HOUSE OF COMMONS

Scottish Affairs Committee

Oral evidence: Coronavirus and Scotland, HC 314

Thursday 10 September 2020

Ordered by the House of Commons to be published on 10 September 2020.

Watch the meeting

Members present: Pete Wishart (Chair); Mhairi Black; Deidre Brock; Wendy Chamberlain; Alberto Costa; Jon Cruddas; Sally-Ann Hart; John Lamont; Douglas Ross; Liz Twist.

Questions 407 - 458

Witnesses

I: Dr Donald Macaskill, Chief Executive, Scottish Care, Theresa Fyffe, Director, Royal College of Nursing Scotland, and Wilma Brown, Employee Director, NHS Fife, and Lay Activist, UNISON.

Examination of witnesses

Witnesses: Dr Donald Macaskill, Theresa Fyffe and Wilma Brown.

Q407 **Chair:** Welcome to this sitting of the Scottish Affairs Committee to help us with our inquiry into coronavirus in Scotland. Today we have representatives of key workers, and we are very grateful that you have found the time to join us and help us out today. For our record, could you say who you are, who you represent and anything by way of a short introductory statement? We will start with Dr Macaskill.

Dr Macaskill: Thank you, Chair. My name is Donald Macaskill. I am the Chief Executive of Scottish Care. Scottish Care is the representative body of providers of adult social care, mainly older people, in Scotland. Our membership covers the voluntary, charitable, not for profit and private sector in Scotland, and collectively employs just over 100,000 workers.

Appearing before the Committee, it is difficult to make any statement without making reference to the fact that, as of yesterday, 1,956 individuals have lost their lives to Covid or Covid-related symptoms in Scotland's care homes. In addition, tens of hundreds of individuals have lost their lives in the community—individuals who received home care. For the workers, regardless of who they are—be they in the community or in care homes as nurses and frontline staff—their experience of the last six months has been one of immense hardship and desolation. It is impossible for us, as an organisation, to reflect on the period that we have just come through—and are still in—without thinking about each of these individuals.

While the nation has stopped clapping for carers, we have continued every Tuesday evening at 7 pm to light a candle for care. That is a candle in the last few weeks that has remembered the grieving that has happened, is happening and is still going on. We remember those who wait to be reconnected with their family again, maybe after six months of separation, and we remember the astonishing professionalism and dedication of women and men who went beyond themselves to express humanity at its best.

Despite all the issues we will doubtless talk about this afternoon, I want to start by recognising that for the care sector in Scotland, we owe an immense debt of gratitude to those who work in it. All the time we need to remember and hold before ourselves those who have lost their lives in the community and in care homes. Thank you, Chair.

Chair: Thank you very much for that, Dr Macaskill—very wise words. I will come back to that once we have heard from everybody else.

Theresa Fyffe: I am Theresa Fyffe. I am Executive Director within the UK Royal College of Nursing and I am also the Director for Scotland. I also happen to be the executive lead for the development of an

independent health and social care sector strategy on behalf of my organisation.

The nursing workforce have been unstinting in their professionalism and agility as key workers to provide care throughout the pandemic. However, there were both immediate issues and deep-rooted problems that affected nurses' ability to fight Covid-19. Two of the biggest concerns for our members were around PPE and Covid-19 testing for health and care staff. The Royal College of Nursing and the trade unions reacted to this crisis within care homes in every area of our activity over the last six months, and we are determined that the problems that have been highlighted by the crisis do not fade away into the background. It would be a huge failure if we do not learn the difficult lessons of the pandemic and tackle head-on many issues that have for years been placed in the too-hard-to-do box. Thank you.

Chair: Thank you very much. Lastly, Ms Brown.

Wilma Brown: Good afternoon, thank you. My name is Wilma Brown. I am the Employee Director in NHS Fife. I am the representative of workers across all sectors within health for UNISON. I can hopefully bring to this Committee some of the real experience of what happened when this pandemic hit our wards, departments and care homes—lots of different issues—and speak up for those staff who felt totally lost and anxious for their own health and their own safety, and that of their families, while without hesitation fighting at the frontline to make sure that our patients were cared for properly. This is not just nurses and doctors but the whole team. It is not about nurses or doctors; it is about the whole team who bring care to these patients and ensure that they are fed, ensure that the hospital is clean and ensure that the stock is brought to the frontline—all that. It is a huge exercise and we were very happy to support our staff members through that pandemic and continue to do so.

Q408 **Chair:** I am grateful to all of you. Reflecting on the words of Dr Macaskill at the outset of this session, from all the Committee we want to pass on our gratitude for the efforts and dedication of all your members, who have done everything possible and beyond the call of duty to keep everybody safe, so we want to thank you and your members. I hope that is going to be passed on from all of the Committee here today.

Dr Macaskill reminds us of the 1,956 cases, and I think 46% of all the total deaths have occurred in care homes. While we were grateful that we heard yesterday there have been no further coronavirus deaths in the sector, something went wrong given the fact that so many people have died in our care homes. I want to ask you first of all where you think the problem occurred. What happened to lead to these levels of deaths in our care homes? Is there anything that you observed that you felt could possibly have been done to mitigate some of the things that we saw? We will start with Dr Macaskill.

Dr Macaskill: The first thing to say, Chair, is that we knew when the virus started to appear in December/January in China that it was particularly virulent among a sector of the population who were over a particular age, and who had comorbidities and essential vulnerabilities. The care home sector in Scotland has experienced the same level of trauma as many other care homes across the world. I know from speaking to international colleagues that many of our experiences mirror theirs. We were always going to be in a situation where those who we term "the older old"—those who are particularly frail—were the most vulnerable to this pandemic and the virus. I am very cautious of using the word "hindsight", because I think it has sometimes been overused, but we were aware of the dangers.

At the beginning of February, as a national organisation we held our first meeting. We issued the first guidance to the care home sector—indeed, among the first in Europe—on 26 February. We recognised that the whole of society needed to prioritise the care and support of older individuals. That is clearly not what we saw. Instead, we saw in every country in Europe—Scotland was no different—the prioritisation of the acute medical clinical sector and the priority to create capacity in that sector. That led, I think in no small part, to a disproportionate focus on readying the NHS at the expense—because you only have a limited amount of energy and resource—of the social care sector. I think that is the first thing.

We should have seen and we should have heard what was happening elsewhere in the world. Collectively across the United Kingdom, we failed to do that and by so doing we failed some of our most vulnerable citizens. In later discussions this afternoon, we may go on to talk about issues such as PPE, but one of the first elements that has caused the care home sector particular difficulty was confusion around the issuing of guidance. That guidance gave the impression—however erroneously, but nevertheless the impression was given—when it was issued on 12 and 13 March that individuals in care homes should not be enabled to be removed from those care homes and should be treated and supported in the care home sector.

Q409 **Chair:** Can I just stop you? We are going to come specifically to guidance and we will be touching on issues with PPE, but I just wanted your general impressions. That is really helpful and thank you for that, but I am keen to make sure that we get the best out of your time here today. We are going to come back to Dr Macaskill in a minute, but I would like to hear from Ms Fyffe.

Theresa Fyffe: Care homes have been at the centre of the crisis, despite the commitment of staff to try to keep residents as safe as possible, but it became clear from the start of the pandemic, as Donald said, that naturally the focus started with the NHS and thereby the acute hospitals. If you look at the resilience planning that was undertaken, it was fairly clear that both community and care homes were not included in that. It is, therefore, not surprising when the processes that were put in place to

deal with the pandemic became NHS and particularly acute hospital-focused and thereby did not do the right thing by the care home sector. This also impacted on community within there.

The other aspect is that there is a complexity of clinical need within care homes. We have made significant changes to models of care over the years—quite rightly. I see those models of care being the right place for people to not be in acute hospitals, but to be within care homes. But we have not addressed the fact that we have people in care homes with significant clinical need, and need a workforce who can support that clinical need. Prior to the pandemic there were workforce challenges in the care home sector and they became even more apparent in response to the pandemic. That also impacted on community and care homes.

One example is that in order to get ready for staff to be within acute hospitals, particularly in intensive care, community staff were taken back into acute hospitals—for example, health visitors in one area who were there for child protection. The notion that child protection was not going to be an agenda for people when children were not at school and elsewhere was wrong. Again, the focus was on acute, which I can understand because of the worry about the number of people requiring intensive care beds, but it left the care home sector and community at risk.

Wilma Brown: Much of what has been said I completely agree with. The prioritisation around the acute hospitals was huge in the beginning, trying to make sure that we had equipment, staffing and resources for those who would become very acutely unwell, and for having step-down and step-up areas and red and green zones, for example. I believe that there was not enough focus on the staff within the care homes and how they would manage the patients coming and going, as inevitably they were picking up things.

When patients were brought to hospital unwell and did not perhaps need an acute bed, they were automatically sent back home to the care home, because that is their home at that time, and the staff were not ready to care for them. They did not have the resources; they did not have the training. They knew the basics around PPE and infection control, but they did not have the skills or the education to help them to deliver the best care possible.

Q410 **Chair:** Thank you for that. I want to come back to something that Dr Macaskill said. I think the conventional view is that at the beginning of the epidemic, it was the desire to ensure that there was hospital capacity in acute wards that led to the transfer to care homes. You started to talk about the guidance and I want to explore this a little bit further with you, Dr Macaskill. What was the guidance to you from both the Scottish and UK Governments in relation to care home staff and nurses? Was the experience of those who actively worked in care homes listened to as that guidance was designed and put forward?

Dr Macaskill: This has been one of the experiences throughout the pandemic, Chair: we have had a multiplicity of guidance. At my last count we are on to the 13th version of guidance for care homes. It is understandable, as we have changed our understanding of the virus, that there will be additional guidance. I think there are lessons that we have learned about how you communicate those changes, and how you communicate what is new in the guidance that you are issued.

If we go all the way back, the first guidance that was issued by Health Protection Scotland was issued on 12 March. It was followed the next day by clinical guidance from the CMO and the Scottish Government on 13 March. That guidance caused us particular concern and there are elements of concern. First of all, it contains a sentence that suggested that individuals should not be transferred to hospital. I then met the Cabinet Secretary on 18 March, and in response to that, that section was significantly altered to make it clear that that should not be the presumption. That was the new guidance issued on 26 March. However, there was undoubtedly within the system a presumption that care homes should care for and treat individuals who became Covid positive, and that led the interim Chief Medical Officer to reissue a reminder towards the end of April. That was one area of concern about guidance.

A second area was in relation to admission from hospital. I think it is fair to say—I have been very open about this—that we had not had a good prehistory about the assessment of individuals moving into the care home sector. There are lots of reasons for that, but at the very least there was suspicion among my members and staff that people were being inappropriately discharged without the rigorous element of assessment that was required. I am not explicitly talking about testing, but that is an element. That lack of open transparency and trust led the sector to be very uneasy. Some openly admitted individuals—a confidence that the assessment was adequate—and others refused to admit. Again, when I met the Cabinet Secretary on the 18th, we addressed that issue and the guidance on the 26th became much more explicit.

In general terms, as the pandemic has progressed, there has been much engagement with the sector. We have been involved—staff and trade unions have been involved—in the development of additional guidance, but the early stage of the pandemic was illustrative of a lack of prioritisation for social care and, to be honest, a lack of real engagement with social care in the months and years before.

Q411 **Chair:** Thank you for that. Ms Fyffe, could you maybe address some of the issues about the Governments, both Scottish and UK, listening to and acting upon the experience of your members? Did you get a sense that you were being engaged with and that you were being listened to in terms of what was happening in the care sector?

Theresa Fyffe: If I am honest, as I said at the beginning, there is a deep-rooted problem about where the engagement was between the care home sector and others. I am not saying that is just one-sided, because

it is not, but there was a definite problem there. As a result of a flurry of guidance and the need to be acting, it caused a great deal of confusion and anxiety among our members. But the support processes were put in place and there was a lot of learning and a lot of listening.

It was not always easy. I am around the table with Donald in a number of these meetings and recognise that the team working to support the care home sector were doing it with the best intent but, no matter, when you are in a pandemic crisis, people will say things that will be taken the wrong way or misinterpreted, and not necessarily have those relationships. That is what I mean by the deep-rooted problem. This was, for some people, very new because they had had no engagement with each other and, therefore, said things that were not always interpreted the right way.

We felt that we were heard. I am not saying everything we wanted was actioned, because it was not always easy, but we did feel heard with regard to our members and we did feel listened to. I think that we had to keep bringing the message forward because staff voice can get very much lost in all of this. While there is a very clear process for staff voice within the NHS structures, that is not necessarily the case within the care home sector, but I am talking staff voice now, not employer voice. That was a concern for me.

Q412 **Chair:** Thank you for that. Lastly from me, Ms Brown, is that your experience? Is that what you found? Can you tell us a little bit about what happened in terms of communication and the guidance?

Wilma Brown: I think that in the initial meetings the voice of care homes was not there in terms of workforce. We had a Scottish senior leadership workforce group that met initially, I think, two or three times a week, and every day we would be on that call discussing guidance, what is happening now, and what are people's fears and anxieties. I distinctly remember saying, "Where is the voice of the care homes here?" because we were getting more and more concerns and frustrations raised with us by people in the care homes—the members. I remember raising that through the Scottish leadership workforce group. It took probably eight weeks—12 weeks maybe—before we had joined-up working with the care homes and different people were invited to join that group, because that group was very powerful in terms of feeding straight into the Cabinet Secretary. Where we had raised things with the Cabinet Secretary, they were being paid attention to. I think, although it took time, we got there in the end, but it should have been a priority. Those things should have been working together and the care homes were very much brought to the party late.

Q413 **John Lamont:** I start by echoing the comments of the Chairman at the start in terms of the huge respect we have for the care workers and people working in your sector given everything they have had to deal with over the last few months. It cannot have been easy.

I am going to pursue the line of inquiry about communications and guidance, but I want to get some clarity first. The Chairman made reference to guidance from the Scottish Government and UK Government over the last few months, but to be clear, the bulk of the guidance and direction that you have been dealing with over the last six months has come from the Scottish Government as opposed to UK Government ministerial direction. Ms Fyffe?

Theresa Fyffe: No, because as the UK Royal College of Nursing, we were working very clearly with the development of the UK guidance. That guidance, as we know, through the various processes that were put in place, was then taken into Scotland and put into the context of working within Scotland. Because I have an executive UK role, I would be working with the guidance across a number of different places, but obviously in Scotland, we had a number of meetings of groups that Wilma is part of, I am part of and Donald is part of, where thereby the guidance that was available was then discussed. I had also, along with others, individual meetings with the Cabinet Secretary to discuss any issues we had within the guidance, particularly around PPE, and also around testing and some of the assessment areas that Donald has been referring to.

Q414 **John Lamont:** But it was the Cabinet Secretary for Health in the Scottish Government who signed off the guidance for Scottish care homes, yes?

Theresa Fyffe: Yes, specific to the care homes, absolutely. Sorry, I misunderstood that. Yes, absolutely, and we then had a working group—it has now changed its name—that was working on the guidance and all the elements of the hub model, and on support for the care homes. I was party to that as the Royal College of Nursing.

John Lamont: Yes, understood. Dr Macaskill, do you agree with that or do you have anything to add?

Dr Macaskill: No, I agree with that. As you would expect, the Health Secretary in Scotland had ultimate sign-off, especially on infection control, PPE and testing, which was drawn significantly—certainly in the early days—from UK guidance. Indeed, the first clinical guidance on 12 March was substantially that produced by Public Health England.

John Lamont: Ms Brown, do you agree?

Wilma Brown: Yes, I do agree. I did find, however, that sometimes with the guidance that came out, especially in the early days, the Cabinet Secretary was not always informed of everything that was going on. In UNISON, we also had regular telephone conferences with the Cabinet Secretary and there were a number of things that I raised with her around PPE that she was not aware of. I think she is as good as what she is told, but I do not think she was always told everything that was going on.

Q415 **John Lamont:** That is interesting. Picking up on that initial communication, and thinking back to those early days in terms of how

your sector was getting communications and instructions from the hospitals locally, from the council and from the Scottish Government, was it all linked up? Was it done in a strategic way? Was it clear who was in charge?

Theresa Fyffe: Yes, I do believe it was, but in a way it reflects what Donald was saying. It was a flurry of activity. We were responding to guidance and new guidance, and some of that is what I meant about coming from the UK guidance, and changes and evidence coming out, and also then to what is working on the ground—gathering that intelligence from across Scotland—and understanding what was happening. We did have a strategic place to discuss and to work on that. We had a group that worked on its own and reported back into the main group to work more closely on the guidance that was required. That is where there was much more engagement with some care home sector employers.

But if I look back on it, it was at a pace—we were working at a pace with a feeling of needing to address the challenges. I take you back to my point: because there had not been those established ways of working, it was harder to get that into place with the pandemic. I think when we look back and learn, we realise that we needed better established ways of working with the care home sector from a number of different agencies. I think that is a lesson we will have to take and learn for the future.

Dr Macaskill: I would agree with everything that Theresa has just said, but I would also want to indicate that as well as pace, there was real fear in the system. Sitting here as we are in September, we have lost sight of that level of real crushing anxiety as workers went into care homes not knowing what to expect and then, tragically, as multiple lives were lost in those care homes and there was uncertainty at clinical environments over what this disease would mean. Yes, there was a tremendous amount of activity—a flurry and pace—but there was also real anxiety. I am absolutely confident in saying that when we, as an organisation, highlighted the concerns we had, issues were dealt with.

There were problems and there were challenges, but one would expect that in the face of an emerging global pandemic, which none of us had come across. To underline what Wilma said earlier, the care home sector has a basic knowledge of infection control, so if you give us norovirus or the flu, we will manage that well. Give us a new international global pandemic and we are extremely challenged, especially one that attacks the most vulnerable, who just so happen to be in a sector that is the least well resourced to meet that challenge.

Q416 **John Lamont:** Picking up on that initial guidance, I fully accept the challenges that we faced at that particular point, but one of the common complaints I have had from my constituents was about the uncertainty in that guidance. I know we are going to come on to discuss PPE later, but one of the issues that commonly came up in my constituency was whether the initial guidance said that PPE was only to be worn with

positive cases of Covid. From my impression of what my constituents and those in the care home sector were telling me, it was not particularly clear. Are you able to give us some guidance as to what your understanding was of the rules and the guidance at that early stage? Ms Brown, perhaps you can kick off with that.

Wilma Brown: Yes, absolutely. The staff in the care homes were told that they did not need to wear anything other than a mask, an apron and a pair of disposable gloves with any case. They did not know how to look after a cohort of patients. I do not work in care homes, but my understanding is in most of these care homes, patients would be in separate rooms. They were given perhaps one or two masks that were supposed to last them the whole day. They were changing their aprons, but they were going in and out of different patients' rooms—different infections; some without any infection; some who were negative at that time—with the same PPE on. They were given gloves that they were wearing more than once. The reason for that was that they did not have enough.

There were comments made around that time about not distributing the stock that was coming into health boards too far and wide because they needed to preserve it for the acute hospitals so that when patients were in ICU we had the adequate amount of PPE. The nurses and carers within care homes do not wear the same level of PPE that they would wear in an ICU. It is completely different for the PPE that is required, but the nurses and carers in the care homes did not have enough of anything to do their jobs properly.

On the communication thing, I think that there was a clear line of communication eventually. I think that point came when the Chief Nursing Officer for Scotland got the directors of nursing within health boards to put out a mandate to say they should oversee the care homes and they should make sure that the care homes have the information they need, the equipment they need, and any support and guidance to ensure that the same thing was being carried out across Scotland. When we got to that point, the care homes felt that they at least had support and guidance, but up until then the guidance and the communication out to care homes was not great.

Q417 **John Lamont:** To be clear, did that initial guidance you were referring to when you were describing what was happening in care homes come from the NHS, or did it come from the Scottish Government?

Wilma Brown: That came from Scottish Government.

Q418 **John Lamont:** Thank you. Ms Fyffe and Dr Macaskill, do you agree with that or do you have anything to add?

Theresa Fyffe: I agree with that. At the beginning there was not enough stock and not enough clarity about what care homes required for PPE, and many care homes found themselves left without the appropriate PPE that they required. It was not just intervention in our clinical role; there

was also a change in the supply model that very quickly addressed some of those problems. They put in a better process for getting PPE to care homes, because geographically it was a big challenge. If you take the north of Scotland, you have care homes dotted all along the coastline, so there was an issue of getting it there. That improved once they got into a hub model of delivery.

Donald quite rightly referred to the stress of the staff. The thing I understand fully from having spent time with care home staff, and also my own experiences, is that when you are in a care home, with the relatives of the people you are caring for, you can be even more distressed because of that very close relationship with that group of people when people are dying, and also when they felt they were not doing right by their patients and by the residents within care homes. At the beginning it was a very difficult place for the care home staff and for the residents within the care homes.

Dr Macaskill: I think there are two things we need to differentiate here about what the guidance said about PPE and how that changed. The second is the supply of PPE. In terms of the first, the guidance was extremely clear on the 12th, which was the same guidance that was broadly made up and developed by Public Health England, and on the 13th. That did clearly indicate that PPE should only be used for individuals who were Covid positive. We clearly did not know then what we know now, which is asymptomatic presentation and the requirement of using PPE for the whole of the care home population in all instances. There were undoubtedly instances where there was a preservation of stock that was available because it was deemed not to be necessary either in the community or in the care home. Undoubtedly, as we got to know more about the virus, that changed because we realised that we needed to use PPE in the community and in care homes in a different way. Indeed, my own organisation was the first to call for that change on 26 April.

The second issue relates to the supply of PPE. I do not know if you want me to talk about that now, but I think we addressed it differently in Scotland.

Chair: We will leave that. We are going to deal with that specifically, so we are going to leave that just now.

John Lamont: Thank you very much. That was very helpful.

Q419 **Sally-Ann Hart:** Thank you to all our witnesses who have come here today to talk to us. I wanted to talk a bit about the testing. I know that the testing in care homes in Scotland is the responsibility of the Scottish Government, who told us from mid-April that they were testing new residents coming into care homes. I wondered whether this was your experience. Perhaps Dr Macaskill can answer that first.

Dr Macaskill: I think the testing of individuals around admission has been one of the challenges during the pandemic. The first guidance—and indeed the guidance on 26 March and the guidance at the beginning of

April—indicated that it was not necessary to test an individual at the point of discharge into hospital, but that there should be adequate clinical assessments and a risk assessment undertaken on that individual. Clearly, as a representative body, we had adopted the WHO stance of test, test, test, and some of our members refused to admit an individual without them being tested. Others admitted, but then isolated for 14 days on the basis that a test will only tell you whether somebody is Covid positive or negative at that particular period of time.

Over the period, testing got better. First of all, we got testing in mid-April of individuals who were symptomatic in hospital and then discharged. Then following the First Minister's announcement on 1 May, we got two tests for individuals who were symptomatic and Covid positive, and one test for an individual who was non-symptomatic and potentially asymptomatic both from hospital and in the community. That intervention in April and early May made a significant difference. However, I cannot sit here and say that every single discharge at that period adhered to the guidance, but I can say that when we had issues, I brought them directly to the Cabinet Secretary around admission and those were addressed.

I think it took us too long to change our process, but on the very day that the WHO announced a pandemic on 11 March, two days later the UK stopped its test and trace pattern. That was a fundamental flaw, which left the older population in our care homes massively vulnerable. We should have prioritised not just using tests for people in hospital, for people being admitted to hospital and for surveillance, which were the three elements that we were testing in March, but extended the use of what I accept was limited resource to prioritise individuals in care homes and being admitted to care homes. Across the UK, we failed to protect through the use of testing.

Q420 **Sally-Ann Hart:** But in Scotland from mid-April, people were tested as per what the Scottish Government said, so new residents were being tested coming into care homes in Scotland?

Dr Macaskill: That was the recommendation of the Cabinet Secretary and one that we had strongly argued for.

Q421 **Sally-Ann Hart:** Does anyone else want to come in there? I do not know if Ms Fyffe wants to add anything to that.

Theresa Fyffe: Testing was too slow to reach the necessary scale for healthcare staff and the wider public. There were definite discrepancies between testing for those working in the NHS and those either working on temporary contracts in the NHS or outside the NHS. One of the big issues was transport to remote testing sites. I am going to come back to staff here, not just patients, because a comment I did not make when we spoke about PPE is that staff were put at risk by not having PPE and thereby, if not being tested, that was a challenge for workforce within the

care homes particularly in order to maintain sometimes quite small teams.

There was a lot of work and lobbying to try to improve access to testing within the care home, both from the patient point of view, and also from the staff point of view, because understanding how Covid-19 was playing out in the care home was very important from the point of view of understanding how staff were, whether they were also positive with Covid-19, and how you could manage your teams and your workforce.

Q422 **Sally-Ann Hart:** Thank you. Ms Brown, do you have anything to add about the testing of new residents coming into care homes in April?

Wilma Brown: Yes. We were very well aware that that was the guidance. I am not clear that was done for every new resident who went into a care home, especially when leaving hospital. Even if they were tested while they were in an acute hospital, they would be tested and then sent to the care home before they had the result, because the result was taking far too long to come through initially.

The other thing was about staff testing. Initially when the testing started in Scotland, staff had to jump through hoops to get a test done, so they would phone in, perhaps to their line manager, to say that they could not come to work that day as they were displaying symptoms of coronavirus, which was very highly profiled and sent out everywhere. It was on every TV advert break, so people very much knew what they were looking for. If they had any of those symptoms, or their families had symptoms, what they were told was they would be tested as a matter of priority because if they were negative they could get back to work, and if they were positive we could then take the necessary actions. But they had to tell their manager, their manager had to ask their manager, and it had to be signed off by somebody quite far up the tree to get a test done for staff locally. It took far too long and came too late.

Q423 **Sally-Ann Hart:** Have things improved since then? In terms of recent experience of testing people before discharge from hospital to care homes, or for new residents coming into care homes, things now must have changed. Have they? Ms Brown first.

Wilma Brown: Yes, they have changed. They are much slicker. We are getting results back much quicker. For example, I work in Fife. When tests were done in Fife they were being sent over to Edinburgh. Thankfully we had a charity, Blood Bikes, which came and based itself in Kirkcaldy at the acute hospital and was taking the samples through to Edinburgh for us to get a quicker turnaround. Now we have very quick testing, so people are being made aware of the results within 24 hours. My understanding is that people are not discharged to care homes until they have a result.

Q424 **Sally-Ann Hart:** Ms Fyffe and Dr Macaskill, would you agree with that?

Theresa Fyffe: I would agree that patient testing from discharge from hospitals has definitely improved, as Wilma has described. You may want to come back to us later. I think there are still continuing concerns for staff testing within care homes.

Dr Macaskill: I would broadly agree with that. I think we have had problems with testing individuals coming from the community into care homes, but our members are very clear: unless you get a test and unless we have that result, we cannot, except in emergencies and on very clear compassionate grounds, admit individuals. We have painfully learned the lessons of the early weeks of the pandemic when untested individuals entered into care homes.

Q425 **Sally-Ann Hart:** Before we go to the staff and the care home workers being tested, the UK Government are helping the Scottish Government with the provision of testing facilities in Scotland. Is that overall testing provision sufficient? Dr Macaskill, perhaps I can ask you first.

Dr Macaskill: I think it has been well publicised in the last 10 to 14 days that there is a real challenge with the UK social care portal. I am aware as of this morning that the helpline of that portal is saying that there is an expectation of six to seven days before you get your result back. That is wholly and utterly unacceptable. I have had discussions with the Cabinet Secretary and the testing unit at the Scottish Government and they are seeking to maximise the ability of NHS Scotland to undertake more tests in Scotland. We are very well aware of the pressure on the UK portal system through the return of universities and people to work and schools.

There is not sufficient ability utilising that resource alone to give the care home sector in Scotland the confidence that we can get the turnaround to enable staff to be tested, get the result, and be at work in a safe manner. I am very confident, because of the energy that is being put into it, that we will address the challenges but, to be quite blunt, we need to do testing in a much more local national and regional manner than we currently do. The system has to be more localised and I am confident that we will see that happening through the UK.

Q426 **Sally-Ann Hart:** Thank you. Ms Fyffe or Ms Brown, do you have anything to add there?

Theresa Fyffe: Just to say that there was a delay in the results. With routine testing, I have had reports where one test has not even come back before someone is due to have their next test, so that is the delay that Donald is talking about—the number of days it has taken. I do see a difference just now in the pressures, and it has come from the children in nurseries and schools, where I have staff who have had their children referred for testing because they have had a temperature. There must be an increasing challenge on the testing services because I have never seen so many children being sent for testing, which would not have been happening prior to the opening of nurseries and schools.

For me—and with Donald—the job now is that we must get more local testing. Having long journeys and difficulties in accessing testing is not conducive to keeping staff working and care homes running, so we need to get better local arrangements so that we can improve on that.

Q427 **Chair:** Before we go back to Sally-Ann—I do not usually do this—as this session has progressed, we have had an email come into the inbox from a lady who works in care. She says that she is having real difficulty in securing a test. She had to drive to a test centre quite a number of miles away from her location and from her work. What she has been told is that holidaymakers are using up a lot of the tests. That obviously raises a number of concerns. Again, this is the first time we have done this in the Scottish Affairs Committee. Is there a case for a priority for key workers to ensure that they get tested? We have heard a lot about testing in the House of Commons again today, and this week about tests being used up by what the Health Secretary describes as people who do not need them. Is there a case that you guys want to make sure that key workers get priority when it comes to testing?

Dr Macaskill: Without speaking on behalf of colleagues, I think we are making that case all the time. There has been an overuse of testing facilities by the worried well, and I think it is imperative that we prioritise those who work in health and social care. We know that testing is one of the major tools to keep the virus out of the care home sector and hospital sector. We must have a prioritisation. I hope, as everybody else talks about returning to work, we continue to have a prioritisation for the social care and health sectors.

Wilma Brown: Yes, there should be prioritisation because we need these people at work. We are very short of nurses, and we are very short of all skills across the health service, but we need these people back at work as quickly as possible. I do think that we miss out in the care homes. We were late in coming to the table.

We sent all these children back to school in August in Scotland and September in England. I cannot believe, with the amount of public health people we have in Scotland, that nobody thought it would be a good idea to share some information with parents that said, "Remember how when children return to school they get coughs, bugs and all of these things. Why don't you think about stocking up on some paracetamol, have a thermometer and make sure that they are washing their hands all of the time?" to comfort these parents, because parents are anxious and teachers are anxious. I would hate to be a teacher right now. They are so frightened of the children catching this and frightened of the transmission, but nobody thought to give some basic advice to these people, who are not clinicians and have never worked in this field, about having to be careful about infection control. They are teachers and they are children, and nobody thought to give them any advice.

Chair: I hope the lady who is watching our session is satisfied with the responses that she has had from you, so thank you for that.

Q428 **Sally-Ann Hart:** Picking up on pointing towards more local testing, given that health and social care policy and funding are fully devolved to the Scottish Parliament, how can the two Governments work together differently to ensure adequate testing provision? I am trying to work out how. I know we have had a national coronavirus programme, but how can the two Governments then work differently to provide testing and more adequate testing? I do not know who wants to answer that one first; perhaps Ms Brown.

Wilma Brown: Maybe clearer communication between the two Governments. Having officials speaking to each other might be helpful, but I think that they have to work together to get a system in place that suits all. We are too slow at moving things forward and it is not helpful when we get different advice and different patterns of working from each Government.

Q429 **Sally-Ann Hart:** If we are looking at the fact that health and social care is devolved to the Scottish Government, would they defer to the UK Government? I am not quite sure how that works. I do not know if someone can explain that.

Theresa Fyffe: All through Covid-19, the UK Government and the other Governments have been working together in a process, but what has been very obvious at times—

Sally-Ann Hart: Together?

Theresa Fyffe: Yes, but it is obvious at times that things have been announced or decisions taken when they have not always been, as Wilma was indicating, well communicated with each other. Testing is a UK agenda. Testing will enable us to get back to a number of different ways that we need to in the future, so I believe there has to be a clear improvement for everybody on how we are going to test for the public, particularly for key workers working within care homes. We had a workforce shortage in care homes prior to the pandemic. They have small teams. If they cannot return people back to work, they are short of staff. That is not just registered nursing staff; it is also care workers.

As Donald said, this has been an issue for social care and health. Health and social care is a joint process in Scotland, and we have health and social care legislation working together. If anything, I would say the pandemic has brought to the fore how much more we can do and work better at bringing health and social care together. The feeling would be that we were very focused on health and social care where we saw it as necessary. The pandemic has made people aware you have to do the two together and a lot more joined-up working. The Cabinet Secretary is very aware of that from all the meetings we have had where we discussed how we can look back and learn about how we improve.

The resilience planning I mentioned earlier that did not happen enough for the care home community was where there was not that joint working between local government and the Scottish Government at that time. For

me, the way forward is to work together, to be clear with the public and to get confidence for the public that we are getting testing right. I know somebody who recently had to drive from London to Cardiff to get a test for their child. That was a tough call on a family late in the day, because that was the only place they could get a test within a reasonable time. That is a desperate stress on people and on key workers within the care home sector and the NHS.

Chair: Thank you. Is that all, Sally-Ann?

Sally-Ann Hart: Yes. Whether Dr Macaskill wanted to add anything, I do not know.

Dr Macaskill: Not really. To be brutally frank, if I am a care worker or a care manager, I am not that interested in which part of the governmental system is going to be best at getting the results back. What I am interested in is that there is a strategic awareness as we enter autumn and winter that in order for us to keep our care home staff present and, equally importantly, to help families to be reconnected and visit their relatives, we need to get better at getting tests back much more efficiently than we have in the past two weeks. Before then, we were working at 97% compliance and efficiency. We need to get back to that because we have lost that. We know why we have lost it and I think we are confidently working collaboratively to make sure that we get back to where we need to be.

Q430 **Douglas Ross:** Can I echo your words, Chair, in support of what Dr Macaskill said at the very beginning? In discussions I previously held with Dr Macaskill, I made the point that our care workers were not just doing what they do day in day out in normal circumstances, but working under even more trying circumstances during this pandemic, with all the extra fears and concerns. They were also almost a replacement for the lack of family and friends who were able to visit. Sometimes that element of it is not always conveyed and we have to once again reiterate the thanks of everyone on the Committee for what has been done and will continue to be done in our care homes and the care sector going forward.

May I begin on testing and ask why and how people who had received a positive Covid test in hospital were able to be discharged into a care home?

Dr Macaskill: Why and how was in accordance with the clinical guidance that was issued, which indicated that if somebody was positive, it was not a reason for them to be discharged back to the hospital. Indeed, the guidance of 26 March used the phrase that it was imperative that care homes continue to admit individuals. It detailed very clearly what would be expected if somebody who was positive was transferred into a care home and detailed barrier nursing for a defined period of 14 days. In circumstances where somebody was returning to their own home, which was the care home, and they had been positive in hospital, they were clearly tested—otherwise an individual would not be known to be positive—and then they could be transferred. That was the how and the

why of how individuals who were positive were transferred into care homes.

Clearly, as we got to know more about the disease, the clinical understanding of the nature of the pandemic resulted in a decision made later that individuals who were positive should not be transferred, but in the early days that was not the clinical view. Some care homes refused to accept positive individuals and others, particularly because individuals were returning to their own home, clearly did.

Q431 **Douglas Ross:** You will be aware, Dr Macaskill, that when Scottish politicians, including the First Minister, have been asked about this they have said it is not their responsibility for operational or other reasons to oversee why someone would be discharged or not. But we also know about a leaked letter that the Cabinet Secretary was writing to health boards in April urging them to reach this target of 900 delayed discharges getting out of hospital. The Government and Ministers must have been aware of this.

Dr Macaskill: I think you have to distinguish two things here. The first is: was there a drive across the system to encourage the discharge of individuals who were fit to be discharged, who we have often described as delayed discharge, and a drive to increase NHS capacity by discharging those individuals? Undoubtedly that was the case, transparently and publicly, both in Parliament and in communications. As the Chief Executive of Scottish Care, I indicated at the time that the care home sector must support the whole system by receiving individuals who were ready to be received. That is one issue, which I do not think anybody is denying.

The second issue is whether or not there was appropriate clinical risk assessment undertaken. I indicated earlier that at the beginning of the pandemic, we had inherited, as Theresa said, a long period of time where there had been a disjoint between the NHS acute sector and the social care and care home sector. I met the Cabinet Secretary shortly after the first guidance was issued on the 13th. I met her on the 18th and highlighted to her that our members—our providers—were concerned that people were being transferred without that adequate risk assessment. The guidance was changed in a matter of days to make sure that that risk assessment was as robust as possible. I wish we had that robust risk assessment in January/February, but we did not. We do now, and we did at the end of March and the beginning of April.

Q432 **Douglas Ross:** I will come to other witnesses, but those are two issues I wanted to pick up, Dr Macaskill. You rightly highlight that between the discussion you had on the 18th and the guidance being reissued on the 26th there had been the progress you were looking for. That also suggests that for over a week people were still working to the previous guidance. Were they unsure; were they getting any interim advice? Clearly, it was a significant change. From you asserting your beliefs and getting the meeting with the Cabinet Secretary and her changing the

advice, over a week later it then got published. What happened in that interim period?

Dr Macaskill: To be clear, the guidance of 13 March indicated that individuals should only be discharged after appropriate clinical assessment. The guidance of the 26th went into detail about the nature of that clinical assessment and the required robustness of that assessment.

Q433 **Douglas Ross:** Sorry, my question is that if you had concerns about the guidance on the 18th and were able to relay them and get them straight into the Scottish Government, what was happening out in care homes and hospitals between the period of you raising this and the guidance being reissued over a week later? Is this something you think could have been addressed immediately, or do you think that seven or eight days was the right amount of time to take to do that?

Dr Macaskill: I think we have to see this in the context of the relationships that existed before the pandemic. By that I mean that we, as an organisation, had published a number of reports where we said that we were increasingly concerned that individuals who were being assessed at hospital were not being adequately assessed for their needs. We had numerous instances where somebody was transferred into a residential care home who clearly had nursing needs and we had to fight those battles. We knew there had been some difficulties and that comes to what Theresa said about the lack of prioritisation and the lack of real integration of systems.

It was in that culture that my members said in March, "If we are going to be receiving people, we need more robustness around transfer and admission." I spoke, action was taken, clarity was made and the issue was addressed. I would have loved there to have been that clarity in December 2019, but there wasn't.

Q434 **Douglas Ross:** That comes on to a point that I will open to our other witnesses as well. From the work that I know you have done in the past and from the hour we have been in this sitting so far, it is very clear to see the positive influence you have all had during this pandemic. This is not a criticism. It is to try to get to the nub of the issue. If you are all, rightly, so well regarded now and implement changes quickly, do you feel there was a lack of interest or understanding at the early stages? Dr Macaskill, you said you were looking at what was happening around the world in December and could see that the care sector and care homes were going to be vulnerable. Why did the Government still focus all their efforts on hospitals at that stage?

Theresa Fyffe: I mentioned earlier models of care changing over a number of years. In my career, a care home was very different from what it is today. The model of care changed where it was agreed that you could be either discharged to a homely environment, which was in a care home, or you could be discharged to your own home and you still had

clinical need. I will use the word "clinical" rather than "nursing", because that could be clinical need from a physiotherapist, an occupational therapist, a pharmacist, a nurse or whatever. That model of care was adapted and changed, and that is across the four countries, because all hospital acute services thought we need to discharge people who do not require what we understand now as an acute hospital environment. People were discharged either to their home, to a community hospital in some cases, or into a care home.

What has come out of that in those models of care is an increasing complexity of clinical needs within care homes. We were starting to understand in the context of older people's care, and not just older people's care but, for example, people with learning disabilities. The complexity of health needs for people with learning disabilities has been evidenced by a number of high-profile reports. Starting to think differently about the care home sector was slow coming across the UK. That was because we used the term "delayed discharge" as that you were medically fit for discharge. What we meant was medically fit from an acute hospital. What we didn't do enough about was understanding people's clinical requirements. Not everyone in a care home has that. Many people are in there who have social care needs, and that is where they are, but other people have complex clinical needs and the primary care services and care home services were not considered.

For the past couple of years, we have done significant work on primary care in Scotland. We are in the middle of another programme of work on primary care, working with community and care homes. I suppose the truth of it is that the pandemic brought ahead what we knew was emerging, that we had people with clinical need and a gap in how we addressed that while still ensuring that people did not stay long term in acute hospitals because we needed those beds for other things. That is the lesson you could apply to every country in the UK. In fact, the pandemic has highlighted that now and brought that out into the open—what I meant by my message earlier—and we learn from that now and recognise that we have to look at the care homes not as something we put people over to. Nurses who work for the care homes, and I am just going to talk about nurses now, often feel second level—that it is not a great career to go to work in the care homes. We have the most amazing staff I know working in care homes, but they feel that they are seen that way.

I said to you that I have the lead for the independent health and social care sector for my organisation, and that is what we are about. We recognise that a growth in membership for us is there because there is a growth in services provided within different sectors now, and we have to change the way we work to respond to that. That was what went wrong—we hadn't. Long before the pandemic, I had a really healthy conversation with the Cabinet Secretary about the care home sector, but for me there was one thing that clearly showed the problem. We have the legislation for safe staffing within Scotland. As the Royal College of Nursing, we had

a lone battle to persuade people that we had a staffing issue in the care home sector. It was seen as an NHS problem, not a care home problem and not within. I recently discussed that with the Cabinet Secretary to say that was an opportunity missed, and we both agreed we have to learn now and recognise why a number of different organisations, local government and others—

Chair: Ms Fyffe, sorry, we have lots to get through. I know you want to be helpful and give us a full answer. Thank you for that.

Q435 **Douglas Ross:** Thank you. It is a full answer and it is helpful. I have two further points, but to follow on from that, I understand exactly what you are saying.

Dr Macaskill, you are right to say we are all great with hindsight. We could still see around the world that this virus affects those older with underlying health conditions far more seriously than others. Knowing all that and knowing the experience from around the world, we still had this policy to put people into care homes, to quote Dr Macaskill again, "To prioritise the acute clinical sector to ready the NHS at the expense of the social care sector". Why could your message not get across with international examples to say, "This is what is going to happen"? It is not hindsight because you were able to foresee. Why couldn't that message get across? Governments across the world did this.

Dr Macaskill: I, with other colleagues, sit on international forums. I was in one this week and this is the common story of virtually every "developed" country. I wrote in *The National* at the start of the pandemic that the way we respond to the pandemic will illustrate whether or not we are a society that values age and is non-discriminatory. My clear conclusion, internationally and certainly in the UK, is that we do not sufficiently value the contribution of older people, and that the way in which we prioritise their care and support in a secondary manner to the way in which we prioritise the protection of others illustrates that point. This is beyond a political issue to a societal and cultural issue of our failure to value older individuals, and we stand culpable of that, as does, I think, virtually every developed country in Europe and elsewhere.

Q436 **Douglas Ross:** Ms Brown, you mentioned earlier that in discussions you had with the Scottish Government and the Cabinet Secretary on behalf of UNISON, the Cabinet Secretary was not always aware of issues. How concerning was it to you and your members during a pandemic that perhaps the Cabinet Secretary for Health in Scotland was not fully briefed and not fully aware of crucial issues you were bringing to the table?

Wilma Brown: It was very concerning that she was not aware. I spoke generally in that comment, but specifically it was that she was not aware of the PPE situation at its worst. I think that was extremely concerning and I wondered why on earth she was not given that information. When I gave her some information, things moved very quickly.

Douglas Ross: It is really quite concerning for us as a Committee to

hear that and I am sure we will take it up further. Thank you to all our witnesses.

Q437 **Jon Cruddas:** Good afternoon, everybody. I want to go back and give you the opportunity to talk about your members' experiences of the supply of PPE, rather than the question of the guidance on it. I note that the office of the Secretary of State for Scotland, in its written evidence to us, said it "liaised with the Scottish social care sector to understand the issues they have faced in regard to PPE supplies. This engagement has allowed DHSC and suppliers to understand better barriers Scottish care businesses were facing in purchasing PPE", which implies prepare for the future. I want to give you the opportunity to explain to us your members' experiences of PPE supply and how this changed from the beginning of the pandemic to now. Dr Macaskill, perhaps you could begin, because I know that you wanted to touch on this comment earlier.

Dr Macaskill: Mr Cruddas, I am not sure I got all of your question because there was a bit of a break-up, but I will describe our experience. The first issue was that in February we said to our members, "Start stocking up for PPE." What we didn't know then was what PPE to stock up for, because obviously the nature of the virus meant a very different type of PPE from what care homes would traditionally have used. It became very clear fairly quickly that they began to be challenged through their normal supply routes. That primarily was because the vast majority of PPE is manufactured in China, which had, as a result of the pandemic, shut down production and, secondly, because it very quickly became clear that there was a prioritisation for the NHS, which meant that they, as social care providers, were struggling to get supply. In particular, given that most provision of PPE in Scotland's care homes came from England, there was a particular difficulty in Scottish providers getting PPE from England. I openly said that, and virtually was castigated for trying to make a political comment, which of course I was not. I was merely highlighting the reality that because of the prioritisation of the NHS as a whole, social care providers really struggled.

What I think makes things different in Scotland for our members is that because the Scottish Government had worked with the care sector, and particularly my own organisation, last year to prepare for Brexit, we had already in embryo a system in place that had even been trialled as an emergency response to an emergency situation. That system was established on 18 March, so relatively early in the pandemic. I have compared it to setting up Amazon in a 48-hour period. It was an astonishingly remarkable and professional coming together of NHS, NSS, the health and social care partnerships, local authorities and care providers. Of course, there were problems and there were difficulties. That was meant to be an emergency response, so we were meant to use that 20% of the time and our normal supply route 80%, but the normal supply route virtually dried up or we had price scandals where normal PPE was 2,000% more expensive. As a result, there was a flip to using

the triage, as it was called, about 80% of the time and then over time we developed a hub model.

Today I think that we have one of the most effective PPE supply routes into social care anywhere in the United Kingdom. There were clearly problems at the start. The systems were not always working. We didn't always get the right quality, which was why the Royal College of Nursing and ourselves wrote to the Cabinet Secretary about some issues of quality. But it was night and day from the experience I know that some of my colleagues were enduring.

Q438 **Jon Cruddas:** Thanks for that and apologies for the sound. I have quite a bad internet connection here. I will pass to Ms Brown for your workers' experiences of PPE from the beginning to now.

Wilma Brown: From the beginning they didn't have access to much PPE at all. They had basic equipment within the care homes that they would hold anyway for norovirus and different infections, so they had that, but they didn't have large stocks of equipment. They were using it very scarcely and the instruction was to use it on patients who were positive and not negative. But given the way it was manifesting, I think what staff would have felt much happier doing to protect themselves and their families was to be able to wear PPE while they were working, just as we are expected to now in public areas, for example, and within 2 metres distance. Staff felt very vulnerable and they were frightened that they didn't have the PPE.

Q439 **Jon Cruddas:** Ms Fyffe, is there anything more to add for you? I know you mentioned this earlier on.

Theresa Fyffe: Stocks of PPE were based on a modelling for an influenza pandemic and, as I mentioned earlier, care homes were not included in the resilience planning. It is not surprising that when it came to providing PPE for care homes, despite the lack of clarity around the guidance and not being clear about what was provided, there was also a shortage of PPE. Once that had been addressed, the supply model that Donald has referred to has completely improved the process for getting equipment, but it was true to say that in some cases due to shortages some employers in care homes were not using all the equipment. It wasn't just down to Government, and our members would raise that and we would have that discussion locally with an employer to say, "We need you to abide by the guidance and have the appropriate equipment that the staff require."

Q440 **Jon Cruddas:** Given what you have said about the changes over time, what UK and Scottish Government policies ought to be in place now regarding PPE to prepare for a possible second wave or future pandemic, or are you confident that the learning experience through the last few months has prepared us well for any second outbreak?

Theresa Fyffe: If I just stay confident on PPE, because that is a hard one to face the thought of, but there is no doubt we have learnt the

lessons. On the lack of planning for the care homes, being part of the task groups that we are, we have data and understanding now of the care home sector that we never had before. There are relationships, engagement and ways of working between health, the Scottish Government, the local authorities—as Donald said, all the relevant stakeholders. I, as Director of the Royal College of Nursing, along with others, have given up significant time to be around the table to address this agenda. We have never done anything like this before.

For me it became about being important for the staff who are trying to do a job, but also about the people within the care homes. It just mattered so much to get that better for the lives of older people and other people who are in residential care. The drive is there and I believe we can learn lessons as long as we don't forget them and remember that the systems have to talk together, for care homes, community and hospitals, and we have to find a way of doing that. I believe that lack of engagement is what led to the discrepancies that were in place.

Q441 **Jon Cruddas:** Do the other witnesses share the confidence in the preparedness on PPE for any possible second outbreak?

Wilma Brown: Our stock levels are definitely better and the control of those stock levels is much better. I am not sure that if we were hit as badly with a second peak as we were initially, we wouldn't struggle with some things, but I think the understanding is there now, thankfully, that the acute hospital does not take priority—we don't hang on to stock and not give it to a care home just in case they don't need it. Now we give it over to the care homes as and when required, and I think that they are better placed for the use of that training, advice and guidance. I think that we would manage, but I wouldn't say that we would be comfortable.

PPE is a particular bone of contention for me, given the situation for hospitals and care homes. It felt like I was banging my head against a brick wall in some of the meetings that I was at because it was almost as if people did not believe me when I told them that people were without PPE, in both hospital and care homes, that nurses were frightened to go into areas, and that they had to pause and wait until they got PPE to go into areas. At one point I wrote to the director general for Scotland who had put out a statement saying that we were okay, that we had six weeks' worth of PPE for the whole of the country and that we would be fine. There was no way that we had six weeks. I wrote to him—it was Malcolm Wright at the time. He took a long time. In fact, I think I chased him twice on a response to that letter. I got a very offhand letter back saying that we had got enough PPE, and we absolutely did not have enough PPE.

Dr Macaskill: I think this is one area where, to draw on what Theresa has said, we are working so much better in partnership now. We are not resting on what we have done. We are seeking to build on that. There are proposals to consolidate. I am worried about the future and that is not because of the system that we have in place, but it is because of another

issue that we will possibly look at later on, which is the supply chain and the impact on that, particularly with the risk of a no-deal Brexit. That is causing concern and it is why we are maximising production of PPE as much as possible, but we are still significantly dependent on importing PPE—across the UK, but in Scotland as well—from elsewhere. I have very real worries as to the stability of those supply lines as we move into uncertain times.

Jon Cruddas: Thank you very much. That is all from me. I want to put on record, on behalf of all members of the Committee, our appreciation for the extraordinary work of care home workers over the last few months.

Q442 **Deidre Brock:** Thank you to all our witnesses for what has been an incredibly informative and useful session. I know all members of the Committee will find it very helpful. Ms Fyffe and Ms Brown both mentioned the shortage of healthcare workers and I want to go on to that and the immigration issues—in some ways related to Brexit, of course, Dr Macaskill. What extra risks for health and social care sector staffing have you felt have been identified or isolated in light of the pandemic? What action do you think might be needed to mitigate those?

Theresa Fyffe: Before the crisis, nursing staff levels and staff levels generally within the care home sector were very stretched. There are almost 3,600 vacancies in NHS Scotland and that always has an impact on the availability of recruitment to the care home sector. I go back to the morale and the value placed on staff who work in care homes. That always has an impact on the recruitment of staff to the care home sector. A number of other issues come out for staff in the care home sector with regard to their pay, terms and conditions and other things about showing the value of working in a sector that is, and should be, a very commendable job to do and one that society values you for working within. I know many care home sector staff who love and really enjoy their jobs.

What showed in the pandemic is that the staffing crisis became much more to do with the testing issue we were talking about. Two things happened. One is that we did not have in place the appropriate payments for staff who were sick, so staff continued to work when perhaps they should not have worked which, therefore, had an impact on other staff in the care home. If they couldn't get testing and they had to stay away from work, that left a small team. Remember some care homes are very small areas. If you are one down in one big ward area, that might not be so significant, but it would be in a care home. The inability for staff who work in the care home sector to be paid for being off sick was addressed and we lobbied on that. That was addressed and that made a significant difference, because people needed to be able to go off work if they were unwell and then be able to come back to work.

I will stop on that because I will come back on immigration, which is a bigger agenda.

Q443 **Deidre Brock:** Yes, I would like you to speak about that. Dr Macaskill and Ms Brown?

Dr Macaskill: The issue of valuing staff is huge and it has been huge throughout the pandemic. I don't want to add to what Theresa said about terms and conditions and the way contracts have been managed through the national contract, but it goes even deeper than that. We had to issue, within the first three weeks of the pandemic, four media statements basically pleading with our supermarkets—I am not going to name names, but you can go back and look at who we were writing to—to say that a social care worker is of equal value to a health worker. We had workers writing to us in tears because they had been turned away by a supermarket saying, "You're just a carer." In that context, we have come a huge distance because I don't think anybody would get away with that now, although I have heard one or two instances since that may have confused that. We had an issue of value.

I want to say something about immigration and our real concerns in the care sector, not just about immigration but also about the sense of value. Some 8% of the care home and perhaps 10% of home care staff come from the European Economic Area, and there is a question of their sense of value today, having stood side by side with their sisters and brothers in fighting this pandemic and being made to feel massively unwelcome as a result of the measures taken against them. I will reserve comment for later on.

Wilma Brown: The staffing problems within care homes is not new. As has already been said, we have known that for a very long time. It comes down to the fact that it is not a job that people promote very highly. We don't talk about the worth of that job and what it brings. There were many examples on TV over the time of the pandemic of very young people who were working in homes—when they were trying to give us some good news stories—and had connections with elderly residents, and how special the relationship was. I think that is what we need to promote to encourage our young carers to come forward, because we don't encourage them. We don't put it out there as a career, and it can absolutely be a career.

We can have a framework for how people progress and get the skills. People see it as a job if you can't get a job anywhere else. It is poorly paid, the terms and conditions are not good, particularly when they are in private care homes, and we need to do something about that. We need to make sure that there is more consistency about how people are paid, what they are trained to do, what they get rewarded for, and to start to profile these jobs as very worthwhile looking after the elderly in our communities.

Q444 **Deidre Brock:** Absolutely they are worthwhile. Excellent points there, thank you. I will move to immigration and some of the impact that has had on your sectors. There are obviously potentially staffing issues relating to immigration that have occurred as a result of the pandemic,

but I wanted to also ask about the shortage occupation list from the Migration Advisory Committee. How helpful has that been in assisting key roles in healthcare to be filled? I have some quotes from the Migration Advisory Committee, which stated that in 2019 it saw the importance of migration, but that it was not the answer to low level staffing. The quote was, "Ultimately it will take more effective workforce planning and efforts to increase the flows into health professions (and decrease flows out) to meet growing demands". Could we hear your views on that?

Dr Macaskill: I have appeared before the Committee before about the issue of immigration. I find—so do my members, and certainly so do our colleagues who work—the words of the Migration Advisory Committee, in its report that defines social care as being of low skill, deeply offensive. Its recommendations recently are as useful as a chocolate fireguard. They are not contextual. They are not in the real world. They are insulting to those who have quite literally put their lives on the line for the preservation of life and the protection and dignity of older people. To come up with sentiments and statements that define the work of carers of being low skills, of low level, is a complete failure to realise that empathy and compassion, and that the giving and bestowing of dignity to another are just as valued skills to society as any high-level, high-paid professional role.

We are deeply concerned about the proposals for immigration. The care sector in Scotland has been enriched by the contribution of citizens from across the world. It is deeply troubling that at a time at which we need to rebuild, consolidate and, as Theresa has said, diversify and build an even stronger workforce, that door has been shut to us.

Q445 **Deidre Brock:** Ms Fyffe, I think you want to speak about immigration.

Theresa Fyffe: Indeed. We expect the UK Government to ensure that internationally educated nurses are supported to work in the UK and, therefore, call for nurses to continue to be exempt from the salary threshold and to be included in any shortage or priority occupation list. We have also submitted evidence calling for nursing support workers within the RQF 3 to 5 bracket to be included on the shortage occupation list.

I agree with Donald. I am shocked that we equate a lower salary as somehow low skill, so if you are paid more, you look like you have a higher skill. If you have ever experienced the care of a care worker team, working with registered nurses in somebody's end-of-life care, I would defy anyone to say that is a low skill. End of life is the most fundamental point of somebody's life, and when they are cared for in the way that I have seen, that is not what I would describe there.

We have significant workforce shortages for nursing support workers across all health and care sectors. These are more acute in certain sectors and staff groups, but due to the significant limitations and gaps in the available data, we believe there is a strong reason for all to be listed.

That is the challenge. The data was not clear and they have used data to argue they did not need to do that, but we believe that they should list that. The vacancy rates for healthcare support workers within the NHS are rising. What we know now—we have always known it, in fact, but it has become even more evident—is that when you are short of registered nurses, as an example, the NHS will take up every registered nurse it can find and leave the care home sector and other areas of social care where nursing is involved short.

It goes back to the value of working within social care and the value of being seen in that, so your career is not seen as being as developmental if you work there. People will, without necessarily understanding that they can get an excellent experience within the care home sector, think they should go for the NHS because it is much easier to get improved pay, terms and conditions. We didn't have to fight over full pay for sick benefit for staff in the NHS, but we did within the care home sector. You can see why staff might opt to think, "Well, there is a job there, I will go there." We need to change that. We need to turn it around but, frankly, across the UK in all the four countries if we do not address this we will have an acute shortage within social care provision. Sadly, it will be the most vulnerable in our society who will pay that price.

Q446 **Deidre Brock:** That is alarming to hear. Ms Brown, do you want to add anything to that?

Wilma Brown: If we have an extreme shortage within care homes, the impact will be felt at the NHS because we won't have anywhere to put the elderly, vulnerable patients that have multiple problems and comorbidities. We need to look after them and their complex needs, and to understand how we keep them as well as possible, and that will fall back to the NHS. We have to do something and, as Theresa pointed out, the NHS is better paid and has better conditions, so people are drawn there. People are drawn to the NHS from the council and the private, and to the council from the private, because the terms and conditions get better with the different services, and they should be the same. We should not have what we have now. We need to have consistency in what these people are paid and what their terms and conditions are.

Deidre Brock: Thanks very much for that.

Q447 **Mhairi Black:** Thanks very much to you guys for coming in and giving us evidence today. It has been genuinely insightful. I am conscious of time so I will jump right in. Dr Macaskill, I was reading the previous Committee's report and I noted that at one point you said much of what you guys have touched on just now, which is that 68% of social care nurses come from the EEA. Earlier on you stated—and tell me if I am wrong—that at the minute that number has reduced to 10%. Am I correct?

Dr Macaskill: No, the previous report was six to eight, not 68.

Mhairi Black: Okay, that is fine. That is my fault. Maybe that is a typo.

Dr Macaskill: Yes, of which I am personally guilty of quite a lot. The serious point is that we have seen a massive slump in our ability to recruit into the care sector—frontline care workers, but also nursing. It is particularly geographically localised. In the north of Scotland, you can have a care home with as many as 28% to 30% of staff who come from the European Economic Area. They are parts of communities where their children go to school, and their partners may be teachers and do other work in the community. We are doing a huge amount of work, together with Scottish Government and Citizens Advice Scotland, to get people to be confident that Scotland is a country that needs them and values them, and where they are a necessary part of our community, but the narrative elsewhere and the narrative that they often hear is one of exclusion and lack of welcome. That is one thing.

The other story is that our members depend on the ability to recruit workers who do not meet the salary thresholds as proposed by MAC. The ability to recruit those workers from elsewhere in the world is going to be prevented. I should point out that 68% to 70% of social care in Scotland is paid for by the public purse on contracts that are paid for by public authorities, and local and national Government. If we are going to dramatically improve the terms and conditions in the charitable and independent sector, that will cost the public purse a resource that we don't have at the moment.

This is a whole-picture issue that we need to explore, but we do not help ourselves by, first of all, denigrating the value and contribution of people who simply were not born here and, secondly, preventing us from being able to welcome the contribution of those from elsewhere into Scotland.

Q448 **Mhairi Black:** That is helpful. Thank you. Do Ms Brown or Ms Fyffe want to come in?

Theresa Fyffe: I would like to say something I mentioned earlier. In the first part of the Health and Care (Staffing) (Scotland) Act 2019, which was passed and was due to be implemented this year, we had some areas with regard to care homes. This is about the learning from the pandemic. At the time, in trying to encourage that debate and open it up, there was significant resistance, and resistance around understanding the complexity of clinical need and thereby the type of workforce that you require within the care home sector and, therefore, being prepared to fund that and give appropriate contracts and commissions that allow the staff to work there, to be valued, and to be given the appropriate pay, terms and conditions. As I mentioned earlier, in my discussion with the Cabinet Secretary recently, I said that we have an opportunity with the third part of that legislation in the implementation stage to consider the barriers—there were many barriers put up to even considering it—and maybe to learn a better way of working that we have now across stakeholders to understand how we work towards supporting the workforce in social care and the care home sector. The legislation is only one part of it.

We, as an organisation, have lobbied long and hard for improved funding for social care. What I think we have learned to understand now is that if social care is not funded and appropriately delivered it impacts on health. It is a double act. If we do not do it right together, one pays the price for the other and, frankly, at the end it is the people who don't get the appropriate services who pay the price. I come back to that point all the time. It is what has made me work so hard as a Director of RCN—along with others, obviously—personally on this, because what has most distressed me is what is happening to people and to those who care for people in those environments who want to do the right thing by them.

Q449 **Mhairi Black:** That is really helpful. Thank you. Ms Brown, do you have anything to add on that? Okay. Moving on a bit, you have talked about how there was potentially—seemingly it is already starting—this hole in social care with staffing and things. If this is directly impacted by the immigration system, I would be really interested to hear from each of you: if you could make one change to the immigration system for nurses, what would it be? What would be the focus?

Dr Macaskill: I wouldn't just change it for nurses, because this is about the whole of social care: in-home care; health support; care homes. We have been fairly outspoken on this issue. We have said that we want to see a distinctive category for social care. The last time I appeared before this Committee I asked the Migration Advisory Committee to reach out to the social care sector in Scotland to understand our needs of geography and demography, of need and of the sort of issues that Theresa has expressed with the skill base. I am still waiting. I think we need an immigration policy built on a relationship with those who matter, who are the workforce, and the providers and employers. The changes in the recent document by the Scottish Government suggest proposals that include membership on the MAC, a distinctive occupation list, prioritisation of social care, the removal of salary thresholds, and at long last a recognition that skill is not the money in your pocket, but the ability of your compassion and the dignity that you give to another. Those would be five areas I would quite like to say to MAC.

Q450 **Mhairi Black:** Excellent. I could not put it better myself. Ms Fyffe, do you want to add to that?

Theresa Fyffe: Yes. I think the new health and care visa was a prime opportunity by the Government to acknowledge the value and contribution of all international health and care staff. The exclusion of social care staff is just wrong. Perhaps people have just not understood the importance of social care to the lives of people wherever they are across the four countries, and how much that impinges on the dignity and respect and way of life that people require. Perhaps that is what has gone wrong. We expect the visa to be inclusive and apply to all health and care staff regardless of pay or qualification. I made the point earlier that it is somehow shocking that because we don't, in society, pay people a particular salary, we therefore rate them as low skilled. I find that very disturbing and a very poor reflection on us as a society.

Mhairi Black: Excellent. Thank you very much.

Chair: Thank you, Dr Macaskill, for referencing our previous report. I think you were one of the most significant witnesses that we had here. We hope at some point to revisit some of the issues that we brought up and see if we can encourage the Government to look a bit more thoroughly at the recommendations we made last time.

Q451 **Liz Twist:** It is really a bit of time for reflection for me. We have covered a lot of issues. Do you think, looking back, that care providers and hospitals were at all prepared for a pandemic?

Wilma Brown: No, I don't think we were prepared for a pandemic at all. Not enough thought had gone into that and I raised issues of our PPE stockpiles. We had a stockpile that is contained in the distribution centre in Scotland. The kit that was coming out of there was more than four years out of date and that was particularly the FFP3 masks. We were able to get those retested and get them out for use; there was nothing wrong with them. But what shocked me—and I asked this question and still haven't had an answer—was that anywhere I have ever worked as a nurse, when you do your cleaning and your stocking, you stock rotate all the time. That is what you are looking for. Everything has a use-by date and that wasn't done in that warehouse. I specifically asked who was responsible for that stock. I do not believe that the people who worked in the warehouse did not have those skills, because they do that all the time. They look at the stock rotation. It seems that this stock was in a corner of the warehouse for a pandemic, probably an influenza pandemic, left there for when in use, but nobody was checking it. The most I got back as an answer to that was that that was the responsibility of people within Scottish Government.

It is not about blaming one Government or the other. It is about the fact that we were not thinking about the stock that we had, never mind the stuff that we would need, and nobody had checked that. If it was out of date for four years, it had not been checked for four years. Not only were the masks out of date, but we didn't have the necessary levels of stock that we needed to be able to furnish everybody with what they needed to have.

Theresa Fyffe: Pandemic preparedness? I hope we learn the lessons, because I have already indicated we didn't have care homes and communities in the resilience planning in the way we should have had. Our modelling for PPE was based on a flu, influenza, and that perhaps is where the stock of PPE started wrong because of that. We rightly got concerned about the provision of acute hospital services with this pandemic because of the way it was presenting and the number of lives. But we focused on acute hospitals in isolation—and we still have a tendency to do that in health policy, I am afraid, across all countries; we tend to think of acute hospitals first—and they were considered in isolation and our systems didn't talk to each other.

Hospitals are part of a system and that is a system that would grind to a halt if it wasn't for primary and social care services. There is that to think through now. We have to have a whole-systems approach to this. We have managed to do that now, to get everybody around these different tables in a way that we probably would never have thought we would do before, different people who have probably never worked together in the way we are doing now. Maybe that is the lesson we learn: the pandemic has forced us into saying that what matters at the end of the day is that we are doing right by the people in Scotland, and not right by all our different isolated ways of working.

Health and social care integration has been long term, as you know, in legislation in Scotland and out of this we have learnt where the weaknesses are. There are weaknesses in why that didn't work in quite the same way. I am not suggesting there were not some areas that did many of the right things and good things, but it was not uniform across the country. There is a lot to learn from why and how we did not get that local resilience planning in place, because there is national resilience planning, UK resilience planning, and then there is the local resilience planning, and that did not work well in some areas either.

Dr Macaskill: I completely agree with what Theresa has said. Clearly, we were not prepared because we did not listen to each other. We did not have real relationships with each other for health and social care. We did not know each other's worlds, and beyond all the systems that we didn't adequately prepare for—and to some extent, with the nature of this pandemic, I am not sure even the best prepared would have been able to respond—a lot of our resilience planning, and this is no exception, has massively failed to prepare for the human cost and impact. I, like others, have received countless emails showing the amazing dedication from workers, but also the sense of real desolation. There was a lack of a structure of support for those who have lost people who were their friends—not one a day, but maybe five people in the space of two days and then 10 in the space of a fortnight. I certainly do not think we could have imagined that level of desolation and emptiness. We certainly didn't prepare for it, but in the future whatever planning we do cannot be just about systems. It has to be about individuals and how we support our workforce to go out and undertake the experience, which for many has been pure hell.

Q452 **Liz Twist:** To follow up on that, how prepared do you think the UK and Scottish Governments were to support you as care providers and hospitals during the pandemic?

Theresa Fyffe: I look back at the start of this and the months of knowing a number of people in government, local authorities and care homes—everywhere—and we worked very hard. I think that everybody was trying to do their best. Of course, when you look back we will see things that could have been done better and we have certainly learnt at times when we thought that was the case—the guidance we mentioned

earlier. There was a tendency to think we needed guidance for everything. You can see that because it became a feeling of if we have guidance, we are being clear, and that became almost a sense of if you said anything somebody would say, "Let's have more guidance." That became very difficult for the people on the ground who needed guidance because they felt that they wanted to discharge responsibilities to ensure they were getting things right.

I believe there will be, with inquiry, learning that will help us think how we want to work in the future, but I would like to say that I saw very little ego in the way people worked. I saw people being just profoundly concerned for the country as to how to deal with this pandemic. On a personal level, I worked those hours because for me what mattered was the members that I represent and my own organisation put in that effort because that is what mattered because the members were caring for people.

Chair: Can we leave it there because I am really keen to try to let you get away by 4 o'clock? We have the gold medal for patience, which goes to Wendy Chamberlain with our last set of questions.

Q453 **Wendy Chamberlain:** Thank you very much, witnesses, for all your time today. I think it has been the most impactful session that we have all experienced during this inquiry.

Ms Fyffe, you talked about the fact that a great deal of learning has taken place over the duration of the pandemic. Something encouraging we have heard this afternoon is that things seem to be in a better place with the communications and joined-up thinking. In my last questions I want to look specifically at some of the learning that had taken place in the past, particularly Exercise Silver Swan and Exercise Cygnus, which took place in England. One of the key observations from Silver Swan—indeed of the second meeting of participants in that—is that there was a consistent view that their ability to plan and prepare for the pandemic would be limited by time and capacity within the NHS. I would like to get the panel's reflections on that. Ms Fyffe, as I have mentioned you, could I start with you?

Theresa Fyffe: The RCN was not involved in Exercise Silver Swan, but the fact that the social care sector was not involved highlights again that a whole-system approach was not taken towards resilience in emergency planning. Health and social care partnerships must consider and include all health and care facilities in their areas and local resilience didn't do that at times and that was a weakness. That includes the independent sector care homes in resilience and emergency planning. For me, not to have had social care there, well—

Q454 **Wendy Chamberlain:** Was obviously a real failing. Dr Macaskill, I assume that would be your view as well?

Dr Macaskill: Absolutely. The social care sector has long been treated like Victorian children: to be there at the table, but not to be seen and

not to be heard. If we are going to improve things moving forward, we cannot be seen as just an adjunct, but as a key member of the family and to make sure that we learn lessons that have been far too painful during the pandemic.

Q455 **Wendy Chamberlain:** Ms Brown, do you have any comments?

Wilma Brown: I agree with the comments made. I think the feeling was that everybody was not at the table at the same time. We did not move forward together. We moved forward in stages and it was not until we found out what was happening and going wrong in another area that we started to pull people forward. We should never have to do that because everybody wants to be at the table; it is just sometimes they are not invited.

Q456 **Wendy Chamberlain:** Have there been any assumptions made within either of those exercises that might have impacted on the initial Covid response? I am thinking here about the section in Silver Swan on anti-virals, which almost seemed to suggest for outcomes that we would actually have the treatments required to deal with a pandemic. As we know with Covid, we have been learning on the go because an actual effective treatment has not been available. Ms Brown, do you have any thoughts on that, any assumptions that potentially were made in error?

Wilma Brown: I think that it just wasn't expected. We were not prepared, not expecting but, as Dr Macaskill said right at the beginning, we had lots of time to learn lessons from other places and we were not listening to that. We were not bringing things forward, so I think it is a complete lack of—maybe there was an "it would never happen to us" kind of thought process about that and we were completely unprepared.

Q457 **Wendy Chamberlain:** Dr Macaskill, what are your thoughts on that?

Dr Macaskill: Again, with hindsight, it does seem a little bit stupid to have planned for a pandemic that had a vaccine when it was clear, certainly from the World Health Organisation, that pandemic planning needed to consider the potential of a virus that was unknown or which at the very least did not respond to a vaccine. There are clearly lessons that we need to learn moving forward. I am hopeful that we have learned those lessons and as we plan throughout the winter, we will be able to better respond to whatever happens. All of us are very aware that the virus has presented itself in a particular way up until now. We don't know what the winter and a resurgence of the virus, potentially in a new way, might mean to society. Today's and yesterday's announcements highlight that while we are being reflective today, we are still very much in a battle against something of which we have limited knowledge even six months on.

Q458 **Wendy Chamberlain:** Ms Fyffe, a last comment from you, and this is about the learning going forward. I was very struck by what Dr Macaskill said about the human impact—about the loss and devastation of people working across the health and social care sector. It seems to me that we

will be dealing with mental health issues—PTSD—for some of the staff working in the sector. From your perspective, Ms Fyffe, what do we need to be doing to ensure that we provide the necessary support?

Theresa Fyffe: We are all very acutely aware now of the psychological impact this has had on staff within the health and social care sector. A number of services are being considered, as well as how we are going to provide that, but I don't think we will fully understand that yet. Some people are what we consider to be more resilient and able to keep going and then later, when they stop, it will have a profound impact. As we go into winter we will have not only an impact—we already have a recognised impact on mental health. You have seen the reports that have come out about people with dementia and the impact it has had on their lives.

We have so much to learn from, but how we recover and allow people who work in these sectors to recover while we deal with having to get services back—because ill health is there and needs to be treated—mobilised, as we are calling it in Scotland, while recovering, is quite a tough act really. That is where the workforce pressures and the valuing of the workforce will be critical. My worry is—our survey shows this—that more nurses have indicated they would walk away now, and that is very worrying. People have had all their careers in either the NHS or another sector, and deciding they may just walk would have a profound impact on the service of people. It is very difficult to understand and explain. I believe if we put in the right supports and value that workforce, we might not lose people who have survived and worked in this current pandemic.

Wilma Brown: The public support made the health workers, in both care homes and hospitals, feel very valued. They took that public support on board and pushed on every day. Even when some people didn't feel mentally well, they pushed on and they have done a lot of work around that. I think that Government need to take some recognition from that to understand the way that they need to value staff. We have heard lots of talk about how we make sure that continues. We have put in support hubs. There is a national phone line. There are lots of things that the care home staff are using as well, but we need to do more. We need to make sure that these staff are looked after, not only in our normal occupational health services, but with anything we need to make sure that they recover from things like this is taken forward.

Wendy Chamberlain: Make it a profession that is valued as well. That has come through very strongly. Thank you very much, everybody.

Chair: Thank you. On that very positive note, we will have to call proceedings to a halt. We knew this would be a fascinating and insightful ; you have not disappointed us. Thank you ever so much. If there is anything you feel you could usefully contribute as this inquiry continues, please feel free to get back in touch with us. I am pretty certain we will see you all again at some point to continue with more of this work. Thank you for today's session.

HOUSE OF COMMONS