UK COVID-19 INQUIRY

CLOSING SUBMISSIONS (MODULE 6)

ON BEHALF OF

THE CARE INSPECTORATE SCOTLAND

Introduction

1. The impact of the Covid-19 pandemic across the UK was wide-ranging and, for a great many people, devastating. Particular challenges were faced during the pandemic by those living and working within the adult social care sector. The focus of the Inquiry's Module 6 was to investigate the impact of the Covid-19 pandemic on the publicly and privately funded adult social care sector, across the four nations of the UK, particularly with a view to assessing what recommendations the Inquiry may consider ought to be made in due course, in order that learning from the Covid-19 pandemic might best inform improved practices and procedures in contemplation of preparedness for any future pandemic.

2. Against that background, the Care Inspectorate in Scotland ('the Inspectorate') was able to make what is hoped was a useful contribution to the work of the Inquiry in Module 6. As the regulatory body charged with the regulation and inspection of care services in Scotland, it is the responsibility of the Inspectorate to provide independent assurance that care services in Scotland meet the required standards and provide high quality care addition, the Inspectorate plays a significant role in supporting the implementation of improvements in the quality of care delivered in Scotland. In Scotland, there are approximately 760 care homes for older people, in which approximately 44,000 staff are employed to care for around 31,000 people. Across all its work, the Inspectorate provides independent assurance and protection for people who experience care, their families and carers, and the wider public.

3. The Inspectorate's inspection function is critical to its responsibility of ensuring that

high standards of care are met in Scotland, in adult social care and across its wider remit. It was understandable, therefore, that evidence relating to the pausing of inspections of care homes in Scotland, and across the UK as a whole, was a key theme in Module 6.

4. The Inquiry heard evidence at its Module 6 hearing between 30 June and 31 July 2025 which explored issues central to the adult social care sector. Oral witness testimony was supplemented by documentary evidence in the form of documents and detailed witness statements.

5. Principal issues amongst the stated remit of Module 6 were:

   (i) the impact of the pandemic, including restrictions imposed, on recipients of care and their loved ones and the impact on staff working in the care sector;
   (ii) the key decisions made by the UK and Scottish governments and the consequences of government decision making relevant to the care sector; and
   (iii) the steps taken in adult care and residential homes to prevent the spread of Covid-19 and the capacity of the adult care sector to respond to the pandemic, including the pausing of inspections by regulators.

6. Submissions on behalf of the Inspectorate will address these broad issues in turn, and will conclude with suggested recommendations, some of which were foreshadowed in oral submissions, alongside others that have followed a more considered reflection of all of the evidence presented in the module.

7. Whilst the Inspectorate is hopeful that, upon a close analysis, the Inquiry will find that there was merit in its responses to the pandemic, it is not complacent. It regards the Inquiry as an opportunity to benefit from the insight that independent consideration of its actions brings, and to learn, not only from the Inquiry's formal findings and recommendations but also from the evidence heard by the Inquiry and from its own ongoing reflections on its practice in light of that evidence.

8. In particular, the Inspectorate welcomes the opportunity to share learning with its regulatory counterparts across the four nations. It recognises the importance and value of listening to the evidence given on behalf of the Care Quality Commission, the Care

Inspectorate Wales and the Regulation and Quality Improvement Authority, to gain insight into the challenges faced by those organisations during the pandemic and, importantly, any learning outcomes they have identified thus far.

9. As was stated in the Inspectorate's written statement at the outset of Module 6, should the Inquiry identify improvements or changes which the Inspectorate can make to any aspect of its work, these will be made. Where changes or improvements to the services it regulates are necessary, it will encourage and – if necessary - enforce those.

Impact of Covid-19 Pandemic on those living and working within adult social care

10. From the statements of the relatives of those living in care homes from March 2020 onwards, it is clear that the impact of the pandemic upon many living in care home settings was profoundly negative. Restrictions upon visiting brought about isolation and, to many residents, confusion and hurt. That devastating impact was eloquently, often movingly, laid bare in the accounts given by those who gave parole evidence to the Inquiry. The effect of isolation upon many residents of care home settings, and the corresponding feelings of helplessness and frustration experienced by their families and friends on the 'outside', cannot be over-stated.

11. The Inspectorate also had an insight into the challenges faced by staff in adult social care services during the pandemic. They had to continue to work in a professional way throughout Covid-19 outbreaks in their workplaces, and to do so despite concerns for their own health. They had to deal with deaths of many people for whom they had cared and whom they held in affection, and to support grieving families.

12. The impact of the pandemic upon staff in adult social care was, of course, not limited to Scotland: the evidence given to the Inquiry by Mrs Helen Hough who, with her husband, worked tirelessly during the pandemic in the care home that they owned and managed, provided a tragic and compelling insight into the frustrations and challenges with which those working in adult social care were faced. In particular, Mrs Hough's evidence as to her frustration over lack of PPE and equipment with which to alleviate suffering for those in her care will no doubt chime with the frustrations felt by many other dedicated care providers.

Government decision making

13. Perhaps the most significant decision to impact upon the adult social care sector was the decision by the Scottish Government, as with the other devolved administrations and the UK Government, to restrict visiting in care homes during the pandemic. In Scotland, that decision was based on public health advice, particularly from the Clinical and Professional Advisory Group (CPAG) and the Chief Medical Officer. Evidence at the Inquiry demonstrated clearly that the restrictions created a severe imbalance between infection control and residents' human rights, particularly for people with dementia or sensory impairments.

14. The Inspectorate's witnesses criticised aspects of the visiting restrictions, especially their unintended consequences; namely, the emotional and psychological toll on residents. In her written statement to the Inquiry [INQ000587754/2-3], the Inspectorate's Ms Marie Paterson stated that she had specifically raised this as a concern at three meetings with Directors of Public Health on the 1st, 8th and 12th May of 2020. Along with Dr Donald Macaskill of Scottish Care, she raised the impact on residents' rights at a meeting of the Scottish Government National Contingency Planning Group on 27 May 2020 [INQ000587754/3]. Despite these concerns having been expressed, repeatedly and by many, visiting restrictions persisted and continued to adversely impact upon care home residents and their families.

15. The Inspectorate supported efforts to reintroduce "meaningful contact" and repeatedly voiced concerns about excessive visiting bans through internal meetings and representations at CPAG. They also worked with the Scottish Government and stakeholders, such as Scottish Care, to improve visiting policies and ensure that people could maintain contact with their loved ones.

16. As the inquiry heard, the Inspectorate has welcomed the development of Anne's Law, which gives residents a right to maintain contact with a nominated loved one during outbreaks. In his evidence, the Inspectorate's Mr Kevin Mitchell described this as a crucial correction to the initial approach, which had at times been overly risk averse.

Response to the pandemic by adult social care sector

17. In considering the Inspectorate's response to the pandemic, it is submitted that it is

imperative at the outset to recognise two key points:

(i) the context in which the Inspectorate's response required to be made; and,
(ii) the limits to the Inspectorate's powers and functions.

Context of decision making

18. In terms of the context in which the Inspectorate's response to the pandemic was made, it is submitted that key decisions, in particular the decision to pause inspections, were all taken at a time when there was no vaccine, a glaring lack of PPE, and significant concern about the effect of the pandemic and how best to deal with it. The Inspectorate, together with the UK public at large were assured by Governments across the UK that their decisions were made on the basis of the best clinical and scientific advice and guidance.

19. In these circumstances it would have been difficult, and indeed irresponsible, to second-guess that advice, in a very uncertain and fast-moving climate. As a result, an over-abundance of caution was instinctively preferred to the careful balancing of risks against rights that was undertaken at a later stage.

Limits of Inspectorate's powers and functions

20. In terms of the limitations upon the Inspectorate's powers and functions it is important to emphasise that, unlike the position with regulators elsewhere in the UK, the Inspectorate in Scotland has no remit over health services. This limitation is of particular significance in relation to two key matters upon which the Inquiry heard evidence, namely the decision to discharge patients, untested, to care homes and, further, questions arising in relation to the use of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders.

Hospital discharges to care homes

21. Hospital discharges to care homes in Scotland were carried out on the basis of decisions by clinicians. The Inspectorate, with no remit over health care in hospitals,

had no role in the implementation or oversight of any such decisions, either on an individual case basis or at policy level. The Inspectorate was not consulted about any individual discharge nor were its views sought about any risks which might stem from such discharges taking place.

DNACPR orders

22. In relation to DNACPR orders, evidence was led before the Inquiry about these being in place across the UK, often without the knowledge of an individual or their family. That such an order could be in place, or given effect to, without the knowledge of any individual or their family member is clearly a matter of the utmost concern. However, it is submitted that there was no evidence of any 'blanket' DNACPR policy in Scotland.

Pausing of Inspections

23. A significant amount of evidence was led about the pausing of inspections by regulators across the four nations, including by the Inspectorate in Scotland. Regulators have been criticised for appearing to retreat during the pandemic as opposed to stepping forward to carry on with their important work. Again, in the specific consideration of the pausing of inspections, it is submitted that sight should not be lost of the context in which the Inspectorate, and the other UK regulators, were operating at that time: the rapidly evolving situation was, on any view, serious and fast-moving with Care Inspectorate staff having no access to PPE and no access to testing.

24. Bearing in mind that, even during a pre-pandemic outbreak of norovirus, the public health advice would be for the organisation not to inspect care homes, it would have been reckless, if not inconceivable, to ignore advice and continue inspections, or to recommence them prematurely and unilaterally at the outset of a lethal and highly contagious outbreak. Furthermore, had such a decision resulted in transmission of the virus from one home to another with a causative link to fatalities, the legal consequences would be very serious.

25. The evidence of the Inspectorate's Mr Kevin Mitchell, both in his written statement [INQ000475130/60-62, 66-68] and in his parole evidence to the Inquiry [6/36/14-23, 6/37/5-9] detailed the approach which was taken in Scotland. Inspections were

paused in Scotland from 13 March, following extensive and careful consideration of the difficulties posed by the serious situation which was developing at that time. The decision to postpone inspections of low/medium risk services was one taken on a temporary basis. The possibility for higher risk facilities to be made subject to on-site inspections was left open, should that be necessary. The proposal was shared by email with the Scottish Government on 12 March 2020 and was approved by Ms Haughey (Minister for Mental Health) on 13 March, "… *with no comment to make."* [INQ000475130/61 and INQ000520498].

26. The decision to pause inspections was in line with the precautionary steps adopted not only by other regulators across the UK and Ireland, but also as outlined by the Scottish Government. For example, the National Clinical and Practice Guidance for Adult Care Homes in Scotland during the Covid-19 Pandemic (Updated 15 May 2020) [INQ000383486/19] stated at sec 12.9: -"…*Staff who work across a number of locations including community nurses and temporary staff e.g. "bank" /agency staff can leave care homes particularly vulnerable to transmission of COVID-19. Where temporary staff need to be used, it is advised that their employment is restricted to one care home as the movement of staff between care homes can increase transmission*…". Similarly, on 26 April 2020, Public Health Scotland published guidance for care homes [INQ000189331/22] which advised minimum use of bank or agency staff and that, if used, they should only be used in one facility (see section 2.16).

27. Whilst routine inspections remained paused, the Inspectorate carried on with service support work remotely. The Inspectorate significantly increased its level of contact with services to offer advice and support. It contacted every care home weekly, and sometimes daily, to carry out checks including whether IPC measures were being followed, whether PPE levels were adequate and whether staffing levels were appropriate. This oversight included contact with services by telephone and the introduction of video consultation, which enabled the Inspectorate to examine services' environments, systems and practice, albeit at a distance.

28. It has been submitted to the Inquiry that the pausing of inspections in care home settings resulted in a loss of opportunity to understand what was happening in the care sector during the pandemic and the impact of the pandemic on service users. The

Inspectorate agrees entirely that there cannot be, and ought never to be, any substitute for full on-site inspections, provided these can be carried out safely and responsibly. However, it is submitted that the remote steps taken by the Inspectorate during the pandemic were useful and did, in fact, allow for significant and real-time insight to be gained as to the challenges faced by care home staff and service users in order that steps could be taken to address any concerns reported.

PPE/ Testing/ Vaccine

29. At the early stages of the pandemic, there was a global and national shortage of PPE for frontline health and care workers. Inspectorate staff were not designated as frontline workers. A small supply of PPE was obtained by the Inspectorate on 3 April 2020. On 23 April 2020, the Inspectorate escalated its concern about the ongoing paucity of PPE to Scottish Government. In his parole evidence to the Inquiry, Mr Mitchell acknowledged that there would have been value in Inspectorate staff having been designated as frontline workers at an earlier stage in the pandemic [6/40/3-25, 6/41/1-4 & 9-25, 6/42/12-17 & 6/43/9-23]. Again, however, context is key: it is difficult to imagine that such a request would have been successful at an earlier point when doctors, nurses and care workers did not themselves have adequate access to PPE.

30. Enhanced testing of care home staff, visiting professionals and outbreak management was announced in Dec 2020. From 6 May 2020, processes were put in place to support inspectors who required to carry out on-site inspections to be tested [INQ000475130/137]. This was after the Inspectorate had resumed its inspections. Therefore, during the period of inspections being paused, Inspectorate staff had no access to testing for Covid-19.

31. By December 2020, vaccinations became available for the first time. Early availability was offered for Inspectorate staff [INQ000475130/115]. Therefore, for a significant period following the pausing of inspections, Inspectorate staff continued with resumed inspections in the absence of vaccines, relying upon PPE and IPC measures to do so safely.

The Role of Public Health

32. A Scottish Government Resilience Room (SGoRR) ‘Deep Dive’ around the impact

of the Covid-19 outbreak on the care home sector was held on Tuesday 14 April 2020. It was chaired by the First Minister (FM) and attended by Peter Macleod, then Chief Executive of the Care Inspectorate. There essentially then followed a regime of enhanced assurance and oversight of care homes involving the Inspectorate, with Public Health taking the lead.

33. Following the meeting, the Inspectorate received from the Scottish Government a list of actions from the 'Deep Dive,' [INQ000233414] including for inspectors to gain assurance about the use of PPE and for assurance to be given that care homes had introduced social distancing measures and had taken action in respect of restrictions on visiting. The action did not specify how that assurance should be undertaken. The Inspectorate was not identified as the lead agency to take this forward; rather the lead agency responsibility was for "Directors of Public Health and urgent activation of health protection teams to visit all care homes to determine compliance/ assess support etc."

34. In a separate section headed "Moving to a more proactive and preventative approach?" there was commitment for: - "….*CI [Care Inspectorate] teams to visit <u>every single care home in Scotland</u> to ensure they are doing social distancing, can use PPE, have enough PPE and have effective infection prevention control measures. This would focus on both prevention as well as reacting to outbreaks…"* [emphasis added] [INQ000233414/3].

35. The Chief Medical Officer (Gregor Smith) and Director for Population Health/Director CHSC (Richard Fogo) were identified as the 'Lead' for this work.

36. Immediately below the commitment to visit every care home was a further commitment for the: - "….*CI to reinstitute <u>some</u> inspections to follow up current telephone approach for greater assurance and support - Directors of Public Health to take clear local leadership to ensure consistency of approach across the country*…" [emphasis added] [INQ000233414/3].

37. This appeared to contradict the commitment to visit every single care home detailed almost immediately above. Importantly, the lead was also identified as CMO and Director for Population Health/Director CHSC. The action also explicitly stated that Directors of Public Health were to take clear local leadership to ensure consistency of

approach across the country. It was, accordingly, made clear that the Inspectorate would plan its work in coordination with Public Health and should not act unilaterally. In practical terms, the Inspectorate required the agreement of Public Health before it could conduct any inspection.

38. The inquiry heard evidence about a proposed inspection in Scotland in April 2020 which did not, in fact, take place. Mr Mitchell made reference in his parole evidence to his proposal to inspect a particular home on 4 April 2020, due to concerns which had been raised [6/52/9-25]. Public Health did not agree with his proposal to inspect the home and, on that basis, the inspection did not take place.

Resumption of Inspections in Scotland

39. The Inspectorate resumed inspections on 4 May 2020, following a report of concern regarding a home in the immediately preceding days. Prior to carrying out its inspection, the Inspectorate required to obtain the agreement of the Director of Public Health for the relevant area. At that time, the protocol for Care Inspectorate Visits to Care Services Covid-19 [INQ000363246] being produced by Public Health Scotland, in consultation with the Inspectorate, was still in draft form.

40. Mr Mitchell identified two inspectors to carry out the 4 May inspection, with the agreement of Public Health Scotland. Prior to agreeing that the inspection could take place, Public Health Scotland sought a full risk assessment including assurance from the Inspectorate on: (i) the arrangements for testing of inspectors; (ii) availability of PPE; (iii) inspector training in use of PPE; and (iv) the urgency and necessity of the service being inspected by the Inspectorate.

41. From 4 May 2020 onwards, the Inspectorate's programme of inspections resumed. On- site visits to services resumed with assistance in inspections being given by other agencies including Healthcare Improvement Scotland, Public Health Scotland and health and social care partnerships.

Evidence of Ms Jeane Freeman, former Cabinet Secretary for Health and Sport

42. Ms Jeane Freeman, the former Cabinet Secretary for Health and Sport in Scotland, gave evidence to the Inquiry on 22 July 2025 and, in so doing, made reference to her

interactions with the Inspectorate between March and May of 2020. Ms Freeman raised three particular matters of note to which the Inspectorate would seek to respond, namely: (i) that she did not agree with the decision of the Inspectorate to pause regular inspections [14/89/9]; (ii) that she had asked the Inspectorate to resume inspections [14/89/12]; and (iii) that she had introduced a regular meeting with the Inspectorate and requested that direct inspections be resumed, focusing particularly on IPC and the social aspects of residential care [14/89/11-15].

(i) Decision to pause regular inspections

43. It was surprising that Ms Freeman stated in evidence that she did not agree with the decision to pause regular inspections. The Inspectorate, through submission of its Intermediate Response Paper on 12 March 2020 [INQ000320094] had advised the Scottish Government of the decision to pause inspections, in light of public health advice at that time. The decision was approved by the Scottish Government. Directors of Public Health had expressed significant concern about the prospect of anything other than absolutely essential visits to care homes as a result of the risk of transmission of Covid- 19 that such visits would pose. Further, and as referenced in Mr Kevin Mitchell's statement to the Inquiry [INQ000473130/134-135] (at para 506), senior officials within Scottish Government were in agreement with the decision. The Chief Medical Officer, at this time, supported the adoption of a "risk-based approach" to visits and inspections.

44. Furthermore, in an e-mail exchange [INQ000520563] on 4 May 2020 between Government officials and the Inspectorate regarding its draft response to a parliamentary question where it had made clear that it had not inspected since around mid-March [INQ000475130/136-137] *"….due to the Covid-19 outbreak and the significant risk of our staff transmitting and spreading the virus to multiple sites"*, a senior official, on the basis of what he described as *'"the Cab sec's sensitivity on this subject…"* suggested the following redraft:

> *"…The Care Inspectorate's normal programme of inspecting services has changed since around mid-March 2020 due to the Covid-19 outbreak and the significant risk of our staff transmitting and spreading the virus to multiple sites…"* [emphasis added]

45. This demonstrates that the Scottish Government was fully aware of the position that the Inspectorate had adopted and agreed with it. The final draft response prepared by the Inspectorate, and shared with Government officials, went on to say: "……This decision is consistent with public health advice that we follow routinely in any outbreak of infection in services and agreed with Scottish Government" [emphasis added] [INQ000520563].

46. It is unfortunate that Ms Freeman was not pressed on her reasoning as to why she did not agree with the decision to pause routine inspections, not least because her position on the matter, as advanced to the Inquiry, is wholly at odds with the considered views of directors of Public Health, the Chief Medical Officer and her own senior officials. The Scottish Government was fully aware of the position adopted by the Inspectorate and had been in agreement with it and the reasons for it.

(ii) Request to resume regular inspections

47. It is not clear when Ms Freeman suggested she requested that the Inspectorate resumed inspections. The Cabinet Secretary gave a briefing to the Scottish Parliament on 21 April 2020 [INQ000520529 and INQ000475130/97] in which she stated that: "*we're equipping the Care Inspectorate for an enhanced role of assurance across the country, including greater powers to require reporting,"* with no mention being made of any request to re-instate inspections.

48. Public Health advice issued on 24 April 2020 stated that: "*undertaking physical visits by individuals or small assessment teams, that are not immediately necessary, could exacerbate the risk of introducing COVD-19 into a previously unaffected care home. As such, at this time of heightened risk, we recommend that care home visits should be considered very judiciously. Instead, risk assessments will be used drawing on a variety of formal and informal data sources including telephone assessment. Where a visit to an individual care home may potentially be of benefit, consideration should initially be given to use of a virtual visit (face time, etc) either as a precursor to, or instead of, a physical visit. Any decision to physically visit a home will be based on a robust risk assessment…'*.[INQ000520512].

49. On 29 April 2020, the Inspectorate received a letter from Ms Freeman [INQ000320166] suggesting that there had been agreement at the SGoRR 'Deep Dive' on 14 April that the Inspectorate would re-instate inspection visits. This is not consistent with the list of actions arising from the "Deep Dive." [INQ000233414]. On 1 May 2020, the Inspectorate responded to the Cabinet Secretary [INQ000320168] to outline the position taken by the Directors of Public Health and the interim CMO and to clarify what the Inspectorate was doing at that time whilst not undertaking on-site inspections at that point. No response was received from the Cabinet Secretary.

(iii) Regular meeting with Inspectorate to request inspections be resumed with focus on IPC and social aspects of care

50. The first meeting which the Inspectorate had with the then Cabinet Secretary for Health and Sport did not take place until 28 May 2020. By this time, the Inspectorate had already resumed on-site inspections. It is important to note that it was the Inspectorate that suggested meeting with the Cabinet Secretary [INQ000652339].

51. The request to focus on infection prevention and control arose from the Coronavirus (Scotland)(No.2) Act 2020, which came into force on 27 May 2020, which required the Inspectorate to lay before Parliament a report every two weeks setting out: (a) which care home services for adults had been inspected during those two weeks; and (b) the findings of those inspections. To meet the duties imposed by the Act and to comply with the associated Scottish Government guidance [INQ000501207], the Inspectorate had to ensure that in each report there was a particular focus on infection prevention and control, PPE and staffing. The Inspectorate itself included a focus on wellbeing; it was not directed to do so by the Scottish Government or anyone else.

The Inspectorate's response to the pandemic

52. It is submitted that the decision of the Inspectorate to pause inspections between 13 March and 4 May 2020 was, in all the circumstances, proportionate and entirely in keeping with public health advice available at that time. As was highlighted in oral submissions on behalf of the Care Quality Commission [20/108/4-15], it would have been extremely difficult for regulators to have continued inspections contrary to best clinical advice and, furthermore, in the absence of PPE. It is unrealistic to

suggest that the Inspectorate could have continued to inspect, contrary to Public Health advice. It is submitted that the Inspectorate appropriately balanced risk against what it could actually do in practical terms.

53. In terms of the response of the Inspectorate to the pandemic, it is submitted that the two key questions to which the Inquiry may wish to consider are:

    (i) whether its decisions to pause on-site inspection activity briefly, while aligned with those of equivalent regulators elsewhere in the UK and in Europe, were reasonable, proportionate and justified;

    (ii) whether its approach to recommencement of inspections using prioritised and risk assessed on-site inspection, combined with the use of technology, was reasonable, proportionate and justified.

54. It is respectfully submitted that, for all the reasons outlined above, the answer to both questions is that these decisions were indeed reasonable, proportionate and justified.

Recommendations

55. The Inspectorate has put considerable effort into learning from what happened in the pandemic, and in making changes where that is appropriate and within its powers. But the evidence led in the course of this Module, which considered all aspects of the sector in a rigorous and structured manner, has shed further significant light on the role of regulators, and where that may be improved. Having considered that evidence and drawing from its own experience, the following suggestions are made to assist the Inquiry in its crucial task of making recommendations. It should be stressed that in doing so, the Inspectorate continues to place the rights of those in care at the front and centre of the care system.

1. Recognising Human Rights

56. There is an urgent need to further strengthen a human rights-based approach to regulation, with inspection frameworks ensuring (a) the dignity and autonomy of care users, and (b) that relationships are always respected, even in times of crisis. This is particularly important in relation to visiting restrictions and the implementation of Anne's Law. In short, the rights of residents should be of paramount importance.

2. Parity of Esteem

57. There can be no doubt from the evidence led that the care sector has not been accorded the same level of attention, respect, and funding as the National Health Service, and that its status requires to be elevated to that level. Whilst it is understandable that at the onset of an outbreak primary healthcare services are prioritised, the evidence has suggested that implications for the care sector were not given the attention they deserved.

3. Improving funding

58. Whilst the Inspectorate would not normally comment on matters of funding within the sector, it is clear from the evidence that the pandemic placed an almost intolerable strain on a system that was already near to breaking point. It is submitted that any delay in addressing this issue may result in a similar backdrop in the event of another pandemic. A further benefit of increased funding might be to assist in achieving the sort of equivalence with the NHS – the parity of esteem mentioned above - that is clearly necessary. Whilst there may be a nationwide consensus that the need for investment in adult social care is exacerbated by an ageing population, there is less clarity as to how that should be achieved.

59. One area that the Inspectorate submits is calling out for proper, and urgent, investment is domiciliary care. The root cause of delayed discharge from hospital is the lack of capacity of care at home services (domiciliary care) and residential care home places. As well as the negative impact on people remaining in hospital when they are assessed as being clinically well enough to be discharged, this also deprives other people from receiving hospital treatment that they may need. The problem could also be improved with more investment in the Hospital at Home scheme.

4. Involving the regulators

60. As indicated in its evidence to the inquiry, to the best of its knowledge the Care Inspectorate has never been involved in any dialogue, consultation or exercise on pandemic planning with the Scottish Government. Nor has it been consulted by the Scottish Government on the formulation of any specific recovery plan in relation to care

homes, or the social care sector more broadly in the aftermath of Covid-19, (beyond that which is described in Mr Mitchell's statement [INQ000475130/70,176] (paras 251 & 651). It is submitted that regulators should be consulted on relevant matters of pandemic guidance and legislation in a formal and consistent manner in future.

5. Equipping the regulators

61. A key theme that emerged from the evidence was that regulators require to be properly equipped to continue with their crucial regulatory work in the event of a pandemic. In oral closing submissions before the Inquiry, Counsel for the TUC proposed that: (i) regulatory bodies should be required to hold stocks of PPE; (ii) inspectors should be recognised as key workers from the outset of any pandemic; and (iii) inspectors should be prioritised for access to PPE, IPC training and testing [20/68/16-21]. The Care Inspectorate wholly endorses that proposition.

62. To this end, it is submitted that there would be merit in the Scottish Government having clear contingency plans in place that include future sourcing, and coordinated distribution, of PPE to ensure that supplies for both the health and care sectors are adequate.

63. It is hoped that these measures will provide something of a head start in enabling onsite inspections to continue to during the earlier stages of a future pandemic.

6. The Development, Management and Communication of Guidance

64. During any public emergency, guidance will undoubtedly play a key part in the response. It is inevitable that any existing guidance will require to be adapted and augmented. The manner in which this was done in the pandemic was often sub- optimal, with a feeling by care providers that guidance was often unclear, sometimes contradictory and seemingly always issued on a Friday afternoon [INQ000475130/80] (para 290).

65. In its evidence, the Care Inspectorate suggested that the development of guidance for the future is best led by those most closely involved in the 'specialist' nature of such decision-making i.e. Public Health Scotland (PHS), the Scottish Government and the

Health and Social Care Partnerships (HSCPs) [INQ000475130/103] (para 361). The Inspectorate's role would be to raise awareness of such guidance with care service providers and to monitor compliance, something that it did through its Flexible Response Team, along with the provision of regular provider updates.

66. However, the Care Inspectorate and others have highlighted that, in the course of the pandemic, guidance was often geared more to health care environments and did not sufficiently distinguish care services - which, as the inquiry heard, should be regarded as being people's homes - from the more sterile environments required in clinical settings, such as hospital wards. In his oral evidence, Mr Mitchell drew attention to the negative consequences of the application of these clinical standards on care home residents, particularly those with dementia [6/66/12-25, 6/67/1-3, 6/68/2-8].

67. In these circumstances it is submitted that there would be merit in a comprehensive review into:

- how guidance might be better developed, managed, and communicated;
- how a better balance can be struck between the protection, safety and wellbeing of care users, and their human rights;
- how the distinction between care homes and other social care settings, and clinical settings, may be recognised and firmly embedded in the future provision of guidance.

68. Given its experience in discussing the clarity and efficacy of the guidance with care providers and others, it is submitted that the Inspectorate was well placed to comment; that a failure to do so, and to include the organisation in the development of the guidance, may be regarded as a missed opportunity, and that it ought to be fully involved in the sort of review described above.

7. Strengthening the regulatory framework

69. There should be a change in the legal framework so that improvement notices can be sustained beyond the point of initial compliance. At present, if a care home meets the terms of an improvement notice, that notice is discharged, even if improvements are not maintained. This leaves a gap in ensuring long-term protection.

8. Maintaining risk-based and intelligence-led inspections

70. The Scrutiny Assessment Tool (SAT), developed during the pandemic [INQ000475130/149], which had been used to prioritise inspections based on complaints, intelligence, and staffing data should be maintained and improved. This approach was more responsive and targeted, allowing for more effective use of regulatory capacity.

9. Clarifying roles across agencies

71. Having reflected on the apparent confusion and overlap between the Care Inspectorate, HSCPs, local authorities, and the Directors of Public Health during the crisis, there is a need for clearer definitions of responsibility, especially during public health emergencies, to prevent duplication and ensure coordinated action. The importance of having a coordinated communication strategy to minimise duplication and ensure messages are shared with the right people at the right time.

10. Requiring effective design

72. The Inspectorate has put significant effort into promoting the importance of design and the physical infrastructure of Care Homes. It is vital that any new build homes, or renovations to existing properties, are designed to be able to cohort residents and staff in the event of an outbreak, as well as having adequate ventilation. As it was put by Mr Mitchell:

> *"What we learned from the pandemic about IPC, about ventilation, and fresh air, is that it's possible to design care homes better to take account of those… So for example, in a large care home, small group living is better. Creating spaces, if you like, that can be used to cohort both staff and residents - if there's an outbreak - is helpful. But if the building is designed to accommodate that, it's even more helpful."* [6/81/20-25, 6/82/1-5].

73. However, it must be acknowledged that safety measures are only one aspect of design. In the course of the final day of evidence, Ms Rhona Arthur, spoke very movingly about her late father's time in a care home – how he rejuvenated the greenhouse, showed nursery school children how to grow vegetables, and played the piano in the residents'

lounge. That evidence chimes with what is said in the Inspectorate's Design Guide [INQ000510071/11]. *"A Care Home must not only be seen as a physical building but as a culture and a society within which a person lives, experiences support, opportunity and citizenship."*

74. It is vital that care home design facilitates, and prioritises, that aspect, as well as the health and safety of the people who live there. Treating people in care with respect and dignity and allowing them to live their fullest lives, in as safe an environment as possible, should be the cornerstones of care home design in future.

11. Instituting exercises between stakeholders

75. The Care Inspectorate, like most large organisations and public bodies, has contingency planning arrangements covering eventualities that might impact substantially on the delivery of its day to day business; for example, the loss of IT systems and cyber-attacks. Exercises are undertaken on a regular basis to familiarise staff with response plans that are regularly updated and refined. These exercises often highlight the challenges and developments that are needed to address them. Overall, this approach means that staff are familiar with what might be asked of them in the event of such a situation arising and the resources available to them internally. This is of particular benefit to staff who might be new to a particular role within a senior/strategic leadership team.

76. Drawing from his prior experience as a senior police officer [INQ000475130/2], Mr Mitchell recommended expansion of such exercises to cover drills with other key organisations. Together with an increased familiarity with processes and the building of relationships with other stakeholders, this should result in a more coherent and considered response in the event of another pandemic.

77. In the Inspectorate's submission there would be considerable merit in key public bodies in this sector mirroring the emergency services' approach to carrying out major Incident exercises, every few years, to test the inter-operability of their individual systems and processes. This would provide an opportunity to:

    a. Test organisations' individual and collective contingency planning arrangements to assess their responsiveness,

resilience and preparedness;

b. Identify areas of strength and where improvement, or additional investment, is required;
c. Develop and strengthen relationships between key strategic leaders, senior managers, civil servants and politicians;
d. Improve knowledge and understanding of each other's roles and responsibilities. (In this regard, in his written evidence Mr Mitchell highlighted what he felt was a lack of understanding of the Care Inspectorate's role and responsibilities)
e. Provide reassurance to the public as to the overall level of preparedness in the sector.

78. This process would be best led by Scottish Government, in order that the involvement of key parts of Scottish Government and other public bodies can be ensured. To date, the Inspectorate has neither been approached to take part in any such event, nor has it been asked for its views on the utility and feasibility of the concept.

12. Dealing with data

79. During the pandemic, there was an increased burden placed on care home providers by multiple, overlapping, data collection systems (e.g. the Safety Huddle Tool and Care Inspectorate notifications). There is a need for streamlined and integrated reporting mechanisms to reduce the workload for care providers and improve data quality.

80. With regard to the collection and analysis of information, a matter that has been the subject of considerable comment, the Inspectorate agrees with Mr Mark Drakeford, who articulated what is required in a succinct manner, namely: there should be a review of all data systems currently operating and an exploration of how they can operate to agreed, shared standards, and be combined - within the confines of Data Protection safeguards - to aid data capture and to increase their value in national and local surveillance.

13. Retaining on-site inspections

81. In his oral evidence, and in keeping with evidence from other regulators, Mr Mitchell confirmed his preference for inspections to be undertaken in person / on-site, where an inspector can better observe how the service is operating and can speak to residents and any relatives who may be present [6/58/20-25]. Based on what he and the Inspectorate now know, if faced with a similar situation again, he would expect the inspection of services to continue through on-site visits, provided Inspectors have access to PPE and testing.

82. Whilst the Inspectorate acknowledges that there is clearly a potential role for greater use of technology and artificial intelligence (AI) in the delivery of social care, and that there would be merit in a recommendation reflecting this, it is submitted that it should also be reinforced that inspections are best undertaken through an in-person visit by inspectors, wherever that is possible. During any similar public emergency in the future, inspectors should be supported by government and other public bodies to do so, treated as frontline workers, and have access to all that they need in order to facilitate this.

14. Valuing care workers

83. Workers in this diffuse and challenging sector provide an essential service and should be recognised for doing so. A starting point would be an improvement in their terms and conditions of work. This should result in a greater continuity of staffing within care services. Ensuring there is no financial detriment, or other adverse consequence, for care workers as a result of falling ill or complying with self-isolation requirements, will also mean that staff do not feel compelled to come into work. Addressing these issues should help to mitigate the risk of bringing viruses into, or across, services.

Conclusion

84. In conclusion, the evidence produced by the Inspectorate provides a detailed account of its operational decisions, along with practical and forward-looking recommendations to strengthen care regulation and coordination in future emergencies. At its heart, that evidence underscores the importance of clarity, proportionality, collaboration, and rights-based care across all aspects of the social care system.

85. Finally, the Inspectorate pays tribute to the respectful and skilled way in which the Inquiry has explored this complex, and often emotive, subject and wishes the Chair well in addressing the terms of reference.

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