OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Thursday 4 June 2020

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 4 June 2020

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HEALTH AND SPORT COMMITTEE
15th Meeting 2020, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

*George Adam (Paisley) (SNP)
*Miles Briggs (Lothian) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*David Stewart (Highlands and Islands) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Donna Bell (Scottish Government)
Jeane Freeman (Cabinet Secretary for Health and Sport)
Professor Fiona McQueen (Scottish Government)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

Virtual Meeting

Scottish Parliament

Health and Sport Committee

Thursday 4 June 2020

[The Convener opened the meeting at 09:30]

Covid-19 Scrutiny

The Convener (Lewis Macdonald): Good morning and welcome to the 15th meeting in 2020 of the Health and Sport Committee.

The first item on our agenda is an evidence session on the impact of Covid-19 in care homes. To inform the session, we invited care home staff, residents, families, owners and managers to submit evidence, and we are grateful for all the submissions that we received.

A number of respondents asked us to keep their submissions confidential. In order to get as much evidence as possible, we have chosen not to make submissions public. We want everybody concerned to feel that they can tell us what they know without fear of adverse consequences. Although our usual approach to written evidence is to make it public, we recognise that, in the current circumstances, we need to offer those who are on the front line some additional protection so that we can hear from as many people as possible.

All members of the committee have access to all the submissions, which help to inform our work in scrutinising the Government's response to the pandemic. Anyone who has made a submission to the committee is, of course, free to make it public on their own behalf.

I welcome to the committee the Cabinet Secretary for Health and Sport, Jeane Freeman, who is accompanied by the chief nursing officer, Professor Fiona McQueen, and the director of mental health and social care in the Scottish Government, Donna Bell. Thank you for joining us.

Because of the challenges of managing a virtual meeting such as this one, we will again take questions in a pre-arranged order. After the cabinet secretary's opening remarks, I will start with the first question, to which I will invite the cabinet secretary to respond. Each member will then ask questions in the order that we have agreed. Once each member has exhausted their questions, I will ask the next questioner to put their questions. It would be helpful to the broadcasting staff if members could say when they are on their final question.

All questions and answers should be kept as succinct as possible. Please give the broadcasting staff a few seconds to operate your microphone before you begin to ask your question or to provide an answer.

I invite the cabinet secretary to make an opening statement of up to five minutes.

The Cabinet Secretary for Health and Sport (Jeane Freeman): I thank the committee for the opportunity to be with it to answer questions. I am conscious of the time, so I will be brief. I am sure that members have a number of questions.

It is important for me to say at the outset that the Scottish Government and I have been clear about the importance of taking steps with respect to care at home and care homes. That is why we issued guidance to care homes on 13 March. We have regularly updated that guidance since then, most recently on 4 May. We intervened to engage in the direct provision of personal protective equipment from 19 March, when we were informed—and it was clear—that the provision of PPE to care homes through private routes was falling. To date, more than 53 million items of PPE have been distributed from the national health service's national stock to more than 1,000 locations across Scotland. On 2 April, we issued PPE guidance for health and social care settings.

The first set of clinical and practice guidance was issued to care homes on 13 March. That guidance has been regularly updated since then. On 17 April, guidance was issued to general practitioners to ensure that their role with respect to care homes was being enacted and to check that they did not need anything more from us. On 20 April, we tasked directors of public health with providing enhanced clinical leadership for care homes.

The recruitment portal through the Scottish Social Services Council to ensure that care homes could access staff if staff absence rates meant that their rotas were at risk went live on 29 March. Members will recall that those people are NHS and social care returners who had volunteered to go back and be employed in the health service and social care over the period of the pandemic.

On 12 April, I announced the 3.3 per cent uplift for adult social care providers, which was payable from 1 April. On 24 May, I confirmed the in-hand sick-pay arrangements and the death-in-service payments from Government for those social care workers and care home workers whose employers' terms and conditions were causing those individuals personal dilemmas about being tested, because their income would be severely reduced if they tested positive. Members will be aware of the testing regimes that were introduced on 15 April.

From the outset of the pandemic, we have followed the best advice and made judgments that

we believe to be correct, but there are undoubtedly lessons for us to learn and more work for us to do. It is worth reminding members that 38 per cent of adult care homes have lodged no notification of suspected Covid-19 incidents with the Care Inspectorate since the start of the epidemic, and 58 per cent of adult care homes have not registered any suspected cases of Covid-19 in the past 14 days.

With that, convener, I am happy to stop and take questions from you and other colleagues.

The Convener: Thank you, cabinet secretary. We put out two calls for evidence, one of which was specifically directed at care home owners and managers. Many responded, and every one of them told us that they had begun instituting measures to protect residents either in February or during the first fortnight in March, before the lockdown was announced on 23 March. Given the alertness of care home managers and the fact that they put measures in place, why has Covid affected in the order of 40 per cent of care homes in Scotland?

Jeane Freeman: At this point, it is not possible to reach a definitive view. That will come only as we gather evidence and data over time. Prior to the pandemic, all care homes would have been expected to abide by the "National Infection Prevention and Control Manual", and the Care Inspectorate would have inspected care homes against that manual. Infection prevention and control should therefore not be new to care homes. It is clear that many felt better prepared to enhance their measures. Many might have felt that that was more a normal part of their regime than others did.

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

It is difficult to say at this point why some care homes have not had any cases while others have. We can understand that, if there are one or two cases, the risk of transmission to other residents is high in certain circumstances. The evidence is not yet complete, but a distinction appears to be emerging between care homes of different sizes. Smaller care homes with 30 beds or fewer appear to have done better at handling the virus than other, larger homes. That must be heavily caveated, as the information that appears to suggest that is just emerging.

The Convener: I presume that clinical screening of patients who were discharged to care homes, as new or as returning residents, would have been done at the hospital end. What is the final tally of patients who were discharged to care homes in those circumstances? What advice about preparation was given to care homes to ensure the health and safety of new or returning residents? In particular, what was the advice on Covid testing of patients who were discharged in those circumstances?

Jeane Freeman: Assessing the clinical appropriateness of discharge should be undertaken in the hospital setting and by the receiver in the setting to which the patient is being discharged. That applies whether the patient is returning to the care home or is entering it for the first time. Many discharges from hospitals to care homes are only for intermediate, short periods—for example, while care packages are put in place in the patient's own home. Those clinical assessments should be undertaken at both places, so that the receiver knows about the individual's physical condition, the medication that they are on and what other health support they might need before they are discharged from hospital.

The advice was clear on the need for people to be isolated in their rooms. We are talking about people who are clinically ready to be discharged—in other words, the reason for their being in hospital in the first place has been addressed and they no longer require treatment that only a hospital can provide. That is the first condition for a discharge.

The assessment should be done by both parties, so that when an individual is admitted to a care home from a hospital, the home knows what their overall health condition is and what their medication needs are. Of course, many care homes employ nursing staff. Care homes should know who the local GP is so that on-going care can be provided. The advice on isolation was clear.

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

Jeane Freeman: During the early period of the outbreak, they did not.

The Convener: Now that the lockdown restrictions are being eased, what additional preparations should care homes be making? What guidance will be provided? Care homes have told us that they struggle with the fact that a multitude

of guidance is issued. Bearing that in mind, what clarification will you provide to care homes?

Jeane Freeman: The current easing of lockdown measures for the general population does not have a direct impact on the guidance that is offered to care homes. They should continue to follow the most up-to-date guidance. They should expect that any admission from hospital of someone who has been there because of Covid should follow two negative tests. The care home should be assured of that before accepting the individual.

The clinical assessment process should continue, alongside testing. Someone who has been in hospital for a non-Covid reason should have one negative test before being admitted to a care home. That also applies to community admissions. In both those cases, there is also a requirement to isolate the person and to support them in their own room throughout the possible incubation period to ensure that no Covid symptoms emerge despite their testing negative. We know that the test tells us whether someone is positive or negative only on the day that the test is taken; it does not give a long-term negative result.

09:45

We continue to supply PPE to care homes. We have undertaken direct deliveries, but I understand from Scottish Care that the hub route is working effectively. Of course, if issues are raised with us, we address them.

As you know, in Highland, NHS staff are supporting a particular care home. Support is available elsewhere, including through the portal that I mentioned, to ensure that if staff are absent and rotas are compromised, additional staffing and support can be offered.

The Care Inspectorate is in daily contact with many care homes—it is definitely in weekly contact with all care homes—to ensure that homes have support and any clarification of advice that might be needed. In addition, there is our enhanced clinical work through directors of public health, who are also in contact with care homes in their board areas.

As the committee will be aware, we now have a testing regime that involves the testing of all residents and staff in care homes that have a single case and the testing of care workers in homes where there is no case.

The Convener: You mentioned a possible emerging pattern of smaller care homes coping better. I know that we are at a preliminary stage in this regard, but are there other lessons that you can draw from the care homes that have not had cases of Covid-19 in the past few weeks?

Jeane Freeman: Primarily, it seems that size is an indicator. We have asked the Care Inspectorate to look at whether there is any connection between its assessments in previous inspections and how homes have coped with the current situation, but the inspectorate has not concluded that work, so I do not know. It is a matter of trying to understand why 38 per cent of homes have not had a single case and what might be the issue.

We understand that some care homes have taken additional precautions, with staff staying in the care home. That is a significant ask of staff. However, the data that I have is not yet clear in showing whether there is a correlation in that regard with the 38 per cent of homes that I mentioned.

The Convener: Thank you.

Brian Whittle (South Scotland) (Con): Good morning, cabinet secretary. The guidance was fairly clear that the care sector was key in freeing up capacity in hospitals. We know that more than 1,000 patients were discharged into care homes to help with hospital capacity.

What early preparations were made, before March, by the Scottish Government, to protect care home residents and the staff who work in homes? Do you think that enough was done early on?

Jeane Freeman: As I said, all care homes should be following the "National Infection Prevention and Control Manual". That forms part of the basis on which they are inspected. Early discussions were held with Scottish Care about preparedness and what might be needed—as you know, I regularly discuss with Scottish Care the issues that are coming through to it from its members. Scottish Care engages with many officials in the health directorate as well as with local health and social care partnerships.

Health and social care partnerships were actively engaged in considering what might be possible in their own mobilisation plans. They were aware that, where there were additional cost requirements, including from care homes, on top of the money that was already allocated through the 2020-21 budget, the Scottish Government would meet those additional costs. We have already allocated some initial funding to the sector, but more might be needed on top of that.

There were early discussions about understanding the importance of infection prevention and control and preparing for it. As I said, we were making sure that the 13 March guidance was clear about the requirement for shared clinical assessment before discharge.

The numbers are as Mr Whittle quoted. Importantly, though, the April numbers are reduced and, in fact, are lower than the number of discharges to care homes in April 2019. Of course, we are now in a different situation with the testing regime that is required.

Brian Whittle: The evidence that has been gathered indicates that new guidance was issued frequently, sometimes with only minor changes. One person said that

"you find that you are required to read the same document numerous times"

to find small amendments.

Why have there been so many revisions to the guidance for care homes? I think that there have been four since the end of April.

Jeane Freeman: Government guidance was issued on 13 March, 26 March and 15 May. Health Protection Scotland issues additional guidance for particular purposes and it reviews and updates that. As Mr Whittle said, some of the updates might be relatively minor, in order to align guidance with its previous guidance and Government guidance.

I would not demur from the comments that have been made. I think that the issue is less about there being too much guidance and more about a degree of effort being required to navigate through all the guidance. There is a clear lesson for all of us about streamlining and making it as easy as possible to follow the most up-to-date guidance. If guidance is revised, it needs to be made very clear to people which bits have been revised, so that they do not need to read the whole thing to find where the changes are. That is an entirely reasonable point for the sector to make to me and HPS. We will take that on board and try to ensure that we provide as much clarity as we can about what people should find in the guidance and make it easier for them to understand the guidance that they should be working to. In that, we are very well aided by the work of Scottish Care, which has made that point to me recently.

Brian Whittle: One comment in the evidence was that there is

"a lack of clarity around the government advice".

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

Jeane Freeman: There might be a case for that. Certainly, the guidance that should be issued in the current circumstances is from Government. That clinical and practice guidance is signed off or cleared, if you like, by our chief nursing officer and our chief medical officer, and then by me, before it is published. Of course, HPS, in its very particular role, also issues guidance.

I am aware of at least one instance—there may have been more—where it appears that the local health and social care partnership issued additional guidance that did not help to clarify matters and created a degree of confusion.

It remains unclear to me why our health and social care partnerships should feel the need to issue anything, rather than working as I would expect them to from the guidance issued by our senior medical and clinical advisers in Government and by HPS. I do not know why that is, but Professor McQueen, our chief nursing officer, is with us this morning and she might want to say more on the question of guidance and clarity.

Professor Fiona McQueen (Scottish Government): As the cabinet secretary said, on the issue of Health Protection Scotland and providing guidance on infection prevention and control and personal protective equipment to keep our residents and staff safe, we absolutely agree that, if the feedback from care homes is that the guidance is complex and too demanding, we want to try to streamline it. However, we cannot hold back information or guidance if we think that it will be to the benefit of the residents. The issuing, and reissuing, of guidance is for that very purpose.

We have now put in place more clinical oversight through daily contact with care homes, asking questions in a supportive way to make sure that they know and understand the guidance and to find out whether there are residents who they are worried about or any issues with staffing, personal protective equipment or how they should be supporting the residents. That dialogue will be much better than anything issued by the health and social care partnership.

We are trying hard to wrap around care homes and give them support as well as the guidance from Health Protection Scotland that is developed by infection prevention and control experts, which changes as the knowledge of the virus changes. That happens frequently, so it is important that we update the guidance and help and support care homes to understand the practical implications and what they can do to keep the residents as safe as they can at all times.

Brian Whittle: Finally, one submission suggested that the guidance assumes that care homes are equivalent to hospitals in terms of accommodation and that they can move people and beds around at will. It suggests that that is not true. How was the care sector involved in discussions about what guidance was required and how will you liaise with the care home sector

in anticipation of potential further outbreaks of the pandemic?

Jeane Freeman: There is a difficult balance to strike. We have touched on that before in conversations either here in committee or in the chamber. It is the balance between ensuring that the right clinical procedures, protections and preventions are put in place in the care home setting while recognising that care homes are people's homes. That can jar at times. Donald Macaskill from Scottish Care and I have discussed on a number of occasions the difficulty of getting that balance right. Neither he nor I would claim that we have yet got to a place where the balance is right.

Clearly, the focus at the moment is on providing the right clinical and medical support to prevent the introduction of the virus into care homes, as best we can, and the transmission of the virus inside the care home. That goes all the way through from the guidance on 13 March. It can be a difficult situation for care home residents who, since 13 March, we have said should spend most of their time in their own room. They were used to activity and social engagement to make their time in that homely setting as stimulating and enjoyable as possible, while staying safe.

Some of the stimulating and enjoyable elements have been sacrificed in order to ensure that the residents are safe. That is particularly difficult for individuals who suffer from dementia, but it is difficult for all individuals whose family members and friends have not been able to visit. I am supremely conscious of that and, as we make progress, I will want to see whether any of that can be eased in any respect. Just as there are impacts for the rest of the population, particularly for people who are shielding, from what we have asked people to do, there are impacts on the wellbeing of care home residents.

10:00

Learning lessons from all of this will be central to how we go forward. I am not sure that we will ever successfully balance the homely setting of the care home with the need for measures to address a virus that has the capacity to have such a devastating impact on individuals, particularly elderly and frail residents. However, dealing with infection is not a new idea for care homes, given that we have the flu, winter vomiting and other infections every year. We are not past the pandemic at all, but there are clearly lessons to be learned from this period, which we should and will discuss with care homes, on how influenza and other infections are handled, particularly as we approach the winter period.

David Stewart (Highlands and Islands) (Lab): Good morning. My questions will build on the cabinet secretary's answers to Brian Whittle. I will quickly summarise three points from the submission that you touched on earlier. First, care homes are, obviously, not hospitals. Secondly, options on separation of residents are not always available in care homes and, thirdly, implementing isolation and containment for people with severe dementia, while respecting their human rights, is challenging. Will you reconsider the guidance to care homes in order to take account of those points?

Jeane Freeman: Good morning to you, too. If you mean the current guidance in dealing with the coronavirus pandemic, we would not reconsider that to any great extent. My colleague Donna Bell might say whether we can offer care homes more advice on residents with dementia, for whom staying in their own room for a significant period adds to their distress and anxiety—for many, not least because their cognitive capacity to understand why that must be the case is diminished. We could consider whether we can ease that by giving guidance on mitigating measures that care home staff could take to allow individuals to spend more time out of their bedrooms.

I am conscious of the issue around human rights. I am sure that it will be no surprise to the committee to hear that my colleague Ms McKelvie is also actively concerned about the matter, and that we are due to discuss it further. The issue is the balance between what we need to do to protect an individual from a significant and immediate health harm that could, clearly, cause death, and other health harms that could arise as a consequence of dealing with that protection.

I am afraid that I do not have any straightforward answers for Mr Stewart. I assure you that I am very conscious of that real and pressing dilemma. We are looking at some areas. Members might want to hear a word or two from Ms Bell, particularly on dementia, and from Professor McQueen, who would, if we were to do anything on that, be engaged in deciding what mitigating measures we could take that would protect residents and staff.

The Convener: That is helpful. I will bring David Stewart back in. Bear it in mind that we can, if we have time, hear from the other witnesses, too.

David Stewart: I have a final question. Earlier this morning, I looked at statistics that were helpfully published in *The Press and Journal*, which show that from 20 April the number of deaths from Covid-19 in care homes has been higher than the number in hospitals. What plans are there to beef up the resources and powers of the Care Inspectorate to identify residents who are

particularly at risk, and to deal with providers that fail to meet requirements to improve the service? I understand that there are currently some rights and responsibilities, but my point is whether we can beef up the inspectorate. I am asking, "Who is guarding the guards?"

Jeane Freeman: I think that you are referring to numbers that were in a National Records of Scotland publication yesterday. Of course, NRS, as it is doing in other areas, seeks to publish as much data as possible once it is confident that the data is robust. The figures that were published yesterday show that the number of deaths in care homes is now higher than that in hospitals.

The Care Inspectorate has a number of important powers, which we have seen it exercise with regard to Home Farm care home on Skye. The Care Inspectorate has taken the very serious step of applying to the court to have the owner of that care home deregistered, and the court will reach a view on that later this month.

Towards the end of last week, I had a call with the Care Inspectorate in which we discussed a number of the on-site inspections that it has been carrying out. From memory, I think that it has, in the past two to three weeks, carried out 27 on-site inspections involving 19 establishments. It sometimes carries out an on-site inspection, then, because it has required the establishment to make improvements, returns to see whether the improvements have been made. Of course, if improvements are not made and the inspectorate considers that the issue is serious enough and affects the safety and wellbeing of residents, it can take further steps.

That does not rule out the possibility that the Care Inspectorate could have more powers than it currently has. I am happy to look at that in the round and, of course, to take the Care Inspectorate's view, as we learn lessons. There is an immediate set of lessons to learn as we prepare for the continued presence of the virus and for the coming of winter, when we expect more respiratory infections and so on to appear, as normally happens. There is also the longer-term view about the landscape of care in care homes and in the community.

David Torrance (Kirkcaldy) (SNP): My questions are on primary care support. A number of care homes have said that general practitioners have not come into the home to diagnose or treat patients, regardless of whether they had Covid-19, which has meant that managers have had to manage residents' symptoms. When was clear advice sent to GPs about visiting care homes to treat non-Covid-19 patients?

Jeane Freeman: Primary care providers and general practices all have connections with care homes. Given the circumstances of the pandemic, not all, but many general practices took the approach that they would, as far was clinically correct in their view, deal with their patients in care homes as they were dealing with patients elsewhere, which is through digital technology and telephone discussions with care home staff.

However, that has not precluded GPs from, in many instances, visiting care homes to see residents about other health concerns. As you know, we took steps very early on to ensure that our general practices have had the necessary deliveries and stocks of PPE, which they need in order to undertake such visits.

I am not aware of GPs having refused to visit care homes when a visit has been required. However, in caring for patients in care homes, they have used a mixed approach—[*Temporary loss of sound*].

The Convener: We seem to have a momentary interruption to hearing from the cabinet secretary. I will ask Donna Bell to comment on the Care Inspectorate's guidance document, "Dementia care during the coronavirus (COVID-19) pandemic", which was issued on 22 May. How far was the care home sector consulted in producing that guidance?

Donna Bell (Scottish Government): The dementia guidance was widely consulted on. The cabinet secretary has outlined very well the balance that needs to be struck between minimising distress to care home residents and keeping them safe. We are very much aware of the need for that balance, and a lot of work is already under way in care settings to manage that approach and to ensure that the right mitigating measures, such as social distancing and cleaning, are in place.

Further work that is currently under way includes engagement with a range of partners, including experts in the world of dementia and various people who work in care settings, in order to set out how we will manage our approach through the next and subsequent phases of the route map.

At all times, we must keep in mind the need for balance to ensure that we minimise distress while keeping residents safe. My colleague Fiona McQueen might want to come in at this point, as she probably has more direct experience of what is currently going on in care settings.

Professor McQueen: Many residents in care homes have dementia, and our care home staff are very experienced in caring for older people with the condition. The advice and guidance say that people should isolate, but a healthcare worker's individual judgment would also apply.

Although we have said that there should be no visiting, we would, when a resident is experiencing real distress, expect the family to be able to come in and support them. We would also expect the care home to be able to respond to the situation—for example, by providing a specific room or more activities or therapy for that person to keep them occupied and settled.

Where a resident is well enough to wander, it would, from a human rights point of view, be fair and reasonable to allow that to happen. From a staffing perspective, that person would need to be accompanied so that they could be guided and supported. Additional cleaning would also be required, because if older people wander round a care home they will be touching surfaces and using hand rails. Care homes are well used to putting in place additional cleaning regimes when there is an outbreak of infection and people are being cared for in that way.

One aspect that can be distressing for people with dementia in care homes is when there is increased cleaning to reduce the risk of passing on infection, and they do not understand why their ornaments and knick-knacks—the reminders of their previous life—are taken away.

10:15

It is difficult, but I have every confidence that staff in care homes are used to supporting their residents sensitively, and to making sure that there is a balance in terms of providing the ornaments and furniture that help residents to feel safe, soothed and comforted.

The Convener: It is helpful to understand that. The evidence that David Stewart referred to was about creating a homely setting for residents and recognising that some of the guidance that might have been relevant to hospitals is less relevant in the context of care homes. I ask Professor McQueen to say a little more about what might be done to create that homely setting or to acknowledge the concern that has been raised with us from the care management side that it is difficult to get the balance right. Do you anticipate any adjustment being made to achieve that?

Professor McQueen: Absolutely; we need to work with our colleagues in the care home sector so that we can find the best balance. In some of that guidance, when we talk about people who have infections—in this case Covid-19—we know that to minimise the spread of infection we can group together the residents who have that infection and the staff who would care for them so that staff are not going from caring for people with Covid-19 to caring for people without it, although with good personal protective equipment that should not be a problem.

From the transmission-based precaution and infection prevention and control point of view, we know that, if we have the people with the infection in one area and cared for by the same staff, transmission of the infection is reduced. If there is winter vomiting bug in a hospital, four patients with it might be in the one room and will be moved from room to room in the hospital. In care homes, residents have their own room and, as I implied earlier, they have their own furniture, ornaments and perhaps shawls—reminders of their past lives—or pieces of equipment that give them comfort. They might be in that room for a year. The suggestion that we group together residents who have Covid-19 on one floor means that a decision would have to be taken to move residents from one floor to another, which is incredibly difficult.

The reason for doing that would be to protect other residents from being infected. You would be asking one resident who was already infected to be disrupted from their room and be moved to protect other residents. That is incredibly hard and therefore I think that there are other interventions that could be made. For example, additional staffing could be brought in or there could be additional cleaning to ensure that it is as easy as possible for the social care staff to care for their residents in a way that prevents transmission in the care home and keeps the residents safe.

There is a tension, because there is public anxiety about deaths and infections in care homes, but on the other side of that coin there is public anxiety and particularly families' anxiety at not being able to be with their loved ones. It is almost an impossible decision; we need to apply that to each individual resident. We would absolutely work with Scottish Care and the wider sector on that, with advice from the specialists in dementia.

David Torrance: Cabinet secretary, if GPs are not visiting care homes, is it safe for care home managers to carry out clinical procedures?

Jeane Freeman: My apologies for disappearing; I am now using a different device.

The guidance that was issued to care homes on 17 April was from the chief medical officer, and there has been subsequent engagement with GPs by the British Medical Association, the Royal College of General Practitioners and the chief medical officer around care and support for residents of care homes.

As for the question of managers carrying out clinical procedures, as I said, many care homes employ nursing staff, who will have the skills to carry out clinical procedures in certain circumstances. However, where that is not possible, care home staff should expect to receive

the right level of care from their local primary care practice.

As I said, residents in care homes are in their home. Just as people living in their home elsewhere expect to get primary care and support from their GP or others in the primary care practice, residents in care homes should expect that, too.

George Adam (Paisley) (SNP): I have a question regarding PPE. In evidence, some care home managers have expressed their desperation about their attempts to source PPE to protect their staff and residents. That is understandable, given what they are trying to do. Many care homes are private or are run by other organisations. Please correct me if I am wrong but, if I was running a care home, it would surely be my responsibility to ensure that the company had the proper level of PPE and other equipment that the home needed.

Jeane Freeman: Mr Adam makes a fair point. At the outset of the current situation, we understood that care homes might have to source an additional volume of PPE. We undertook to ensure that we could make provision from the NHS stock to support that. However, in the context of a global pandemic and huge global demand for items of PPE, a number of privately sourced routes failed to deliver the single-use and other items of PPE that care homes needed and that our guidance said should be there for staff. We therefore stepped in—and we remain in that area—to ensure that all care homes had the levels of PPE that they need. That involved us increasing our orders and the volume of our orders.

It is appropriate to thank NHS National Services Scotland on the record for stepping up to ensure that a sector that it had never previously been required to supply could be supplied in very short order, not only by direct delivery to individual care homes but through the local hubs, which it set up very quickly, together with health and social care partnerships to ensure PPE availability to care homes, and now to unpaid carers and personal assistants. All of that was done in addition to the work that NSS undertook to provide direct routes for ordering and delivery to the primary care sector, pharmacy and so on, as well as hospitals.

Mr Adam's point is fair, but our position was that we could not leave the provision of PPE to the vagaries of the marketplace. We had to use the expertise and the stockpiles that we had, as well as the capacity to order in volume, track orders and be assured of quality through NSS, so that care home residents and staff had the personal protective equipment that they needed.

George Adam: You have obviously been helping care homes in the current situation, but if the virus spikes again, will there be an adequate supply of PPE, or will we have access to one? You mentioned that privately sourced routes were not available to care homes. Some care homes have said that the charge for PPE was very high, given the market when PPE is needed. I am sorry to labour the point, but surely care homes, as businesses or other organisations, have to know that they can get access to that type of thing on their own.

Jeane Freeman: In as much as the vast majority of our care homes are provided by the private sector—I have heard one provider describe care homes as an industry; that is not a term that I would use—in the running of any business, there are overheads to be met, and those include consumables, such as PPE. The "National Infection Prevention and Control Manual", which predates the pandemic and which care homes should have been following in normal circumstances, tells them that they need to have PPE.

I believe that the care home sector views what the Government has done to ensure that care homes have PPE as a temporary measure, and that they will be taking steps in normal course to ensure that their supply routes stand up. Of course, where those routes look to them to be unreliable or unlikely to give them the volume that they need, we will continue to top up the supply to ensure that they have all the PPE that they require to undertake the level of infection prevention and control that is needed.

We have seen cases in which the prices for PPE were hiked considerably because of the level of global demand, although that issue has diminished a little. The NHS in Scotland has had a procurement operation for many years and has good relationships with suppliers and significant expertise in negotiating reasonable deals. Without doubt, we have benefited from the intervention and role of my colleague Ivan McKee, such that we now have used a difficult situation to create opportunities for Scottish companies to increase the number of jobs that they offer by beginning to supply items of PPE domestically. That is considerable progress, particularly given that we are looking at the likelihood of on-going demand for PPE and continued variability in global supply chains.

The Convener: I will call George Adam for a final question, and then I might suspend the meeting briefly while the minister's video is restored.

George Adam: Cabinet secretary, given how the care home sector has dealt with the PPE situation, and struggled with it to a degree, do we need to look at another model of delivery for that sector in future? How would we go about that?

10:30

Jeane Freeman: A couple of weeks ago, I said that it would be entirely legitimate to have a debate, in due course, about the landscape of social care and the care home sector, whether as a country we want to improve that landscape, and, if so, how we do that. The Scottish Government has intervened when the terms and conditions of people's contracts have not been adequate in relation to statutory sick pay and death in service and have certainly not matched the fair work principles that we uphold and on which we have reached agreement with the Scottish Trades Union Congress. There is a debate and discussion to be had about how social care looks in the medium to long term and how it is funded, regulated and provided. That is entirely appropriate.

As you would expect, my focus is on what we need to do now and in the weeks and months ahead to continue to provide as much protection and support as possible to the care home sector and its residents and staff, and to provide care at home by working in partnership with our colleagues in the Convention of Scottish Local Authorities. However, we want to take early steps to begin to have the conversation with all interested parties, including the Scottish public, about their views on the provision of social care in Scotland.

The Convener: Cabinet secretary, I am conscious that it is important to see you as well as hear you if possible, so in order to deal with the immediate technical challenge, I will suspend the meeting for a few minutes to allow your videolink to be restored.

10:31

Meeting suspended.

10:38

On resuming—

The Convener: Thank you for your forbearance, everyone. I apologise to those who are watching the live stream of the meeting, as we lost the cabinet secretary's video connection for some time. However we did not lose the audio, and her words are what we are here to deal with.

Miles Briggs (Lothian) (Con): My question relates to what the First Minister and the cabinet secretary said at the beginning of the crisis about patients being moved from hospitals to care homes. Can the cabinet secretary outline the process behind the decision to transfer people who were discharged from hospital to care homes, given the evidence that we had on that from Italy and Spain?

Jeane Freeman: I thank Mr Briggs for his question.

I go back to my statement in Parliament of 3 March, in which I outlined the advice on the likely worst-case scenario: that the virus would impact on 80 per cent of the population, with 4 per cent of that number requiring hospitalisation, and, from memory—I will correct the figure if I am wrong—1 per cent requiring intensive care treatment. At that point, we talked about what we had to do in order to ensure that our NHS in Scotland could cope with that volume of demand, if it should transpire.

On 10 March, I talked about working to reduce the numbers of delayed discharges. That has long been an area of discussion in the Parliament, pre-pandemic. On 3 and 10 March, there was certainly no opposition from any party to what we were aiming to do.

People are not discharged from hospital exclusively to care homes. Many elderly individuals—the folks that we are talking about—are discharged to their homes, with the appropriate social care package, and many are discharged to care homes for a short period only, as an intermediate step.

The guidance that was issued included proper clinical assessments, as I have described. I also need to make the point that all our guidance has complied with the World Health Organization's guidance. That was the approach that was taken.

Given the importance of the infection prevention and control manual for care homes, pre-Covid-19, it was reasonable to assume that infection prevention and control measures would be in place in care homes. Moreover, the shared clinical assessment that was required by the 13 March guidance—and which has always been required—would have highlighted when a care home felt unable to take an admission; for example, if staff would find it difficult to isolate the individual in their room, as was required.

The Convener: Thank you very much. I remind members and, indeed, the cabinet secretary, that we have lost a little time, so, once more, I encourage brevity in questions and answers.

Miles Briggs: Thank you, convener; I will try my best.

Will the cabinet secretary confirm that no one who has tested positive for Covid-19 is now being discharged from hospital?

Jeane Freeman: I confirm that no one should be discharged from hospital who has a positive test for Covid-19. If they are in hospital and have tested positive for Covid-19, they should remain there and be treated for the virus.

Miles Briggs: On reflection, looking back over the pandemic, the Government's actions, and the uncertainty about the spread of the virus, was it appropriate to push for such levels of delayed discharge, and to purchase care home beds as you did?

Jeane Freeman: It was entirely appropriate to ensure the discharge from hospital of any individual, regardless of their age, if they were clinically fit to be discharged, and they no longer required the care and treatment that only a hospital could provide.

In the circumstances, and based on the evidence that we had and the judgment that we made about it, it was correct and reasonable to anticipate that a hospital, which was gearing up to receive large numbers of Covid cases, was not the safest place for someone to continue to stay when they were clinically fit to leave. That was a reasonable judgment to make at that point.

On the basis of the information, evidence and knowledge that we had and the judgments that we made, it was right to give that guidance to care homes, working on the presumptions that we made about their level of infection prevention and control, and that we supplemented that with support on PPE and so on. As I have said, the guidance that we issued and continue to work to as it is updated complies with World Health Organization guidance.

10:45

At the time, we took all the steps that we could reasonably have been expected to take. As always with such matters, as knowledge of the virus, how it is transmitted and behaves and the practicalities of dealing with it in a care home setting or elsewhere develops, we will take different judgments and views, as we have done.

On the use of resources, we were aiming to say to all those that are charged with providing social care, whether they are local authorities or care home providers in whatever sector, "You need to do what you need to do to prepare and support your residents for the pandemic, and if that requires additional resource, the Government will provide that for you." I think that that is the right decision for a Government to take. Questions about resources should not stand in the way of organisations or individuals making the provisions that we were asking them to make and that they knew that they were required to make.

Miles Briggs: The cabinet secretary has outlined that the figure for discharges in April 2020 was lower than that in April 2019. We know that a record number of delayed discharge patients were sent to care homes in March. Was that an acknowledgement of the concern about patients contracting Covid-19 in a care home setting? Could the cabinet secretary outline how many families have tried to prevent or veto their loved ones being moved from hospital to a care home setting?

Jeane Freeman: I would not have information about the last part of Mr Briggs' question and if I did, it would be entirely anecdotal, but I do not have even anecdotal information. Of course, if Mr Briggs has that information, I would be very happy to receive it and consider it in the proper way.

On the discharge figures for March and April, to be clear, the March figure would have been high because we were dealing with a backlog of delayed discharges. I am sure that Mr Briggs, and indeed Mr Stewart and other colleagues, will recall the many feisty debates that we have had in the committee and the chamber about the levels of delayed discharge and the demands that Government should act to reduce them.

That is why we were dealing with a historical number in March and why there was a reduction—taking into account all the guidance and precautionary steps that I have described. Of course, the figures for delayed discharges at the start of April were clearly lower than those at the start of March, as was throughput into our hospitals for non-Covid-19 related matters. In the chamber this week, we had a debate about restarting the NHS. The number of other healthcare procedures undertaken in hospital was reduced to ensure that the health service could cope with the demand that was caused by Covid-19. We can now gently and safely begin to restart those measures.

Emma Harper (South Scotland) (SNP): I have some questions about the Care Inspectorate, which the cabinet secretary has already referred to.

First, I will raise a point that the cabinet secretary made when she talked about care homes being described as an industry and the language that is used about them. I read an article about a large care home provider that said that there had been an increase in annual sales. I was a bit shocked at that language, because it is very businessy. I believe that we should think about care homes as homes for our older people. It is interesting that the language of industry is used.

My question is about the most recent emergency legislation, which increases the ability of Scottish ministers to intervene in care homes, if necessary, through the Care Inspectorate. How has it been able to continue to make inspections? I read about digital investigation, and am interested in your comments on the approach.

Jeane Freeman: The Care Inspectorate has done 27 on-site inspections in 19 locations—I

think that I said that earlier from memory, but I will correct it if I am wrong. That reflects situations in which the Care Inspectorate believes that important improvements needed to be made after its first inspection. It set those improvements out very clearly for the provider, then went back within a relatively short time to inspect whether they had been made.

The inspectorate is also in weekly contact with all care homes in Scotland, and in daily contact with some. It makes the judgment about whether contact with a care home should be daily, weekly or on site. It works from the information it has about, for example, the number of notifications of infections and also from its previous inspection reports of its assessment of any particular care home. It determines all that, and it follows a weekly plan of the care homes it intends to visit and inspect. Contact is a mix of on-site visits, which are properly PPE-ed and so on, and digital and telephone.

Emma Harper: Are the Care Inspectorate's powers in more normal times adequate to ensure that care homes are safe and are providing high quality care?

Jeane Freeman: As we touched on earlier, the Care Inspectorate is now exercising its important power to make a court application to deregister a care home provider. That is a serious and important power. It is set out that it is for the court to decide, so that it can hear from all parties and take a view.

The Care Inspectorate is thoughtful, as am I, about whether it should have more powers. It is in discussion with Healthcare Improvement Scotland about expertise in infection prevention and control, and some of the on-site inspections involve HIS with its particular expertise, so the Care Inspectorate might consider that there are areas that it would like to strengthen with regard to inspections that it normally undertakes and the powers that it would then have and the procedures that it would use.

We touched on the issue briefly last week when I spoke to the Care Inspectorate's chair and chief executive and their colleagues, and I am sure that we will return to it. However, right now, the Care Inspectorate is focused on the immediate situation, as it should be, and on what it needs to do to ensure the safety of residents and staff.

Emma Harper: We know that many health and social care partnerships are working really well with the NHS, the Care Inspectorate and everybody to provide good support across the care sector. You talked about streamlining reporting and engagement. What streamlining of reporting is already in place so that care homes do not duplicate effort in reporting to the various agencies? Can we make the process more streamlined and seamless as we go forward?

Jeane Freeman: In the care sector as in the health sector, there is certainly room to streamline reporting. By streamlining reporting, we can give ourselves room to gather more of the data that we need to understand everything that is going on in the health and social care sectors, and to make that information public. During the pandemic, we have taken a number of steps to secure and quality assure data so that we can be confident that it is robust enough to publish. As members know, we publish a great deal of data and we have committed to publishing more in the future.

We will have a conversation with the Care Inspectorate and Scottish Care about what reporting is required from the care home sector and whether improvements can be made, while still providing the information that is needed by the Care Inspectorate and, more importantly, by relatives and residents. Last week, I discussed with the Care Inspectorate the information that is now available as a matter of course in hospitals about infection levels, falls and a number of other important indicators that matter to patients and relatives. We could look to duplicate that provision, in an appropriate way, in the care home setting. We need to have that conversation to ensure that that is the right thing to do.

The Convener: We know that the Care Inspectorate carried out inspections of the Home Farm care home in Skye in November and January. Did it also carry out an unannounced inspection of that care home during lockdown?

Jeane Freeman: Yes. I think that the Care Inspectorate carried out two unannounced inspections, but I am not absolutely certain. Certainly, one inspection was done. The Care Inspectorate made its decisions, and we are now waiting for the court's decision.

Alex Cole-Hamilton (Edinburgh Western) (LD): My questions will initially follow up on those of Miles Briggs, and are on testing. On 30 January, *The New England Journal of Medicine* cited the case of a Chinese woman who had infected eight people in Germany before becoming symptomatic. All told, during February and March there were a further seven global alerts about people passing on the disease before the onset of symptoms. The international health community was screaming about asymptomatic transmission, but your Government accelerated the decanting of 1,300 patients from hospitals when we were not able to understand the spread of the infection into care homes without Covid testing. Why did your Government ignore those international alerts, and who was ultimately responsible for the decision to decant so many patients into care homes when their Covid status was unknown?

Jeane Freeman: I will make a number of points in response to Mr Cole-Hamilton. First, I would not use the word "decant". People were moved from hospital to what I would call a homely setting—many of them moved to their own homes. We have rehearsed all the reasons for that and have noted that there was at the time, it is fair to say, cross-party support for the Government's approach.

On the international health alerts, there was and there remains a dispute in the science and health communities about asymptomatic transmission. For example, the World Health Organization's daily Covid report on 2 April stated:

"There are few reports of laboratory-confirmed cases who are truly asymptomatic, and to date, there has been no documented asymptomatic transmission."

11:00

There is a lot of discussion and debate around the issue. I think that it was reasonable for us to expect that our care homes were operating according to the "National Infection Prevention and Control Manual", as they should have been doing for other infections, including flu. We set out guidance on 13 March that was very clear about undertaking the mutual clinical risk assessment before a person was discharged from hospital to a care home setting, and about all the steps that we were requiring care homes to undertake.

Testing is, of course, important, but a test tells us only whether someone is positive on the day that the sample is taken. We required isolation for seven days to 14 days, proper infection prevention and control measures, and correct use of PPE. Those steps are all required in order to prevent infection spreading; one on its own will not do it. We know that the polymerase chain reaction test is very robust in detecting the presence of the virus when a person is symptomatic, but it is less robust in detecting the presence of the virus when the person is asymptomatic.

There is a difference between someone being infected and their being infectious, and work continues on understanding exactly what that difference is and whether it is of sufficient margin such that we should pay attention to it in terms of guidance and advice.

Alex Cole-Hamilton: You have leaned a couple of times on the suggestion that the measures had cross-party support at the time when we were in the foothills of the crisis. That might be true, but we did not have the wealth of scientific advice that you were privy to; we were given only what was filtered and had been decided on. Obviously, we were given scientific evidence to back that up.

I will press you to answer my question about who was ultimately responsible for the decision to move patients, but before I get to that, I have another point to make. During the months of high infection, you have said that Government policy continued to be to test in care homes only people who exhibited symptoms. You have maintained that it was largely futile to test those who did not seem to be unwell, and you largely reiterated that in your answer to me, just now.

However, we now know that the PCR test does readily pick up Covid in asymptomatic patients; indeed, we learned yesterday that 45 members of staff of Renaissance Care tested positive despite having no Covid symptoms. When the decision was taken not to test asymptomatic patients before their transfer to care homes, what empirical scientific evidence was offered to you or your advisers that the PCR test was ineffective?

Jeane Freeman: In answer to the last part of your previous question about who is responsible, I say that I am responsible. I do not think that there is any doubt about that and I would never go against that: of course the decisions sit at my door. I have done my very best to explain them.

On the PCR test for asymptomatic individuals, I do not believe that I have ever said that it was of no value. What has been said is that the degree to which its value is considered appropriate has changed over time. We know that it is less robust in detecting whether the virus's presence is because the person has already had the virus and a remaining viral load is being detected, or is presymptomatic and is about to develop the illness.

I will be happy to provide the information for the convener later, but I think from memory that the chief medical officer's point about the PCR test in symptomatic individuals is that it is 93 per cent accurate in detecting a virus and 100 per cent accurate in detecting this particular coronavirus. In asymptomatic individuals, the percentage is significantly lower—from memory, I think that it is in the 80 per cent range. If that information is not absolutely accurate, we will let the committee know.

On information and evidence, I have cited some from the World Health Organization. There is other information and evidence. What the World Health Organization has said about testing of asymptomatic individuals has developed over time from what it said on 2 April, to when more evidence points, on balance, to the value of testing individuals who have no symptoms. Of course, that is what led us to decide to test all care home workers regardless of whether they work in a care home that has an active case.

Sandra White (Glasgow Kelvin) (SNP): Good morning, cabinet secretary. Before I go on to my other question, I will touch on a matter that has

been bothering me, but has not so far been raised by anyone else. Would it be fair to say that failings in the quality of infection prevention and control in some care homes have led to cases of Covid-19?

Jeane Freeman: I hesitate to be absolutist about that. Although that might seem to be a reasonable conclusion to come to, before it would be reasonable to give an absolute yes or no answer, we would need to look care home by care home at whether cases had been identified as quickly as possible; at what steps were taken; at whether guidance from 13 March, 26 March and subsequently was followed; at levels of PPE; at how confident staff were in the training on putting it on, taking it off and key points about its use; at whether staff had the right PPE; and at other steps. Those are the areas that need to be looked at and are, of course, currently subjects in the Care Inspectorate's telephone, digital and on-site inspections.

Sandra White: I thank the cabinet secretary for that answer. Perhaps that will feed in to my question about the social care review. The cabinet secretary mentioned—I think on 24 May—that care homes are a very mixed economy that includes private care homes, not-for-profit care homes and so on. Is that mixed economy fit for purpose? The committee was going to do an inquiry into care homes. We now hope to do so when the time is right and we have time.

I know that the Scottish Government's adult social care reform programme is going ahead. Will the cabinet secretary give us more details on the plans for that, including timings? Is that an additional review, and will it consider a national care service such as George Adam touched on earlier?

Jeane Freeman: Ms White is absolutely right that, before Covid-19, we had begun our review of adult social care to look at the sustainability of the sector, which has a number of work streams. Clearly, that review was paused in order to divert people and other resources to what we needed to do, and still need to do, to deal with Covid-19.

I will need to consider how the review will progress. Learning from the pandemic, particularly in respect of care home and social care settings, needs to be factored in to how the review will continue. However, no decision has yet been taken on whether that review should be subsumed into a wider review of funding, regulation and provision of social care, including care homes. It is certainly in the mix, and, as Sandra White said, around 24 April I made it clear that it is, in my view, entirely right and proper to have a wider look at provision of social care, including care homes. That would also involve looking at what we can do together and at what the Government, the people of Scotland and colleagues in other parties think the landscape should look like, as we go forward.

We will give some thought to how the reform of adult social care—which we had started—should be progressed, and to whether it should feed in to the larger review.

Sandra White: I want to know the timescale for that, but due to Covid-19 we cannot say what it will be. I have no more questions.

The Convener: We have a moment to squeeze in one last brief question from Miles Briggs.

Miles Briggs: I received a response from the cabinet secretary when I asked questions on adults with incapacity. Can she confirm whether 88 individuals who are in the category of adults with incapacity have been moved from hospitals to care homes?

Jeane Freeman: If that is what my letter said, Mr Briggs, that is correct. Of course, the movement of individuals who are in the category of adults with incapacity is not a Government decision; I think that I set that out in my letter to you. There is a significant and important piece of legislation that covers that. It is a matter for local mental health officers in local authorities, and it is for our courts and the Mental Welfare Commission for Scotland to regulate and determine what is best for such individuals.

The Convener: Thank you very much, cabinet secretary. I also thank Fiona McQueen and Donna Bell for their participation, which is much appreciated. The evidence session has run a little later than planned, but in the circumstances I am pleased that we managed to get answers to so many questions.

Subordinate Legislation

Adults with Incapacity (Ethics Committee) (Scotland) (Coronavirus) Amendment Regulations 2020 (SSI 2020/151)

11:12

The Convener: The second item on the agenda is consideration of an instrument that is subject to negative procedure. Members have no comments. Does the committee agree to make no recommendation on the instrument?

Members *indicated agreement.*

The Convener: That concludes the public part of this morning's meeting. The next meeting of the committee will be on Tuesday 9 June. Details will be made public in the usual way. As agreed, we move into private session.

11:13

Meeting continued in private until 11:41.

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