AAMER ANWAR & CO
SOLICITORS & NOTARIES

IN THE UK COVID-19 PUBLIC INQUIRY

MODULE 6

WRITTEN SUBMISSIONS FOR SCOTTISH COVID BEREAVED

1. At the outset of this Module, Senior Counsel for Scottish Covid Bereaved told the Inquiry that, while every Module is important, for many of the Bereaved this Module was of particular importance. The Inquiry was told that, for those who lost loved ones in care and nursing homes, the inevitable grief that follows any loss was compounded in many cases by the inability to spend those precious last few hours together and feelings of having left family members to die alone. Many bereaved have been left wondering how their loved ones came to contract Covid-19 in the first place, whether they received the care they needed, whether they were unthinkingly made subject to a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order, and whether the system which they trusted to care for the most vulnerable was fit for purpose.

2. During the course of the Module 6 hearings, the Inquiry heard from, amongst others, Judith Kilbee and Rhona Arthur, on behalf of Scottish Covid Bereaved and, more importantly, on behalf of those who are no longer able to raise their own voices. Their evidence, and evidence of the Bereaved from across the United Kingdom, was eloquent of the pain and suffering still felt by those whose loved ones lost their lives in care settings during the course of the pandemic. There is little that can, or needs to be, added to their words.

3. The Bereaved did not become Core Participants to this Module simply to share their pain and grief. For many of the Bereaved, the universal horrors of the pandemic were compounded by a nightmarish, mis-named care system which was underfunded, understaffed, and underprepared. Prior to the evidence led during this Module, the Bereaved had concerns that staffing levels and bed capacity immediately prior to the pandemic was wholly unfit for purpose. The evidence led reinforces the Bereaved's belief that deaths relating to Covid-19, both of recipients of care and staff, were based in part on those pre-existing problems.

4. A key issue for the Scottish Bereaved prior to the evidence starting was decisions made by the Scottish Government in respect of the care sector. These included decisions relating to the discharge of people from hospital into adult care and residential homes in the early stages of the pandemic. There were many questions surrounding the state of knowledge of key decision makers; whether there was sufficient information about, and consideration of, the possibility of asymptomatic transmission; whether there was sufficient testing; whether care and nursing homes were being provided with sufficient and appropriate PPE; and whether there were sufficient facilities to allow for the safe discharge of patients from hospitals into care and nursing homes.

5. Many of the Bereaved realised that, for them, their conception of justice will never be achieved. They hoped that this Inquiry, and this Module, would assist in their search for truth and accountability. The Bereaved are grateful to the Chair and all of the Inquiry team for all they have done to help the Bereaved, and the nation, discover the truth of what happened during the pandemic. Accountability, however, requires an acceptance and assumption of responsibility for decisions made and actions taken by the decision makers themselves.

6. Having had the opportunity to reflect on the evidence led in Module 6, the Bereaved are more convinced than they were at the time of the oral submissions that witnesses have sought to evade accountability for their decisions. While it may suit those in positions of power to be unable to recall key decision making moments and processes because of the passage of time, the Bereaved do not have the luxury of saying '*well, it was a long time ago*' and having their memories dimmed. Their lives, and those of their families, have been changed forever. As the Inquiry has been told, the Bereaved

remember what happened to their loved ones, and to them, as if it were yesterday. The passage of time does not dim those memories.

7. In their oral closing submissions, the Bereaved highlighted that they consider it to be the professional, moral and ethical duty of those who were in positions of power during the pandemic to take responsibility for their acts and omissions. The passage of time does not absolve them from their responsibility, or the need for accountability. The Bereaved were clear: to think otherwise disrespects all those who lost their lives in care and nursing homes during the pandemic, and it disrespects the Bereaved. It was with a great deal of disappointment that the Bereaved listened to the closing submissions of the Scottish Ministers and others, realising that personal and organisational accountability remains some way off.

8. As the Bereaved outlined in their oral submissions, the evidence heard during this Module made clear something which the Bereaved long suspected: protecting the NHS came at the cost of sacrificing care and nursing homes. Untested and infectious patients were cleared from hospital wards into settings where they came into direct contact with those who were amongst the most at risk from the pandemic. The Bereaved share the reflection of Professor Banarjee, of wondering whether the effect of the policies in place was to protect the NHS from people in social care, rather than to protect those people in social care from Covid[1].

9. In oral submissions, the Bereaved stated that the use of statistics by witnesses, from both politicians and professionals, to attempt to explain away hospital transfers as a mode of infection brought to mind the words of a fellow Scot, Andrew Lang, who noted that some use statistics as a drunk man uses a lamppost: more for support than illumination.

10. The Bereaved consider that little or no trust can be placed in these statistics when hospital patients were being transferred into care and nursing homes without being tested; when the sick and dying were not being tested; and where the homes were suffering from clinical abandonment, with GPs refusing to come out and give even the

---

[1] 23/20/4-12

most basic care and treatment[2]. The overall impression of the Bereaved was that many in the Scottish Government and Scottish health services were content to conclude that an absence of evidence must have meant that there was evidence of absence.

11. Those in positions of power must, however, have known that the policy of transferring untested patients into care and nursing homes was causing outbreaks and deaths. Public Health Scotland were made aware by Ed Humpherson, head of the Office for Statistics Regulation, that the data showed a 'dose-response' pattern in the adjusted hazard ratios that was consistent with a causal relationship between positivity and outbreak[3]. The phrase '*causal relationship between positivity and outbreak'* could hardly be clearer, or starker. It is not difficult to understand. It is not clear to the Bereaved why those in Scotland failed to grasp the very obvious point made by Alasdair Donaldson, the official responsible for setting up the Vivaldi Project, that as a matter of basic epidemiology and common sense, discharge without quarantine of tests was very dangerous indeed[4].

12. The Bereaved consider that it is not good enough to claim that, in the early days of the pandemic, it was sufficient to leave matters of discharge to clinical assessment. From early March 2020, Scottish Care were advocating that there needed to be robust clinical assessment and testing of residents entering care homes both from the community and acute NHS settings. At the outset of the pandemic this was not in place and there was an urgency to discharge elderly residents from care homes, which contributed to the spread of Covid-19 within care homes[5]. At times during the pandemic care homes had concerns about accepting new residents due to their lack of confidence in discharge practices that were being adopted at the time[6].

13. There is evidence before the Inquiry on behalf of Scottish Care that, during the pandemic, it often appeared that decision makers relied on information from the healthcare sector to make decisions about social care which was not always

---

[2] INQ000509530/0021
[3] INQ000346830/0003
[4] INQ000598578/0008-0009
[5] INQ000509530/0036
[6] INQ000509530/0037

appropriate[7]. Decisions made by the Scottish Government frequently resulted in contradictory advice and guidance being provided to staff in care homes. A clinical approach was applied to care homes by practitioners who did not have any experience in a social care context[8].

14. It may be suggested that care home size is more strongly associated with the risk of an outbreak than all other care home characteristics. If that were indeed the case, the Bereaved are left wondering why steps were not taken to limit the size of care homes during the pandemic. There has been no evidence to suggest that, since the pandemic, steps have not been taken to ensure that care homes do not become so large as to become a risk when there is an outbreak of disease. The Bereaved consider that any government who considered care home size to be a risk factor when considering the outbreak of disease would surely have taken steps to address such an obvious factor.

15. The Bereaved listened with great care to the evidence of Jeane Freeman. Her evidence has evolved over the course of Inquiry, and over the course of the years. In Module 2A, and on publicly available podcasts, Ms Freeman was willing to accept that she had an inadequate understanding of how the adult social care sector operated and to not responding quickly enough[9]. By the time Module 6 came to be, Ms Freeman had, apparently, developed a good understanding of the adult care sector in Scotland and was able to take this into account when making key decisions[10]. The Bereaved submit that, unlike Schrödinger's cat, it is not possible for Ms Freeman's understanding of adult social care to be both inadequate and good enough to be the basis of key decisions. It is unlikely that Ms Freeman's knowledge and understanding of the sector has improved since retirement. The Bereaved listened with bemusement to Ms Freeman's attempts to explain away her shifting positions. It is a matter of regret that key decisions, affecting the lives and deaths of thousands, were based on such imperfect knowledge.

---

[7] INQ000509530/0014

[8] INQ000509530/0015

[9] PHT000000067_0215/21-25, Transcript of UK Covid Inquiry Module 2A Public Hearing dated 29/01/2024

[10] INQ000606530/0020

16. In light of the foregoing, the Chair is invited to consider making the following recommendations:

Care Homes

17. The following submissions are made in respect of care home staff who are vastly undervalued by society at large. Although briefly during the pandemic they were recognised for their work, as the pandemic horror faded in the minds of some, so did the interest in the way care workers were treated. Care workers are the heart of our care system, and without them we have no care service.

18. To that end, we recall the evidence of Paul Featherstone:

"I'm sitting here and I'm struggling to think of an answer, but I mean, it certainly wasn't all bad. I think the -- I mean, the vaccine rollout was, I think, is a good example of things that did go well. That was done very, very quickly, even though there was a, you know, there was some reluctance on some people not to get vaccinated but I think the government should be commended on the speed in which the vaccine rollout was implemented. I think that's probably the biggest spotlight I could shine on something that did go well.

Q. And then, in terms of looking to the future, you've identified some key objectives that you think are important. Perhaps you could explain what they are.

A. I mean, moving forward, I think -- and probably I'm repeating what a lot of other people have said sat in this chair, but we need to give proper recognition to our workforce, and that would be my biggest recommendation, is let's get our amazing workforce properly recognised. And dare I say it, properly paid and remunerated. We need to do more around the narrative of how brilliant being a care professional is, rather than concentrate on the negative side of care working. That, for me, moving forward, would be job done. If we can get our amazing workforce -- I keep calling them amazing because they are. I mean, they're the ambassadors for their providers, they're out there doing the job, you know, seven

days a week, 365 days a year. We need to give them that respect, can I say that? They need to be respected and recognised as the amazing people that they are. And I can't -- I mean, it might seem silly and a little bit simple to say those things but that's what I would love to see, moving forward, is that focus given to our workforce, and being brought up to the same level as our colleagues in the National Health Service. We need it. It's far too long overdue." [17/144/18-17/146/3]

19. It is submitted that pandemic planning must include properly addressing the current work conditions of care workers and provide them with better protection. As noted by Professor Fu-Meng Khaw's evidence, going in to the pandemic the social care sector was in a state of disarray.

Pre-existing problems

"Q. From the TUC's perspective, please could you give a brief overview of the biggest concerns faced by the sector going into the pandemic, so February, March 2020?

A. Yeah, so going into the pandemic it was the -- we were dealing with the legacy issues or the ongoing issues of the problems within the social care sector which was a lack of cohesion, very little central information, no central control at all; certainly worse in England than anywhere else, but not particularly great elsewhere across the UK. And a sector that was -- had high vacancy rates, had high numbers of staff on insecure work so there would be a high number of staff on zero-hours contracts or who were agency workers, who didn't get paid even the minimum wage because of the travel time issues, that is they don't get paid – many workers don't get paid for travel time. So it was a sector that was in a lot of flux. High turnover of staff. And, you know, they're – just really difficult to get a grip of it. And no partnership working at national or, indeed, local level most of the time. There were –…" [6/164/7 – 6/165/2]

20. There was a common theme to the evidence in the Inquiry, that the NHS was favoured and prioritised over the care sector. Although this was denied the adage "actions speak louder than words" repeatedly saw the care sector sidelined and not consulted. The

evidence on day 15 of Professor Sube Benerjee was particularly pointed when he suggested that if a ring was put around care homes, it was to protect the NHS from people in social care, rather than to protect those people in social care from Covid. Raising the status and training of care workers would be particularly positive in promoting parity between the NHS and Care Sector by society and by Government.

"So there's a set of reasons why those sorts of things might happen, but they are all based on a lack of priority given to care in -- social care, compared to care in healthcare. There is talk of the, is it the steel boundary, or the ring of steel -- Q. The ring -- A. -- that was put around care homes and just looking at the evidence, you wonder whether that -- well, firstly, there's very little evidence of it, but you wonder if its effect was to protect the NHS from people in social care, rather than to protect those people in social care from Covid." [15/20/1 – 12]

21. The evidence of Dr Chris Llewelyn was that there should be a minimum wage for Social Care Workers. It is submitted that this recommendation should be taken up:

"Well, it's something we constantly lobby on. There is -- you know, there has been a recognition of the need to pay at a level of the real living wage. There has been some progress, but we need significant further progress, I think." [8/41/24 – 8/42/3]

22. Although Caroline Lamb in Scotland highlighted that since 2016 that social care staff are paid the "real living wage" rather than just the minimum wage, but that payment is still low for the service they provide to the public, and does not address the problem of zero hour contracts.

"**In terms of funding and support for the work force, we did a number of things. So, one of the things I think was that we recognised that terms and conditions across the social care sector are variable, and are not always as good as we would want them to be. We recognised that some employers would only pay statutory -- if people were off sick, they would only be entitled to Statutory Sick Pay, so we put in place arrangements to ensure that they could receive an amount equivalent to their normal pay, so they weren't suffering financially if they were off sick or**

indeed if they had to isolate because a member of their family was off sick. We also put in place a number of wellbeing supports. We had a national wellbeing hub to offer support, advice, to people working across the sector, because it's an incredibly stressful time for people. Scottish Government has also, consistently, since 2016, met the costs of ensuring that social care staff are paid the real living wage rather than just the minimum wage." [14/150/11 – 14/151/6]

23. Dr Jane Townson remarked that it was a "national disgrace" on the way that care home employees were treated:

"You set out in quite a bit of detail in your statement the pre-existing challenges that the sector faced going into the pandemic. I won't go into all of those; they are set out in your statement. But can I just ask, in terms of the financial instability that you describe, is it fair to summarise it like this: that pre-pandemic, on average, councils were paying less than the minimum price for homecare services, and most of homecare services were paid for on a zero hours basis? And the way it was procured and commissioned meant that providers were effectively encouraged to race to the bottom on price to win packages of work? Payments for care were also delivered in arrears. How do you say that that combination of factors impacted on the ability of the sector to be able to respond to the pandemic?

A. It has a massive impact. And I think we're the only part of the entire health and care sector, and possibly the only part of the entire economy, where workers are paid by the minute. It's honestly a national disgrace. And if the person that you're supporting has to go into hospital, the councils and the NHS stop paying the provider. So this creates a working environment with insecure income, unpredictable, and insufficient, because the rules are that you have to be paid for all of your working time, so that is the visits to the people that you're supporting and also travel from one person to another –

Q. Okay –

A.-- and the amount that's paid isn't enough to cover all the costs, and the people that suffer are those drawing on services and the care workers." [9/27/14 – 9/28/21]

24. In light of the problems in the social care sector, it is submitted that the Professor Fu-Meng Khaw's evidence form the basis for a number of recommendations.

"Q. If I can ask you, then, to reflect and looking forwards, if there was to be a future pandemic, and there was consideration about such an initiative, how could care workers practically be encouraged back into the sector?

A. Well, one of the key things would be you'd have to look at the way care is set up at the moment, the way the care services is set up. So now it is one of the worst paying, worst set of conditions, the worst anything when it comes to workforce, happens in the care sector. You know, most staff are on minimum wage or, as I said earlier, sometimes even less than that, if you're a domiciliary care worker. Their conditions are appalling, so they don't get paid sick pay or they get paid the absolute minimum sick pay, they have minimum annual leave. Many of them are on zero-hours contracts. So to bring them back to a workforce where they're contrasting themselves with an NHS workforce which has a whole different set of terms of reference, where staff are treated with dignity and -- by and large with dignity and respect, they're seen as valued members of the workforce, that just doesn't happen in the social care setting." [6/172/7 – 6/173/3]

25. There needs to be a recognised umbrella organisation that protects the rights of workers in the care sector.

"Q. Could I pick up on something that you said, that this was initially an NHS initiative. Perhaps, would a practical example be if it had been a joint initiative from the outset? Would that be something practically that could have been done?

A. It would have been, if there was some -- part of the problem you've got is that there was no -- there's no central lead in the care sector. So there was no employers' body that was one employer's organisation. There was no one provider organisation, or one commissioning organisation. The nearest you had to anything that would represent the workforce were the three unions that are part of this. We were always happy to discuss these things. But even for us, the difficulty we had

then – and to an extent even now we still have is -- there is no recognised employers' body or umbrella organisation that represents the care sector, and the government certainly did not represent the care sector. They very much took a hands-off approach to the care sector.” [6/173/4 – 23]

26. Jeane Freeman accepted that in Scotland there were steps to be taken to improve the care sector, including the terms and conditions for staff, ensuring adult social care is properly and equally recognised and for example there was appropriate PPE for the sector. She also highlighted the need for “attitudinal changes” in the adult care sector. She highlighted the Feely review, which recommended consideration of the movement of staff and how that might be changed to provide better outcomes. These are in line with the other proposed recommendations from witnesses.

“Q. Was the adult social care sector, in your view, the poor relation to the NHS in Scotland?

A. No, I don't believe it was, in terms of my actions with respect to how we would respond to the pandemic in that setting. I think, though, it is clear that the adult social care sector is disadvantaged in terms of the terms and remuneration to the staff who work in that sector and the absence of clear career progression, all of which makes it difficult to attract the numbers of staff that you would need to that profession. Now, that is complicated, as we've said before, by restrictions that arose from Brexit, but the fundamental problem is the terms and conditions. And that was one of the reasons, for example, why, during the pandemic, we intervened in order to provide sick pay to those whose terms and conditions of employment provided nothing more than Statutory Sick Pay and made it very difficult, then, for staff who wanted to comply with our requirements, for example, if they had Covid themselves or, more often, a member of their family did, with our requirements for them to stay at home, that was a financial loss that we stepped in to try and alleviate so they could comply. But that was because their terms and conditions of employment were poor.” [14/41/21 – 14/42/19]

“A. So I would not agree that it wasn't prioritised alongside the NHS in our pandemic response. And I think it's important for me to say that. But as we look

ahead to what we need to do for the next pandemic that will appear, I think many, if not all of the recommendations from the Feeley report, should be implemented. I think, as I've said before, that our testing infrastructure needs to be, at a base level, better than it was at the start of the pandemic we're discussing. I think we need to -- and in terms of the Feeley report, that is about agreed national standards, consistently applied across the country in whatever setting adult social care is delivered, and inspected and regulated to ensure that that is happening and where it's not, that steps are taken to achieve those improvements. That all also links into how, as any Scottish Government works with and seeks to offer people with disabilities the equity of opportunity that those of us without that enjoy or have before us.” [14/43/15 – 14/44/9]

“A. So the care at home sector was included in the additional supply of PPE that we introduced. So the concern about the supply of PPE to residential social care first flagged up the problem that existed, to which our response was then to use our National Services Agency which supplies PPE to our NHS, to increase the volume of supply and the routes to include residential care but also care at home, and unpaid carers, personal assistants, and a range of others. And you'll know from the material that's already been provided to the Inquiry the various routes that we implemented in order to ensure that that was the case. I don't recall specific issues being raised with me in terms of care at home, with one exception, and that does relate to PPE, where, from the trade unions representing staff delivering care at home, they raised a concern that their members in some instances were not given an adequate supply of PPE to deal with the number of individuals in any given day that they would be visiting to provide care, and I made the determination that those staff in all circumstances should be given, if they were visiting, for example, five clients, they should be given five full sets of PPE and allowed to use their professional judgement on what PPE was appropriate for each individual.” [14/44/15 – 14/45/14]

“A. So I think ... mm. I think that in terms of, if you like, the narrative around adult social care, too often we, collectively, confine our thinking to only those in residential settings and confine our thinking to the elderly, where, as I've said, adult social care is also a vital service to many much younger people which,

provided properly to meet their individual needs, allow them to, for example, go to work, meet their friends, have the kind of opportunities in terms of education and otherwise that those of us who are fortunate take for granted. So I think there is an attitudinal question that needs to be addressed with respect to adult social care as you would broadly define it, and properly define it.” [14/46/4 – 17]

“A. So I'm not sure, with the current arrangements of how residential care is provided, i.e., it is a mix of public and private sector provision, primarily private sector, that mandating that is feasible, but that's not to say that the overall nature of our provision of residential adult social care does not itself require some consideration as to whether or not the model that we currently have is the best model. And again, that is something that the Feeley exercise and those recommendations considered.” [14/98/9 – 18]

27. A coherent approach to ensure stability is required, to understand what the care sector is and what its requirements are, to provide consistent training and have a central distribution centre for PPE.

“Q. And so, in terms of what a good coherent approach would have looked like, can you help us with what the TUC would want to have seen in terms of the organisation?

A. Yeah, so there would have to be a central distribution system the way there was for the NHS, which is, one, they'd have to know where all the care homes were and what kind of services were being provided in those care homes. Where were they getting their PPE initially? You'd have to find a way to direct the care homes to actually -- and the care providers for domiciliary care -- to give out PPE in a certain way. That took a long time, and was very confusing to try to get that during the pandemic. I'm not sure we ever got it right. But it certainly wasn't -- certainly the first few months it was a nightmare. And so there was -- that would have to be getting thought about now. You had need things in place now, where they had mapped what the care sector looked like, they had worked out what the regional distribution centres would be like or who would be responsible for it, whether that was going to be local authorities or it was going to be some NHS providers. But

there'd have to be a system put in place. And it should be in place now, because if there's a pandemic tomorrow, we're -- as far as I'm aware, that system is still not in place.” [6/176/4 – 6/177/3]

28. There should be a national care service which has both responsibilities and duties for the whole sector, to provide cohesion:

“Q. And do you have any suggestion as to who would be the responsible body for delivering such training?

A. Well, I think there's -- it all goes back to the fact that there is no central department that seems to have responsibility even now for those kinds of issues. So I don't know whether that would be -- whether there needs to be some kind of national care service. We've been calling for this for some time, a national care service that has responsibility for a range of things, not just the pay and conditions of the staff, but actually what happens in that service. And if we had something like that, that was like the NHS, and had that kind of parity of responsibility, parity of esteem, whatever you want to call it, that's an organisation that could look at how do you train staff, how do you make sure that they've actually got the information necessary to deal with the patients that they look after, and to, you know, deal with issues around PPE. Which are still there in the sector

Q. That document can come down. Thank you. You talk about the establishment of a PPE task and finish group. Did that assist things at all?

A. It helped in that it meant -- I think I was the only trade union person on that, if that was -- I get confused at the different ones. I was on one and one of my colleagues was on another, on some of the others.” [6/180/12 – 6/181/12]

29. The issue for the need for training was also flagged by Maria Rossi of Public Health Scotland:

“**However, these are -- there are over 1,100, I think, care homes in Scotland, and 14 health protection teams, for example, so the -- any training or advice and**

guidance that was brought from the health protection teams to care homes was very much focused on outbreak management rather than routine training, and I think that that's a need that needs addressed.

Q. And would it be the health protection teams that would be best placed to deliver that training, in your view?

A. Interesting question. Something that really needs to be worked through. The health protection teams would use ARHAI's National Infection Prevention and Control Manual for that training, so the resource is there produced by ARHAI nationally, but who does the training is actually something for each of the health boards to determine.” [17/72/8-23]

30. As the evidence showed, there was a real problem of care workers moving between care homes as a vector for infection. Much would be assisted in this regard if workers were paid better wages and had more work protection and less zero hours contracts. It is not suggested this is banned – as per Matt Hancock, rather that the working conditions are improved such that workers don’t need to take on multiple jobs.

“A. So a large number of care workers will have more than one job, whether that's in two care homes or more than two care homes, or there might be a care worker and a domiciliary worker, or they might work in a care home and work in a supermarket. I mean, it's very common to have more than one job. And I think banning them outright like that, without -- in a system that is so fragmented as it currently is, I can't see that working. And I can't imagine that this would even be considered if you were talking about -- you know, if you said this would apply to nurses or doctors who worked in two different medical centres, without thinking through what the compensation would have to be for those workers. But somehow when it came to care workers, no consideration was given to whether they should be compensated for this when it was proposed at the time. And I remember raising it vociferously at meetings with people, saying, "These are already low-paid workers, and you're telling them you're going to ban from working anywhere else."” [6/186/11 – 6/187/5]

31. There should be implementation of a system wide easy use risk assessment tool, that can be used by all so that everyone is using the same parameters when taking decision on risk.

“Q. And do you think that the recommendations of the group in Wales was something that was acted upon by the Welsh Government and is that an example of good practice?

A. Yes. I mean, the fact that the Welsh Government took this more seriously, that they had set up a group, and that they had recommendations to follow was definitely something that should have happened in England.

Q. And the Inquiry has also heard evidence about the All-Wales Covid-19 workforce risk assessment tool, and is that something that should be implemented in the event of a future pandemic or something like that?

A. There should be a risk assessment tool that applies to all staff, and again, the care sector is so unstructured as opposed to the NHS that you absolutely need a proper risk assessment methodology toolkit to make sure it has an impact in that sector, because a lot of the time you're talking about small care homes or even a large care home or a domiciliary care group. It's very different from a large hospital and the way they would structure -- and they'll have their own head of health and safety, for example. You wouldn't get that probably in a care home.

Q. Can you give a brief overview, perhaps, of how the risk assessment tool would have helped.

A. So having a risk assessment tool that was easy to follow and understand, that employers are familiar with, that unions could have gone in and said, "Have you followed this?", that workers would have been familiar with it, I think it would have helped the managers in the sector, as well, to be able to deliver, you know, better care for their workforce if they had something simple and easy to follow.” [6/190/3 – 6/191/9]

32. Following on from the establishment of a union for care workers, a register to ensure that those working in the area have completed minimum standards of training.

> **“Q. Can I move on, then. One of the things you mention in your statement is the possibility of having a register of social care workers for England, and you explain that that's something that does exist in the other nations of the UK. Why would registration or having a register of care home workers have been of further assistance in England and are there any examples of how that did help in the devolved nations?**
>
> **A. I think once you've got that, it means you can see -- there is some, then, central control, you have some central information about where staff are. You have some central information about what their training is, have they had some minimum training? In England, there is nothing like that, and there's such a high level of turnover among the workforce that I think it must be incredibly difficult to keep control of that. And, you know, given the kind of work, the nature of the work that care workers do, for me, it's almost unthinkable that you would have people going into individuals' homes or giving close personal care to people in a care home where there isn't a register, and that there isn't minimum standards of training available to people. I would argue that having that surely must help with outcomes in any kind of setting.”** [6/191/10 – 6/192/9]

33. The establishment of such a register was supported by Dr Jane Townsend who said a “care register” ought to be brought into being:

> “**A. Well, I think in terms of trying to find out how many providers there are, what their needs are, what the risks are to the people that they're supporting, was hugely difficult. Obviously with the CQC-registered organisations it's much more straightforward, and the CQC has got rights to any information it requests. But for everybody else, it's very difficult. We think that -- in the devolved administrations there are registers of professional care workers. We think that everybody should do what's Scotland is doing, and add the unregulated personal assistants to that register. Of the devolved administrations, we feel that Northern Ireland has done it the best. They have focused their register on competence and**

conduct, not qualifications. And I think that is the most pragmatic approach for our sector.” [9/43/16 – 9/44/7]

34. Melanie Minty also gave evidence on the need for a level of training in various sectors:

“A. I think it improved. I think probably the most horrendous examples were from early on in Covid, and it's about that lack of messaging. We had -- I think I used an example of a care home in North Wales where they couldn't get the GP to come out, the staff were having to take observations that they weren't trained, because there was no one else there to do it. The person was in horrendous pain, and they had to –

Q. Sorry to interject. Would training, for example, in those circumstances have been something that may have helped?

A. I think, yes, it would help if we prepared social care workers to step up further, and I suppose there are elements of that happening. But I think, you know, it was that nobody knew what was going on so nobody would go in and offer help.” [9/181/19 – 9/182/10]

“Q. In terms of training, who would deliver training in those scenarios? Or who should deliver training? A. I think there are some good modules probably from health that could quite easily be rolled out. I mean, certainly, we're doing more and more with medicines, administration and so on, for care workers and domiciliary care workers so…” [9/182/13 - 19]

“Possibly some level of palliative care training because I know a lot of people who died were in residential homes where you wouldn't expect someone necessarily to die in the care home unless they were supported and had that wrap around service. And I think the counselling for care workers themselves probably came later than it should have done.” [9/183/2 - 8]

35. Caroline Abrahams of Age UK who gave evidence on day 19 also highlighted the need for training and the need for a need to “professionalise” the care sector employees both

to assist them and to raise their standing and doubtless their income, which will result in fewer people taking on multiple jobs.

“**I think our view then, and continues to be at Age UK, that the business of providing social care is a highly skilled task undertaken by people who are hugely committed. It's a much more difficult, demanding task than our usual systems for accreditation tend to recognise, and that care work deserves to be professionalised, and people who do it deserve the terms and conditions that go with it. Part of professionalising the social care workforce probably means putting more structures and systems around it, more expectations of training that you are then accredited for having taken, which might help you to earn more money, which is important in attracting more people to do this very important work. And if we're going to do that, we probably need a register or something that writes down in one place who a care worker actually is, so we can -- the public can monitor what training has that care worker got? Have they got the skills to help my mum? Are they the right person? It would probably, we think, improve --it would certainly be more transparent. It would help to identify, perhaps, people who shouldn't be doing care work, and we think would increase public confidence in social care as part of professionalising this career.”** [11/33/15 – 11/34/13]

36. She concluded her evidence pulling together some of the foregoing themes as recommendations which it is submitted consideration should be given to:

“**So what that tells me is that, in future, we do need something much more like a genuine national care service. We need more national infrastructure to support it. We need quality standards. We need transparency. That would have supported a stronger social care system when the pandemic hit. The second point I would particularly draw attention to is the need for much more recognition of the rights of older people, particularly, for example, in care homes, where they have no rights, really, at all. It was a source, I think, of great sadness and surprise to families who had always thought they were partners in their loved ones' care with the care home, that once the pandemic struck, it didn't feel like that at all. And that their loved one didn't have any rights, really, either. So that definitely needs to be addressed. And then thirdly, and finally, you'll be pleased to hear, important**

that we put some more structures in place to hear the voices of older people and those who represent them in government. As I have said, when the crisis hit, there's an absolute understandable tendency in government to circle the wagons, to look inwards. You're much more inclined not to listen to people outside. There's a lot of tension and anxiety, and there's some confidentiality too. And that didn't help older people during the pandemic because there was no one inside government thinking particularly about older people, and not enough people thinking about social care. So, addressing that through appointing a commissioner for older people, probably a minister with more responsibility setting up a cross-cutting unit of officials, these are all the types of things that could easily be done, and they would have made it less likely, I'm sure, that older people would have been forgotten too often during the pandemic.

A. It's not the right way to do it at all. It's a very frightening call to get out of the blue, isn't it? What we need to see more broadly is an approach to advanced care planning where these things, as far as possible, are done in advance, so that you can have a conversation outwith a crisis where you can make your wishes known. That's obviously the ideal approach. When it is much more of an emergency, I think those sorts of calls just are -- you know, and it was expressed to me how terrifying those calls could be. So it is an area where I believe there are actions that can be taken to improve processes into the future and those need to be taken." [11/35/25 – 11/37/11]

"The first one is that I think the pandemic demonstrated the insidious ageism that is embedded in our society, the way in which, as we get older, too often our lives are not valued in the same way. The way in which the stereotypes and assumptions that people make about older age can then feed into policy and decision making. I think there's a need to treat ageism, in combatting ageism, much more seriously and that needs to be done throughout organisations in terms of training and awareness, and, within that, much more serious adherence to the issue of the rights of older people." [9/137/17 – 9/138/3]

37. Reference is also made to the letter sent via Scottish GPs which Caroline Abrahams gave evidence about:

“Q. I would like to ask you, if I may, about a letter that was sent by a GP practice to a care home resident in Scotland, in which the recipient was informed that the practice would be ceasing visits. So if we may have on screen, please, INQ000591762.And starting with the second paragraph. Now, the quality isn't particularly good on this version, but I will read out the part that I would like to draw your attention to. So the second paragraph, it states: "... we need to minimise patient contact to all unless absolutely essential." And then in the fifth paragraph, in regard to patients that get Covid-19, it states: "We would plan to continue to nurse our patients ...and not to transfer them to hospital. Sadly if they are so unwell as to require breathing support from a ventilator it is unlikely that given their frailty they would survive." Firstly, is this the type of letter or the approach, one, that Age UK heard people experienced during the pandemic in Scotland or elsewhere in the UK?

A. We heard these kinds of things right across the UK. What is unusual about this is that the practice actually wrote it down and took the trouble to communicate with patients and care homes formally about it. More often, I think, these things happen informally, or they were conversations. They weren't actually documented. And to an extent, I think this practice deserves some credit for it being upfront with people about what it was intending to do, even though we wouldn't necessarily agree with it. Certainly the issue of whether an older person in a care home would be taken to hospital if they became unwell was something we heard quite a lot about right across the UK, and I think I put in our written evidence about talking to a very senior clinician who had had to intervene personally with the hospital to enable an older person with a very routine respiratory problem to be admitted. It was absolutely something the hospital could help with, but had he not intervened, there would have been no possibility of that person attending.

Q. Yes, I think you've described concerns about non-conveyancing practices during the pandemic.

A. Yes.

Q. So, again, were they quite widespread, from the evidence that you've received?

A. Very much so, yeah.

Q. And did you try to bring such issues to the attention of national decision makers or even local governments or practices?

A. Yes, we very much did try to raise this as a real concern, as a concern about the way older people were being viewed and treated, and the lack of respect for their human rights and their ability to access healthcare, alongside everybody else of all ages. Regardless of whether you're in a care home or living at home or in hospital, we all have the same right, and that right was not being observed. And we shared those concerns across our Age UK family and with the commissioners in Northern Ireland and Wales, and we published a statement actually saying that. And there was some response to it, but I think, from what we heard, there was patchy implementation thereafter on this issue, as indeed many others throughout the pandemic." [11/21/23 – 11/24/13]

38. Before moving from DNACPR the following evidence was heard also from Ms Hands on the individualisation of DNACPR notices. Although the Chair no doubt has the full grasp on this, we add it for completeness:

"**LADY HALLETT: Sorry, just before you do. MS HANDS: Yes. LADY HALLETT: I've heard a great deal about how decisions, for example DNACPR, should be individualised.**

A. Yes.

LADY HALLETT: What this letter seems to be doing is lumping people together. Is that one of your concerns?

A. A huge concern. Yes. I don't know the context of this and whether this was -- it says it's from the Royal Society of MENCAP, whether it was possibly to a learning

disability setting, which is even more worrying, but yes, I think it is -- it is very scary. It is a blanket form of decision making, which goes against all the core principles of Good Clinical Practice. And it may be that for an individual, after discussion, the outcome would be not for resuscitation. But it must be on an individual basis, rather than: this population have dementia, or this population have learning disability, therefore no. I mean, that is -- I'm sorry, I'm going to use the word "shocking", and -- well, I don't apologise for using the word "shocking". It's, um ... yes, thank you.” [19/41/8 – 19/42/5]

“Q. And the question is, going forward, how do we ensure that DNACPR notices are not interpreted as a proxy for "Do not treat"? A. Thank you. A really important question. Forgive me if I say a little bit about the ReSPECT document. That was developed by a close colleague of mine, Dr Zoë Fritz, who researched standalone DNACPR documents and identified significant harm from the inpatient setting that people who were -- for DNACPR were not turned, et cetera, et cetera. And it was precisely, as you say, identified as almost do nothing, and that -- out of that research Dr Fritz developed in our locality the ReSPECT form, which puts it very clearly in the context of that broader discussion. So that's -- one answer to that is don't have standalone DNACPR conversations, have them in a broader, ACP conversation. And I think there needs to be patient and family and public explanation, and that this is simply a decision that should this patient's heart stop, we will not attempt cardiopulmonary resuscitation, but this doesn't exclude anything up to -- of necessity, it doesn't exclude anything up to and including that. And I mentioned, you know, if someone falls and fractures their neck of femur, because they've got a DNACPR, well, yes, okay, but they may well need to have it pinned. I don't know if that helps.” [19/49/18 – 19/50/20]

39. In relation to the end of life care, DNACPR and other palliative matters, the SCB would particularly commend the evidence of Professor Stephen Barclay who gave evidence on day 19. He stressed that the difference between palliative care and end of life care was not well understood, and that there was need for national guidance moreover he stressed the need for advance planning for end of life care. It is submitted the following ought to be given consideration in relation to recommendations:

“Q. I'd like to go on now to consider palliative and end-of-life care during the pandemic but before we do so, by way of background, are you able to briefly explain what palliative care is and how it differs from end-of-life care? A. Thank you, and I think we may come back to that later under the question of visiting a bit later. So palliative care is understood as the care of people with progressive life-limiting conditions, irrespective of prognosis but based on need. End-of-life care -- and there is a confusion here -- end-of-life care, I think in the eyes of the general public, tends to be more that final period of life: Final days, maybe hours, maybe very few weeks of life. NHS England policy describes end-of-life care as the last 12 months of life, and that's the current policy view at the moment, but I think, in the light of some of the comments that have been received at this Inquiry, particularly from the care home setting, we may need to rethink that, because that caused confusion and upset because people were told that my loved one is on their GP's end-of-life care register, which we're encouraged to have, which is roughly broadly the last year of life, but the care homes were saying: yes, they're not sufficiently end of life. And that was hurtful and confusing and it was the health service that was creating that confusion, I think.” [19/9/1 – 19/10/2]

“Q. So the system that you have referred to in Scotland, is that one that you think could be replicated across the UK in a future pandemic?

A. I think it would be very helpful to have set up in advance, when the next pandemic hits us, in terms of the symptom -- end-of-life care for whatever the agent is: here is a group of people who are going to jump into action and, in collaboration, produce rapid, flexible guidance for the nation. That would be really helpful.” [19/18/25 – 19/19/9]

“Q. I'd like to move on to a new topic now, and that's advanced care planning. Can you briefly explain what advanced care planning or anticipatory care planning, as it's referred to in Scotland, is and why it is so important.

A. So certainly, it has a number of different names, but this is something that is broadly recommended, that it's a process of discussing with an individual and those close to them, their wishes and preferences for the future. And it's an offer

of a conversation about "what if" and "what when". It requires very sensitive communication skills, and some people will indicate, "not now" or "not with you", or "not today, thank you", and these are often conversations over a period of time. But it can be enormously helpful to get a sense of what's important, particularly if, in the future, that person should lose decision-making capacity. So we know that what was important to this person was whatever it was. And to then, in some sort of document -- and there are a range of different documents out in the country --which is a patient-held document which documents: my understanding of my condition, my preferences for the future, and the clinical recommendation, and in the form I'm most familiar with called ReSPECT, right down in the bottom right-hand corner is the shared decision about resuscitation, but it puts resuscitation in the context of "We're on the same page, we understand what's happening, and let's do some planning together."

Q. You've described the ReSPECT forms in your report as being much more about -- much than just resuscitation decisions –

A. Yes.

Q. -- and completing a DNACPR form. So is that what we can take from your evidence there?

A. Very much so. It puts the DNACPR decision in the context of the wider discussion. Critical.

Q. And you mentioned a moment ago, and in your report, how there are many different types of forms and systems used to record these discussions. Are any forms better or more helpful when recording such decisions, perhaps for the patient's wishes but also for the professional that's completing the form?

A. I find that a really difficult question to answer. It is, I think, an issue that there is a variety of forms. Many of them have been locally developed, some of them have been more widely developed. There's a Scotland form, there's a London form, there's the ReSPECT form. I don't think I can comment on "This one is

definitely better than the other ones". The content is all pretty much the same in terms of, you know, what I've outlined for the one that I'm most familiar with.

Q. And you have referred to there being online tools and resources available in Scotland to support staff –

A. Yes.

Q. -- to have person-centred anticipatory care planning conversations.

A. Yes.

Q. Do you know if they are also available in other parts of the UK?

A. Absolutely, yes, yes. If you, as again, I'm more familiar with the ReSPECT, there is a plethora of online resources around holding the ReSPECT conversation and the London form, as well, has similar online resources. So yes, absolutely." [19/31/12 – 19/33/25]

40. One of the ways in which the rights of older people could be improved is including family members as part of the care team, as also suggested by Professor Stephen Barclay on day 19:

"**Q. Professor, listening to what you say, I wonder if some of the harm that was caused might have been overcome or prevented if family carers were understood as a core part of a patient's care team. Is that something you'd agree with and that you think would be an appropriate way of understanding the role of family carers?**

A. I think there's no question that family carers are a core part of the care team, and therefore need to be able to access their loved ones. And it was hurtful for all concerned that that was not possible. And both in a care home setting, where there are professional carers already, but maybe particularly, actually, in the homecare setting, where family carers do the huge bulk of the care of a loved one towards

the end of their lives. The doctors and nurses visit, but the family are there all the time. They are the lynchpin. I don't know if that helps.” [19/55/4 – 22]

41. Moving to the work of the UKHSA it is submitted that the evidence of Helen Whately on day 12 ought to be given consideration, in relation in particular to social care being included in strategic planning:

“**obviously, I think there's a role for UKHSA, UKHSA, in this as well, and there's something about, you know, building up greater research capacity in social care like we have for healthcare. I mean, for instance, I did actually look at the UKHSA strategic plan recently, and that mentions the NHS times, but social care is only mentioned four times and it's only mentioned in the context of the Department of Health and Social Care. So why is that organisation not seeing social care as something that, given what happens in the pandemic, why is social care not a feature in their strategic plan? So there's getting to the bottom of what happened and building up that research capability and oversight of infectious disease management in social care. There's, going back to sort of kind of where we started today, there's proper pandemic planning and, clearly, when the pandemic starts, it's too late to make a plan when your pandemic has already started. And in fact, we know from looking through the data that, you know, deaths were occurring in care homes almost certainly from Covid from mid-March onwards. So it was there, but the planning was, you know, hadn't -- was --came subsequent to that, really. So you do need a proper plan that goes through all the things like PPE and the discharge process and what you'll do about funding and visiting and vaccination policies and the various scenarios. So that needs to take place. There's this point about having some greater level of capability and infrastructure at the centre to be able to do a coordinated response. It took time to build that up. We went from having I think less than 100 people in the Social Care part of the Department of Health and Social Care to 300, you know, we have built it up, but there was the time it took to do that. And similarly, local authorities needing to have the capability, and care homes themselves having the capability to respond to a pandemic. And like all those levels, need to be in place. On the staffing side, and we have talked about that a bit, you know, the need for, you know, recognising staff, you know, professionalising, recognising the status and skills of staff, making**

sure staff do have a formal set of skills and giving as much attention to the supply of social care staff as we do for other staff across health and social care. I think that is very important, and I'm not confident that it's happening. There's the status and representation of social care in government and also the relationship between the NHS and social care sectors. So we've talked quite a lot about what happened with the discharge process and how that happened and the NHS sort of saying "social care needs" or "requires" or "will take" people. As I say, I understand the NHS lens on that, but why didn't NHS leaders say, or think about the impact of that on people living in care homes and the health of those people? It was almost as if what matters was hospitals and not the health of the whole population, including those living in social care. What would it take for your, you know, at the time the chief executive of NHS England, and okay, NHS England has been disbanded but the leadership of the NHS to be thinking about the health of the whole population, including those who receive social care? And I think that is worthy of thinking, work on. And then I'll say -- so one more thing just to reflect on is, as part of pandemic planning or being ready, is thinking about how you prepare and support the leaders of your system, that's both civil servants and other people in positions of responsibility and, indeed, ministers themselves to be able to respond and do a good job in an extremely unusual situation. Because, you know, providing leadership through a pandemic is very different from almost anything else you're ever going to experience. And I know I thought about it at the time, as like, what do I need to do to make sure that I am making good judgements, that I'm getting the right balance between absorbing huge amounts of information and keeping my head clear to make the right calls, to ask the right questions, or to make sure stuff is happening? Sometimes you've asked me questions about, well, you know, that was a policy, did it actually happen? Like, how are you making the judgements about how you spend your time? So all of that, I think it would be worth in a peacetime, outside a pandemic, as to thinking how would you make sure that those people who are doing leadership roles at a time like that, are, you know, best supported to do the best possible job in what is going to be, in almost any circumstances, however well prepared you are for it, to do as well as it could be done.

MS CAREY: Ms Whately, no doubt great food for her Ladyship's thought.” [12/164/8-12/169/12]

42. The treatment of the care sector by the Government ought to be treated with partity to the NHS and also have proper training, a frequent theme. This was highlighted particularly in the evidence of Claire Sutton on Day 18:

“Q. And in terms of if there were a future pandemic, how do you think we could improve support to ensure that there isn't such a negative impact on retention rates in future?

A. I think social care often feels like a second-class citizen, a poor relative. And there are so many reasons for that, and they are reasons that go widely beyond anything that could be -- you know, becomes a recommendation from this. But I think having -- if we were to have parity of esteem and equity of access to the same resources and the same testing and PPE and everything that the NHS have got, then that would definitely support social care to not feel that they were the poor relative, and would boost staff morale and hopefully go some way towards changing those perceptions around whether people would want to stay in their job and improve staff retention as a result.” [18/9/4 – 20]

“Q. Do you think it would be helpful to have that training embedded in normal times, in preparation for a future pandemic, should there be one?

A. Absolutely. I think that would be a really good thing to have for future pandemic preparedness. To have that background knowledge of what you may have to step up and roll out quite rapidly to have that background knowledge and training in place would be very beneficial.

LADY HALLETT: To cope with a pandemic which may have a virus with different characteristics, the training is going to have to be "This is what you're going to have to do for this kind of virus. This is what ..."?

A. Potentially, yes, and I don't think it needs to be particularly extensive training but I think there needs to be a basic background level of training and understanding, and then the ability to roll out rapid training. It's so difficult to be able to predict what any future pandemic characteristics may be like but there does need to be a background level, I feel.” [18/23/16 – 9/24/9]

CC/CQC

43. It is submitted that the CQC and the CC did not act sufficiently in terms of their duty to ensure the care of those in care. At the very time it was most important to ensure work was being carried out properly, its supervision came to a halt:

“Q. I have two final topics I would wish to ask you about. The first is the regulatory inspection regime over the course of the pandemic, and just two questions on this, please. Was the lack of regulatory inspections something that may have put workers in homes at risk?

A. Oh, I'm sure it did. I mean, it seemed strange to me, and still does, that the CQC stopped going out to do inspections at a time of a pandemic. And I know the government's view at the time was red tape's a disadvantage, et cetera, but –

Q. Sorry, could I possibly -- if you can, focus on the impact it might have had on the workers.

A. Well, if CQC were going in and looking at homes where, one, PPE was locked in a cupboard and staff couldn't get it, surely they could have done something about it. If they'd gone in and seen there was inadequate PPE, you'd have hoped they would have actually done something about that, and maybe reported it back to somewhere to make sure they were getting PPE. If they were able to see that there were high levels of infections in particular care homes, then couldn't questions have been asked about that? And somebody sent in to assist the care home with looking at infection control, and that didn't -- none of that was happening, you know, because there was nobody going in to do the infections or pick up on any of these particular issues.” [6/196/7 – 6/197/8]

44. This issue of the lack of oversight of CQC/CC was also highlighted in the evidence of Kevin Mitchell on day 6, which also highlighted the lack of input into critical decisions and its failure to address the "clinical abandonment" of care homes by GP services, which it did not act on quickly enough:

"**DR MITCHELL: In your statement you advised that the Care Inspectorate had no involvement in the discharge of individuals from hospitals to a care setting. As a strategic organisation that advises on the impact of policy, what, if any, advice did the Care Inspectorate give on the impact of this policy to care homes?**

A. The issue, as I understood it, came to light iteratively during the pandemic in terms of the discharge that, you know, from individuals in hospital to care homes, and we saw the impact of that through the increased number of deaths. Our role -- we don't have a role in the individual decisions for discharge. That's first and foremost a clinical decision by the GP or consultant. They do liaise with social work services, which are the domain of the health and social care partnership, and that's primarily to assess the needs of the individual upon discharge. I think one of the difficulties that I've already alluded to was the unavailability in many cases of domiciliary care, care at home, or a care home place. But that -- those individual decisions are not ones that the Care Inspectorate are involved in.

Q. Indeed, and I understand that. That's why it was prefaced in my question. But what I was looking at is asking whether or not the Care Inspectorate gave policy advice –

A. No.

Q. -- to care homes?

A. No, there is general admissions guidance to care homes, and it's made very clear to care homes that they should only take on residents, admit residents whom they have the ability to provide care for. So, for example, if they don't have nursing care, they shouldn't obviously take on an individual who requires nursing care on

a 24-hour basis. But in terms of discharge from hospital, it's entirely the responsibility of the care home, the individual care home, to decide whether they can meet the needs of the individual upon discharge and upon admission to the care home. But beyond the general advice, we didn't give any particular advice, nor were we asked to, during the pandemic, at that particular period.

Q. Well, the duty to ensure the safety and wellbeing of all persons who use -- are eligible to use a care service are to be protected and enhanced is the role of the Care Inspectorate. Was the discharge of untested patients from hospitals to care homes consistent with ensuring the safety and protection and wellbeing of people using care home? Care was paramount.

A. We understood, on a daily -- we understood that, in the UK -- throughout the UK, in Scotland and England, we heard daily that the decisions that the Scottish Government and indeed UK Government were taking were based on the best clinical advice and guidance. That was clinical advice and guidance far in excess of what we ourselves would have access to. So our assumptions, when decisions were being made by government, particularly those where we weren't consulted, was that they had access to the advice that they -- the best clinical advice, and that they took the decisions they took on that basis. If we had been made aware of such a policy decision being made, we might have given a view, although it's difficult, if I'm being honest, to see how we would have given a view against the best clinical advice that government said they had on a daily basis.

Q. Given that the statutory duty was on you, should you have been in the room when these questions were being asked and answered? Because at the end of the day, it's the Care Inspectorate's job to ensure the safety and wellbeing of persons using care.

A. The primary responsibility for the providing care is the care service itself. The placing partnership in Scotland, health and social care partnership, have a duty of care. Our job is to provide independent assurance of the quality of that care and the safety and protection in the service. So, again, it's not a decision we were involved in. There were a number of decisions we might have expected to have

been asked about. I know in -- I understand that in England our colleagues were asked specifically for their opinion. In Scotland, we were not.

Q. So if -- going forward in terms of recommendations, ought you to be involved in that process and ask those questions about particular implementations of -- (overspeaking) –

A. I think based on what we know now, as opposed to what we knew then, I think we would certainly expect to be involved in such a decision in the future.

Q. Moving on. In your evidence that you said you required the director of public health agreement for visits in March and April of 2020, was the requiring of this agreement by the director of public health consistent with the discharge of your statutory duty as the Care Inspectorate?

A. It was very clear to us that we were not allowed to act unilaterally. That was a decision that was made very clear following the deep dive that was chaired by the First Minister. In terms of our responsibilities, we have responsibilities, but it's a very difficult decision to go against the advice of Public Health Scotland, who are the experts in infection prevention and control. We did, as said earlier, maintain a policy position reserving the right to do so, because we thought that was important, but we never actually exercised that.

Q. So, ultimately, the responsibility of whether or not to enter the home and to inspect it fell to the Care Inspectorate, not to the director of public health.

A. We have power of entry to a care home at all times in Scotland, and those are legally enforceable. But the advice, the strong advice we had from Public Health Scotland and individual directors of public health was not to do that. We reserved the right to go against that. And indeed, I was prepared to do that on 3 May, but managed to get that advice. But that was the closest I got to going against the advice, was in respect of the 3 May inspection that we talked about.

Q. Yes, and we covered that in your evidence-in-chief. I wonder, then, if I could move on to another issue, and that is Mr Macaskill, a final issue that he raised. In his statement, Mr Macaskill described members of the care home staff as reporting a sense of clinical abandonment with difficulties in accessing GPs or GPs refusing to attend care homes. First of all, he said that it appeared that there was a presumption against external visits by GPs. Was the care home inspectorate, firstly, aware of this issue?

A. I think this was the inconsistent response that resulted from the Cabinet Secretary's direction of 17 May. It was applied inconsistently and, as the subsequent clarification in the December of that year confirmed, there was an inconsistent approach resulting in what you've just described. In some areas, that clinical support from the community, from -- whether that be allied health professionals or indeed public health nurses, did not take place. But in other areas, it did take place.

Q. What was the Care Inspectorate's role in ensuring that such a policy, if it was being applied, wasn't applied? Ie, should the Care Inspectorate have done something as soon as it became aware of it?

A. So when we did find services where -- that weren't getting that support, because by that time, remember, we were out in inspecting again from 4 May, where we did find that support lacking, we escalated it to the health and social care partnership to ensure that it was put in place. And indeed, the government were aware of that inconsistency and clarified that. We reported -- also when we found failings, we briefed government on those significant failings as soon as we identified them, and that enabled the government to liaise with the relevant health and social care partnership through the Office of the Chief Nursing Officer's directorate in Scottish Government. So that was how we fulfilled our role going forward.

Q. And you explained about that from 4 May, but what I'm talking about is the period of time earlier than that, as well. What about the period of time before 4 May? Were you aware that GPs weren't going in and visiting –

A. We weren't aware of that prior to the 4 May, no.” [6/84/18 – 6/91/15]

45. We can compare the more proactive approach of the Welsh Care Commission in contrast to the CC Scotland. As day 6 in the evidence of Professor Fu-Meng Khaw:

“Q. If we can stay on this email, then, and scroll up to page 1, and you've helpfully confirmed that the guidance was shared, the draft guidance, on 6 April, and there was a comment from Margaret Rooney of Care Inspectorate Wales, and her opinion was: "In general, my feeling is the tone of this guidance is very much about care homes accepting people being discharged from hospital and it may feel very much like we are saying you must take people. I feel this would be more accepted if the tone was more about -- here is some guidance on how to care for people in this period and as part of that you may be admitting new people from hospital." And Tracey Cooper's response was: "There is an increasing level of urgency and it's taking quite a time to agree whilst care homes are desperate for guidance." Now, that document can come down, please. The following day, Margaret Rooney said she was not happy to brand this a CIW as it currently stands, and whilst it was appreciated that it mirrored the approach in England she said: [As read] "We feel we need to pause and reflect on whether this is the right approach for Wales." The response of Public Health Wales was: [As read] "The guidance had been well thought through. The risks of not getting it out now are greater than getting it out as it is." And my question, then, is: was anything changed in the guidance following the comments of Care Inspectorate Wales?

A. No, and that comment was repeated the following day, on 8 April, and the guidance draft that we sent through was approved that evening by Albert Heaney.

Q. Reflecting back on the concerns expressed, do you think any of the concerns of Care Inspectorate Wales were valid and worth raising?

A. I think the whole issue about hospital discharge testing was an area of interest from the outset. Care homes clearly had a duty of care to their residents and were concerned about incursions of Covid into a vulnerable population, and that was

manifest through trying to make sure that any policies relating to discharges from another high-risk setting, hospitals, wouldn't pose a threat to care homes. And that is perfectly understandable. However, it was at a time when we were really clear that isolation provided an additional control measure, so that in the case of any positive or infectious individuals, we were able to also, through that measure, control transmission in that setting.

Q. The final guidance was published on 9 April along with the letter to the care homes, and as you've confirmed, the public health content was taken directly from the Public Health England guidance. Do you agree that there was a delay in publishing that guidance in Wales and if so, what do you attribute the delay to and how can that have been avoided?

A. I think as I said earlier, the delay was partly about ensuring the alignment with existing guidance that they weren't contradictory, alignment with policies that may or may not have existed in Wales at the time, and also, differing views that you've heard and expressed earlier about hospital discharge testing.” [6/128/24 – 6/131/12]

46. In all, the Care Commission did not acquit itself well in the pandemic. It did not carry out the role that was required of it to protect those in care. In light of the foregoing it is submitted that the Care Commission in Scotland ought to have a policy in place to continue to carry out its supervisory role in a pandemic, a requirement to be involved in any critical decisions taken by Government (and an duty on the Government to seek its views) in relation to the care sector. Further, it should be clear on its independent role, and not subvert its duty to the decision making process of another body.

47. In relation to the Social Work Department working with the care sector it is submitted that they should have input too when significant governmental decisions are being taken which affect their role in the care sector. Again, a duty should be placed on Government to consult in that regard, as per the evidence on day 4 from Dr Ruth Allen:

“A. So I think, having reviewed a lot of this for this hearing, I think, you know, we produced some really useful guidance that was well received, that aligned with

what the government was saying, it wasn't contradictory, but it really augmented and where necessary, went in slightly different directions that weren't being covered. So I think we were well placed to do that and we had a lot of feed-in because we had a running, open communication which ended up with about 2,000 submissions from social workers. So we were able to draw on that and use our own knowledge. I think for the future, for pandemic preparedness, we would expect to see social work on the same footing as any other profession, being recognised for its role in emergencies and disasters, for which there's quite an extensive and growing body of work, contemporary work around that. And then the -- to, for instance, use some of our guidance and to work together with government and others to have things in place -- the type of pandemic or emergency, each would be different, so it wouldn't be exactly the same, but there are some principles I think we could draw on about what social workers need to know to discharge their duties that overlap but are different to some of the other duties of other public professionals.

LADY HALLETT: Sorry to interrupt. I'm not quite following. How are you saying we should prepare for it differently? In other words, it sounds to me as if you were very much the experts in the field and therefore your guidance was particularly helpful to social workers, but what are you suggesting should happen in the future? Are you suggesting there should be more government involvement or government principles? I'm just not quite following what specifically you're suggesting.

A. Sure. So social work is represented within the governments. There are social work leaders in governments, chief social work officers with slightly different titles. So there is a context in which social work can be represented in, for instance, highest-level pandemic planning, highest-level disaster or emergency planning, what's the role of the social worker? So I'm saying that that -- I don't -- that wasn't there. I don't think that had been thought about previously in pandemic planning, and that could now be considered. And an organisation like BASW, just like the BMA or the RCN or the colleges, the royal colleges, we've got lots of detailed knowledge and experience and expertise to share, and could inform that. So there should be a partnership, really, between government recognising the role of social

workers and the experts who are in different organisations, can add to that.” [4/14/4 – 4/16/4]

“A. Yes, the -- I think the overarching -- an overarching issue is to understand that social workers have key and distinctive statutory responsibilities that are placed on them by governments and by society, and they have therefore -- and they also have particularly practices they need to fulfil, and they couldn't fulfil them without better guidance. And they can't fulfil those without the right context and conditions, being supported in that, whether that's by resources or guidance, or recognition. But also a recognition, particularly in adult social care, of their leadership, coordination, and risk management role, and protection role. And I think that was sidelined in the coronavirus period, and that left individuals vulnerable and it left families unsupported. And I think the particular importance that we've already touched on around social workers being seen as key in emergencies and disaster situations and being part -- that -- the role of social workers being represented in the most senior governmental and regional level planning, as well as in the provision of guidance, which of course, as we've talked about, can be a collaboration between governments and professional bodies. And really, that social work should be seen as an equivalent to health colleagues, and social care to be seen as equivalent to healthcare in the importance in protecting and supporting individuals and families.” [4/40/12 – 4/41/14]

48. The fact that care sector decision making ought to include all those professionals involved in the work was highlighted by Professor Vic Rayner:

“**Q. You talked about there now being an adult social care team. Just before we end this topic, are there any other specific recommendations that you would invite to help with improving the understanding of decision makers and people who are drafting guidance when it comes to the realities of adult social care operation on the ground?**

A. Yeah, I mean, I think that they shouldn't -- you know, those kind of decision-making groups shouldn't exist without the experience of -- the operational experience of both people delivering care and support and people receiving care

and support. I mean, I think you can see that in all sorts of decisions that were made, that they didn't -- they would have been much better able to be implemented if they had had that operational experience right from the start.

Q. From the start.

A. And I think that is an -- there's an underpinning message there about recognising the professionalism and expertise within the sector, that when there are -- I mean, I was listening carefully to Mr Hancock's evidence yesterday when he was talking about social care representation being him and his minister. You know, we are still in a position where the, sort of, leadership and expertise of social care is not properly recognised and built in, and I think that's -- having that as a legacy of the pandemic would be really valuable, to have that built in.” [4/108/22 – 4/109/24]

49. The suggestion of a more cohesive approach in pandemic planning for professionals who were involved was highlighted by Professor Susan Hopkins, who also highlighted the one of the main take-aways from the whole inquiry that being the need for a cohesive database accessible by all 4 nations using the same system so there is seamless data sharing, not only across healthcare systems but also through professional bodies involved in the care sector.

“**A. I'll do it quickly. So the first one is -- I mean, I think developing guidance because this was such a big part of this, pre-pandemic, and having principles for guidance laid out in advance of an emergency, so that we are able to bring in stakeholders' views, the lived view, into that guidance, so that people understand why we're saying things, for me is really important. And the second, I think, is everything that we can do to improve data allows us to assess things better in those early days, and ensure that we're able to evaluate the interventions in the best way possible. Where I think the first is, we can do within the resources that we have in UKHSA, the second requires a whole-of-government and a whole-of-system approach and does require additional finance for technology and data and digital to put together, but, you know, data is critical in being able to make decisions, especially in emergencies.”**

50. The need for cohesive data sharing was also highlighted by Professor Stephen Barclay on day 19:

> “**Q. And what exactly is the impact of that missing data that you observe?**
>
> **A. So we don't know, as of today, who is currently receiving palliative care across any of the four nations, let alone who's receiving care from specialists, or who's receiving such care from our social care colleagues. It may be recorded in individual teams. It is in no way shared, it is in no way linked with our big national data sets. And we are in the dark. There was obviously lots of research activity, but if we could more clearly identify and share that information and be able to track people through the health and social care system, which can be confusing, to make sure that we're getting all the right people in at all the right times and having all the right conversations, that would be hugely important.”** [19/13/20 – 19/14/11]

51. Moving emphasis from the Care Sector directly to those who use it, it appears that the way older people are treated is a reflection of the way they are viewed in society, namely being of limited use. Whilst these are huge cultural issues that need to be addressed, and no doubt beyond the scope of the Inquiry, it is important to note that any efforts that can be made by Government to enhance the status of older people should be made. The dangers of viewing older people, (and people with disability) as “less than” can be seen in the evidence on DNACPR. The Chair already has significant submissions in that regard but the SCB would like to highlight the distressing evidence of Helena Herklots as a whole. Whilst it may not form a recommendation it is submitted that obtaining a strong commitment from Government to protect and promote the wellbeing of older people and to specifically identify a body to ensure protection of their rights, given the vulnerabilities of older people. [9/131/24 – 9/132/11]

52. The evidence there was a surprising gap in community settings in relation to infection prevention and control. It is submitted the suggestion that the suggestion of Maria Rossi be considered, that the 4 nations work on this such as they did in the Mpox outbreak:

“A. It's a big point of learning, that one, I must say and we've taken that on board to work with the -- across the four nations much more closely on that and to have a recognised structure pathway for that, including with infection prevention control colleagues. Sometimes changes that we would need to reflect in our guidance came to us very late in the day, sometimes even through press briefings by our political leaders. And we would immediately try to find what was meant by it, what the source was, what was the understanding behind it, in order to put it into our guidance, and that took time.

Q. So better lines of communication may be one way?

A. Yes.

Q. And just finally, in Module 3, Dr Phin told the Inquiry: "I think it's important to realise that ARHAI's remit is defined because it's part of the NHS Assure, which is for healthcare-associated infection. That does leave a gap when it comes to community settings. "He referred to: "... the role of Health Protection Scotland intaking the principles that were developed for the healthcare setting, and adapting and trying to use them in those wider settings. This is something that's being discussed at the moment to make sure that ... gap is addressed, and we're in ... discussion with ARHAI, and indeed with Scottish Government about how we address this going forward." Was there a gap, then, as regards IPC guidance for the sector during the pandemic, and if so, how is that being addressed?

A. So during the pandemic, as I mentioned earlier, we were working very closely with ARHAI. I think probably the gap there was more along the lines that ARHAI's remit very much concentrates on healthcare settings, and in pandemic, suddenly we had to do a lot of infection prevention control, interventions, guidance, in relation to the wider community. Things like physical distancing was something that it was -- we were aware of it as a concept, a potential public health intervention but, actually, finding the evidence base to back that up required time, and that wasn't in the outright remit of ARHAI, hence we did have a gap that Public Health Scotland very much wishes to address now.

Q. Is work going on, then, to address that?

A. So there is work going on in terms of how these gaps that may relate to ARHAI's work and Public Health Scotland's work, how do we address them? Are there true gaps, and how can we fill them? But the other way to think of that is, which is what we're also proactively taking forward, is working more closely at four nations basis. So UKHSA, on our guidance formulation, and you may be aware of the Mpox outbreaks that arose in recent year, we were very much more embedded in with their guidance teams than during pandemic, and we hope to see more of that going forward.” [17/75/13-17/77/17]

53. Moving away from recommendations, the Scottish Covid Bereaved, as mentioned in the introduction, was not impressed by the evidence of Jeane Freeman. One of the greatest failings of the Scottish Government was to say that the matter of movement from hospital to care homes was a clinical matter whilst they were aware that there was no testing available to provide the robust safeguards required. The failure to properly understand the risk was highlighted in the report which had to be amended in light of representations from the Office for National Statistics. The questions asked on behalf of the Scottish Covid Bereaved are highlighted in this regard. We have highlighted the part we would ask the Chair pay particular attention to, i.e. that the Scottish Government took decisions on an incorrect understanding of risk, and that decisions were taken assuming that protections were in place which were not. Further, we also flag up that the GP system was not fit for purpose at a critical time (relevant parts highlighted in bold).

“Q. Moving on, we have heard evidence this morning from Alasdair Donaldson, and the Inquiry also has the benefit of his statement. He was a member of the DHSC's adult social care policy from April to October of 2020, and was officially responsible for creating the Vivaldi project. Were you aware of the project at the time?

A. I don't believe so, no.

Q. Were you aware of its findings later?

A. I can't recollect them.

Q. In his statement, and simply for the purposes of the Inquiry, that's at paragraphs 31 and 32 of his statement, he discusses how politicians in England used the Vivaldi data in relation to discharge in care homes, and he states the following: "But, again, the study suggested how the disease was being spread within and between ... homes in May. Our data was not able to give definitive insight into how the virus got into many homes in the first place back in March, for the simple reason that there had been little or no testing back then." And I pause to say: there was little or no testing in Scotland; is that correct?

A. That's correct.

Q. "Indeed, staff movement between homes would not have been so dangerous if the homes themselves had been genuinely protected in the first place, rather than full of the virus. "32. I believe this is very important because --perhaps in a psychologically understandable effort to absolve themselves of their responsibility for the original decision to discharge thousands of people from hospitals into homes without quarantine or tests, our study has been used to suggest that such a policy was not dangerous -- when in my view, as a matter of basic epidemiology and simple common sense, it probably was very dangerous indeed. Absence of evidence cannot be claimed to be evidence of absence, and there is no good data for the period when the main hospital discharge occurred for the same reason it was potentially so reckless: because there was no testing. "Reflecting on what he has said about the fact there was no testing, do you consider that the Scottish data contained in the Public Health Scotland report is notable to give a definitive insight into how Covid-19 got into many Scottish care homes in March 2020?

A. I think it gives as good an insight as it could at that time. I think there are other factors to be considered. For example, from my recollection, 843 individuals were discharged from hospital to care homes, and 348 were involved in -- care homes were involved in an outbreak. So, for example, a number of care homes who received a discharge from hospital did not have an outbreak of Covid. So I think this is a complex and complicated question, and an area we've not touched on is the risk to those individuals of remaining in hospital when they were clinically able to be discharged.

Q. I think the Chair has already heard evidence in that regard, so the Chair is already aware of that situation. But do you agree, as a matter of basic epidemiological and simple common sense that discharge of untested patients from hospitals to care and nursing homes in Scotland was probably, and I quote, "very dangerous" indeed?

A. No, I don't agree that it was very dangerous indeed. I believe that that decision, like many others, carried a degree of risk. As I've said earlier, there were no risk-free decisions in any of this at any point, and I believe that the mitigation measures that we put in place were there precisely because we did recognise the level of risk involved.

Q. But you've accepted in your evidence earlier that part of the mitigation process or procedures that were put in place you thought was happening when it wasn't?

A. That's true, and was subsequently addressed.

Q. So the decision taken to have the discharge was taking place on an understanding which wasn't correct, about the risks?

A. It was taken on an understanding that proved itself to be incomplete, but that does not answer the question as to why some of our care homes that received discharge from hospital did not have an outbreak, and some did.

Q. Well, given the lack of testing, how could it be that a proper clinical analysis could be done before deciding to send someone to a care home?

A. So that is for clinicians to answer, not me, as a non-clinician, I believe. No one is discharged from hospital without a clinical assessment as to whether or not that is appropriate. That clinical assessment is then for the individual care home to determine whether or not they wish to accept that discharge.

Q. And I understand that, but I wonder if my Lady would allow me to ask a follow-up question?

LADY HALLETT: In fact, and if you want to -- the point of the question was the point about the testing. Clinical assessment is obviously not for you but I think the point -- so follow it up. DR MITCHELL: I'm obliged, my Lady. The question, as my Lady has identified, is about the testing. You knew, as minister, there was not the ability to test.

A. Yes.

Q. Therefore, how could it be that you considered that a proper clinical analysis could be carried out before deciding to send someone to a care home if you knew that there was no testing?

A. I'm genuinely not sure I understand your question. I certainly knew at that point, in the early stages of the pandemic, we did not have sufficient testing capacity to undertake those tests. Whether or not someone was clinically able to be discharged from hospital was a clinical assessment. Whether or not the care home accepted them was a care home decision. And what we put in place to mitigate against the absence of testing were the measures that you're aware of. I'm not suggesting that they were fully adequate, but they were the only measures available to us at that point, and the alternative was to leave someone ready for discharge in hospital, which was a high-risk environment, given the level of Covid patients, and an environment that, prior to the pandemic, was widely understood as one that would carry a serious risk of physical and mental deterioration.

Q. I'll perhaps simply try the question a different way. What did you consider the purpose of requiring tests and getting tests into hospitals as soon as possible for people being discharged was? What was the point of them?

A. It was an additional mitigation measure.

Q. An additional mitigation measure. Do you not think it, with respect, would be the primary mitigation measure?

A. No, I don't, because, as you'll know, there were, in the early stages of testing, concerns around the validity of test results. That improved over time, of course, but the test itself was not the silver bullet.

Q. We had people going from hospitals into care homes without being tested, which is one procedural mitigation, as you've described it, and then also going into care homes which did not or were not able or, for some reason, you say, weren't carrying out the tests that were required. So both of those procedural safeguards were not sufficient; is that correct?

A. So the care home procedural safeguard was a practice of infection prevention and control as required by their contract and set out in the manual. That, as experience demonstrated, was not universally practised in all care homes.

Q. Moving on, if some GPs were refusing to visit care homes, as this Inquiry has heard, and not going into care homes meant that residents were not being tested, what if any impact do you consider that had on the data contained in the Public Health Scotland report?

A. I'm not sure I'm equipped to answer that. There certainly were concerns around GPs being unwilling to go into care homes that we sought to address directly. Whether or not that had an impact on the data that -- the independent report from Edinburgh and Glasgow produced, I don't believe I am equipped to comment on that. I do believe, if those two universities had felt that they did not have adequate data to undertake the work, they would have raised that and made that clear.

Q. I think, in fairness, in that report they do make clear the relative limitations –

A. Mm-hm, they do.

Q. -- in that report; do you recall that?

A. Yes, I do.

Q. Mr Macaskill has also indicated that there were feelings of what he described as clinical abandonment in relation to care homes. Now, when taken alongside the lack of testing to care homes in March 2020, would that cause you to reconsider your views of the impact of discharge of untested patients into the care homes?

A. I think the only difference it would make is that I would have introduced the engagement of directors of public health and nurse directors sooner than we did.

Q. And you say earlier on, it's one of the questions I think has already been answered, that you were aware of GPs being unwilling or refusing to attend care homes and there was an intervention. Can you explain to us when you took the steps to address it, when you became aware of it, and when you took the steps to address it.

A. I'm afraid I don't have those specific dates in mind. What I do recall is that, in circumstances like that --and this is purely an assertion on my part, I believe the dates, if we check them, will back this up -- but as soon as I was aware of issues like that, then I acted as quickly as I could to address them.

Q. And we'll be able to look at the evidence of Mr Macaskill in that regard. Again, moving back to Mr Donaldson, who gave evidence this morning, in his statement to this Inquiry, he said that the reason why so many thousands of excess deaths in care homes in England were not reported was the result of there not being enough tests to establish that these were Covid infections in the first place. Do you consider there is the possibility that many deaths in care homes in Scotland were not reported as Covid deaths because there was a lack of testing?

A. I don't believe that I am qualified to answer that question. I think the body in Scotland that produced the data on deaths because of Covid or where Covid is mentioned in the death certificate is better placed than I to say whether they believe the data they drew that from was adequate or not.

Q. And was that something you considered at the time? When you were looking at the number of Covid deaths, did you think: if there's not testing, how are we able to get this number?

A. No, I don't believe I did consider that at the time.

Q. Moving, then, on to my final question. It relates to evidence that we heard earlier this morning from yourself about the data system for adult social care, which I think you called Centennial; is that correct?

A. Sentinel.

Q. Sentinel, sorry?

A. It's the surveillance system.

Q. The surveillance system. And that is a surveillance system for adult social care?

A. No, it's a surveillance system for health in Scotland.

Q. Okay, which –

A. Not confined to adult social care.

Q. Okay, but includes adult social care?

A. Yes, it does.

Q. Yes. So you said, and I'm not quoting exactly here, but broadly, you said that it relied on GP practice to provide data on infection and other data around the provision of care, the quality of care, and the adequacy of staffing via the Care Inspectorate, when you were talking about care homes; is that correct?

A. Not quite. The Sentinel exercise is simply around the prevalence of infection, and that comes -- that was --pre- existed pre-Covid and comes through GP practices. The other matters are around the Care Inspectorate, and their inspections, and the information that they provide from those inspections.

Q. I see. So the former only relates to the GP practice –

A. Yes.

Q. -- and infection –

A. Yeah.

Q. -- and the latter about care relates to the Care Inspectorate?

A. Yes.

Q. Given that the Inquiry has heard of the limited contact with some care homes of GPs, you've touched on it earlier yourself, and also the cessation of contact with the Care Inspectorate, this means, it would appear, that you weren't getting the provision of data on infection, and also the provision of care, the quality of care, the advocacy -- the adequacy of staffing, and the Care Inspectorate was also not there. Does this mean that the data system wasn't -- or does this mean that this system wasn't fit for purpose to give you the information about adult social care?

A. So I think there's no question that the system, at that point, was not as useful as we would have wished it to be. **However, the Sentinel system does not rest on every single GP practice. As I recall it, it is a system that statistically takes what the individual practices involved say and projects that to give you a Scottish-wide position. And during the pandemic, we increased the number of GP practices that were engaged in providing data for the Sentinel system. The inspections from the Care Inspectorate, as you rightly say, on 13 March, they paused their inspections, and you'll also know that as soon as possible thereafter, I required them to recommence their inspections**.

Q. Does that mean that the system, for a time, wasn't fit for purpose?

A. So there would be a period when the information coming via the Care Inspectorate was not as adequate as I wished it to be.

Q. Or indeed at all, because there was a cessation in the –

A. Well, no, there was a cessation of their in-person inspections, and they moved to, I suppose, Teams or Zoom-type inspections which I did not consider adequate.

DR MITCHELL: My Lady, that's my time and those are my questions.” [14/98/22 – 14/114/1]

54. The Scottish Covid Bereaved conclude by thanking all those who cared for their loved ones in the pandemic. Some were very poorly paid and badly served by confusing and ever- changing advice. It is hoped by the next pandemic we have learned a valuable lesson in treating people who care for our most vulnerable with the proper respect and financial remuneration they are due. We hope for a societal understanding of the critical role these workers play in the lives of our older and vulnerable community. We hope that Governments ensure that before taking critical decisions they consult with all the healthcare professionals, and that the care sector is not treated as a lesser part of the system. We hope that Governments properly acquaint themselves with an understanding of risk, that they take critical decisions being fully informed from the professionals who work in the field as to their views. We hope that families are included in the provision of care for those at the end of life, including having their views heard, where appropriate, on such things as DNACPR We hope that there is a data system in place which works across the 4 nations for all areas of public life from medical reports, GP reports to social work and social care reports, a cohesive and comprehensive system which allows the UK to be dealt with as an epidemiological whole and can give important real time and comprehensive data to ensure that stocks and supplies are where they need to be. Data is a fierce weapon which much be primed and ready to act before the next pandemic.

55. The Scottish Covid Bereaved also wish to thank the other Core Participants, the numerous Counsel to the Inquiry and the Chair for their hard work and careful consideration of all the issues raised in Module 6.

Dr Claire Mitchell KC
Kevin McCaffery, Advocate
David Welsh, Advocate
Kevin Henry, Advocate
Counsel for Scottish Covid Bereaved

Aamer Anwar - Principal Solicitor
April Meechan - Senior Consultant
Sarah Murray - Senior Associate
Aamer Anwar & Co., Solicitors for Scottish Covid Bereaved