UK COVID-19 INQUIRY

MODULE 6

CLOSING SUBMISSIONS FOR THE SCOTTISH TERRITORIAL AND SPECIAL HEALTH BOARDS

INTRODUCTION

1. The integrated nature of health and social care in Scotland meant that the Scottish Health Boards (who we refer to collectively as "the Boards" unless the context requires) played a key role in supporting the Adult Social Care (ASC) sector during the Covid-19 pandemic. Eight Rule 9 responses have been submitted to Module 6 on behalf of the Boards.[1]

2. The Boards, both directly and through their representatives, have listened carefully to the oral evidence in this module, including the powerful and moving evidence from Judith Kilbee and Rhona Arthur of the Scottish Covid Bereaved. The ASC sector experienced harrowing pressure, strain, and loss during the pandemic. The Boards recognise the significant distress experienced by residents, loved ones, and staff within the sector, and their greatest sympathies are with all of those who were affected. The Boards commend the hard work and dedication of all those caring for individuals in ASC during the pandemic and all of those supporting that care.

The Boards' place within the structure of Adult Social Care in Scotland, both pre- and during the Covid-19 pandemic

3. Local authorities have statutory responsibility for ASC services in Scotland, while the territorial health boards have responsibility for provision of healthcare (see the Boards' Module 3 submission for further detail, if required). There is a legislative requirement that territorial health boards and local authorities work together by

[1] Susan Webb on behalf of Scottish Directors of Public Health (INQ000613179); Dr Adam Crawford McGuffie on behalf of NHS Ayrshire & Arran (INQ000587718); Dr James Cotton on behalf of NHS Tayside (INQ000587766); Laura Skaife on behalf of NHS Orkney (INQ000587717); Dona Milne on behalf of NHS Lothian (INQ000587768); Sarah Horan on behalf of NHS Borders (INQ000587794); Dr Emilia Crighton on behalf of NHS Greater Glasgow & Clyde (INQ000587827); & David Park on behalf of NHS Highland (INQ000587833).

integrating their health and social care services.[2] There are 31 Integration Authorities in Scotland, established through partnerships between 14 territorial health boards and 32 councils. Most Integration Authorities delegate these services to Integration Joint Boards (IJBs), of which there are 30. The services are governed by IJBs but are agreed, planned and delivered by 31 Health and Social Care Partnerships (HSCPs) across Scotland.[3]

4. NHS Highland is unique in that, in part, it operates a Lead Agency Model for health and social care in the Highland Council area. This means that, within Highland Council's area, NHS Highland has responsibility for delivering ASC, though the underlying statutory responsibilities remain unchanged. The Highland Council therefore retains statutory responsibility for delivering social care in its area.[4]

5. Care homes in Scotland are operated and staffed by a mixture of private companies and local authorities, rather than by health boards. Health boards both before and since the pandemic do however provide certain assistance to care homes. Within each of the 14 territorial boards, a Health Protection Team (HPT), led by a Director of Public Health (DPH), provides advice and support to care homes in the event of outbreaks or individual cases of infectious disease.[5] For more complex scenarios, Public Health Scotland (PHS) is able to assist local teams. HPTs were expanded to support the pandemic response. In some health boards, support to care homes is also provided by Infection Prevention Control (IPC) Teams.[6]

6. As the Inquiry is aware, the NHS in Scotland was placed on an 'emergency footing' from 17 March 2020 until 30 April 2022. This provided the Cabinet Secretary with

[2] As required under the Public Bodies (Joint Working) (Scotland) Act 2014.
[3] Nicola Dickie, COSLA, Inquiry transcript 21/07/25, p.99, line 19 – p.100, line 11; Jeane Freeman OBE, former Cabinet Secretary for Health and Sport, Inquiry transcript 22/07/25, p.34, line 22 – p.36, line 5; Nicola Sturgeon, former First Minister for Scotland (INQ000339033), para.444.
[4] NHS Highland (INQ000587833), para.23.
[5] For further detail, see Scottish Directors of Public Health (INQ000613179), paras.1.1 - 3.4; Public Health Scotland (PHS) (INQ000587252), paras.9.2.2 - 9.4.3.
[6] E.g. NHS Lothian (INQ000587768), para.25.

powers to direct the Scottish Health Boards and meant that the Scottish Government were responsible for all key decision-making in relation to the pandemic.[7]

7. During this period, the Scottish Government directed the territorial boards to play an enhanced role in providing support to and oversight of ASC in Scotland. An overview is provided in our opening submissions to this module and will be discussed more fully below. It ought to be noted that this did not change or replace existing accountabilities or responsibilities for the delivery of ASC.

8. From 27 May 2020 to 1 October 2022, territorial boards were provided with emergency powers under the Coronavirus legislation to enable them to direct care homes to take steps in certain circumstances.[8] The boards did not exercise these powers.[9]

9. Having considered the written evidence and listened to the oral evidence, the following topics appear to the Boards to be ones in which some input might assist the Inquiry. They are:

    a. Hospital Discharges
    b. Enhanced Oversight and Assurance
    c. Access to Healthcare
    d. Visiting Restrictions and Inspections
    e. Overall Reflections

A. <u>HOSPITAL DISCHARGES</u>

10. Patients were discharged from hospitals into care settings in Scotland during the pandemic. These discharges have been criticised, with some considering that they led to an increase in infections in care homes. Whether that is epidemiologically correct, or whether the underlying policy of reducing delayed discharge from hospital is

[7] 'Article by Scottish Government […] dated 17/03/2020.' (INQ000235164); 'Module 3 Closing submissions on behalf of the Scottish Territorial and Special Health Boards, dated 19/12/2024' (INQ000532393), paras.3 - 7).
[8] Public Services Reform (Scotland) Act 2010, ss.63A & 63B, as amended by the Coronavirus (Scotland) (No.2) Act 2020 s.16.
[9] NHS Tayside (INQ000587766), para.79; NHS Lothian (INQ000587768), para.124; NHS Borders (INQ000587794), para.58; NHS Greater Glasgow & Clyde (INQ000587827), para.74; NHS Highland (INQ000587833), para.109.

capable of criticism are not issues upon which the Boards take a position. Rather, in this section the Boards seek simply to explain their role in discharges from hospital and to explain some of the issues involved from a clinical perspective.

11. Decisions as to whether patients are medically fit for discharge from hospital are made by clinicians, on a case-by-case basis following clinical assessment.[10] Clinical assessment does not, in the first place, consider the place of any discharge. Rather, once a clinical assessment of fitness is made, multidisciplinary teams across the hospital and community assess the safety and appropriateness of discharge.[11] If an individual is to be discharged into a care home, discussions take place between the hospital and care provider.[12] The result is that there are often patients who are medically fit for discharge, but who cannot be discharged until a place is found for their care. This long predates the pandemic[13] and is referred to as "delayed discharge".

12. On 6 March 2020, the Scottish Government wrote to territorial health boards and local authorities to request that, as part of efforts to increase capacity, they take urgent steps to reduce the numbers of delayed discharges.[14] This was reinforced in guidance issued on 13 March 2020.[15] The guidance was, of course, being implemented alongside other measures needed to increase hospital capacity, which the Boards addressed in detail at the end of Module 3. The guidance did not change the underlying need for assessment of medical fitness and safety and appropriateness of the place of discharge, discussed above.

13. On 21 April 2020, the Scottish Government announced formally that Covid-19 patients discharged from hospital to a care home should have given two negative tests before discharge, and that other new admissions to care homes should be tested and isolated for 14 days.[16] The position was reflected in Public Health Scotland guidance of 26 April

[10] Jeane Freeman, Inquiry transcript 22/07/25, p.68, lines 10 - 19; NHS Lothian (INQ000587768), paras.31-32; NHS Highland (INQ000587833), para.40.
[11] NHS Tayside (INQ000587766), paras.26 & 29.
[12] NHS Lothian (INQ000587768), para.43; NHS Tayside (INQ000587766), paras.33 - 38.
[13] Jeane Freeman, Inquiry transcript 22/07/25, p.59, line 24 – p60, line 10; written statement (INQ000606530), paras.123-131.
[14] 'Letter from Malcom Wright […], dated 06/03/2020' (INQ000470123).
[15] 'Letter from Jeane Freeman […] dated 13/03/2020' (INQ000280689).
[16] 'Publication from Scottish Government […] dated 21/04/2020' (INQ000280688; INQ000292544).

2020 and further clarified in guidance on 29 April 2020.[17] Prior to this, there was no requirement to routinely test patients prior to discharge. Patients who displayed symptoms consistent with Covid-19 were not considered appropriate for discharge and met the criteria for diagnostic PCR testing.[18] If a hospital patient was known to have Covid-19, they would be managed in hospital in line with the national IPC guidance.[19]

14. Much evidence has been heard about the limited testing capacity available in Scotland in the early stages of the pandemic, at a time when there was only a developing understanding of the nature of the virus and its transmission.[20] Had guidance been in place requiring routine testing of patients prior to discharge during that early period, there was no capacity to undertake such testing. Logically, it would have prevented discharge taking place.

15. Against that must be balanced the negative features of patients, who are otherwise clinically fit for discharge, remaining in hospital. Clinicians have acknowledged that being in hospital during the pandemic may be associated with increased risk of acquiring Covid-19. Discharge of a patient to an appropriate care setting was generally viewed as the safer option for vulnerable patients.[21] It is, in any event, well recognised that keeping a patient in hospital for longer than is clinically necessary risks a detriment to their physical and mental health.[22] Discharged patients would usually be returned back to their own private home or into the care home that had been their place of residence before they were admitted to hospital.[23]

16. Evidence before the Inquiry has also highlighted the limitations of testing patients prior to discharge as a method of preventing infection transmission. Witnesses have pointed

[17] PHS guidance dated 26 April 2020 (INQ000189331); NHS Greater Glasgow & Clyde (INQ000587827), paras.32-33.
[18] NHS Lothian (INQ000587768), para.33 & 36; NHS Greater Glasgow & Clyde (INQ000587827), para.28.
[19] NHS Tayside (INQ000587766), para.40; NHS Borders (INQ000587794), para.25.
[20] E.g. Jeane Freeman, Inquiry transcript 22/07/25, p.43, lines 20-23; Caroline Lamb, Inquiry transcript 22/07/25, p.156, lines 1-3; Humza Yousaf, former Cabinet Secretary for Health and Social Care (INQ000615529), paras.111-119.
[21] NHS Lothian (INQ000587768), para.35; NHS Borders (INQ000587794), para.23; Jeane Freeman (INQ000606530), para.137.
[22] Jeane Freeman: Inquiry transcript 22/07/25, p.59, line 24 – p60, line 10 & written statement (INQ000606530), para.128; Nicola Sturgeon, former First Minister for Scotland (INQ000339033), para.457; Claire Sutton, Royal College of Nursing (INQ000587657), para.90.
[23] Caroline Lamb, Inquiry transcript 22/07/25, p.138, lines 14-20.

out that a negative test does not guarantee that an individual is not carrying a virus at the time of discharge.[24] Testing patients prior to discharge is not appropriate in all circumstances - for example, where a patient does not consent, is at end-of-life, or is in distress.[25] These limitations highlight the importance of IPC measures such as isolation and use of Personal Protective Equipment (PPE) in preventing outbreaks of infection in care settings.[26] How these various factors might be balanced against a practical block on discharges must be determined by those setting policy.

17. The Inquiry has also heard that, consistent with the pre-pandemic position, it was the decision of the receiving care provider as to whether they could safely admit a discharged patient. Care homes had the right to refuse admissions,[27] albeit the sense of urgency in the country at that time may have made that difficult. Rhona Arthur of the Scottish Covid Bereaved provided an example of a care home implementing a policy of refusing to accept patients discharged from hospital who had not had a negative Covid-19 test.[28] Some health boards are also aware of examples where care homes refused to accept patients from hospital in March 2020 due to the risk of transmission of the virus.[29] If the care home was not able to accept the discharge for any reason, then alternative arrangements were made.[30]

18. Guidance on IPC measures within care homes to facilitate the safe discharge of patients from hospital, such as isolation policies, was issued to care providers by the Scottish Government and PHS.[31] HPTs within each of the territorial health boards (led by DsPH and supported by PHS) were available to provide 24/7 support and collaboration to care homes in their locality in relation to the practical implementation

[24] This point was made by Dr Rossi of PHS during her evidence to the Inquiry. See Inquiry transcript p.95, line 25 – p.98, line 20. A similar point has been made by Jeane Freeman (INQ000606530), paras.82-84.
[25] A point made by NHS Lothian (INQ000587768), para.48,
[26] PHS (INQ000587252), para.12.1.5; Caroline Lamb, Inquiry transcript, 22/07.25, p.139, lines 4-10.
[27] Jeane Freeman, Inquiry transcript 22/07/25, pp.66 & 68; Caroline Lamb, Inquiry transcript 22/07/25, p.131, lines 21-24.
[28] Rhona Arthur, Scottish Covid Bereaved, Inquiry transcript 30/07/25, p.131, line 15 – p.132, line 8.
[29] E.g. NHS Lothian (INQ000587768), para.46.
[30] NHS Tayside (INQ000587766), para.34.
[31] E.g. Scottish Government guidance dated 13 March 2020 (INQ000280689) & 21 April 2021 (INQ000280688) and HPS/PHS guidance dated 12 March 2020 (INQ000189305) & 26 April 2020 (INQ000189331).

of that guidance.[32] The extent of the collaboration put in place between the health sector and care homes is detailed in the Rule 9 response of the DsPH.[33]

19. In addition, HPTs made efforts to find innovative ways of supporting care homes with the practical challenges that arose.[34] For example, NHS Orkney introduced an isolation bungalow with separate staff, where patients could be isolated prior to being transferred to care homes.[35] Other board areas had stepdown facilities in place if required.[36]

20. Evidence has been heard about potential problems associated with stepdown facilities, including the negative impact of moving an older person between settings, and the difficulties staffing alternative facilities where staff are already stretched.[37] The Boards agree with Dr Rossi of PHS that stepdown facilities are worthy of consideration in future pandemic planning, though such measures will not always be appropriate given the associated risks.[38]

21. As indicated, the Boards do not take a position on whether – in future – a different decision ought to be made. Rather, the above is simply to aid understanding in relation to any recommendations being considered by the Inquiry.

B. ENHANCED OVERSIGHT & ASSURANCE

22. During the pandemic, enhanced oversight and support was provided to care homes by DsPH, supported by HSCPs, HPTs and IPC Teams. On 17 April 2020, the Scottish Government tasked DsPH to take "immediate action to deliver an enhanced system of assurance around the safety and wellbeing of care home residents and staff." DsPH were asked to provide weekly assurance reports to the Scottish Government.[39]

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[32] Dr Maria Rossi, PHS, Inquiry transcript 28/07/25, p.109, line 21 – p.110, line 4; PHS (INQ000587252), para.8.2.16; NHS Orkney (INQ000587717), para.43; NHS Borders (INQ000587794), para.12.
[33] Scottish Directors of Public Health (INQ000613179), paras.8.10 – 8.15.
[34] E.g. NHS Lothian (INQ000587768), para.222; NHS Highland (INQ000587833), para.46; NHS Ayrshire & Arran (INQ000587718), para.44.
[35] NHS Orkney (INQ000587717), paras.15-16 & 44.
[36] E.g. NHS Greater Glasgow & Clyde (INQ000587827), para.29; NHS Tayside (INQ000587766), para.27.
[37] Jeane Freeman, Inquiry transcript 22/07/25, p.72, line 18 – p.73, line 2; Caroline Lamb, Inquiry transcript 22/07/25, p.133, line 20 – p.134, line 3.
[38] Dr Maria Rossi, PHS, Inquiry transcript, p.94, lines 8-14.
[39] 'Letter from Malcolm Wright […] dated 17/04/2020' (INQ000509955; INQ000364126).

23. This was a new role that Boards were expected to fulfil. It has, with the experience of the pandemic now gained, been seen as generally positive, leading to better coordination and closer working relationships between ASC and healthcare settings. Greater clarity from the outset as to the roles expected of each party might have helped to bed the system in more efficiently.

The introduction of assurance visits

24. On 20 April 2020, the health boards were instructed by the NHS Chief Executive to complete an initial assessment of every care home in their area (by phone or visit), and to use this to develop a programme of "associated visits" to each care home by 24 April 2020, with weekly reporting to the Scottish Government thereafter.[40]

25. On 17 May 2020, the Cabinet Secretary for Health and Sport directed that the role of Executive Nurse Directors in each territorial health board now included an extended clinical and care oversight function to support each care home in their area.[41] The Chief Nursing Officer (CNO) wrote to the Executive Nurse Directors on 15 June 2020 to clarify that they were not accountable for the care being provided by external care providers. Rather, the responsibility was a professional advisory role.[42] The role was further clarified by the CNO on 1 October 2020.[43]

26. A directive was also issued by the Scottish Government that multidisciplinary teams consisting of clinical and care professionals across HSCPs were to take on additional responsibilities for clinical support in each local care home.[44] This placed a greater focus on IPC and care homes' compliance with the implementation of relevant national guidance.[45] Details of the steps taken by health boards to respond to this direction are contained within the Boards' Rule 9 responses.

[40] 'Letter from John Connaghan […] dated 20/04/2020' (INQ000323166; INQ000363375; INQ000320165).
[41] 'Letter from Jeane Freeman […] dated 17/05/2020' (INQ000228376).
[42] 'Letter from Fiona McQueen […] dated 15/06/2020' (INQ000429267).
[43] 'Guidance from Chief Nursing Officer for Scotland […] [File name indicates date of October 2020]' (INQ000429273).
[44] 'Letter from Jeane Freeman […] dated 17/05/2020' (INQ000320162); 'Paper from Scottish Government […] dated 17/05/2020' (INQ000320169).
[45] NHS Greater Glasgow & Clyde (INQ000587827), para.50.

27. Broadly speaking, territorial health boards set up local assurance groups to coordinate the response.[46] Initial assessments were conducted between 17 and 24 April 2020. Standardised questionnaires were created, based on the joint national framework developed by DsPH and PHS,[47] and circulated to care homes. This helped to identify gaps in staff training, knowledge and experience which could then be addressed collaboratively in support of care homes.[48] Red, Amber, Green (RAG) ratings were used for each care home to identify and prioritise support based on risk. The measures were implemented based on the evidence and guidance available at the time. There was regular, often daily, contact between health boards and care homes in their locality during the relevant period via remote calls and in-person visits.

28. Associated visits, and latterly assurance visits, were undertaken to care homes. These visits were conducted to provide support and assurance, including training, in relation to IPC measures, social distancing, the safe use of PPE, staffing levels, and the effective use of testing.[49] The assurance visits were carried out by multidisciplinary teams set up within HSCPs in accordance with the government's direction. They assessed the IPC practice and compliance against the National IPC Manual and related guidance.

29. Health boards developed comprehensive assessment tools to facilitate the visits. The teams worked closely with the Care Inspectorate and conducted daily huddles to identify concerns using available data.[50] They subsequently utilised the Scottish Government's safety huddle tool (TURAS) to report and collate national data on individual care homes.[51]

30. The assurance visits highlighted issues such as the importance of care homes having adequate PPE supplies and adequate IPC knowledge, and the challenges for care

[46] E.g. NHS Greater Glasgow & Clyde (INQ000587827), paras.35-36; NHS Orkney (INQ000587717), paras.17 & 22; NHS Highland (INQ000587833), from para.65; NHS Lothian (INQ000587768), para.68-80; NHS Borders (INQ000587794), paras.17 & 41-47; NHS Ayrshire & Arran (INQ000587718), from para.63.
[47] Document from Scottish Directors of Public Health titled Final Joint National Framework for Action – COVID-19 Care Home Settings, undated' (INQ000515879).
[48] Scottish Directors of Public Health (INQ000613179), paras.8.1 & 9.7.
[49] Caroline Lamb (INQ000614179), para.319; NHS Orkney (INQ000587717), para.19.
[50] NHS Tayside (INQ000587766), para.59; NHS Greater Glasgow & Clyde (INQ000587827), paras.52-53; NHS Ayrshire & Arran (INQ000587718), paras.70-71.
[51] NHS Lothian (INQ000587768), paras.57 & 84; NHS Highland (INQ000587833), para.79; NHS Ayrshire & Arran (INQ000587718), para.73; Caroline Lamb (INQ000614180), para.260.

homes in implementing IPC measures such as isolation, social distancing, and the safe donning and doffing of PPE.[52] Concerns were raised about staff movement and sick pay which could impact on staff's willingness to self-isolate.[53] There were occasional concerns about hospital-level IPC standards being applied to residential settings,[54] though this was not the case across the board.[55] Where these issues occurred, health boards took steps to address them.[56]

31. The visits were intended to be supportive in nature and aimed to identify areas where the care homes could benefit from further support and advice. They were not, and were not intended to be, regulatory.[57] Most conducting the visits had a clear understanding of their role and purpose being to provide support for improvement as opposed to inspection and scrutiny.[58]

32. However, in the initial phases there was some uncertainty surrounding the role and remit of staff involved in these visits, particularly for those who had not previously been involved to a large extent with care homes.[59] Kevin Mitchell of the CI told the Inquiry that confusion arose from the wording of the Cabinet Secretary's letter of 17 May 2020 - for example, the use of the term "assurance" caused some to think that it was a secondary form of inspection. It took time for the government to provide further clarity on the roles and responsibilities expected under the new arrangements.[60]

New initiatives to support wellbeing

[52] NHS Tayside (INQ000587766), para.75; NHS Ayrshire & Arran (INQ000587718), para.78; Scottish Directors of Public Health (INQ000613179), para.11.2; NHS Orkney (INQ000587717), para.29.
[53] E.g. NHS Greater Glasgow & Clyde (INQ000587827), para.73; NHS Lothian (INQ000587768), para.61; Scottish Directors of Public Health (INQ000613179), para.10.16.
[54] E.g. NHS Borders (INQ000587794), para.85; NHS Lothian (INQ000587768), para.60.
[55] E.g. NHS Highland (INQ000587833), para.99; NHS Tayside (INQ000587766), para.82.
[56] Scottish Directors of Public Health (INQ000613179), para.10.12. E.g. NHS Tayside (INQ000587766), paras.85-86 - INQ000618202 & INQ000618203 & INQ000618204 & INQ000618205; NHS Lothian (INQ000587768), paras.126-127 - INQ000590651.
[57] NHS Lothian (INQ000587768), paras.62 & 92-93; NHS Tayside (INQ000587766), para.64; NHS Greater Glasgow & Clyde (INQ000587827), paras.42 & 56; NHS Highland (INQ000587833), para.85.
[58] NHS Lothian (INQ000587768), para.108; NHS Orkney (INQ000587717), para.27; NHS Borders (INQ000587794), paras.35-36; NHS Highland (INQ000587833), para.113.
[59] NHS Tayside (INQ000587766), paras.71 & 82-86; NHS Borders (INQ000587794), para.50.
[60] Kevin Nolan Mitchell, Care Inspectorate Scotland, Inquiry transcript 08/07/25, p.63, line 9 – p.64, line 6; p.65, line 3 – p.66, p.2; 'Guidance from Chief Nursing Officer […] [File name indicates date of October 2020]' (INQ000429273).

33. Health boards delivered a range of initiatives to support the wellbeing of ASC staff during the pandemic.[61] They also provided NHS staff to support the care sector during periods of staffing shortfall.[62] An example of this was referred to by Judith Kilbee in her evidence when she described a notice issued by the local public health team offering staff support to care homes in the area if needed.[63]

Support with training

34. Whilst IPC and outbreak management were features of ASC prior to the pandemic,[64] it became apparent that there were inconsistencies across the sector in terms of adherence to the National IPC Manual.[65] This led to further training, some of which the Boards assisted in providing through the Care Home Assurance groups which were established. Prior to the pandemic, local HPTs supported care homes with outbreak management only, as opposed to training.[66]

35. The Boards' Rule 9 responses provide a range of examples of training initiatives delivered by health boards to care homes during the pandemic, for instance, on the implementation of IPC measures and the use of PPE. Training and advice reflected the relevant national guidance, albeit the Inquiry is aware of the challenges around changing guidance.[67]

36. Notwithstanding, training and education remained (and remains) the responsibility of an employer. There are over a thousand care homes in Scotland and only 14 territorial boards/HPTs.[68] It is, for good reason, not the responsibility of territorial health boards

[61] E.g. NHS Highland (INQ000587833), para.40; NHS Greater Glasgow & Clyde (INQ000587827), paras.116-119; NHS Ayrshire & Arran (INQ000587718), paras.123-131; NHS Tayside (INQ000587766), paras.112-114; Caroline Lamb (INQ000614180), para.297 & INQ000614179), para.498.
[62] E.g. Scottish Directors of Public Health (INQ000613179), para.8.21; NHS Tayside (INQ000587766), paras.109-110; ; NHS Lothian (INQ000587768), paras.180-184; NHS Highland (INQ000587833), para.147; NHS Borders (INQ000587794), para.92; NHS Greater Glasgow & Clyde (INQ000587827), para.115; NHS Ayrshire & Arran (INQ000587718), para.77.
[63] Judith Kilbee, Scottish Covid Bereaved, Inquiry Transcript 01/07/25, p.41.
[64] Fiona McQueen, former CNO for Scotland (INQ000598501), para.12.
[65] Jeane Freeman, Inquiry transcript 22/07/25, p.52, line 16 – p.53, line 6 & written statement (INQ000606530), para.172; Caroline Lamb, Inquiry transcript 22/07/25, p.125, lines 4-11. E.g. NHS Tayside (INQ000587766), paras.105 & 116.
[66] Scottish Directors of Public Health (INQ000613179), para.3.4.
[67] PHS (INQ000587252) paras.8.2.6 &.8.2.14. E.g. NHS Tayside (INQ000587766), paras.106 & 121; NHS Lothian (INQ000587768), para.111; NHS Borders (INQ000587794), para.55; NHS Highland (INQ000587833), from para.143; NHS Ayrshire & Arran (INQ000587718), paras.26, 38 & 43.
[68] Dr Maria Rossi, PHS, Inquiry transcript 28/07/25, p.71, line 21 – p.72, line 23.

to ensure that staff in the care sector are adequately trained in and delivering IPC measures. That is the role of employers, overseen by the Care Inspectorate (CI).[69]

Reflections

37. It has largely been acknowledged that the enhanced oversight and assurance arrangements were beneficial. The arrangements provided positive support to care homes as well as assurance that the care homes had a good understanding of the relevant issues and processes required.[70] Some health boards already had well-established networks and good working relationships with care homes in their area.[71] The model nevertheless presented new opportunities for close collaboration between stakeholders and improved understanding of respective roles and responsibilities.[72]

38. Whilst the support was generally gratefully received, in some instances it took time to build relationships of trust and support between oversight teams and care home providers.[73] Some care providers were resistant to direct visits due to fear of introducing the virus into the care home.[74] Others initially perceived the visits as an additional layer of scrutiny and inspection.[75] The arrangements tended to work much better when there were relationships of trust and effective communication,[76] and where there was a clear understanding of their supportive nature.[77]

[69] Scottish Directors of Public Health (INQ000613179), paras.3.1 & 10.17; NHS Lothian (INQ000587768), para.25.
[70] NHS Tayside (INQ000587766), para.80; NHS Lothian (INQ000587768), para.125; NHS Ayrshire & Arran (INQ000587718), para.83; Scottish Directors of Public Health (INQ000613179), para.14.1; Nicola Dickie, COSLA, Inquiry transcript 21/07/25, p.118, lines 2-6; NHS Highland (INQ000587833), paras.79, 110 & 112; Jeane Freeman, Inquiry transcript 22/07/25, p.91, line 6 – p.92, line 21; Caroline Lamb, Inquiry Transcript 22/07/25, p.146, line 5 – p.148, line 5 & written statement (INQ000614180), para.79.
[71] E.g. NHS Highland (INQ000587833), para.77; NHS Borders (INQ000587794), paras.50 & 101; NHS Orkney (INQ000587717), para.25; NHS Greater Glasgow & Clyde (INQ000587827), paras.66-67.
[72] NHS Highland (INQ000587833), para.100; Scottish Directors of Public Health (INQ000613179), paras.6, 8.10 & 8.32-8.35; NHS Greater Glasgow & Clyde (INQ000587827), para.66; NHS Highland (INQ000587833), para.164-169.
[73] NHS Borders (INQ000587794), para.50; NHS Lothian (INQ000587768), para.223.
[74] E.g. NHS Lothian (INQ000587768), paras.56 & 59; NHS Borders (INQ000587794), paras.37-38; NHS Highland (INQ000587833), para.111.
[75] NHS Highland (INQ000587833), para.111; NHS Tayside (INQ000587766), para.81; NHS Lothian (INQ000587768), para.126; NHS Borders (INQ000587794), para.62.
[76] NHS Borders (INQ000587794), para.62; NHS Ayrshire & Arran (INQ000587718), para.84; NHS Orkney (INQ000587717), paras.32 & 44; Scottish Directors of Public Health (INQ000613179), para.12.12.
[77] NHS Borders (INQ000587794), para.50.

39. Jeane Freeman told the Inquiry that in hindsight, she could have directed the provision of enhanced support to care homes earlier in the pandemic.[78] The Boards agree that earlier implementation of these arrangements would have further benefitted the ASC sector. It is, however, of fundamental importance that different bodies and organisations collaborate effectively and have a clear understanding of their respective roles and responsibilities.[79]

C. ACCESS TO HEALTHCARE

Visits from healthcare professionals to care settings

40. The Inquiry heard during Module 3 that the pandemic impacted significantly on service delivery within the healthcare system, including GPs, ambulance services and specialist care services.[80] These challenges impacted whole communities, including those receiving ASC.[81]

41. Although GP provision in Scotland is generally delivered through the independent contractor model and thus not the direct responsibility of health boards, the Boards' understanding is that GPs continued to visit care homes throughout the pandemic where clinically appropriate, though that was a question of professional judgement. There was, however, an increase in remote appointments.[82] Some health boards experienced issues relating to access and supply of some medicines,[83] and lack of connectivity to facilitate remote GP consultations.[84] The lessons learned throughout the pandemic regarding the conduct of remote appointments is likely to lessen the impact of restrictions in any future pandemic.

[78] Jeane Freeman, Inquiry transcript 22/07/25, p.78, lines 11-16.
[79] A point also made by Caroline Lamb, Inquiry transcript 22/07/25, p.148, lines 12-13; and Kevin Nolan Mitchell, CI Scotland, Inquiry transcript 08/07/25, p.74, lines 10-13.
[80] These issues are detailed in 'Module 3 Closing submissions on behalf of the Scottish Territorial and Special Health Boards, dated 19/12/2024' (INQ000532393), Section A2.
[81] This is discussed by Dr Michael Mulholland, Royal College of General Practitioners (INQ000613178), paras.31-40. See also comments by Humza Yousaf (INQ000615529), paras.205, 209, 212 & 217.
[82] E.g. NHS Tayside (INQ000587766), paras.90-91; NHS Orkney (INQ000587717), paras.33-34; NHS Lothian (INQ000587768), paras.129-141; NHS Borders (INQ000587794), para.66.
[83] NHS Greater Glasgow & Clyde (INQ000587827), para.98.
[84] NHS Highland (INQ000587833), para.124; NHS Lothian (INQ000587768), paras.95-96.

42. The Boards' Rule 9 responses provide examples of steps taken by health boards to maintain access to healthcare, such as the continued provision of community nursing,[85] and to ensure that care homes were receiving clinical support,[86] including in relation to palliative care.

Transfer from care settings to hospital

43. The health boards are not aware of ambulances refusing to transfer patients with suspected or confirmed Covid-19 to hospitals for escalation of care. Caroline Abrahams CBE of Age UK referred in her evidence to a letter sent to a care home resident from an individual GP provider in Scotland which indicated that the practice did not intend to transfer patients to hospital.[87] The health boards had no role in any such decisions. From the Boards' perspective, hospitals were open to admissions of patients with clinical need.

44. HPTs worked closely to support care providers and ensure that they understood that hospital admissions required to be assessed on an individual basis.[88] An example of this was provided by Judith Kilbee of the Scottish Covid Bereaved, who referred in her evidence to a press statement having been released by a local health board which emphasised to the public and professionals that there was no barrier to care home residents with Covid-19 being admitted to hospital.[89]

Anticipatory Care Planning (ACP) and "Do Not Attempt Cardiopulmonary Resuscitation" (DNACPR)

[85] E.g. NHS Highland (INQ000587833), para.136; NHS Greater Glasgow & Clyde (INQ000587827), para.80; NHS Ayrshire & Arran (INQ000587718), paras.112-113; NHS Tayside (INQ000587766), para.99; NHS Orkney (INQ000587717), paras.34 & 37.
[86] E.g. Scottish Directors of Public Health (INQ000613179), para.8.12; NHS Greater Glasgow & Clyde (INQ000587827), paras.83-87; NHS Highland (INQ000587833), paras.114-120; NHS Lothian (INQ000587768), paras.132, 147 & 151.
[87] 'Letter from GP to care home resident or relative of resident, regarding minimising patient contact and visits, undated' (INQ000591762); Caroline Abrahams CBE, Age UK, Inquiry Transcript 16/07/25, p.21, line 23 – p.23, line 4.
[88] E.g. NHS Ayrshire & Arran (INQ000587718), para.106.
[89] Judith Kilbee, Scottish Covid Bereaved, Inquiry Transcript 01/07/25, pp.52-53.

45. The Inquiry has heard about the processes and decision-making around ACP and DNACPR in this module and previous ones. We refer to our closing submissions in Module 3, in which we cover this topic in some detail.[90]

46. Good practice surrounding conversations with patients (and, where appropriate, relatives) about ACP and DNACPR has been set out by Professor Stephen Barclay, Expert in End-of-Life and Palliative Care.[91] The health boards endorse Professor Barclay's observations on good practice, as reflected in our Module 3 submissions.

D. VISITING RESTRICTIONS & INSPECTIONS

47. Guidance on visiting restrictions in care settings came from the Scottish Government and PHS,[92] and care providers required to implement that guidance. Local HPTs, under the direction of DsPH and with support from PHS, assisted care homes in implementing visiting restrictions in line with the applicable national guidance.[93]

48. At times during the pandemic, the Scottish Government implemented blanket restrictions to visiting care homes, according to local authority.[94] At other times, decisions were based on individual risk assessments. DsPH were asked to assess the risk and approve visits to care homes in coordination with the local care providers.[95] A tiered system was implemented in Scotland later in the pandemic whereby different rules applied to different areas across Scotland, based on infection risk.[96]

49. This module has heard much evidence, including from experts, regarding the damaging impacts of visiting restrictions on those with dementia, learning disabilities, and those at end-of-life, their loved ones, and those caring for them. The Boards recognise the benefits of physical contact with loved ones for those receiving ASC and

[90] 'Module 3 Closing submissions on behalf of the Scottish Territorial and Special Health Boards, dated 19/12/2024' (INQ000532393), paras.84-90.
[91] Professor Stephen Barclay, Expert in End-of-Life & Palliative Care, Inquiry transcript 30/07/25, p.31, line 12 – p.43, line 3.
[92] E.g. 'Letter from Jeane Freeman […] dated 13/03/2020' (INQ000280689); Scottish Government guidance from 15 May (INQ000383486) & 15 September 2021 (INQ000505932).
[93] PHS (INQ000587252), paras.10.2.1-10.2.4; Scottish Directors of Public Health (INQ000613179), paras.10.1-10.4.
[94] PHS (INQ000587252), para.10.4.12.
[95] Scottish Directors of Public Health (INQ000613179), para.10.1; Jeane Freeman (INQ000606530), para.299; Caroline Lamb (INQ000614179), para.824.
[96] Nicola Dickie, COSLA, Inquiry transcript 21/07/25, p.146, lines 12 – 23.

acknowledge the significant distress caused to families, residents and staff who were tasked with making extremely challenging decisions on visiting during the pandemic. Learning regarding the impact of blanket or inconsistently imposed visiting restrictions will be a valuable aspect of future pandemic planning.

50. It is important to recognise that the visiting restrictions aimed to protect groups of vulnerable people who were most at risk from infection, and the significant harm that could arise.[97] Scientific evidence has highlighted the risks of ingress of the virus from various individuals going into care homes from the community.[98]

51. In the early stages of the pandemic, when there were limits to PPE and testing, as well as uncertainties surrounding the nature of the virus, DsPH were concerned that visits to care homes would increase the risk of introducing the virus to these settings.[99] Once more was known about the nature and transmission of the virus, and the position as regards to PPE, testing and vaccinations improved, there was more scope for safe visiting.[100]

52. Decisions were extremely difficult and involved complex balances of risk. For instance, the Inquiry has heard that there were polarised views in relation to visiting. Some care providers and families of residents did not want visitors who could bring in infection, whereas others campaigned for visitation.[101] This was incredibly challenging for those having to make these difficult decisions.

53. There is evidence to indicate that the guidance was generally well applied by local HPTs working as part of Care Home Assurance groups.[102] There were some inevitable

[97] PHS (INQ000587252), para.10.4.3 & 10.4.8.
[98] E.g. Professor Laura Shallcross MBE, Inquiry transcript 01/07/25; Professor Susan Hopkins CBE, Inquiry transcript 09/07/25, p.59, line 4 – p.63, line 4; Professor Dame Jenny Harries, Inquiry transcript 09/07/25, p.175, line 18 – p.189, line 17.
[99] Scottish Directors of Public Health (INQ000613179), para.9.11.
[100] Dr Maria Rossi, PHS, Inquiry transcript 28/07/25, p.102, line 8 – p.105, line 10.
[101] Matt Hancock, Inquiry transcript 02/07/25, p.24, lines 6-17; Helen Whately MP, Inquiry transcript 17/07/25, p.196, lines 5-25; Professor Dame Jenny Harries: Inquiry transcript 09/07/25, p.192, line 18 – p.194, line 10; written statement, INQ000587394, para.9.11.
[102] PHS (INQ000587252), paras.10.4.10-10.4.11.

inconsistencies in the application of visiting restrictions across different care homes to reflect local circumstances.[103]

Inspections

54. The CI decided to pause on-site inspections from around 17 March 2020.[104] DsPH provided advice to the CI in relation to visits and as mentioned above were responsible for reviewing and approving visits into care homes. The decision and responsibility as to whether to carry on-site inspections is ultimately one for the CI, which retained the power to conduct on-site inspections throughout the relevant period. [105]

55. As discussed above, DsPH and care providers had serious concerns about the risks associated with physical visits into care homes in the early stages of the pandemic. At that time of heightened risk, DsPH recommended that care home visits should be considered very judiciously. This was discussed at a national level, and in close liaison with the CI.[106]

56. On 1 May 2020, the Scottish Government directed the DsPH that in assessing risk, they should factor in that "undertaking physical visits by individuals or small assessment teams, that are not immediately necessary or could be done over the phone, could exacerbate the risk of introducing COVID-19 into a previously unaffected care home", and "[w]here a visit to an individual care home may potentially be of benefit, consideration should initially be given to use of a virtual visit (FaceTime, etc.) either as a precursor to, or instead of, a physical visit."[107]

57. The Boards understand the importance of on-site inspections, as well as in-person assessments from social workers, as highlighted by witnesses in this module.[108]

[103] Dr Maria Rossi, PHS, Inquiry transcript 28/07/25, p.113, lines 9-22; PHS (INQ000587252), paras.10.4.4 - 10.4.8.
[104] Letter from Peter Macleod (Chief Executive, Care Inspectorate) to Care Services and Providers, regarding COVID-19 update, dated 17/03/2020; (INQ000501204); Kevin Nolan Mitchell, CI Scotland, Inquiry transcript 08/07/25, p.34, line 14 – p.37, line 1.
[105] Kevin Nolan Mitchell, CI Scotland, Inquiry transcript 08/07/25, p.62, lines 1 - 15; p.88, line 16 – p.89, line 20.
[106] Scottish Directors of Public Health (INQ000613179), paras.8.4 & 8.30.
[107] Scottish Directors of Public Health (INQ000613179), para.8.5, with reference to document AB/76.
[108] E.g. Paul Featherstone, National Association of Care and Support Workers, Inquiry transcript 28/07/25, p.146, line 21 – p.148, line 7; Helen Wildbore, Care Rights UK, John's Campaign and the Patients Association, Inquiry transcript 29/07/25, p.69, line 13 – p.70, line 15; Dr Ruth Allen, British Association of Social Workers, Inquiry transcript 03/07/25, pp.10-11.

However, this had to be balanced with the risk of infection to vulnerable people from visits to care settings, particularly where there was limited availability of PPE and testing. It is notable that the enhanced oversight and assurance arrangements provided a method of safeguarding during the time that in-person visits were limited.[109]

58. Kevin Mitchell told the Inquiry that the CI had limited access to PPE and testing in the early stages of the pandemic. He agreed with the Chair's suggestion that the root of the challenges to conducting in-person inspections at that time was a lack of pandemic planning and preparedness in terms of testing and PPE.[110]

59. The Boards consider it essential that a rapid and robust risk assessment approach is taken to care home visiting in the event of a future pandemic. Effective and efficient scaling up of measures such as PPE, testing and vaccination would facilitate safe visiting in future.

E. OVERALL REFLECTIONS

60. The Boards recognise that the pandemic was an incredibly difficult time for the ASC sector. They are extremely proud of the commitment, collaboration and partnership between their staff and stakeholders in supporting the ASC sector with the unprecedented challenges. The benefits of collaborative and supportive relationships, some of which were pre-existing and others which positively developed through the pandemic, cannot be overstated.

61. In the event of a future pandemic, the Boards consider that the ASC sector would benefit from clear, national and workable guidance from as early as possible. The sector would also benefit from pandemic preparedness planning for individual providers. This plan should ensure core capabilities including safe visiting are sustained in the event of a future pandemic. There is also an opportunity to improve training for

[109] Scottish Directors of Public Health (INQ000613179), paras.10.6-10.7; Nicola Dickie, COSLA, Inquiry transcript 21/07/25, p.137, lines 16-19; Fiona McQueen (INQ000598501), para.27.
[110] Kevin Nolan Mitchell, CI Scotland, Inquiry transcript 08/07/25, p.39, line 14 – p.44, line 6.

staff across health and social care in areas such as IPC measures, use of PPE, palliative and end-of-life care, Anticipatory Care Planning, dementia, and learning disability, and human rights. Further consideration will be required as to how and by whom this training is most appropriately delivered. These areas ought to be embedded in pandemic planning.

62. The Boards understand the importance of data-sharing across health and social care which has been highlighted throughout this module. They agree that further improvements could helpfully be made to data linkages across those systems.

63. It is acknowledged that there is a wider societal issue with regards to the culture and value associated with a career in the ASC sector. The Boards support the recommendations made to the Inquiry relating to improved terms and conditions of employment for staff in the sector. It is hoped that greater pandemic planning and preparedness will facilitate the rapid and equitable scale up and distribution of measures such as PPE and testing across the health and social care sector in the event of a future pandemic.

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