, social care providers were required to pay social care workers and then recoup the costs from their local authority. There were however long delays in payments being reimbursed to social care providers and Scottish Care worked closely with trade unions, COSLA and the Scottish Government to try to resolve this issue. The Fund was initially put in place for approximately four months but it was extended a number of times. Each time it was very close to the expiry of the period for which the fund was in place before an extension would be confirmed, on at least one occasion it was extended the day after it had expired. This caused stress and anxiety for providers and staff.

Data requests

69 During Scottish Care's online meetings, members raised concerns about data requests that they had started to receive. They would receive multiple requests for the same information from their local authority, the Scottish Government and the Care Inspectorate.

70 I do understand why some of that data capture was necessary, indeed, Scottish care had been the first to recommend sector wide data collection in resilience planning when preparing for Brexit. However, the sector was already overstretched and unnecessary additional pressure was put on providers and managers by requests by different organisations for the same information in different formats, some to be submitted daily, some weekly – which meant they could not simply forward the information to each organisation making the request. This again took staff away from caring for residents and supporting people in the community. There was also no reciprocity – care providers

were not given access to the data at a strategic level to show them the impact that the data provision was having. This remains the case.

Scottish Care's engagement with the Scottish Government

71 During the pandemic the social care sector often felt like it was not being heard by those that were making decisions in relation to it and that its expertise was not respected. Scottish Care sought to be the voice for its members and the wider social care sector in Scotland and to advocate for it throughout the pandemic.

72 In part, Scottish Care did this by attending meetings and working groups convened by the Scottish Government. It also maintained regular and direct communication with Scottish Government officials on key issues including the financial sustainability of care providers, testing, regulatory and other oversight, PPE and workforce related matters.

73 Scottish Care participated as subject matter experts in groups including:

73.1 **National Contingency Planning Group** ("NCPG") from 12 March 2020. NCPG was chaired by COSLA and comprised representatives from Health and Social Care Partnerships, service providers, regulators, national and local government and unions. NCPG had oversight of all issues relating to social care including data and statistics, updates from the World Health Organisation, financial matters and clinical practice It later merged with the Pandemic Response in Adult and Social Care Group referred to below.

73.2 **Clinical Practice Advisory Group for Care Homes** ("CPAG") from 22 April 2020. CPAG was jointly chaired by the Chief Medical Officer ("CMO") and the Chief Nursing Officer ("CNO"). CPAG was essentially a sub-group of NCPG and was set up due to being a significant issue which required an additional forum for discussion. Meetings were initially held on a weekly basis on a Thursday from 1pm to 2.30pm. The frequency of meetings later reduced to fortnightly and at the end of the life of this group meetings took place occasionally, as required. This group was disbanded on 15 December 2022.

73.3 **Mobilisation Recovery Group** from 22 June 2020. This group was chaired by the Cabinet Secretary for Health and Sport with attendance from the Minister for Mental Health and the Minister for Public Health, Sport and Wellbeing. A wide range of stakeholders were represented at this group. The Scottish Government described the role of this group as generating "key expert, stakeholder and system-wide input into decisions on resuming and supporting service provision, in the context of the COVID-19 pandemic". This group met once or twice a month until Spring 2021;

73.4 **Pandemic Response in Adult and Social Care Group** ("PRASCG") from 9 September 2020. PRASCG was jointly chaired by COSLA and the Scottish Government. It was a wide stakeholder group with a focus on the whole of the social care system. Non–clinical issues

including those in relation to finance, sustainability, workforce and partnership were discussed at PRASCG. Meetings were held weekly immediately before meetings of CPAG;

73.5 **Care Homes and Staff Testing Group** from September 2020. This group met weekly to discuss issues relating to testing for COVID-19. At these meetings, Scottish Care frequently raised local issues that had been experienced in care homes and by homecare providers including issues relating to access to testing;

73.6 **Coronavirus (COVID-19) – Care Home Outbreaks: Root Cause Analysis – Reference Group** in October 2020. The Cabinet Secretary for Health and Sport commissioned a review into the circumstances surrounding the occurrence and transmission of COVID-19 infection within four care homes in Scotland. The review team was assisted by a Reference Group, on which Scottish Care was represented by Dr Donald Macaskill. The Reference Group's role was to review the process, methodology and list of stakeholders to be interviewed by the review team and to provide a sense-check of the high-level findings and recommendations of the review process. The Reference Group met on 15 and 27 October 2020; and

73.7 **Social Care Systems Pressures (Silver) Group** from 5 October 2022. The Silver Group is a stakeholder group which was established to replace PRASCG and to consider a national approach to pressures on the resilience of the social care sector.

73.8 **Financial Support for Social Care Providers Working Group** from July 2020. Scottish Care met with COSLA and the Scottish Government from May 2020 to discuss the sustainability payments for the sector. These sustainability discussions lead to the forming of the working group. The group had its first meeting in July 2020 and met frequently until the group was disbanded in 2022.

74 Either Dr Macaskill or I attended these meetings on behalf of Scottish Care – on occasion we both attended NCPG, CPAG and PRASCG. This gave us the opportunity to make representations to Scottish Government and other bodies on behalf of our members.

75 There were a number of instances where Scottish Care was able to help effect change or where Dr Macaskill's or my contributions helped to shape the decisions that were taken – for example in the discussions in relation to banning the use of agency staff in care homes referred to above, Scottish Care was able to explain that, while care homes always preferred to have their own employees, it was at times necessary to use agency staff to ensure adequate staffing levels due to staff shortages, illness or when staff had to self-isolate. These views were taken into account and the ban was not issued.

76 However, there were other times when it felt like the representations made by Dr Macaskill or me were not taken into account by the groups. At other times we felt that we were not given the opportunity to contribute as, for example, some meetings were used as a platform for the Scottish Government to provide an update setting out the most recent collated data, which was generally dominated by

healthcare data. This was frustrating as we were often the only representatives from the social care sector in these groups despite them having being established to focus on social care. After some time, representatives from two care home providers were included in CPAG however there was always a greater number of representatives from the healthcare sector included in these groups.

77 During the pandemic it often appeared that decision makers relied on information from the healthcare sector to make decisions about social care which was not always appropriate. In May 2020, the Cabinet Secretary for Health and Sport announced arrangements for "*enhanced professional clinical and care oversight of care homes*" which instructed Health Boards and HSCPs to establish multidisciplinary teams to scrutinise and support care homes. Executive Nurse Directors were given responsibilities to establish teams to inspect infection prevention and control arrangements in care homes. This approach frequently resulted in contradictory advice and guidance being provided to staff from these teams and the Care Inspectorate. This also resulted in a clinical approach being applied to care homes by practitioners who did not have any expertise in a social care context. However, more generally social care staff felt that their experience and expertise was not respected by those who were providing oversight. This had a significant impact on staff morale.

78 It was against this background that I spoke to one care home manager who told me that they felt suicidal as a result of pressures they were experiencing in pandemic response and this pressure was heightened following a visit by an infection prevention and control oversight team which they found demoralising and distressing. I had to be clear that I was not qualified to support them but I was able to speak with them. I felt a responsibility to do something and I knew I could put my energy into tackling the system and the systemic challenges perpetuating the lack of confidence and self-worth in care staff. Scottish Care continued to raise the issue with Scottish Government about the impact the oversight teams were having on care home staff via PRASCG and CPAG groups even into 2022.

79 Scottish Care then hosted a focus group with members about their experience of regulation and oversight during the pandemic and issued a survey to all members. I wrote a report in November 2021 based on the experiences members shared which was shared on Scottish Care's website. While this was not an academic report, it contained valuable evidence from the care sector about the challenges it was facing. I shared an embargoed copy with Scottish Government and the Care Inspectorate as. The Care Inspectorate responded on the same day it was issued and they asked to make some changes before the report was published. I never received any formal response to the report from Scottish Government although it was presented at CPAG. A few months later the Scottish Government commissioned a similar piece of work and they asked me to co-chair a group in connection with this work.

80 In terms of Scottish Care's engagement with HPS/PHS and guidance, when HPS first published guidance in relation to care homes, and after much persistence, Scottish Care was given a very limited opportunity of a few hours to review it before it was published. However, on most other occasions Scottish Care did not see the guidance before it was published and had to review it once it was published to ensure it was fit for purpose. Scottish Care was able to provide feedback on how guidance

would operate in practice, which was often informed by information gathered from members during our online meetings. A recent example of this is when care homes were included in the same guidance as prisons in relation to winter planning. Scottish Care had to highlight how inappropriate this was and it was later changed. Throughout pandemic response, I believe that the input of Scottish Care/the social care sector could have reduced some of the unintended consequences or made the guidance easier for the sector to understand and follow. This must be a key learning and an approach to pandemic preparedness for future.

Signed:

Personal Data

Date: 14/03/2024