Tuesday, 26 September 2023

(10.00 am)

LADY SMITH: Good morning and welcome back to our hearings in this phase of case study work.

We turn today to the Care Inspectorate and, Mr MacAulay, I'm told that the witnesses are ready, is that right?

MR MACAULAY: Yes, good morning, my Lady. Yes, there are two witnesses that are being asked to perform in a panel format. That is Helen Happer, who has already given evidence, and Andy Sloan.

LADY SMITH: Thank you.

We are going to just bring them both in together, and they'll both give evidence together as appropriate.

MR MACAULAY: Yes.

LADY SMITH: Good. Thank you.

Helen Happer (affirmed)

Andrew Sloan (affirmed)

LADY SMITH: Do both sit down and make yourselves comfortable.

Is it all right if I call you Helen? --

MS HAPPER: It is.

LADY SMITH: -- I think I did when you last came.

Let me check, Andrew, are you happy for me to address you by your first name?

MR SLOAN: I am.

LADY SMITH: Thank you also for providing your paper on regulation of Children and Young People's Services by the Care Commission and Care Inspectorate over the last 21 years, it will be now. I know 2002 doesn't seem like a long time ago to some of us, but that's quite a span that the work of the Commission and the Inspectorate has been covering, and I thank you for being prepared to give evidence in this form.

It's worked before and I hope it will work today. I understand that you two do know each other and so you might just be used to talking together about a subject, that is so dear to both of your hearts.

When you are ready I'll hand over to Mr MacAulay. You have in the red folders, I think, the excellent paper you provided for us. Thank you for that, but we may also bring some material up on screen as and when that might be helpful, including the paper itself.

Mr MacAulay.

MR MACAULAY: My Lady.

Questions from Mr MacAulay

MR MACAULAY: Helen, can I refer to you as Helen?

MS HAPPER: Yes, you may.

MR MACAULAY: "Andy" I think you are normally called?

MR SLOAN: Normally called, yes.

MR MACAULAY: I think the broad position is that, Helen, you will speak to the more strategic overarching matters, and Andy will speak to the more operational matters. There will also be matters that both of you can make a contribution to, provided it's not a duet. You've also provided us with a crib, as it were, to indicate the areas of the report that one or other of you might feel more comfortable dealing with.

I'll bear that in mind when I'm asking my questions.

Helen, as Lady Smith has just said, you have already given evidence, 10 May 2022, and that was in the Foster Care Study. Your CV has already been looked at and I'll just look at that quite briefly now if I may.

Your present position is that you are Chief Inspector with the Care Inspectorate; is that right?

MS HAPPER: That's correct.

Q. You've been in that position since 2016?

A. That's correct.

Q. Just reading from your CV, you're responsible for:

"Development and delivery of all strategic scrutiny activity across adults, Community Justice and Children and Young People's Services (joint inspection of strategic partnerships and Link Inspector responsibilities)."

Quite a wide church?

A. Yes.
Q. That gives us a sense that although we are looking at a particular area of the Inspectorate's jurisdiction here, it's a much broader jurisdiction?
A. Yes, that's correct.
Q. I think you have been attached to the Inspectorate since 2011?
A. That's correct, yes.
Q. Before that, you were an inspector with HMIE?
A. Yes.
Q. Also before that, you were employed by the Social Work Inspection Agency?
A. That's correct.
Q. That may be quite relevant to some of the areas we'll be looking at today.

Andy, so far as you're concerned, you tell us that you graduated with a BA honours in public administration in 1990?

MR SLOAN: That's right.

Q. Subsequently in 1994 you obtained a postgraduate diploma in social work at Glasgow University?
A. That's right.
Q. Looking quickly at your employment history, would it be right to say that you've spent quite a considerable amount of time actually in residential organisations?

A. Yeah, that's correct.
Q. Where you've had extensive contact with children --
A. Yes.
Q. -- is that right?
Then if we look at your history with the Care Commission and the Care Inspectorate, I think you began with the Care Commission in 2003. Is that right?
A. That's correct.
Q. That was quite near the beginning of its existence. What was your role at that point?
A. I think the post was team leader, it was called. It's changed throughout the 20 years between team leader and team manager, but essentially a front-line manager role.
Q. I think you tell us in April 2010 you became a Regional Manager?
A. That's right.
Q. What did that involve?
A. It was the final year of the Care Commission -- one of the regional managers had retired, so I acted up for that final year. So therefore, I was responsible previously as Team Leader for Dundee, the area of Dundee, and as Regional Manager, I had a wider responsibility for the Local Authority areas of Fife, Stirling, Clackmannanshire, and Angus.
Q. When you mentioned the final year, were you moving away

from a regional structure to a different form of structure?

A. Yes, the regional structure remained at the Care Inspectorate for the first 18 months or so, but that was the move at the start of the Care Inspectorate.

Q. From 2011 to date, I think your position is that of Team Manager, Children and Young People?

A. That's right.

Q. What does that role involve?

A. Well, there are three team managers that each manage a group of between nine and ten inspectors who inspect the range of registered services for children and young people, so that's your care homes, secure accommodation services, fostering and adoption services. What we do is: each of the eight teams of inspectors has a collection of those services that we regulate, and while we have three different teams, we try to operate as a national team and co-ordinate between the teams to make sure that we have quite a flexible service.

Q. We might look at the present structure later on.

It is the case that the Care Inspectorate has produced a number of reports to the Inquiry over the years.

Helen, you have already given evidence, as have other members of the Care Inspectorate, and indeed

a former inspector has given evidence, so we have heard quite a bit of evidence about the way the Care Inspectorate operates.

But you were also served a Section 21 notice, with a number of questions, tailored to address issues raised in what we're looking at now, is that right?

MS HAPPER: That's correct.

Q. I think the way your report is structured, you are essentially answering matters that were raised by the Inquiry?

MR SLOAN: That's correct.

Q. If we have report up on the screen, it's at CIS-000001056.

Am I right in thinking, Andy, that so far as -- and Helen, as far as this part is concerned, either or both of you can speak to this introductory section?

A. Yes.

Q. Perhaps if I put this to you, Helen, since you've had experience in giving evidence. At 2.1 on page 5 of report, and we're looking at the numbers at the bottom right -- it will come on the screen -- do you identify the service types that you seek to look at for the exercise that you are carrying out in the report?

MS HAPPER: Yes.

Q. What are these?

A. The service types would be secure care, residential, special schools and the mainstream school care accommodation and fostering and adoption services.
Q. Although I think foster care has already been considered?
A. Yes.
Q. Really, for our purposes, we're looking at secure accommodation services, special residential schools, and care homes for children and young people?
A. My understanding is that there are services which were operating as secure services which are no longer operating as secure services, so it covers a wider range of services than are currently registered with us as secure services.
Q. In this introductory section I will touch upon some matters already addressed to provide context to the focus of your report. You begin the report by providing a history of the Care Commission, beginning with the enactment of the Regulation of Care (Scotland) Act 2001, which established the Care Commission in April 2002, is that right? That's really the starting point for both of you?
A. Yes.
Q. What you do say is that prior to the 2001 Act you describe the position as "outdated" and there was

a clear need for change. Can you just develop that for me? What do you mean by saying it was outdated?

A. Sorry, would you like me to answer that?

Q. Yes, please.

A. My understanding -- it's important to say that this is not from personal experience for either my colleague or myself, because we weren't around at that particular point, but I think there was a national drive to move inspection away from those organisations that were commissioning the service to a much more independent body, albeit that that body was taking information from arm's-length organisations.

So prior to the creation of the Care Commission, scrutiny of care services had been held within arm's-length organisations, so run by people who were commissioning them. So, for example, Edinburgh City Council and Edinburgh and the Lothians had its own arm's-length Inspectorate, and it was felt that that was not a helpful model, and it needed to move to one single body, which had some degree of independence, and therefore objectivity.

Q. Do you want to add to that, Andy?

MR SLOAN: Yes, and I think that the other aspect was to offer some national consistency to standards, across the country, because each of those arm's-length inspection

units that the Local Authorities operated had slightly different standards or different expectations, and there was a desire and felt there was a need to have national consistency in relation to the standards that were expected across the country for all services.

Q. If you are looking at 32 Local Authorities, with their own individual arm's-length inspection units for example, I think what you are saying is: there may be perhaps significant differences between their approaches, and this was a way of bringing together in a unified way the system of inspection, for example?

A. That's correct.

Q. The other major piece of legislation that we have already heard about was the Public Services Reform (Scotland) Act 2010. It is that that established the Care Inspectorate as from April 2011.

It would appear that the Care Commission had a relatively short lifespan?

MS HAPPER: A decade.

Q. Or just under a decade. Have you any comments to make on that, as to why it had such a short lifespan?

A. I think that's a question you would probably have to ask Scottish Government, but I think Professor Crerar's report, which was really looking at all the regulators, not just in social care, but also in healthcare and so

on, felt that there were too many different bodies that, again, every body was doing their own thing to their own standards, and that it would be helpful and possibly more cost-effective to pull different bodies together to clarify roles. There was the creation of the Care Inspectorate, at that point there was also the creation of Healthcare Improvement Scotland, and that was something that fell in the same legislation.

Q. Yes, I think Professor Crerar reported in 2007 and I think you are telling us that that was an important landmark --

A. Absolutely.

Q. -- that led to the creation of the Care Inspectorate?

A. The Care Inspectorate, yes.

Q. Then if we look at the position prior to the establishment of the Care Commission, let's just focus on that period. I understand it's going a bit further back than you were involved, but the Social Work Services Inspectorate was established in April 1992. Are you aware of that?

A. Yes.

Q. As we heard I think from Professor Levitt, that was the successor to the Central Advisory Service, CAS otherwise. Did the Social Work Services Inspectorate then have inspectorate functions?

A. It had scrutiny functions. One of the criticisms of the Social Work Services Inspectorate is that they were too close to Government. It was a part of Government, and therefore wasn't seen as independent and wasn't seen as particularly robust in its questioning of Local Authorities.

The creation of the Social Work Inspection Agency, that's where I started my career in scrutiny and inspection, was at the shadow period of developing the Social Work Inspection Agency. That was a very strong philosophy within the Social Work Inspection Agency, was to make sure that it was independent and working at arm's-length from Government and was not a part of Scottish Government --

Q. I'll look at that in a moment --

A. -- and the Executive, as was.

Q. As far as the SWSI was concerned, did it have any inspection responsibility in connection with secure units?

A. Yes, it did.

Q. But whereas the other care organisations, like for example a care home for children, that would fall under the Local Authority jurisdiction?

A. Yes.

Q. So there was that difference?

A. Yes.
Q. Again, we learn from Professor Levitt that the SWSI became the Social Work Inspection Agency in 2005. Were you at the SWIA at that time or not?
A. I was, yes. I was not working in the secure part though.
Q. When the Care Commission took over there were, I think, five secure units. I think you set that out in one of the papers. There was: Kerelaw; Rossie; St Mary's Kenmure; The Elms, which is in Dundee; and St Katharine and Howdenhall, that became Edinburgh Secure Services. I think that reduced to four with the demise of The Elms; is that right?
A. I'm aware that The Elms closed, yes. I'm not sure of the date of that.
Q. That would leave four, but I think recently ESS, the secure unit, has closed down?
MR SLOAN: That's correct.
MS HAPPER: Yes.
Q. Was that as recent as June of this year?
MR SLOAN: That's correct, but there are four secure units that remain --
Q. I think I missed out the one in Bishopton, Good Shepherd?
A. Good Shepherd, that's right.

Q. Just on that, since there are only four or there are four, do you see the reduction -- either of you can answer this question -- in secure units as something that might cause problems in finding spaces going forward.

Andy?

A. It really just depends on the other strategies that happen within the wider childcare sector in terms of preventive practice about the role of the residential sector in undertaking that intensive work that means that young people can't -- that young people don't need to take that step into the secure environment and to be locked up. So there is always a pressure there, I think, because you don't want to have a secure unit that's lying empty. So over the years there have been spikes where there have been pressures and pressure on spaces and then that has dipped.

I think it's too early to say whether that will cause issues or not. You know, we have a number of English young people that reside in secure accommodation --

Q. I'm sorry, what young people?

A. Young people from England that are also placed in secure accommodation services, so when there are pressures on numbers it's not always to do with Scottish young people

that are there. I know the Scottish Government with CYCJ is undertaking a project, Reimagining Secure Care, to look at that, and part of that is looking at that dynamic about where young people come from and how that is managed, especially with the Care and Justice Bill and the implications for that, about how those numbers will be managed and the decisions that will need to be taken when a young person is to be sentenced and requires a place at a particular time.

Q. I think we have heard, again from Professor Levitt, that there have been occasions in the past when a place could not be found for a Scottish child --

A. Yes.

Q. -- and other arrangements had to be made, but you raised an interesting point there, Andy, and that is the cross-border placement.

I know this wasn't one of the questions that was posed in the Section 21 notice, but I would welcome your views on that, and either of you can choose to pick that ball up.

As you've just said, there are English children who are placed in Scottish secure units, but is the opposite also the case? Are there Scottish children that are placed in English secure units?

A. I don't know.

MS HAPPER: I believe that that has happened. I believe it's a rare occurrence and there are children placed in Scotland in much higher numbers from both south of the border but also from other parts of the UK, so there are children perhaps placed from Northern Ireland in Scottish units.

Q. Can you help me? Do you know why children are being placed let's say from England and Wales to Scottish secure units?

A. So it's quite a complicated picture. In terms of children coming across the border, there are an increasing number of children placed not only in secure, but in other residential accommodation in Scotland from other parts of the UK. And there are a number of theories about what's generating that traffic.

One of those is that there is an insufficiency of placement in other parts of the UK and there needs to be greater investment in that, or investment in other services that will stop children having to come into residential care.

There are clearly occasional situations where it is in the best interests of a child to be placed at distance from home. I think that's quite a rare occasion that that's a choice.

There are some other theories about potentially whether placements may be cheaper here than the placements that would be available in England and that hard-pressed Local Authorities south of the border are making economic choices around that.

It's very difficult to say whether all of those are equally true or not.

But there's certainly a dearth of suitable placements across the border.

Q. If a child from England were to be placed in a care home or secure unit in a Local Authority area, would the Local Authority require to be reimbursed for that?

A. Sorry, can you say that again?

Q. If a child from England were to be placed in a Scottish home would the relevant Local Authority be remunerated for that or not?

A. No, because they're being placed in independent services. To my knowledge, there are no Local Authority run services that are taking children from across the border.

Q. What about the local service then, would the local service require to be paid for housing the child from England?

A. Yes, handsomely.

Q. So there could be a cost factor, at least from the

perspective of the provider here?
A. There are some providers that we are aware of who are taking exclusively children from across the border.
Q. To me that sounds surprising.
MR SLOAN: Yes.
I think good childcare practice would say that young people should be looked after as close to their local community and home as possible, so that they can remain and have contact with those support networks that were there, and also because we know that those young people return back to those local communities. So, yes, the further you are away the less opportunities you have for that contact and those support networks to be sustained.
Q. As Helen said, you are aware of one provider or more than one provider that accommodates exclusively children south of the border?
MS HAPPER: It would be more than one provider.
Q. More than one provider.
Although these are children who have been put into care from south of the border, whose care has been organised from south of the border, would these children still fall within the jurisdiction of the Care Inspectorate?
A. Yes. We regularly inspect the placement and the service rather -- correct that, the service and not the

placement. So the service comes under our jurisdiction, regardless of where the children in that service originate. Or regardless of who has legal responsibility for the children, we still regulate the service.

Q. Would you follow exactly the same procedures with these providers as you would with providers who are accommodating Scottish children?

A. Yes.

Q. So you would speak to the children and all the rest of what you tell us in the report?

A. Absolutely, yes.

LADY SMITH: Helen, I should for the sake of the transcript just confirm that you are talking about children being accommodated in Scotland who have come from south of the border, not from Scottish organisations having a place south of the border where they are accommodating children?

A. That is correct, from both south of the border and also perhaps from other parts of the UK, from Northern Ireland for example.

LADY SMITH: Thank you.

MR MACAULAY: Do I take it from that, then, that the equivalent inspectorate south of the border would not have an involvement with the children from south of the

border in Scottish institutions?

A. That's correct.

If I might explain one rider. Decisions about the placement are made by the placing authority, so the placing authority has still retained responsibility for that child. So an example, a child who is placed from say Wolverhampton, as an example, it is still that Local Authority that would hold responsibility for the child. The Care Inspectorate, if we have particular concerns about a specific situation, a specific child that we wanted to raise, we have a memorandum of understanding, a protocol, with Ofsted south of the border, who might then take that up with the Local Authority, because we don't have any reach to that Local Authority.

Q. It would be the Social Work Department of Wolverhampton who would retain responsibility for the child placed in Scotland?

A. Correct.

Q. And the allocated social worker for example would retain contact with that child?

A. That's right.

MR SLOAN: That's correct.

Q. I've gone off piste slightly because of something Andy said about English children, but going back to the report, I think the position is that after the

establishment of the Care Commission, can you tell me: what was the role of the SWSI up until it became the SWIA?

MS HAPPER: I'm sorry, I'm not able to give you chapter and verse on the particular role of SWSI.

Q. Can you help us with that, Andy, because you were with the Care Commission from 2003 and I think the SWSI remained in situ until 2005, when the SWIA took over?

MR SLOAN: I'm sorry, I was just dealing with regulated services in my role then.

Q. In any event, in April 2005 the SWSI was dissolved and it was replaced by the SWIA .

I think, Helen, you can help us there?

MS HAPPER: Yes.

Q. What role did the SWIA play?

A. SWIA is the acronym -- I'm not sure how that will work in the transcript. So SWIA was set up to inspect, carry out routine inspections, of social work services, so those are social work services providing by Local Authorities across adults, children and justice. It was also providing some advice and support to social work services around their provision for vulnerable people.

Q. What you are saying is that SWIA had a particular target and it was the Local Authority Social Services that was being targeted?

A. Yes.
Q. They were being inspected?
A. Yes, that's right. Local Authority social work services.
Q. Yes. I think I take it from what you have already said that you are not able to say whether that was a role in any way that was being carried out by the SWIA?
A. My understanding and when I went -- when I first started work at SWIA, I was an Inspector, so I wasn't involved in a management role. But my understanding was that in the previous years there had been an annual visit by designates of SWIA to Local Authorities, and I think it was a day where they met with different senior officers to run through what they were providing, any issues and any challenges that they had.

There was not an inspection programme as such, with fieldwork and so on. SWIA took on a role where we inspected social work services and sent a team out to actually conduct an inspection, assessed performance and published a report after that.
Q. In the next section of your report, this is section 4, on page 7, through to page 9, you identify for us the definition of services and their initial registration, is that correct? When the Care Commission took over were certain services deemed to have been registered?

MR SLOAN: That is correct.

Q. These were pre-existing services?

A. Yes, some pre-existing service types were deemed as registered.

Q. Any new provider would require to apply to be registered?

A. That's correct.

Q. Indeed you turn, on page 9, to the whole issue of legislation and new care homes and new special residential homes for example, they had to apply to register?

A. That's correct.

Q. What was required, as set out in the legislation --

A. That is correct.

Q. -- the threshold that had to be overcome.

Are you able to give me any insight into post the Care Commission establishment, to what extent would-be providers were refused registration?

A. Sorry, I don't have those figures, no.

Q. Insofar as secure accommodation services were concerned, I think you say that no secure accommodation services have been registered since the existence of the Care Commission?

A. That's correct, they were all existing services.

Q. They all existed?

A. Yes.
Q. Can I just now look, we touched very briefly earlier on on this, and that's the structure of the Care Commission and the Care Inspectorate, and it has changed over time.

I think, Andy, as you indicated earlier, to begin with there were these regional areas and I think there were five regional areas, is that correct?
A. That's correct.
Q. There was a Regional Manager for each area?
A. That's correct.
Q. Was that the role that you played latterly?
A. Yes, for the last 12 months, that's correct.
Q. I think you also tell us that each region was split into a locality?
A. Yes. For the first couple of years, there was a more formal structure within each region, where there were I think up to three or four localities within each region and there would be a locality manager managing that, so we had a locality manager in Tayside for example, so there would be a team leader for Dundee, covering Dundee City Council, myself, Angus and Perth and Kinross Council and then there would be a locality manager above that. Within two or three years, I think, that level of management was removed and the locality structure really was just amalgamated into a wider

regional structure.

Q. You were a temporary Regional Manager, to who would you be answerable to?

A. I was answerable to -- oh, my goodness, a Head of Service of some sort. I can't recall, to be honest. Apologies.

Q. Let's move on to the restructuring then of the Care Commission and moving into the Care Inspectorate.

There was a restructuring in about 2005/2006?

A. Yes. I think that would have been the restructuring in relation to -- that would have involved locality managers as well potentially.

Q. Let's then focus on the emergence of the Care Inspectorate.

There was further restructuring after the emergence of the Inspectorate in 2011?

A. That's correct.

Q. Can you tell me about that?

A. Yes. So for the first, I think, probably about 18 months the regional structure continued to exist within the Care Inspectorate, but a decision was made to move to a more functional organisation with national specialist teams for the range of registered services. So there would be an adult services national team, one for early years -- early learning and childcare and one

for Children and Young People's Services. Then what happened is rather than those inspectors and teams having a mix of caseload with other colleagues, then it would focus that the teams were dedicated to those service types.

Q. Can I ask you to look at some charts that you have provided to the Inquiry? These are to be found in the appendix to the report. The first one is at page 67, we'll get it on the screen as well.

The narrative at the top is new structure chart and Chief Executive. We read that:

"Between 2012 and 2014 the scrutiny and assurance function of a Care Inspectorate were led by a Director of Inspection, reporting to the Chief Executive. Two Deputy Directors for Children Services, Criminal Justice and Adult Services led the specialist national teams."

Then we read:

"In 2014 an internal reorganisation led to a revised structure of a Director of Scrutiny and Assurance, supported by four chief inspectors, for: Children and Young People; Adults; Regulatory Care (Adults) and Complaints; and Regulatory Care, Early Learning and Children and Registration."

We'll look at the structure chart in a moment. Do we see here then a schematic of the set-up post-2014?

A. That's correct.
Q. We have the Chief Executive and beneath him four Executive Directors?
A. That's correct.
Q. If we move on to the organisational chart that is appendix 2, on page 68. It's probably quite difficult to read off the screen. If we look at this, we see the Chief Executive is not mentioned but we have the Executive Director of Scrutiny and Assurance at the top of the tree, is that right?
MS HAPPER: Yes.
MR SLOAN: That's correct.
Q. If we move to the left, do we then see that there is a chief inspector for children and young people?
A. That's correct, and that is Helen.
MS HAPPER: That's the role that I play, although I also have responsibility for link inspectors, who work across adults and justice, strategic so ...
Q. Andy, where do you fit in this chart?
MR SLOAN: Just under the dark purple, I'm one of the three team managers in Children and Young People's Teams.
Q. While we have the chart on the screen, it gives us a picture of the extensive jurisdiction that the Care Inspectorate has, doesn't it?
MS HAPPER: Yes.

Q. We have a chief inspector for adult services.

We then move across to chief inspector regulatory care (adults) and complaints. Is that complaints in relation to adult services or complaints across the board?

A. No. There are two roles within the Care Inspectorate, complaints and registration, which cover all services, but need to fit somewhere with one line of accountability. So complaints in there -- although it sits under my colleague who has primary responsibility for regulatory care for adults, that is complaints across all services.

Similarly for registration, sits with my colleague who really holds responsibility for early learning and childcare, but also holds responsibility for registration.

Q. That is the final head to the right, chief inspector, in connection with registration. Just trying to get some sense, are these separate departments within the organisation or is there a cross-over?

A. The four chief inspectors that sit under our Executive Director work very closely together and share information and meet regularly and share responsibilities. So these are functional lines and they're certainly areas of accountability, but they are

not separate across the organisation.

LADY SMITH: What does "Regulatory Care (Adults)" refer to?

A. Care homes for older people, care homes for adults, any registered service, housing support services for adults, offender accommodation services.

LADY SMITH: I just wonder what the word "regulatory" is intended to connote?

A. It is clumsy and at times confusing language, we have just failed to find something that is better. When we talk about our regulatory work, we mean individual care services that are registered as care services with the Care Inspectorate, that are subject to a particular cycle of inspection. Our strategic work is our joint inspection work, the work that we may come on to talk about, where we are looking at Local Authority services such as social work services and the health services that work with them. They are not registered with the Care Inspectorate in the same way.

LADY SMITH: And "Regulatory Care (ELC)"?

A. It is "Early Learning and Childcare", so there is childminders, day nurseries, day care. They also have holiday provision for children and young people.

LADY SMITH: Likewise have to be registered and are subject to particular statutory regimes?

A. Correct.

LADY SMITH: Thank you.

Mr MacAulay.

MR SLOAN: Sorry, can I also say, as Helen was saying that there was the dialogue and communication at chief inspector level, at operational level as well the inspectors that are responsible for the registration and complaints activity within Children and Young People's Services also have close links. For example, they attend our national team meetings et cetera and will undertake some of the same training, so there is a read across at operational level as well.

MR MACAULAY: You have provided us with another two charts, I'll just put these on the screen while we are looking at the appendices. The first of these is appendix 3, page 69.

Can you help me with this: this is a chart setting out strategy and improvement directorate structure chart. This is a quite separate directorate?

MS HAPPER: Yes.

Q. Can you give me a sense as to what this directory does?

A. In short the Scrutiny and Assurance Directorate is the directorate where people are going out and inspecting and reporting on services.

The Strategy and Improvement Directorate are people who are enablers to that process, and also who are

supporting improvement work. Most of our improvement work sits around services for older people, particularly care homes for older people.

But these are people who are enablers to that work. So there is an intelligence team, which gathers data, gathers information, manages statistics, statistical data and feeds that into the process for planning of inspections and then for carrying out inspection activity, for example.

There is a policy team, which gathers information about government policy, directions of travel, helps analyse that and helps feed that into make sure that scrutiny and assurance is working around the areas that it needs to be working in. So these are enablers to the process. Does that make sense?

Q. If I can ask you this then in that context, later we'll look at examples of, for example, how to write a good report, a good inspection report and how to evaluate evidence. Does that material emanate from this group?

A. It wouldn't emanate from that group, but they would have a contribution to make to that.

Q. Who would be responsible for example for drafting how to produce a good report?

A. The communications team would be providing guidance around -- that sits on the right-hand side there, in the

orange. They would have a role in helping to produce guidance around plain English, around accepted forms of writing and so on.

The methodology team, which sits within the Scrutiny and Assurance Directorate, they would be helping work with us on developing a methodology.

Then we would also have people like Andy, the service managers and the team managers, feeding into that process. So they would support the process.

Q. The final chart then I just want to put to you, since we're here, is appendix 4, page 70. That is headed:

"Corporate and customer services structure chart."

I think the heading tells us what this chart is about. Can you just help me with, for example, Head of Legal Services, I think we can understand that; so this is like back-up to the work that, for example, the inspectors carry out?

A. That is correct. These are our backroom functions, but really important to keep the engine working.

Q. What these charts tell us, I think, is that the Care Inspectorate is a large organisation?

A. It is.

Q. Do you know how many are now employed by the Care Inspectorate across the board?

A. I couldn't tell you that, I think we have around 300

inspectors.

Q. Sorry?

A. I think we have around 300 or so inspectors, and I think that is around 60 per cent of our workforce perhaps. So it's a sizeable organisation --

Q. Yes.

A. -- and covers the whole country.

Q. Can I then take you to section 6 of the report, page 10? Here you are looking at the role of the Care Commission and the Care Inspectorate and its responsibilities for the inspection of care services.

As you can gather, we are particularly interested in this.

At 6.2.4 you make reference to the National Care Services (sic) and how these fed into the way in which inspections were being carried out by the Care Commission.

Can you help me with that?

MR SLOAN: The National Care Standards?

Q. Yes. How they feed into at that time the way in which inspectors carried out their work?

A. Well, they provided the basis of how providers -- it was -- I suppose a way of developing a nationally consistent language between the providers of services, and also the new national regulator, about the standards

that were to be expected.
Q. Just to stop you for a moment. Were these standards developed by Scottish Ministers?
A. Yes, my understanding is that they were, yes, they were Scottish Government badged.
Q. I think I have a note that they were produced by a committee known as the National Care Standards Committee on behalf of the Scottish Ministers?
A. They were certainly badged as Scottish Executive or Scottish Government standards, that's right. They were produced at -- I think just prior to or at the same time as the launch of the Care Commission.
Q. I have a note here of a number of principles, dignity, privacy, choice, safety, realising potential, equality and diversity. Were these the broad principles upon which the National Care Standards were based?
A. Yes. I think there was about 19 or 20, I think, different sets of National Care Standards for all the different service types, but the principles were the same for each of the sets of National Care Standards and the way that they were supposed to be implemented.
Q. Were the principles based upon the topics I've just mentioned?
A. I don't know in terms of how the National Care Standards were formulated, because I wasn't involved in that, but

I'm assuming that those -- certainly in working with them, those principles ran through what I was using and my team was using in terms of the National Care Standards, yes.

Q. Perhaps you can tell us how these relate to the National Care Standards -- fed into the way in which you would conduct an inspection. What would you be setting off to test whether or not the provider was a good provider or a not so good provider?

A. Well, we would have -- I think over the first four or five years of the Care Commission there was an aim to inspect against all of the standards, so each of the standards within each care service type would be inspected over that time period. So as part of our inspection methodology, the self-evaluation that would go out once -- when that had been developed the self-evaluation that we would send out to the service would be based on the structure of the National Care Standards.

Then our methodology and the structure of what we would go and inspect against would be the framework of the National Care Standards. So, for example, we may inspect the site inspect one year standards 1, 4 and 7 for example, and that would provide us with the focus of our inspection activity.

LADY SMITH: If I can just interrupt one moment there.

I see from 6.2.4 that you weren't informed by any designated National Care Standards for secure care services.

A. That's right.

LADY SMITH: You had to fall back on the standards for school care, accommodation and care homes for children.

A. That's correct.

LADY SMITH: That would mean, of course, that if for example you looked at what, if I may say, the excellent position paper you published in June this year on restricting liberty, you wouldn't get any care standards matching the criteria which you have set out should be applied for addressing whether or not children's liberties were being restricted?

A. That's correct.

LADY SMITH: And how they were being restricted. Thank you.

I'm not suggesting that you are not aware of it and not thinking about it when inspecting, but it doesn't come in to that bracket of looking at compliance with National Care Standards. Thank you.

MR MACAULAY: You have a section in the report, I think it is headed "fieldwork", we'll come to look at what happened on the ground. Just sticking with the standards, did I understand from what you said that when

you carried out an inspection you wouldn't be having regard to all the standards?

A. No.

Q. You would select a number of standards, and what was the basis of the selection?

A. Well, I think the basis of the selection was -- to be honest, I don't know what the basis of the selection was. I think certainly from my understanding, and working at the time, was that there was a corporate aim to make sure that all of the standards had been inspected against in the first set period of time of the Care Commission.

Q. I think later on we see that you developed a grading system. At this point in time, there is no grading system?

A. That's correct.

Q. You just simply make recommendations and make findings?

A. That's correct.

Q. We'll look at recommendations and indeed requirements later.

One word you mentioned there in passing, Andy, was "self-evaluation". Do I take it that, and this is prior to what the position is maybe later on, there was a process before the emergence of the Care Inspectorate whereby a provider was asked to provide some form of

self-evaluation or is that something that comes later?
A. I think that came -- for the first few years my understanding is that there wasn't self-evaluation, but that was developed quite early on. The request for a self-evaluation of a service prior to inspection was developed quite early on within the Care Commission.
Q. What did that involve then?
A. That involved the service answering a range of questions about their view about how at that point they were meeting the National Care Standards and then, when we moved to grading, how they were meeting the quality themes and quality statements that we were using.
Q. Are you saying this system was in place before the emergence of the Care Inspectorate?
A. Yes.
Q. Would the questions that the provider was being asked to self-evaluate upon mirror the questions that you would be asking when you carried out your inspection?
A. Yes, it was the same framework that we were using, yes.
Q. Would you then -- once you had done the inspection, and considered the self-evaluation -- compare and contrast?
A. Yes, yes.
Q. Looking to your own experience, in carrying out that exercise, how close or how far off the mark were the self-evaluations?

A. Well, I think that assessment in itself gives you some idea about the service, the quality of management and leadership is about whether what you are seeing when you go and inspect matches the service's assessment of where they are operating. So that process of reflecting on what are we doing well, what do we need to improve and what's our action plan for making sure that we progress through those improvement, that gives you an idea. If you were going in, and that is reflecting the totality of the evidence that you are triangulating, it gives you that evidence again about the credibility of the management and leadership of the service.

Q. If there was a close match, that would give you some comfort?

A. Well, if it's -- yes, yeah, yes, unless it's a self-evaluation saying we are doing terribly and you are feeling that and you are not feeling that -- there is that bit where a service can be saying, "Well, we're not doing very well here, but we've got this agenda for action" and you as a regulator have to make a decision about still whether the standards for young people are good enough while this development plan is progressing. But it provides a good framework for assessment.

Q. There is mention in the report of an annual return?

A. Yes.

Q. Is that something different to self-evaluation?
A. That's correct.
Q. What is that?
A. Every year -- I think it opens in December or January -- we ask every service to complete an annual return, which requests a whole range of data about their staffing, their training, the notifications that they've had et cetera. That gives us, I suppose, a state of the nation for each individual service and gives us a range of data, which then helps inform our risk assessment as we go along.
Q. Can I then take you to section 6.3 of the report, page 14? Here you have a heading or you are covering the period 2008/2009 to 2011/2012 inspection procedures and activity. You tell us that there was a revised approach to inspection based on a quality assessment framework introduced in 2008, can you tell me about that?
A. Yes. I think there was a sense that the National Care Standards ... that we had 19 sets of National Care Standards, so the assessments and methodology were -- not the methodology, our methodology was the same, but the assessment was rather complex in terms of the totality of measuring.

What was decided is that we would have an assessment

framework so the National Care Standards we would still use as the backstop for our recommendations and areas for improvement, but our methodology, so our way of assessing, would change and we would develop a grading system, which we felt was more accessible and that revolved around quality themes and quality statements.

Q. The grading system I think you tell us about in the report, and I'll come to that in a moment, but do I take it then that this approach, the QAF, the Quality Assessment Framework approach, was designed to increase the scrutiny on the service?

A. I think it was done to standardise and improve the scrutiny activity, because I think what we had was a more robust and nationally consistent methodology -- or, sorry, assessment framework then to measure services against.

Q. The grading framework you tell us about is: excellent, at six; very good, five; good, four; adequate, three; weak, two; to unsatisfactory, one.

You set that out at 6.3.4 of the report?

A. That's correct.

Q. Would every report of an inspection grade, under these six heads, various aspects of the inspection?

A. That's correct.

Q. Am I correct in thinking that the quality assessment

framework that we're talking about at the moment is different to what has happened in more recent years?

A. That's correct, yes.

Q. I'll come to that in a moment.

I think is what has happened recently also referred to as a "quality framework"?

A. Quality framework, yes.

Q. The language is quite confusing.

I want to put a document on the screen for you, just covering these points. This is at CIS-000000830. The document's title, "Improving the quality of care in Scotland: an overview of Care Commission findings 2002 to 2010", do you see that?

A. Yes.

Q. Broadly, this covers the life of the Care Commission. It's a very lengthy document. I think it has 189 pages, so it's clearly a detailed review of the work of the Care Commission across the board.

Are you familiar with the document?

A. I remember it at the time, but ...

Q. I want to ask a couple of things about what's in the document. But the first thing I want to ask you is there a more up-to-date equivalent document?

MS HAPPER: For the Care Commission or the Care Inspectorate?

Q. This covers eight years or so of the life of the Care Commission. Has there been a similar review from 2010 onwards that you are aware of?

A. The Care Commission from 2010 would --

MR SLOAN: Yes, from 2011 it became the Care Inspectorate, so I think this was probably a review of the Care Commission's tenure.

MS HAPPER: A swansong.

Q. The short answer probably is that there isn't an equivalent document.

I want to take you to page 23, I'm taking you here simply to try and summarise some of the points we have been discussing.

The first topic there is, "How we assess the quality of care services". I'll just read that out:

"We assess the quality of care services individually through inspection and grading."

I think, Andy, that what you have been telling us about:

"In the course of our wider regulation work we gather a range of information which gives us further evidence of the quality and availability of care across service types in Scotland."

I do want to ask you about that. Is that referring to gathering intelligence that might feed into the way

in which you might approach a particular provider?

MR SLOAN: I think that probably reflects to the information that we gain from the annual return, because the annual return was information that wasn't just used for the risk assessment process for individual services, but was also used for wider statistical information which we also provided to Scottish Government, so the annual return had a wider role and some of that information would have been contained in that.

Q. I think you also seek to in gather intelligence that might feed into the way in which you would approach a particular provider?

MS HAPPER: That's true. I'm not sure that we were really thinking in that way as far back as 2012.

Q. Is that a more recent --

A. A more recent development, I think, around understanding the importance of intelligence in informing the work that we are doing and informing assessment of risk.

Q. Can you give me any examples of what sort of intelligence might feed into how you would assess risk?

A. So there are -- we are talking currently now, not about the time of the end of the Care Commission?

There would be two particular ways in which we would use that, I'll give you two examples.

One would be if we gather information from

inspection findings and also from the annual returns around themes that are arising. For example, around fostering perhaps, we might gather intelligence from what staff tell us during fostering inspections, inspections of fostering services and also data that's coming in from the annual returns and from our contact with the sector, with umbrella groups in the sector, and form a view perhaps about the impact and the potential impact of a decrease in the number of foster carers for example.

That would then inform discussions perhaps with Scottish Government. It might inform the lines of questioning that we take in inspections and so on. So that would be one source.

The other source would be intelligence around a particular service or a particular provider of a service. Some providers have a large number of services, including a range of different service types. So we might gather information or be given information about providers that might make us think that we need to formulate a new inspection plan. We might need to inspect earlier than we were intending to inspect, we might want to follow up on an inspection or we might want to have particular lines of enquiry when we go in to do an inspection, because of that information.

LADY SMITH: Helen, when you say "intelligence", are you talking only about intelligence that tells you what to worry about, if I can put it that way, or is it also intelligence as to what is working well, what is good, so as to inform you what type of practice you should try to instill in the parts of the sector that aren't doing so well?

A. We are very interested in what is working well and we try and gather that information and find opportunities to share that information. Usually we don't really count that as intelligence in the same way. So there's maybe a language issue there. So we're interested in that and we want to know about that, but when we're talking about intelligence we're really looking at thinking about how concerned do we have to be, do we need to change our tactics, do we need to do something differently, in order to understand better whether there's a risk that we need to take action about.

I think it's the way in which we're using the language.

LADY SMITH: Thank you.

MR MACAULAY: Before I leave intelligence, would complaints form part of intelligence?

A. Yes.

Q. We will look at complaints later, and you have a system

for complaints, so that feeds into the intelligence and your picture of a provider?

A. Complaints are a very important source of intelligence, although the volume is important. So the volume of -- for some of our services and intelligence that we have gathered for some of the services, care homes for older people for example, just because of the sheer number that there are is more useful in that sense than when there is a very small number.

Q. Moving on to page 24 of this document. There is a heading near the top, "Lay Assessor Scheme".

I'll just pick that up with you while we have the document on the screen. What I can read is:

"We introduced the Lay Assessor Scheme in 2004. Lay assessors are people who have experience of using a care service, or they have cared for someone who has used a service."

You go on to say:

"During our inspection year 2009/2010 lay assessors spoke with over 4,000 people who use care services and were involved in 369 inspections."

Can you help me with this: has this been a beneficial innovation?

MR SLOAN: I think it's evolved. In terms of the lay assessor initiative at that stage, it was useful but in

terms for Children and Young People's Services I would say it was limited, so we had a lay assessor for example who accompanied us on some mainstream boarding school inspections, but I think the Lay Assessor Scheme was the genesis of our current Young Inspection Volunteer Scheme or Project, which I think has accelerated the value of having people who know about care services involved in service inspections.

Q. That scheme you are talking about, is that a more recent --

A. That is a more recent scheme, yes.

Q. Are these persons who themselves were in care, by that I mean either secure care or care homes?

A. That's correct, in terms of the Young Inspection Volunteer Scheme or Project.

In terms of the Lay Assessor Scheme, it's a while back but my recollection was it was the person who was involved at that time in the Lay Assessor Scheme and children and young people was the parent of a child who had attended a mainstream boarding school and had experience of that through that and also had a child with additional support needs. So we were able to use her skill base in terms of both of those in a range of inspections.

Q. The more recent scheme, has that been beneficial?

A. I think so, enormously so, yes.

MS HAPPER: Can I just clarify one point? That of the young inspection volunteers that we have working with us at the moment, not all have experienced residential care, but we have young people who have young carers' experience and also who have had significant contact with social work services, but may have been in a kinship care placement or may have been cared for at home by their family but on an order. So not only young people who have been in residential care.

Q. If we are focusing on residential care, as we are, then there are young inspector volunteers who have been in residential care?

A. Yes.

Q. Would they then join the inspector in an inspection of a particular service?

MR SLOAN: Yes, yes. That would be part of their role.

Now, I have to say, it's a relatively small number of young inspection volunteers we have. I think at the last count it was perhaps nine or ten, but they play both the role at an individual inspection level, but equally as importantly, when we have produced our documentation, our methodologies, our frameworks, our good practice guidance, we work with them as a group to have their thoughts in terms of jointly developing those

approaches, so that we get their input into the value that they think it will bring.

Q. Does the description "volunteer" tell us that they truly are volunteers?

MS HAPPER: Oh, yes.

MR SLOAN: Yes, definitely.

Q. How do you entice the volunteer to become a volunteer?

MS HAPPER: It's an area of a lot of consideration at the moment and development, because we recruit young people -- we commission an organisation called Move On to help recruit, train and support young people. It's a complicated area, because we want young people who have had that experience but we also want young people who can bring some perspective and who are doing quite a complicated job and we need to make sure that they get something from that.

So that's a complicated and a skilful role in supporting them to develop their own skills and their training and development. So we don't find it hard to attract young people, but keeping those young people and keeping them engaged, making sure it's a good and positive experience for them and helping them to develop skills that they could then help take into a workplace setting, into references for jobs, into other work, anybody who works with young people on a volunteer basis

will tell you that that's challenging and needs a lot of thought and consideration.

LADY SMITH: Do you do anything to take account of the fact that many of the young people who are working with you this way will have trauma in their background?

A. Yes, absolutely, and many are still living quite chaotic lives as a result of that and that's what makes this really an area that we have to be very thoughtful about, how we support them, how we hear what they have to say, how we make sure that they have a good experience through that and are not exposed too much to something that might actually trigger trauma and trigger poor experiences --

LADY SMITH: Do you specifically adopt trauma-informed practice?

A. Yes.

LADY SMITH: In terms of applying the principles of collaboration, choice, empowerment, trust and safety?

A. Yes.

LADY SMITH: And perhaps, above all with such young people, ensuring you do all to keep them emotionally safe as well as practically safe in the work they do for you?

A. Yes.

LADY SMITH: Thank you.

MR MACAULAY: Finally then in connection with this document,

if I can take you to page 25, that is the pagination at the bottom right, there is a section dealing with registration and then inspection and I think this summarises some of the discussion we have had, because under the heading "Grading" we can read:

"In April 2008, we changed the way we inspect and introduced a grading system. Now, when we go out to inspect services, we grade them. We publish these grades in our inspection reports, so that people can see, at a glance, how well services are performing against specific quality themes that reflect the National Care Standards."

So we are still using the National Care Standards as the foundation here?

MR SLOAN: That's correct.

Q. The themes are set out. I needn't read them all, quality of care and support, how the service meets the needs of each individual in its care, so that would be one of the themes that would be in your preparation when you are carrying out the inspection?

A. Yes, and that would be one of the themes that we would inspect against, yes, when we were out on inspection.

Q. Would that be one of the themes that the provider would self-evaluate against?

A. Yes.

Just to explain, there would have been a number of quality statements against each of these quality teams, so it wasn't just the heading as you see it there at that time.

Q. You set out at the bottom of that section the grading system that we have just discussed?

A. Yes.

Q. Could I put this document on the screen. It's at INQ-0000000764.

This is a recent report in connection with Edinburgh Secure Services. If we just scroll down a little bit we can see that the type of inspection is described as "unannounced", and we'll come back to that. This inspection was completed on 20 May 2002 --

LADY SMITH: I think that is 30 May, isn't it?

MR MACAULAY: 30 May 2022.

LADY SMITH: Does that mean the date that actually the inspecting was completed or the report was signed off?

A. It's the date that feedback is given to the service.

MR MACAULAY: So the inspection would have been some time before that?

A. Before that, that's correct.

Q. The reason I'm putting this on the screen at the moment is to take you to page 13 of the report, this is a section that's headed, "Detailed evaluations".

If we scroll down, this is then set out in the format of a report of this kind?

A. Yes, in terms of our current methodology of the quality framework, that's correct, yes.

Q. I'll come back to the quality framework in a moment, but can we see that you are still using the same grading system?

A. Yes, that's correct.

Q. How well do we support children and young people's well-being? And the answer there is "weak"?

A. Yes.

Q. I think you said that one of the purposes of having this grading system was to make it clear to people how the service was performing. I think that links into the fact that these reports are published on your website?

A. That's correct.

Q. So any person can go to the website and see how a particular service is performing?

A. That's correct.

Q. So you have transparency in that sense?

A. That's correct.

LADY SMITH: Mr MacAulay, it's now just coming up to 11.30 am. Would that be a good point to take our morning break now?

Fifteen minutes or so, I'll sit again after that.

(11.29 am)

(A short break)

(11.45 am)

LADY SMITH: Helen, Andy, are you ready for us to carry on?

MS HAPPER: Certainly.

LADY SMITH: Thank you very much.

Mr MacAulay.

MR MACAULAY: My Lady.

Shortly before the break, I looked at the rather large document that sought to set out the work that the Care Commission had carried out over the time that it was in existence, and it's a lengthy document. Clearly a lot of work went into it and it's a very useful document.

I just wondered, thinking about it, whether the Care Inspectorate has any thoughts of producing a similar sort of document to cover, let's say, a ten-year period of its existence, providing the sort of information that's contained in that document?

A. We did produce a document, a triennial review, which I think was referred to actually in Professor Levitt's evidence, possibly. We did produce that in, I think, around maybe 2016ish perhaps. At that time we did talk about producing another one in another three years' time, I think we then got into COVID period.

To be frank, it's a huge amount of work to produce it and I think there is some value in it, whether the value is worth the work involved, I think that remains to be seen, but as a senior management team we have quite a lot of discussions on a fairly frequent basis about how we make the best use of all of the information that our organisation has across a really wide range of services.

Q. It may be something in any event you would keep under review, as to whether a document of that kind, even a triennial review, to build upon the previous review, might be helpful.

Can I take you then to page 15 of the report. You have a section here, 6.4, dealing with inspection procedures and activity in the period 2012-2018. This, of course, is the era of the Care Inspectorate and just to remind ourselves, the Care Inspectorate took over the responsibilities of the Care Commission, the SWIA and the child protection function of the HMIe, is that right?

A. That's correct, yes.

Q. Throughout this period, as we look at the report, it does appear that the approach to inspections does evolve. Can you perhaps help me with that evolutionary process?

MR SLOAN: As I say, I think the big move between 2012/2013 to 2017/2018 was the move from using the National Care Standards as our assessment framework to using the quality assessment framework, 2008/2009, and also grading, I think, was a major step change in terms of accessibility for readers and users of care services in terms of the transparency of our evaluations.

There was also the drive, I think, to have a greater focus on the outcomes for children and young people as part of that -- as part of our inspection activity.

The third main strand again would be just our continued work in making sure that we were evolving our assessment of risk and that influencing the proportionality and targeting of our inspections.

Q. One thing you do say is that at 6.4.3: "A specialist children and young person's national team was part of this development in 2012." Can you just help me with that? What does this team do?

A. Well, as I explained previously, we operated the Care Commission in generic teams, so to give an example I was a manager of the regulatory team in Dundee and the inspectors in my team would cover everything from childminders to care homes for children and young people to care homes for older people, and I was responsible for that team.

That would be the equivalent across the five regions and that was then managed on a regional basis. So the movement in 2012/2013 was for the regulation of all of those services relating to children and young people to be grouped together and to be line managed by one national team, by a group of inspectors that purely focused on the regulation of those type of services, which was a change, because previously inspectors would have, for example, had some childminders, some nurseries, perhaps a care home for older people and some care homes for children and young people as well. So they would have had a mix of case loads. That was a major development, that they would focus just on those care service types related to Children and Young People's Services.

Q. You were in that group?

A. Yes, yes, and I became -- so I moved from being a team leader in Dundee with that generic, to I think it was a team manager then in the children and young people's team.

Q. What essentially you are telling me is that you developed specialist teams?

A. That's correct.

Q. Is there a risk with specialists -- do you refer to this as regulatory fatigue or regulatory --

MS HAPPER: Regulatory capture.

MR SLOAN: Capture.

Q. Sorry.

MS HAPPER: I think it's important to say that I don't believe there's any perfect structure. There are things to be gained and things to be lost by creating a specialist function rather than a national overall function where people are inspecting a range of different services. Whichever structure you have, you have to manage the downsides as well as benefit from the upsides. Within a specialist team for children and young people in the Care Inspectorate, relatively speaking it's a small part of the Care Inspectorate's operation.

The Care Inspectorate has around 14,000 services registered, of which fewer than 1,000, I think it's 790-something at the last count, are services for children and young people. Early learning and childcare is very large in volume, and particularly care homes for older people or care at home services for older people is very large.

So we're a very small part. That said, I'm in no doubt that a move to a specialist team for children and young people has been a very positive benefit, because the amount of knowledge, the understanding of that

particular sector, the understanding of how services have to operate with children and young people is different and we were not achieving that, I believe, within a regional structure.

So that's really important. Regulatory capture is about where you stop seeing -- perhaps in Children and Young People's Services you stop seeing the child or young person and you're too identified perhaps with the particular service or with what it feels like to be the member of staff in that service or the manager of that service. That could happen in any structure. I don't think that it's a particular risk necessarily for children and young people. What can happen in a specialist structure is that you become only focused on your part of the world and you don't understand where that part of the world fits with the wider part.

We are very aware of regulatory capture and the dangers of that. How we try to manage that is by helping people inspect, enabling people to inspect in small teams, making sure that people have others to speak to, the support and supervision that managers like Andy provide to teams of inspectors is really important and a vital link of that, and having points of external challenge up the line. That's also really important measures, so we're very conscious of that and we try

really hard to make sure that we address that, but I don't think that it's particular to a specialist team.

Q. As you said, specialism brings its very important advantages to the inspection team.

Can we move on then to getting up to the present day and the role of the Care Inspectorate, particularly in relation to inspections. At paragraph 6.5.1, page 17, you say:

"The launch of the Scottish Government's Health and Social Care Standards in June 2017 facilitated a major development in inspection methodology."

Who can pick up that ball and tell me what is happening now?

A. Do you want to start?

MR SLOAN: The move from the 19 or 20 different sets of National Care Standards, there was then the publication of the Health and Social Care Standards, which was just a set of standards which covered the range of regulated care services. Again it reflected, as the report says, a more modern thinking and language about person-centred practice but also outcomes, and that's what led to the development of moving from the quality assessment framework --

LADY SMITH: Andy, you made reference to "outcomes" earlier, what do you mean by "outcomes"?

A. Well, if when you reflect back to the National Care Standards, quite a lot of the -- some of the quality statements that were there would be that for example there was a policy or -- as if that in itself reflected that because there is a policy it means that young people are safe, you know there is an interpretation that young people are safe. While this is a move to going:

"Okay, there is a policy, but what are the processes, outputs and outcomes that actually result in actually are young people safe? And what are we measuring within that terms in terms of the robustness of staff knowledge of that? And what about the dynamic and the relationships between children and young people that would actually reflect that young people are safe. Are young people saying that they feel safe?"

It reflects more on the outcomes that may derive as a result of that input from the policy, rather than the policy in itself as a tick.

LADY SMITH: You are not just looking for the policy, do I have this right, judging by what you just said, you are also looking for actual examples of practical successful application of the policy?

A. Yes.

LADY SMITH: Yes.

A. Yes.
LADY SMITH: Good. Thank you.
MR MACAULAY: The trigger for this development, I think you have said, is the Scottish Government's Health and Social Care Standards, which were published in June 2017. Is that correct?
MS HAPPER: Yes.
MR SLOAN: That's correct.
Q. Was it on the back that the quality framework was developed?
A. That's correct.
Q. Is that essentially where we are today in relation to inspections?
A. Yes. I think just, I suppose in the last two years we have refined our use of the quality framework and have developed an additional key question to the quality framework that was published in 2019, called "Key questions 7", which distills all of the quality indicators from the quality framework into a tighter inspection framework, which is the one that we're currently using.
Q. Was that prompted by the Independent Care Review?
A. No, that-- well, it was a collation of things. I think, yes, there was The Promise, there was the pandemic and the recovery that was needed to that in terms of

inspection. And also I suppose -- I suppose just a greater awareness from ourselves about what we wanted to be doing at inspection in terms of the use of the quality framework and even while we had adapted it and developed it in 2019, following The Promise, things had accelerated even in that two- or three-year period.

MS HAPPER: I think it is important to state that because of the hiatus that was caused by the pandemic, when we were able to re-inspect, when we were able to move around again and get into services, we felt a real pressure to cut to the chase, to say: what difference is this service actually making to children and young people? And that's what drove us and that fitted, as Andy says, with a direction of travel anyway, but it really accelerated that. I think we were really impressed by how that stripped away a lot of other things and started thinking this really is the $64,000 question, this is what we should be reporting on. So we have kept that, rather than after the pandemic moving back to a kind of broader framework.

LADY SMITH: Thank you.

MR MACAULAY: You have a short section in the report at 6.6, on page 18, where you discuss the impact of the pandemic. In particular you tell us that in March 2020 the Care Inspectorate suspended all routine inspection

activity in response to the growing COVID-19 pandemic. You go on to say how you were able to try and monitor what was going on; is that correct?

A. Yes.

Q. How was that achieved?

A. It was achieved by telephone contact and Teams contact. We were very fortunate in that the Care Inspectorate just prior to the pandemic, not knowing that that was coming down the line, had invested in making sure that our staff were equipped with Microsoft Teams and with a way of keeping in touch in that way, which served us very well.

So that and telephone contact between caseholding inspectors and inspectors who knew services was a way of keeping in touch with that. We also kept in touch with some umbrella groups for young people, but it was a very difficult period of time, not being able to be out on routine inspection activity during that period of time.

Q. Was there some prioritisation that meant you didn't cut out inspection altogether?

A. We responded to complaints where we felt those complaints needed investigation, and I think we had very little, but we did respond to -- I think there were ...

MR SLOAN: We inspected a number of critical services, where intelligence showed that risk was critical then we

undertook inspections. We just amended our methodology to try and get as much information as we could through desktop and virtually, which therefore shortened the amount of fieldwork that we needed to do and therefore the risks of being in that service and visiting different units or different young people. But, yes, there was some inspection activity, but it was very limited and it was prioritised.

Q. You say at 6.6.2 that you resumed prioritised inspection activity in April 2021, but it was prioritised?

MS HAPPER: It was prioritised. At that time that was based on the intelligence that we had, but also we had a significant number of services which had registered either just pre the pandemic or some which were registered or varied what they were doing during the pandemic to take account of the pandemic, but those services hadn't been inspected. So that was the biggest priority, it was to get out and see services that had never been inspected, because of the time gap.

Q. Looking at the quality framework approach, I'll put a document on the screen for you to look at. This is at CIS-000009300. If we scroll down, do we see that this is described as a quality framework for secure accommodation services?

A. Yes.

Q. We see the date is November 2020.

Is this the framework that is still being used for secure services?

MR SLOAN: Yes, and we have added --

Q. The key question?

A. Key question 7 to that.

Q. Here we are focusing on secure accommodation services, because we are interested in that. But I have seen a quality framework for special schools for example -- special residential schools, and I think a quality framework for foster care, is that right?

A. That's correct.

Q. Although they are bespoke in that sense, the principles are very similar?

MS HAPPER: Yes.

Q. If we go on to page 2, do you tell us in the second paragraph:

"From 2018, on an incremental basis, we have been rolling out revised methods of inspecting care and support services."

Do I take it from that that although this one is dated 2020, another may have been dated 2019, so they are being rolled out as time was going on?

A. That's correct.

MR SLOAN: That's correct. The quality framework for care

homes for older people I think was first in 2018 and then care homes and special residential schools, which you refer to, I think was 2019 and then secure accommodation came in 2020.

Q. I think there is a similar quality framework document for boarding schools?

A. That's correct.

MS HAPPER: Yes.

Q. Perhaps again to get the background narrative, in the third paragraph:

"Since 1 April 2018, the Health and Social Care Standards have been used across Scotland."

We have discussed that:

"They were developed by Scottish Government to describe what people should experience from a wide range of care services. They are relevant not just for individual care services, but across local partnerships. We expect them to be used in planning, commissioning, assessing and delivering care and support. We also use them to inform the decisions we make about care quality."

I think when you look at the different quality frameworks, this material really appears in all these documents?

A. Yes.

MR SLOAN: That's correct.

Q. Can I just take you to this paragraph? It's the fifth paragraph down from the top. What is said there is:

"The core of our approach is a quality framework which sets out the elements that will help us answer key questions about the difference care is making to people and the quality and effectiveness of the things that contribute to those differences. The primary purpose of a quality framework is to support services and evaluate their own performance. The same framework is then used by inspectors to provide independent assurance about the quality of care and support."

Do I take it from that that at least in part this is a self-evaluation tool for the provider?

A. That is correct, yes.

MS HAPPER: Yes.

Q. If we turn to page 5 of the document, although this is a new approach, you have retained the grading system?

MR SLOAN: Yes.

Q. There is a description on this page in fact as to what is covered by the different grading levels.

If we turn to page 6, there is a heading, just scroll down a little further:

"How can this quality framework be used by care services?"

This repeats what has been said before:

"The framework is primarily designed to support care services in self-evaluation. We will work with care services and sector-wide bodies to build a capacity for self evaluation, based on this framework. We have published 'Self-evaluation for improvement - your guide.' The guide is available here."

We are looking clearly at a document that is online?

MS HAPPER: Yes.

Q. Does this reflect the fact that apart from a document such as this, "The Self-evaluation for improvement - your guide", that the Care Inspectorate does publish guidance to providers?

A. Yes.

MR SLOAN: Yes.

Q. Is there a lot of guidance?

A. Yes, and I think that's accelerated over the last three to four years in terms of the amount of guidance, good practice guidance, that we've published, yes.

Q. I suppose there is a balance to be struck as to how much guidance you issue, because if there's too much then it tends to go over people's heads?

MS HAPPER: I'm smiling for exactly that reason. I think there is a real balance to be struck there. Sometimes it just becomes a blunt instrument and it's also

about -- we don't want people -- a good provider won't sit and wait for the Care Inspectorate to tell it what it should be doing. So it's not as if: well, you didn't have guidance on that, therefore you can't expect us to do it.

At the same time, we have had some very positive feedback about guidance that we've produced, that providers are saying, "That's very helpful to us". So there is always a balance to be struck. There is a balance to be struck because, also, the best guidance is written by people who are out understanding that front line of the service and that means inspectors, with help and with support from managers and also from the backroom functions, as I called them, that we talked about earlier on.

But every time we pull somebody off to help write guidance it means that they're not inspecting, so that's a balance for us as an organisation.

LADY SMITH: I suppose you picked up on another factor there, which is that your guidance needs to have credibility.

A. Yes, it does.

LADY SMITH: Coming from voices who do know what they're talking about.

A. We consult on our guidance with people in the sector and

we make changes in relation to that and so on. Sometimes it's about language, sometimes it's about concept.

LADY SMITH: Whilst at the same time protecting against what I might call guidance fatigue.

MR SLOAN: I think the guidance that we have developed over the last four to five years really has been about listening to what our findings at inspection have found, which has prioritised the guidance that we've produced, because we think it will be helpful from the collation of our findings at inspection.

Also I think it's useful to describe how it's used. We don't just put it up on the website and then if a provider wants to take it and if there's too much it just seems like a blur, but it's also used at feedback by individual inspectors. So as part of the improvement agenda, feedback, if we are giving or discussing with a service about an area of practice that they need to improve, it's great to be able to signpost them to something which gives them more than the framework itself. Because the framework itself doesn't give you that. So what it does is it helps I suppose standardise and make consistent the advice and guidance that inspectors are giving at inspection for individual services, and then provides a reference point for the

service as they go forward.

LADY SMITH: I'm sure I've suggested this to you before, Helen, but in a way good inspection must be providing a valuable consultancy service that doesn't actually have to be specifically commissioned, am I right about that?

MS HAPPER: That's absolutely right.

LADY SMITH: Separately though, if a provider has identified a difficulty in particular circumstances that arise in the provision they make, could they come to you at any time and ask for your guidance and help?

A. Yes, they can. In some ways this goes back a little bit to the conversation around self-evaluation. The reason that self-evaluation is a tricky concept for a regulator is because we can't unknow what we know. Once I know something, once our team knows something, then we have to make a decision about how we act on that.

But for self-evaluation to be really effective you have to be honest with yourself. Whatever you are trying to do you have to be honest with yourself. You have to know what your strengths are and also what your weaknesses are. Good providers do know what their strengths and weaknesses are, but you have to be quite brave to tell a regulator your weaknesses, because we then have information that we need to act on.

So there are a lot of barriers to honest self-evaluation from providers, and self-evaluation that isn't honest is worthless. So from our perspective as the regulator, we have to engage with services that doesn't lead them down the garden path, doesn't say to them, "You can tell me anything, it doesn't really matter". But has to help them understand that the way in which improvement happens is by being honest about your weaknesses, and if people are honest about their weaknesses and show that they understand them, and then show that they are willing to take action to address them, then that's a good thing and we will honour that and we will do what we can to help them get there.

It's not just about knowing yourself, because we can all -- I know I can't be trusted near a biscuit tin, but that knowledge in itself doesn't help me be healthy. So it has to be knowledge of yourself plus the willingness to show that can you do something about it. And when a service or a Local Authority does come to us with that or where something comes out in inspection or through intelligence and we have those conversations, we are making judgments about: is this a situation we can work with and help this person or this service or this authority get there?

LADY SMITH: Thank you, Helen, that's very helpful.

Mr MacAulay.

MR MACAULAY: My Lady.

You mentioned bravery there, and I'm going to come on to that very shortly, but before I do, can I turn to page 7 of the document?

Here we have what is described as a diagram that summarises the approach: "How are we doing? How do we know?" Then we have a list of key questions that we see in the body of the document.

A. Yes. Those two questions at the top are equally important. People usually get: how are we doing? They don't often get: how do we really know that? It's a guess rather than a based on good evidence --

Q. This sets out the general structure of the quality framework, ending with: what are we going to do now?

A. Yes.

Q. If we turn to the next page, page 8, the layout here is that at the top we have the key questions running across the page?

MR SLOAN: That is correct.

Q. The heading of the table is "The quality indicator framework". Below each key question, for example: how well do we support children and young people's well-being? Which is question number 1. You set out, I think, four propositions for that particular question.

A. That is correct.

Q. Then we go through the other questions, where there are further propositions set out under each of these heads. If we just take the example of key question 1, moving on to page 9: how well do we support children and young people's well-being? And the questions are repeated. We then turn to page 10, I think this is looking at the first quality indicator that we saw under the heading of key question 1?

A. Yes.

Q. We have two columns, there is "Very good" and there is "Weak". Under the heading "Very good":

"Children and young people develop meaningful and secure relationships with those caring for them. They are based on empathy, compassion, love and fun."

If we go to the other column, we see what might be described as "Weak":

"Children and young people do not feel that the people looking after them like, know or value them as individuals."

This is a self-evaluation tool, you are giving examples to the provider as to what might be very good and what might be weak. Are you expecting then the provider to accept, after a process of self-evaluation, but before any discussions with the Care Inspectorate,

that the provider would accept that children and young people do not feel that people looking after them like or know their value?

MS HAPPER: Yes.

Q. Do you find in practice that providers step up to the mark and take that on board before they have any discussions with the Care Inspectorate?

MR SLOAN: It's difficult. It's complex because I think good services do good self-evaluation. Poor services do not so good self-evaluation. Services which are under extreme pressure and crisis aren't undertaking any self-evaluation at all.

That's a sweeping generalisation, but I think that's a general picture that I think people would see as real when we are out inspecting services. So that's something that we need to factor in, in terms of our inspection fieldwork.

LADY SMITH: You are really taking us back to the "How do you know that?" side of the two fundamental questions: "How are we doing? How do we know that?" And it's not good enough to say, "We believe we're doing really well. What makes you think that?" On what basis do you say that?

A. Yes.

MS HAPPER: I think the other element to that is that and

particularly I would say at the moment because the sector is under a huge amount of challenge and huge amount of pressure, that people understand where they're at, but want to give you a reason why they're not achieving something.

Those are usually very good reasons. They are understandable reasons. The reasons that of course we are interested in knowing about, but at the end of the day, the impact on the young person is still -- that doesn't change the impact on the young person. So we have conversations where people may say for example, just choosing that one, we have not been able to provide continuity of staff and we accept that we are not able to provide continuity of staff, but it's very difficult to get staff, we can't do this, we can't do that, we don't have the staff there.

All that may be true and we may understand that, but when it comes to evaluating the impact of the young people we have to say there's still the impact, still that young people are not getting the continuity of care that they need. And that's a tension that's around.

Q. Looking to experience, Andy, do you find in practice that in the main providers do self-evaluate in a way that tends to mirror your own inspection findings?

MR SLOAN: I don't think that providers necessarily use this

structure, I think providers develop their own self-evaluation structures that have -- that maybe one provider with, say, ten services may have its own self-evaluation structure, another provider may have a different type of structure and a different way of doing it and we don't legislate about the type of self-evaluation structure that they do.

I believe that most of them, though, have as their origins or basis this. That doesn't mean that they're using the language of very good or weak or that they're grading themselves, but the principles of the self-evaluation reflect that framework.

Q. Are you saying they are given the key questions and the quality indicators, but they build themselves in their own way around that?

A. Well, I think what we have -- we do not request now a self-evaluation. So previously we would request a self-evaluation prior to inspection activity. Now what we do is we ask -- when we go out at inspection, that is one of our core assurances that we would inspect their self-evaluation or quality assurance document and improvement plan. So we would do that.

Because I think what we found was imposing an external self-evaluation document or framework on an organisation and it didn't reflect actually how that

organisation worked or operated, was less helpful than the services themselves finding something meaningful, using that as a basis, which they would then use to develop and own themselves.

LADY SMITH: Maybe what you have just said about using that as a basis is the point. They can have regard to your system, have regard to your guidance and then think about how they can achieve the best self-evaluation according to their own facts and circumstances, can't they?

A. That's correct. I think what that means is that when we come out to inspection, I think what we find of value is that when the manager and provider and the inspector share a common language, which this hopefully is, despite them potentially having a different structure to the self-evaluation, that's what adds value in terms of the inspection process.

MS HAPPER: There are two points to that.

One is that some of the providers are large providers with a number of services and some of those have invested in their own frameworks, and so that's what we should be using, because the message we're trying to give to people is self-evaluation shouldn't be something you do because the inspector's coming. It's something you should do all the time.

One of the weaknesses of the previous self-assessment model was it told people we were coming, we're coming to inspect you soon, because we're asking you for that self-evaluation and it linked it to somebody then coming along and saying you've got it right or you haven't got it right. That's not what it's supposed to be about.

It's supposed to be about an ongoing continuous improvement process, that challenges you to say: are we doing okay? How are we doing really? How do we know that? Are we sure about that? How can we find out? That is the message we try and drive home.

But, as Andy said, that conversation about using the same language and the same concepts is really helpful.

The second point is that this document had extensive consultation with the sector, including the illustrations, so that's helped us sometimes where we have said -- because people -- we all usually think we do better than we are. We like to think well of ourselves, and if people are sometimes saying, "Well, yes, I accept that that describes it, but that's not really weak". Well, we say, "Actually, we have all had this consultation and we agreed that's weak and that's very good". So that's a strength. This is not just what the Care Inspectorate thinks. It's trying to get

that view. That's what is good practice. That's what we should be aiming for. And that's helped us in a few tricky conversations.

MR MACAULAY: When did you stop asking the providers to submit self-evaluation material?

MR SLOAN: 2011/2012.

Q. Some time ago?

A. Yes, some time ago. It was when we moved to undertaking unannounced inspections only. It was at that point or around that point that we stopped asking for the self-evaluations.

MS HAPPER: It could be 2013 maybe, I think around that time perhaps.

Q. Thank you both for that.

If we move on to page 19 of the report, you have a section at 6.7, "Inspection focus areas".

Referred to as IFAs, can you just explain what this is?

MR SLOAN: Inspection focus areas -- now at this point we were inspecting against the National Care Standards and, as I say, we were going through a cycle of inspecting the various National Care Standards. But what we also did was we wanted to drill down or inspect certain areas in greater depth throughout that cycle of inspection of the National Care Standards.

So the inspection focus areas provided an additional degree of structure and focus to our inspections at that time. So the inspectors would have an additional structure, questions and areas of practice to examine --

LADY SMITH: One moment, we are back to the report provided to us, CIS-000001056.

MR MACAULAY: Yes, on page 19.

LADY SMITH: Sorry, when Mr MacAulay says "the report", I think he means the document provided by the Care Inspectorate for our purposes. Thank you.

Yes.

MR SLOAN: Then for each inspection there would be -- that area of practice would be reported against, so we had ... as the report says, in relation to child protection, safer recruitment and various aspects --

Q. These particular headings that would be targeted?

A. Yes.

Q. You also tell us about shared inspections with HMIE, Education Scotland as I think we now refer to that, and these are joint inspections?

A. That's correct, yes.

Q. Are these the norm, if you are dealing with a residential school?

A. No. I wouldn't say -- no, I wouldn't say they were the norm. I think what has happened is that Education

Scotland and ourselves get together just prior to every inspecting year and will map out the joint or shared inspections that we'll undertake.

They're governed by Education Scotland's inspection cycle and regime and also coupled with our inspection frequency rules, but also the statutory inspections that we need to undertake. So we try and co-ordinate that in terms of making sure that they tie in with the statutory inspections that we need to undertake and, as I say, the Education Scotland plan that they have at any one point.

Q. If they're planning an inspection of a particular residential school you try and align yourselves with that?

A. Exactly.

Q. Would that mean a number of inspectors attending the provider's premises?

A. Yes, that's correct. For example, there may be three or four Education Scotland inspectors and three or four of Care Inspectorate inspectors for example, if we were going to do a large mainstream boarding school.

Q. Would you all be on the premises at the same time or would you stagger the attendance?

A. No, we're all in attendance at the same time. So we arrive at the same time in the morning. The shared inspections are announced, so the service knows that

we're going to arrive and the inspection team would arrive at the same time.

Q. Can we look at the section that is headed on page 22, 6.10, "Inspection frequency and intensity".

We mentioned this in passing, but let's just look at the period prior to the establishment of the Care Inspectorate, that is 2002 to 2009/2010.

What were the rules during that time in relation to how often establishments should be inspected?

A. Well, the Regulation of Care (Scotland) Act set out the minimum frequency for secure accommodation services, special school care accommodation services and care homes for children and young people, and that was that they were to be inspected twice within a 12-month period, at least one of which should be unannounced.

Q. Would the unannounced inspections pre-date the announced inspection?

A. No. Well, that would depend on the cycle of inspections, but traditionally in an inspecting year, the first inspection would be the announced inspection, where we would receive a self-evaluation and then the second inspection would be unannounced, but in terms of our risk assessment or any particular issues, that wasn't set in tablets of stone, but that was the custom and practice.

Q. Then I think that changed between 2010/2011 and 2021/2022?
A. That's correct.
Q. What was the change and what is the position now?
A. The position now is that those service types now require a minimum of one inspection, unannounced inspection, in every 12-month period.
Q. Those service types are the secure accommodation, special school care accommodation and care homes for children and young people?
A. Yeah, that's correct.
Q. Boarding schools, for example, would not be caught by these regulations?
A. No. They are not one of the service types that has a statutory inspection frequency.
Q. You talk at 6.10.2.4, page 23, about what you described as a more proportionate and risk-based approach to inspection frequency and intensity.

Can you just explain what you are trying to capture there?
A. Well, in operational terms, that was just that better performing services with less risk would have a less intense inspection in terms of fieldwork --
Q. It would still be an annual inspection?
A. Oh, yes. The inspection frequency would remain, but

this was the intensity of the inspections that would take place. So better performing services would have -- this changed over the years, but the pattern was that better performing services that were good and above would be inspected against fewer quality statements within each quality theme, and poorer performing services would be inspected under more quality themes or have more quality statements inspected against them.

Q. You are really tailoring your approach depending on what you know about the establishment, and that would be based, no doubt, on intelligence and indeed previous reports?

A. Yes. The intensity was based on both the previous grades to the service and also the risk assessment or the risk assessment score or assessment that we would make prior to inspection, which takes in information relating to upheld complaints, staffing, changes in manager and a range of criteria. So it's referred to in the report as the RAD, the regulation assessment document, and then the scrutiny assessment tool, which superseded that.

Q. Could there be an instance where because of concerns, however raised, that you would increase the frequency from one every 12 months to two every 12 months?

A. Yes, yes.

Q. Has that happened?
A. Yes, yes.
Q. I think I saw reports for ESS where in a given year there were least two inspections?
A. Yes, for that --
Q. Because there was a troubled background?
A. If a service was being -- let's say the grades were poor and the risk was high, we would be undertaking a follow-up inspection and, depending on that, we could undertake another follow-up inspection.
Q. The next section of the report, at 6.11, deals with notifications. Is this a process mandated by the legislation whereby a provider had to report certain matters to the Care Commission or Care Inspectorate?
A. Yes.
Q. Can you perhaps give me an example of what that might be?
A. There is a range of notifications for example. If there's been an allegation of abuse, the service would have to notify us, an allegation of staff misconduct. When a young person has been restrained or when there has been an incident and our notification guidance gives some parameters to what an incident that merits notification would be. For example, that might be if a young person runs away from the service, we would

expect to be notified.

Q. Perhaps I can look at an example of this, if we look at CIS-000002792.

LADY SMITH: Of course those are notification requirements that date back to 2002, to the Care Commission's work --

A. Yes.

LADY SMITH: -- is that right?

MS HAPPER: The restraint notification is new.

LADY SMITH: That is a new one, but the others on the list date back to that longer period?

MR SLOAN: Yes. I think in the first few years of the Care Commission our guidance about what needs to be notified, that took a step forward with the development of online notifications, which gave us a much clearer system for notifying and a clearer differentiation between what we were asking for. Prior to that, there was still the same broad notifications required, but it was paper based and broader.

MR MACAULAY: The process was put in place by the 2002 Act and the associated regulations?

A. That's correct.

Q. If we look at this document.

If we go to the first page, page 1. We see the Care Inspectorate logo, eForms document and can we see that this is a notification incident. SCSWIS, that is the

Care Inspectorate?

A. Yes.

Q. It relates to a particular establishment. Clearly, this is a notification that was made by this establishment to the Care Inspectorate. Is this the form of documentation?

A. Yes.

Q. If I turn to page 2, there is a heading "Important information". Can we read in the first paragraph:

"Existing conditions. If the conditions of registration of your service have required you to notify the Care Commission of specific events or changes within your service, you must continue to notify SCSWIS of these events or changes. Failure to do so will mean you are in breach of your conditions of registration ..."

That is telling the provider precisely why this process has to be followed?

A. Yes.

Q. If we turn on to page 3, can we see that the second paragraph, about halfway down the page, the very last sentence:

"You must notify us within 24 hours of the event occurring."

So there is a time limit on when notification must be made?

A. That is correct, yes, all the different types of notifications have a timescale.

Q. Different timescales?

A. Yes.

Q. Then on page 4, second sentence:

"What is the date when the notifiable event occurred?"

We are given a date. Then are we then provided with a short description of what the event was?

A. Yes.

Q. Can you see that the event involves a child or young person who had been unsettled, had struck out at a member of staff, injuring his hand and that, I think, he was restrained and he went to his room and he ultimately settled down, I think after his mother had been contacted?

This gives us an example, does it, of an event that would be notified by the provider to the Care Inspectorate?

A. Yes.

Q. What then would be the response of the Care Inspectorate?

A. Well, I suppose that depends on the quality of the notification and the content of the notification.

Q. Take this example, which appears to be one where a child

or young person has become unsettled. Would you take that any further?

A. I think now we would be expecting a lot more narrative than that. I think our notifications guidance now details what we are expecting are the antecedents, more of an explanation of the antecedents and the de-escalation, but that's a distillation.

No, I think that that would not be something that might be followed up, but it may be if there had been a number of incidents in the service and the inspector was saying:

"Do you know what, that's three restraints in the last three days. Oh, it is the same young person. I need to speak to you about that, because actually what I'm not seeing there is something about a revision of a care planning or risk assessment about de-escalation behaviour."

So in itself, perhaps not, but in terms of the totality of notifications and perhaps about that particular young person, then it might be something that the inspector would want to follow up with a service.

Q. When you say "the inspector", would there be --

A. That would be the caseholding inspector. So each inspector has a caseload of services and the notifications for all of those services comes to their

inbox.

Q. The establishment mentioned in this document would be a part of that caseload?

A. Would go to that caseload and would therefore go to the named inspector.

Q. If I can take you to paragraph 6.11.4, page 24. You set out there:

"On the creation of the Care Inspectorate Regulation 4 of the Social Care and Social Work Improvement Scotland Regulations 2011 required that the Care Inspectorate must, at the time of granting registration to a care service, notify the provider of the service of the records the provider must keep and where they must be kept."

That's looking at the point of registration. What about those providers who had been registered prior to the 2002 Act?

A. They were expected to adhere to the revised notifications as well. I think that's what the opening paragraph in the eForms that were shown, there was a line in there that I think indicated that you continued to be expected to adhere to the notification process. I think that's reference to existing providers.

Q. Whether registered before or after --

A. That is correct.
Q. -- they were obliged to follow the -- here we are talking about provisions in relation to records?
A. That is correct.
Q. There was also a duty on the Care Inspectorate to notify the provider in connection with records?
A. Yes. I think we did that prior to 2011, but we have produced a document which details all of the records that a service is required to keep and also all the notifications. It also contains what we expect within those notifications and then the timescales that we expect them to be submitted by. That's had various iterations throughout the years. I think the most recent iteration was when we developed the dedicated physical intervention notification in 2022.
Q. You are pretty exact I think, because I'm going to put a document on the screen that might support that.
MS HAPPER: We have something called the provider update, which is an online mailshot, is it, that goes out. I am sorry, don't know what the technical term for it is.
LADY SMITH: I think I understand.
A. If there is any changes to notifications or any updates or if we feel that something has dropped off the radar a bit for services and we want to bring their attention to it, that goes in regularly to all providers.

MR MACAULAY: Is it the case that the legislation recognises the importance of records to children and young people.

MR SLOAN: Yes.

Q. Can we have on the screen CIS-000009219. This bears the logo of the Care Inspectorate, and just reading the heading:

"Records that all registered children and young people's care services must keep and guidance on notification reporting."

Can we see the publication date is 25 October 2022, this is the most recent guidance?

A. Yes.

Q. If we move on to page 2, just to take some random examples. Clearly details about the child, date of birth, date when the child started using the services. A few down, just above halfway, "Where a bedroom is shared, details of the informed consent of both individuals". That is for care homes. So that is a record that must be kept by the provider?

A. Yes.

Q. If we turn to page 3, it's the third box. This touches upon what you are saying about restraint. Can we read there:

"It is recognised that on occasion, restriction or restraint may require to be used on an emergency basis,

which had not been previously anticipated. However, where it can be anticipated that children and young people experiencing care may be restricted or restrained, their risk assessment/behaviour management/personal plan ... must include ..."

Then there are a list of issues that must be included in the personal plan?

A. Yes.

Q. On page 4 we are given a list of definitions. Perhaps just pick up the first of these, it is "physical restraint", and there is a definition?

A. Yes.

Q. "An intervention in which staff hold a child to restrict his or her movement and [which] should only be used to prevent harm."

There is the reference to the paper on Holding Safely in 2005; do you see that?

A. Yes.

Q. That quote has been taken from that paper?

A. Yes.

Q. What the provider is being told is that all instances of physical restraint must be recorded and follow the organisation's reporting procedures, they should also be reported to the Care Inspectorate?

A. Yes.

Q. This would be by the notification process that we have seen?
A. Yes.
Q. When you inspect a provider, are records in relation to matters such as physical restraint, records that you would look at as a matter of course?
A. Yes.
Q. Would you check to see if there is a reference to an incident whether or not it had been notified to the Care Inspectorate?
A. Yes, we would sample those to check that they correlated. Not all of them, but we would sample some.
Q. This is perhaps an example of guidance -- albeit mandated by the legislation -- being provided to providers as to what they must do and keep, so that you can inspect and see what has been kept?
A. Yes.
Q. This goes back to something I think, Andy, you mentioned earlier this morning, and this is under the heading "Current inspection procedures and activity".
LADY SMITH: This is section 7 on page 25 --
MR MACAULAY: Yes.
LADY SMITH: -- in the report.
MR MACAULAY: It is section 7, yes. The subheading is "New regulatory developments".

Here you draw attention to the findings of the Independent Care Review in 2020. Just more generally, in relation to that review, you describe it as a transformational agenda. Is this something that's impacting upon your work as the Care Inspectorate?

MS HAPPER: Hugely, yes.

Q. Have you workstreams in place to respond to what has been set out in the review?

A. We do. We have six separate workstreams that interconnect, so they shouldn't be seen as completely separate silos, but it's just a way of managing a quite complex agenda. Those have different levels of activity depending on what they are focused on. They are focused, for example, on skilling our workforce, making sure that our own staff are as equipped as they can be for the job that they're doing and understanding the experience of children, experience -- improving their ability to hear, to listen, to engage with children and young people, particularly children and young people with communication difficulties.

We have another workstream that was looking at all the inspection frameworks that we use, making sure that we were thinking about The Promise and making any changes for that. Those are just examples, we have six different workstreams around that.

Q. I take it the Care Inspectorate in particular was targeted by the review because of the position you have in relation to the inspection of services?
A. Yes.
Q. One change that you mentioned earlier, Andy, to do with a new singular key question, 'Key Question 7', was that not prompted by the review?
A. It wasn't entirely prompted by the review. Certainly the review was very important because it was about looking -- we talked about outcomes earlier on. It was trying to focus on what the experience of children and young people were and what the outcome was. What was the impact on that child of that service? That was certainly prompted by and accelerated by The Promise.

Distilling it down to that, let's cut to the chase question, as I said earlier on, the pandemic also featured. It was just that the two things very much came at the same point of time, around 2019/2020.
Q. Can we then just look at this document, it's at CIS-000009237.
LADY SMITH: I was about to ask you if we were going to Key Question 7, Mr MacAulay. Thank you for that.
MR MACAULAY: This is it, I think, isn't it?
LADY SMITH: Yes, it is.
MR SLOAN: Yes.

MS HAPPER: Yes.

MR MACAULAY: The main heading:

"How well do we support children and young persons' well-being?"

We are told: "This key question has two quality indicators associated with it. Children and young people are safe, feel loved and get the most out of life." Feel loved, quite a high bar?

A. It is.

Q. 7.2:

"Leaders and staff have the capacity and resources to meet and champion children and young people's needs and rights."

Do we see, as we move on to the following page, page 2, a similar sort of layout as we had seen in the quality framework?

MR SLOAN: Yes.

Q. I don't think I need dwell on that. We were again given very good examples and weak examples.

How does this blend in to the quality framework and the key questions that we see there?

A. Well, 7.1, quality indicator, the key areas -- which are the bullet points there, "Feel safe and are protected from harm" -- and the quality illustrations reflect the areas of practice and outcomes from the quality

framework of 1.1, 1.2 and 1.3 primarily, with some aspects of, I think, 2.1.

What they do is we have distilled and levelled up the outcomes contained within that, so there is a match, so almost key question 7.1 distills those aspects of those other parts of the quality framework and other key questions into one. Then key question 7.2 distills the aspects of quality of staffing, quality of management and leadership.

So actually you can, as a service, see the progress when you look at the language and the areas of practice and the illustrations and Key Question 7, you can see that that is distilled from the previous key questions.

Q. When you say distilled, are the previous key questions superseded?

A. No. What we have chosen to do is inspect against Key Question 7 in the previous inspecting year and this inspecting year, but the entirety of the quality framework, you know, it is still a holistic document, although Key Question 7 has been added. We say in our inspection guidance that at any point if there is a particular practice issue we can still bring in another key question or quality indicator if we wish.

LADY SMITH: Mr MacAulay, it's 1 o'clock.

MR MACAULAY: That is a good time to have a break.

LADY SMITH: We'll stop for the lunch break and I'll sit again at 2 o'clock.

Thank you very much.

(1.01 pm)

(The luncheon adjournment)

(2.00 pm)

LADY SMITH: Helen and Andy, welcome back. Are you ready for us to carry on?

MS HAPPER: Yes.

LADY SMITH: Thank you.

Mr MacAulay.

MR MACAULAY: My Lady.

Before lunch we looked at the new Key Question 7, that was a reference to paragraph 7.1, on page 25, and also paragraph 7.2.

At 7.1.3, you make mention of a template for care staff interviews at inspection. Can you tell me about that?

MR SLOAN: Yes. We had a review after we received the Edinburgh Report, about just the history of the experiences in --

LADY SMITH: That's the Secure Services report?

A. Sorry, yes, just to be clear.

We just wanted to see what learning there was from that. One of the key bits for us was we looked back at

the report, we had spoken to a lot of young people, we had spoken to a lot of staff, we had spoken to a lot of external professionals, but we didn't seem to be getting to what some of those staff were mentioning to that review, about the pressures they felt about not being able to whistleblow and other aspects.

So we just reflected on how we interview staff at inspection. Part of that was do staff think that they represent their service and that what we're asking is a test? So that actually the last people they are going to speak about anything is to the inspector, because they think it will reflect on them as individuals.

What we did was we set up a template for care staff interviews, which set quite an explicit introduction that described what our expectations were and that they were to be seen as a witness and an assistance to us, rather than as they were seen as a representative, to try and put them as ease, because you are going in there as an Inspector, three days every year, the staff don't have a relationship with you ... know that they can trust you, so we built that preamble around to try to put people more at ease.

That template, also, we decided that we were going to ask every member of staff three explicit safeguarding questions at every interview. That was also designed to

make sure that those safeguarding questions were explicit and consistent at every inspection, but also again to set care staff at ease, because they weren't being asked these questions that they might perceive as an accusation, or that they were failing in their practice, but as something that we ask every member of staff. This is about the safeguarding of children and those questions, so that's the development of the care staff template.

Q. Is that template related to all children in care services, not just secure care?

A. Not just secure care, yes. Well -- yes, for care homes, school care accommodation and secure, yes.

Q. Edinburgh, the ESS Report related to a secure unit?

A. Secure, yeah, but we think that the principles are potentially the same of care staffs' perceptions of us, you know, and potentially how we elicit that information, that they feel they can trust us.

Q. The Edinburgh Report I think was 2021?

A. 2021, yes.

Q. When was the template prepared?

A. It was ready for April 2022, so for the next inspecting year.

Q. I don't think I've spotted it in the documents you sent us. Have you sent it to the Inquiry?

MS HAPPER: I'm not certain.

MR SLOAN: No, I'm not -- we can.

MS HAPPER: We'll find out.

Q. Certainly understanding what you have said, you do mention it in the report, so you may have done, I just haven't --

MR SLOAN: It's an appendix to the addendum inspection procedures for children and young people's inspectors, but we can send it to you.

Q. We can check and let you know. You have sent us a huge amount of documents.

The next point I want to pick up with you, and I should have done this earlier, but I missed it out in passing. That's point you make at 6.5.3, page 17, that in 2017/2018 a dedicated inspection guidance for secure accommodation was developed?

A. Yes.

Q. Can you just help me with that. What was the background to that?

A. There was a realisation on part that the complexity of needs of young people in these services and the complexity of the dynamic of the services themselves, plus that while they were described as one service you actually had three or four distinct units within one service, so for example there may be three distinct

secure units within that one service, required additional resources for us to be able to have the level of intensity of the inspection that we felt these services merited.

It was also to reflect that if we were going to put in a team of inspectors to these services, as the plan was, that what we needed to do was we needed to make sure that that was co-ordinated and that each aspect of each of these units was covered, so it was to give some additional guidance to inspectors within a wider team inspection, and also just to reflect some of the additional aspects, for example, seclusion, searching or whatever, just making that explicit within the guidance about the things that Inspectors would look at as part of core assurances.

Q. Would Key Question 7 still be relevant?

A. Oh, yes. It was really supplementary guidance about the process of inspection rather than the framework of assessment that we would use.

Q. If I could put this document on the screen and see if this takes us anywhere, it's at CIS-000009295.

It's headed "2022/2023 Inspection Procedures Secure Accommodation Services".

A. Yes, that's last year's iteration of those procedures.

Q. That is what you have been talking about?

A. Yes.
Q. It gives detail in relation to inspection preparation, that is the first head.

Then we move on to page 2, "Pre-inspection planning information", which would involve looking at inspection notebooks, copy of last inspection report, copy of previous action plan, copy of the SSIP.

Is that hugely different from what you would have for, let's say, a residential care school?
A. No, no. No. It probably is quite similar to the practice for a large special residential school, yes.
Q. If you look at 3.3, where you talk about the timing and length of inspections. We read:

"The timeframe for all inspection fieldwork would follow the same structure, taking place over two weeks, two to three days a week and one or two days in the following week, week two."
A. Yes.
Q. Again, is that different to what one might find for a residential care school?
A. Yes. I think that -- well, the methodology is peculiar. Normally for a mainstream boarding school or a special residential school it would be one block of time. You would start on potentially the Monday and finish on the Wednesday of that week. But I think the secure

accommodation team -- well, I'm the lead for the secure accommodation -- the complexity of the service and complexity of needs, it was felt that what we needed to do was have some time for reflection and evaluation outwith the service halfway through the inspection to be able to begin to build our evaluations outwith the service and then also afford some planning time in the next week about what further evidence that we wanted to collate and triangulate.

Q. Would these inspections that this was geared for, would they be joint inspections?

A. No, these are for Care Inspectorate Singleton inspections.

Q. When you say Singleton, it doesn't mean one person, it means the Care Inspectorate?

A. It means the Care Inspectorate, yes. I think what we have tried to build and that was where that additional resource was, that there may have been a single inspector or two inspectors previously and now it's a group of three or four inspectors.

Q. If we move back then to section 7 on page 26, there is a section headed, 7.2, "Pre-inspection planning".

You detail there what you do before the inspection is carried out. One of the things you tell us there is that you seek to make contact with children and young

people. Can you just tell me about that?

A. Well, prior to the inspection a letter goes out. So we try and stagger it in quarters, if we can, just so that services don't perceive that when they get the letter from us that they're going to be inspected in the next week or so and it makes their --

Q. Because these are unannounced --

A. Because they are unannounced inspections but we need that pre-inspection information, so we're just trying to find that balance between allowing it to have the integrity of being unannounced but getting that pre-inspection information that we need to be able to begin to assess the evidence.

So a letter will go out to the service asking for the details of external professionals, the names and addresses of the external professionals, that are involved in the service or social workers that have placed young people and then there will also be links to two questionnaires, one for care staff and one for children and young people.

Those links are opened up and a staff member or a young person can fill that out, can fill that questionnaire out, from that link. It then gets transported or sent back to us and business support then collate that into an information pack that goes into the

inspection notebook that gives the inspector an assessment of that feedback.

Q. I take it from the way you have put this, this is all online, is it?

A. Yes, this is all online.

Q. Previously had there been a system whereby children might have been invited to write?

A. Yes. Previously the first iteration of getting care staff and children and young people's feedback was through paper questionnaires.

Q. But for children who nowadays in particular are more attracted to online systems, this is probably a step in the right direction?

A. I think it's right to say it's a step in the right direction. I still think an electronic questionnaire is not where we want to be. I think children and young people live in app land now, and I think that's where we need to get to, if I'm being honest.

Q. Are you heading that way?

A. Yes. Yes. There are a range of ICT developments, but I think that's where we need to be in terms of true accessibility for children and young people.

Q. Are you able to give us any feel for what response you are getting at the moment through this mechanism, from children?

A. From children. I think it's variable, to be honest. I think sometimes we get a good response rate and sometimes we don't. A lot of the time it can be down to actually care staff themselves encouraging the young people to actually complete it. I don't have any figures about the percentage of return rates unfortunately, though, no.

Q. Any particular care environments that are more productive than others?

A. I think the school-based environments probably are better, because I think sometimes what happens is that if there's a PSE class or whatever they'll go, "Right, now's your chance to fill in the Care Inspectorate questionnaire that you got", and it's done in a more organised way. Well, I think probably within a care home environment, because it's more fluid and dynamic within the structure of their living environment, that's probably less so. It's less structured.

Q. Even more less so in secure accommodation or not?

A. No, I think secure accommodation has that structure where I think that -- because there's an education element to that and because of the dialogue there, I think secure accommodation I think our response rates are probably better than care homes, but that would be anecdotal. I'm giving you from a feel rather than any

direct evidence I have.

Q. I think you mention that at this time, prior to inspection, that the manager of the service is also requested to send contact details of social workers?

A. Yes.

Q. Does that allow you then to contact the social worker directly?

A. Yes. What we then do is we then send out an email with a questionnaire or questions asking them for their comments and views on the service and how their young person is being cared for.

Do you want me to expand on that?

Q. Yes, please do.

A. We know that a response rate from placing social workers is poor, it's really poor. We've identified that and we have a project ongoing at the moment with an inspector, so we are working with two Local Authorities and have developed focus groups just to get some sense of understanding from placing social workers about why they may not be giving us the feedback when we send it out to them.

We've got some fantastic intelligence and information about why that is the case. I don't think the report has reached Helen's desk yet about that feedback, but there are a number of really, really solid

strategies now that I think will improve that. So we're going to do a video for social workers, so that that can be part of their induction.

We're talking about potentially going into the final year of social work students at university in their placements to give some discussion about the Care Inspectorate, so that they have a real understanding when they are placing young people about the role of the Care Inspectorate. Because what we found was that their understanding of the Care Inspectorate was actually based on the strategic inspection process, when they felt they were being inspected, rather than their role as a partner in the process of the care of the child in the service.

Q. We must remind ourselves that the Care Inspectorate now inspect the service?

A. Yes, yes.

So that's been some fantastic intelligence, which I think will be able to move us forward quite significantly.

Q. If we look at this document, CIS-000009824, you will see this is headed, "Template 2: Residential services for children and young people - obtaining social workers' views."

This is a template-type email or letter you would

send?

A. Yes.

Q. The social worker then would know that an unannounced inspection was planned?

A. Yes.

Q. Clearly you would expect that to be kept confidential?

A. Yes.

Q. This template goes on to remind the social worker:

"Placing social workers play a vital role in keeping children and young people safe and ensuring they have the best possible outcomes and experiences. With this in mind, we would very much appreciate your views about the quality of the service and how well it is meeting the needs of the child or young person for whom you are responsible."

You are inviting feedback and I think what you have said to date it's been poor?

A. Yes.

Q. By "poor" do you mean no response?

A. Just not the level of response that we would expect. I think I would be expecting most social workers to respond to that request, and we're not getting that at all. I think they're probably the most stable continuous presence for that young person throughout their journey, from arriving at the care service, their

reviews, the visits that that will take, so their feedback is really important. That's what we want to get more of.

What I would say is that inspectors will also phone social workers. If we don't feel we're getting enough feedback or if the triangulated evidence is suggesting that we would want to make sure that we have contact with social workers then we do do that and that's done, so this isn't just the one opportunity.

Q. You mention I think in the previous paragraph that you also make available to the children an animated video?

A. Yes.

Q. What does that tell them?

A. I suppose just in a very accessible way, just with graphics and cartoon characters. But with a voiceover of some of the young inspection volunteers, about the purpose of the inspection, what they can expect and why the inspector wants to speak to them.

Again, it's just trying to make sure that when that stranger crosses the threshold on an unannounced basis that the young people are prepared for that and feel more comfortable with that situation, and don't feel that they're part of the inspection in terms of being tested as well.

Q. Clearly, from what you're saying, a significant amount

of pre-inspection planning has to take place before you knock on the door of the service?

A. Yes.

Q. Could you look at a document at CIS-000009268. Again, we see the Care Inspectorate logo at the top. If we move down a little bit, can we see this is described as being "The inspection handbook for 2016/2017, joint inspection of services for children and young people". So this is dedicated to joint inspections?

MS HAPPER: This relates to the strategic-level inspections, not an inspection that would be carried out of a registered care service between Education Scotland -- I was about to say HMIE, betraying my age -- and the Care Inspectorate. This is about our joint inspection work that was carried out under another part of the Act. We're looking at how Social Services work with health and police and so on to keep children safe in a Community Planning Partnership area. That is the handbooks for those.

Q. Where it sets out in appendix 3 a week-by-week, blow-by-blow step, that is for that situation, not for inspection --

A. Yes.

Q. -- of the premises?

A. Yes. It's a much bigger and longer enterprise.

Q. It's certainly a long handbook.
A. Yeah.
Q. You have a section that's headed at 7.3, page 27, "Inspection fieldwork". I think that is focusing on the inspection itself?
MR SLOAN: Yes.
Q. You set out what inspectors seek to do and top of the list you say is speak to children?
A. Yes.
Q. That's very important?
A. Yes. It's a central component to our inspection activity. I think recently we have tried to refine that by making sure that children and young people recognise that by ... I think traditionally practice would have been that we would have gone in to speak to the manager for an hour or so and set the scene and find out the evidence and then go out, but we have tried to shorten that initial visit and make sure that we get out to see the children and young people, allow maybe one of the children to give us a tour of the accommodation themselves, you know, so that we can try and develop that relationship as quickly as possible.
Q. The children you speak to, how do you identify those that may want to speak to you or you may want to speak to?

A. Just by asking them actually. We'll also try and share a meal time with them as well and sometimes just that informal reaction then allows us -- for example, if an inspector might have asked in the first couple of hours whether a young person would like to speak to us and they'll say "no", but a game of snooker, sharing a meal, them having the opportunity to have a look at their bedroom and discuss a poster on the wall, then allows perhaps on the second day of the inspection, if the inspector asks again, for that young person potentially to go, "Aye, okay".

If not, then what we would do is the inspector would try and gather those views more informally than through an interview. We wouldn't call it an "interview", it would be a chat or a discussion, might it be through a shared activity or a meal time, whatever, and we just try and generate conversation through that, if the young people or young person would feel uncomfortable on that one-to-one basis with the inspector.

Q. From what you say then is it important that inspections take longer rather than a shorter period?

A. Yes.

Q. Do you have a benchmark -- I suppose it may depend on the size of the provider?

A. Yes. Well, we have a workload management tool, which

sort of attaches a rough resource to service size and service risk and service type, so that gives some ballpark figures for the amount of time that inspection would take.

Q. In a general way, are you able to tell us about your own experiences then from dealing with children, whether you do glean information that's very important to the outcome of the inspection?

A. I think it's one of the most challenging things that we ask inspectors to do and one of the most challenging things we expect of young people at an inspection. Really, when you think about the level of trust that has been breached for these young people with adults and then to expect for them to communicate to a stranger, who they have no history with at all, in terms of whether that person's trustworthy, they're then -- I mean, there is a whole complexity about the complexity of relationships, these staff may be quite nice to them at times. So they've got a loyalty to the staff, so do they tell the stranger what some of the things are that they aren't happy with?

Of course we will get young people that will be quite vocal and comfortable with expressing their views, but there is that basis which inspectors have to try and pierce really in a very short timescale. It's one of

the biggest challenges and one of the things that the inspectors, I think, have to be the most skilful at in terms of trying to elicit that.

Again, that also is the totality of triangulating the other evidence.

Q. That is what I was going to ask you about next.

Before we come to that, do you find that the more vulnerable children are more reticent or is it ...

A. Well, I don't want to -- you know what, I don't want to lump -- it's easy to do that. But I think, yes, I think that the young people that are more distressed, are more traumatised will have the most challenges in sharing and exploring how they feel. I think that's probably a given. But I don't want to lump groups of young people. But I would say that would be the case, yes.

LADY SMITH: I suppose you could say, yes, there are always some young children and young people who are reticent, and among that group there are likely to be quite a number who have particular vulnerabilities, probably because of the trauma in their background.

A. Yes.

LADY SMITH: Do you also experience the default position of the children and young people you are speaking to, being they're not going trust you, because they've learnt not to trust people in authority and not knowing you, they

have nothing to go on to change that default belief?
A. Yes. I think that is something that inspectors are going in and facing, yes.
LADY SMITH: You have to be aware of that all the time?
A. All the time.
LADY SMITH: And you must never let them down and prove them to be correct in their inclination not to trust you?
A. Mm hmm.
MS HAPPER: I think another aspect, perhaps slightly less so, possibly, for secure, because children usually are there for a shorter period of time, but for many services that is a child's home. So if you think about your own home it's okay for you to criticise it, but it's painful when other people do. We have to be mindful of that all the time and be skilled in understanding that, that reticence may come about from lack of trust and so on. It may come about because young people find it difficult to discern what ill-treatment is sometimes, depending on their past experience. But it also sometimes might be that it might not be great, but it's the best place you've got and the fear of being moved or something happening is great. So we need to understand and hear of it through all of those lenses.
Q. You mention triangulation, can you just tell me what you

mean by that?

MR SLOAN: I suppose it's evaluating the different types of evidence that we will source at inspection. Primarily that's observation, examination of policies and procedures and documentation and then interviews and it's about matching that information, what evidence supports the other evidence or suppositions that we're seeing, what contradicts that, so being able to then come to a holistic assessment about where the strengths and areas for improvement within the service lie.

Q. As you point out, the views of children when you obtain the views in this triangulation process are critical?

A. Yes.

Q. You also say, and I think you touched upon this this morning, that there is ongoing feedback given to the service by the inspectors in the course of the inspection?

A. Yes.

Q. How does that operate in practice?

A. Our inspection procedures are very clear, and I think as a culture within the organisation is that we believe that when you get to the feedback component of the inspection there really shouldn't be any surprises for the service. They should have some picture of what that evaluation is going to be. So that's done in a variety

of ways by the inspector, so that might be when if there's a question over a particular piece of evidence or something that they've heard, they may ask the manager for example to explain that or to try and tease out what that contradiction might be.

It would also be at the end of the first day of the inspection, just to give an overview of what they've looked at and their initial findings and bits of evidence that they might want to see, so that the manager themselves are taken on the same journey as the inspector. Not necessarily in relation to the actual evaluations and grades, but where the areas of practice are that we have seen that are stronger and the ones where we think that we want to see more evidence of.

Q. You also mentioned that a week or so later you have a more formal feedback meeting with the managers?

A. Yes. I think that's one of -- that's been quite a significant change pre-pandemic to post-pandemic. Pre-pandemic, feedback was usually given immediately after the fieldwork. The fieldwork would be completed, the inspector would still be in the service and collate their evidence and then feedback would be given.

During the pandemic, there was a much greater emphasis on desktop evidence gathering and clearly we didn't want to go back into the service to give

feedback, so what would happen was that we would then give feedback a couple of days after that and it would be done virtually.

Post-pandemic, we have kept with that process of inspection because we can see real benefits for it. That's not saying that we'll stick with it, because it has a time implication and a resource implication, but we're sticking with that at the moment where the fieldwork will be completed, the inspector will leave the service and then a couple of days later feedback will be given virtually, via Teams, to the manager and the provider.

Q. So it's still a virtual exercise?

A. The feedback is now predominantly a virtual exercise, yes.

Q. Is it your experience that you do receive some response to that feedback, whether it's at the time or subsequently?

A. Well, the feedback is given in person, so we would always -- I mean, we will always get some response to that feedback, yes.

Q. What I'm really getting at is if you give bad news, could you get a challenge to that?

A. Oh, undoubtedly, yes. Undoubtedly. We would get challenged at the feedback in terms of an explanation of

the evidence or the conclusions that we've reached. There is then a process when we would issue a draft report and then there is a formal opportunity for the service to challenge our evaluations or whether they think that we've missed evidence or whether they think that there are errors of fact.

Q. I'll come to that in a moment.

At the virtual feedback, if we look at that, and there is a challenge, do you simply respond by playing it with a straight bat and being neutral or do you try and persuade why you are saying what you're saying?

A. No, we would try to persuade. We want the service to work with us and have an understanding about what we are seeing, so we want to make sure that if they aren't understanding that, that we can give as much explanation and context to the assessment and the evidence that we have sourced, which we believe supports that, so that they have a greater clarity. Because the improvement is only going to come from an agenda that they own themselves, it's not something that we impose. So it is about trying to make sure that they own that through understanding.

Q. When it comes to drafting the report, do inspectors try and have a consistent template into which they would build the findings and any recommendations?

A. Yes, yes.
Q. If I could put this on the screen then, it's CIS-000010003.

We're looking at a document with the Care Inspectorate logo at the top, and the heading is, "Report writing toolkit: examples of inspection findings".

Is this a guide to inspectors as to how to write a report?
A. Yes, it is.
Q. This is dated 22 November 2021, would this be the most recent?
A. Yes, that's the most recent and also the most comprehensive guidance as well.
Q. We needn't spend time on this, but you would expect then, would you, the inspectors to follow this format? So when we look at reports we'll see there is a consistency between one report and another?
A. A developing consistency, I would say, if I was being honest. But, yes, and I think we have taken a very strong, I suppose, supportive line with this in terms of quality assurance, because we see the benefits of that because if the report follows the elements of Key Question 7 in terms of what we're reporting, then again it helps the reader evidence the integrity of the

evaluation. Because they can see which key area and which part of the quality illustration we have matched in the report if it follows that structure.

It also allows providers of multiple services to be able to look at their different services and be able to see where the different areas for improvement are, evaluations of their practice or outcomes are across services, while if you don't have that report template discipline it's difficult for providers to look at those themes and patterns. For example, if they're wanting to develop corporate training or whatever.

Q. If you take just one example then on page 2, the heading is "Mock examples to support report writing".

We are told:

"The following sections provide examples of evaluative report writing covering all six evaluations under different key questions."

This next part dealing with Key Question 5: how well is our care and support planned? Excellent is what is described. Would this be what would you expect to see if the grading is excellent?

A. Yes.

Q. In all reports, along these lines?

A. Yes, the strength of evaluative language is that's what we are now expecting from inspection reports. I think,

if I'm being honest, that is an evolving management role for us to improve that.

Q. You mentioned evaluative writing. You also have a toolkit for that. If we could put CIS-000010002 on the screen, we see this is described as precisely that:

"Report writing toolkit: evaluative writing."

This is dated November 2021, is this the most recent?

A. That is correct.

Q. This is quite a lengthy document?

A. Yes.

Q. And describes what is meant by the term "evaluative writing". It provides examples. If we turn to page 4, for example, if you look at about a third of the way down from the top, we are told it's a five-step process to help inspectors write evaluatively and clearly?

A. Mm hmm.

Q. Step 1, I think it is an example of what an evaluative statement might be?

A. Yes.

Q. There is an example 1:

"Children and young people (CYP). Staff were highly skilled at engaging positively with children and young people."

So that is the sort of language we would see if it

was to be a high grading in the report?
A. Yes, that is what this report writing guidance was designed to do, one of the purposes was that our evaluations matched, our gradings matched the evaluative language within the narrative of the report.
Q. I take it that inspectors in the report drafting find these toolkits of extreme assistance?
A. Yes. We have had extremely positive feedback from inspectors about not just this guidance but the training that then was undertaken following the issuing of this guidance.
Q. Was this guidance of this kind in place before November 2021 or not?
A. No.
Q. We're looking at the first versions?
A. Yes.
Q. And still the up-to-date versions of this material?
A. You'll have seen that in the inspection procedures for each year there would be some content about the production of inspection reports but nothing to this level of detail or framework of practice for inspectors at all.
Q. The last document I want you to look at in this context is CIS-000010003. This is again to do with report writing. Here we have examples of inspection findings.

Again quite significant guidance is given as to how the findings might be framed?

A. Yes.

Q. Again, we see the date as November 2021, so it's about the same time as the last document?

A. Yes. They were all issued as a menu of guidance for the training that then followed.

Q. If I can turn to page 4 of the document, the first heading we see is:

"Good. Key Question 1 - How well do we support children and young people's well-being?"

We are then given examples of what could be said in that context?

A. Yes.

Q. After the report has been drafted --

LADY SMITH: I'm just noting in passing, that is exactly the same terminology that is used in relation to secure services I think, isn't it, at Key Question 7, that we looked at before lunch?

A. Yes, it would be the same, yes.

MR MACAULAY: You mentioned a little while ago that the draft report, once drafted, is sent to the service.

A. Yes.

Q. You say somewhere, 7.4.1, that you seek to do that within, is it 20 days of the inspection?

A. Yes.
Q. 20 working days?
A. It's now 15. We have changed that at the start of this inspecting year. It's now 15 working days.
Q. It's quite a tight timeline?
A. Yes.
Q. Do you find though that it's one you can comply with?
A. I think there's been really significant improvements in that. I think that's been a journey of travel during the period of the Care Inspectorate, but I think it's now a common expectation. To me I think that's probably the exception rather than the rule that we don't manage to get them out in those times. That wasn't always the case, but I think there has certainly been a culture change in terms of the issuing of the report.
Q. Clearly, the templates we have been looking at would be of real assistance in that connection?
A. Yes.
Q. But I take it that the -- perhaps I should ask you, who would be involved in drafting the report?
A. The lead inspector would draft the report. So they would take sole responsibility for that. It would then, depending on the evaluations and the grading, or whether there was any issues or challenges with it, it might then just go to business support to be formatted and

proof read and then it would be issued in draft form.

If the service had challenged at feedback or if there were poorer grades, then the report would go to the team manager to have a review of before the draft report would be issued.

Q. One of the purposes you mentioned in sending the draft report to the provider would be to allow the provider to respond, for example by correcting any factual errors?

A. Yes.

Q. I'm perhaps more interested in what responses, if you can tell me, your experience tells you as to what you get when you grade a service weak or unsatisfactory. Do you have any sense as to, in the past, what sort of responses that message would provoke?

A. On occasion -- again, I wouldn't want to lump all providers together, that wouldn't be fair. There are many providers that if they have a poor service are accepting of that and express complete acceptance of the findings and submit an action plan, even prior to the draft report being issued, in terms of the actions that they would like to take.

For other providers and services who have poor evaluations, there are pages and pages and pages and pages of an error response form challenging, almost forensically, every evaluation or piece of evidence or

interpretation of the piece of evidence that we have assessed. So that just is part of what is an expectation when an inspector grades a service.

Q. Are you telling me that it's unusual or not unusual for a provider to challenge?

A. It's not unusual, sorry.

MS HAPPER: It's also not only when inspection findings are poor. We sometimes have challenge that people believe we have graded them as good and they should be very good or they are very good and they should be excellent. So it is more likely to happen with poor findings, but it's certainly not exclusive.

Q. How do you deal with that then? Does the lead inspector carry out any sort of review?

MR SLOAN: When we receive an error response form and there is a challenge -- if there is an error response form and the challenge is really about errors of fact or whatever, the inspector is delegated just to deal with that themselves. If there is a challenge to the evaluations, then a quality assurance process is undertaken with the team manager. So we would review the inspection notebook, the draft report and then meet with the inspector to review their evidence and findings against the evaluations in the draft report. Then there would be a written response to the provider, either

saying that we would accept that or that we were sticking with the evaluations that had been initially drafted.

LADY SMITH: That is a sort of internal appeal?

A. I suppose it is. We don't use that as an appeal -- we don't use that language, but, to all intents and purposes, yes.

LADY SMITH: I can understand and the provider is getting the benefit of somebody else looking at the Inspectorate's homework, and remarking if appropriate.

A. Yes.

MS HAPPER: It's a complicated one, because what we try to do is to make sure that we are not being overly defensive, that we are listening carefully to what a provider has to say and that we are making sure that the process is robust and we can escalate that through the different levels. My phone starts ringing off the hook.

But if you've not been involved in the inspection, it's not for us to say, "We're going to overturn that and change the evaluation". We haven't seen the evidence. So my job at my level, when I'm looking at that, is to be making sure that the process was done robustly, not to get involved in the evidence. That's a really important line for us to tread. Not one that's

always easily understood by providers.

LADY SMITH: Could part of the process checking be, for example, you asking those who were involved whether they had any evidence for saying something they've said?

A. Yes.

LADY SMITH: Because if they did they should be explaining that to the provider --

A. Yes.

LADY SMITH: -- and if they didn't, they may not be able to justify the conclusion they've drawn and they might need to think about that again.

A. That's correct. Sometimes that's about saying: you are able to tell me about something, but I'm not seeing it in the report. You haven't written that well in the report. That's absolutely the job of those less connected with the inspection, to raise that kind of challenge and given the volume that's not possible on every report and it's not necessary on every report, but it does happen. But there's a difference between that and actually saying, "I believe that I know better" in the absence of the evidence, and that really should be recreated ...

MR MACAULAY: I should have asked you earlier, Andy, are detailed notes taken in the course of the inspection?

MR SLOAN: Yes. A dedicated inspection notebook is created

for every inspection, so that's prepopulated with the information that I was talking about in terms of notification summaries, whether there has been upheld complaints, the information about interviews with children and young people and then throughout the inspection there is a structure within it. Then the inspector is inputting that information in evidence or the notification that they've seen, each interview with every member of staff and young person and is noting the record of that as they go through the inspection. Then that is the formal inspection record of the evidence.

Q. If the inspection takes two or three days, then could that be quite a lengthy record?

A. Yes, yes. And for group inspections of secure, you would have four or five inspectors all running their own notebooks and then that notebook is usually collated into one document.

Q. In that situation, would you have some sort of debrief whereby you'd exchange notes with other inspectors?

A. Yes. I think the secure accommodation services guidance which was up, explains there should be a meeting at the end of every inspection day.

Q. Then post-inspection and after the draft has been finalised, it's published?

A. Yes.

Q. You talk about earlier on in your report, you can either have requirements of the provider or you could make recommendations?
A. Yes.
Q. A requirement is a legal matter, in that the provider must comply with the requirement?
A. That's right.
Q. I think you normally give a period of time within which for the provider to comply?
A. That's right.
Q. Would that be something that would be picked up in a subsequent inspection?
A. Yes. So we would -- if there are requirements or areas for improvement made then we would request an action plan from the provider, where they need to return that to us with the actions that they are going to take to meet the requirement or area for improvement and the timescales for that. Then at the next inspection we would then look at the requirements and areas for improvement to see whether they'd been met.
Q. The recommendations, that's not a legal sanction in a sense, but you would expect the recommendations to be followed?
A. Yes, yes.
Q. Would the provider be required to have an action plan to

respond to the recommendations?
A. To areas for improvement, yes, yes.
MR MACAULAY: My Lady, that might be a useful point to stop?
LADY SMITH: Very well.
We'll take a short break just now if that would work for you.
I'll sit again in five or ten minutes, something like that.
(3.00 pm)
(A short break)
(3.12 pm)
LADY SMITH: Andy, Helen, are you ready to roll again?
MS HAPPER: Yes.
MR SLOAN: Yes.
LADY SMITH: Thank you.
Mr MacAulay.
MR MACAULAY: Can I revert back to a point I raised with you after lunch in connection with secure care, I took you to the 1922/1923 inspection procedures for secure accommodation?
LADY SMITH: Did we mean 2022 not 1922?
MR MACAULAY: 2022, my Lady, yes.
Are there also standards called the Secure Care Pathway Standards that were published in October 2020?
MS HAPPER: Yes.

Q. You are nodding, Helen, what are these about?
A. I will actually let Andy tell you about that, because Andy was on the group.
Q. Okay.
MR SLOAN: One of the Scottish Government workstreams historically, I can't --
MS HAPPER: Secure Care Standards.
MR SLOAN: Yes, Secure Care Standards Group, was tasked with developing a set of standards that were designed, I think initially to be transformational for secure care.

What happened was that that committee or group ... The Promise then started at the same time, so much of the work of the committee on secure care was amalgamated into The Promise workstreams.

One of the ones that remained was the development of national standards, so strategic standards, so not at service level, but looking at the secure care environment of young people in their journey from before secure care, their journey through secure care and what happened afterwards.

So a working group was developed by Scottish Government to develop those standards and they were eventually published in 2021. They really are looking at standards for all of the stakeholders involved in the

journey that young people may take who enter secure care. So it's not just for secure care providers, but it's for the NHS, it's for social work departments, for private providers, so it covers the responsibilities of all of those partners or stakeholders, so they were issued and the Care Inspectorate has just for the past year undertaken a review about how those standards are being met across the country.

I think the report is due to be published ...

MS HAPPER: Today.

MR SLOAN: Today.

MR MACAULAY: Does that at all impact upon inspection?

MS HAPPER: It impacted upon on our team, the children and young people's team, both on the strategic side, because that was my second team of people who actually carried out that inspection, along with one of Andy's team.

Also, we looked within that at the inspections of the secure units that had happened and fed that into the piece of work.

Q. I see. That will be on your website today or --

A. Now. I think it was 10 o'clock this morning it was due to be published.

Q. We can access it on the website. Thank you for that clarification.

The next section on page 30 is dealing with future

planned regulatory developments. I think, Helen, you were maybe earmarked to respond to this. Is that correct? It is paragraph 7.6.1 again, I think you looked at the Independent Care Review and the impact of The Promise?

A. These are the workstreams that I was referring to earlier on, the six workstreams that we have.

Q. Yes. You have listed them for us on there.

Then at 7.6.2 you draw attention to the fact that: "In October 2022 the Scottish Government announced:

"an Independent Review of Inspection, Scrutiny and Regulation."

The stated intention of the review which will report in June" -- I know that's not the date any more -- and it sets out the areas that are going to be covered by the review; is that right?

A. That's correct. I believe that report is to be published on Thursday this week.

Q. I think --

A. That is my understanding.

Q. This was a review chaired by Dame Sue Bruce?

A. That is correct.

Q. At least as far as the last minutes go for June, publication was due in September, about now?

A. Yes, I believe Thursday is the date.

Q. Okay.

Will that review have an impact on the Care Inspectorate?

A. I'm sure it will have some kind of impact. What impact it has remains to be seen depending on what Dame Sue Bruce recommends and also what the response of Scottish Government is to that. I have no idea at the moment how far reaching that will be, but like all of those reports, we'll take that seriously and consider its findings and discuss what the implications are for us.

Q. The final part of this section, 7.6.3, you make mention of another two regulatory workstreams that are being piloted to improve inspection practice. Can you perhaps elaborate upon that for me?

A. The second of those is the project that Andy was referring to earlier, around increasing the uptake of social worker feedback, and we're very excited about that.

The first is around piloting different ways of giving feedback to children and young people.

We talked about trust earlier on. One of the really important ways of building trust with children and young people is that you then tell them what you have done with their information. But sometimes by the time we go

back to a service or if we have findings a child may have moved on, so that is difficult. Sometimes interest is gone. Or sometimes it's hard for children to understand what you're telling them if it doesn't accord with their own personal experience, because we're not referencing just one experience. Of course, it's the experience of the whole.

We are looking at different ways of doing that. Andy spoke earlier on about the animation that's been created for us, that we're using. That's been really successful, so we're thinking about developing other ways of that.

We also have our young inspection volunteers are working with us at the moment to try and come up with other ideas. I don't know if you've ever seen a kind of scribbling hand that you see, it's like a cartoon, a film, and as people are talking there is a scribbling hand.

LADY SMITH: Yes, yes.

A. That is one idea that they talked about. Another idea they talked about as a talking head, perhaps them being filmed and the film could be made available online for young people.

It's a way of us really trying to think how do we build that trust by making sure children and young

people get back something from what they've told us.

MR MACAULAY: The next section of the report, section 8, begins at page 31, towards the bottom. The heading here is:

"The role of the Care Commission/Care Inspectorate and its responsibility for the investigation of complaints against care services."

You point out that the 2001 Act required the Care Commission to establish a procedure by which a person could make complaints.

MR SLOAN: Yes.

Q. I take it such a procedure has been put in place?

MS HAPPER: Yes.

Q. The targeted audience for making complaints, children, young persons and staff?

A. Yes, all of those. The number of complaints made to us by children and young people is small.

Q. Yes, I'll come on to that in a moment.

You go on to say that the complaints procedure was established in 2002 and it's been developed since. Complaints could be in writing or by email; is that right?

MR SLOAN: That's correct.

Q. You say towards the bottom of page 32, at this point, at least, that anonymous and confidential complaints were

accepted, certainly at this time?

MS HAPPER: Yes.

MR SLOAN: That's correct.

Q. Over the period there have been reviews of the complaints procedure, is that right, you tell us about that?

MS HAPPER: Yes.

Q. What you do say, at 8.6, is that if the complaint relates to a matter that is 12 months after the cause, that generally that complaint would not be investigated?

A. In general, there are exceptions to that.

Q. The way it's put at 8.6(d):

"Confirmation that the Care Commission would not investigate complaints more than 12 months after the cause for the complaint had arisen, unless in exceptional circumstances."

What I wanted to ask you was, what would be covered by the term "exceptional circumstances"?

A. I could give you a live example actually, without using names. It was actually a parent who has wanted to make a complaint in relation to a matter to us. There was a legal proceeding involved, not for us, but involved in the issue that the person was wanting to complain about and that legal process has taken a fairly long period of time, which has kind of taken it beyond the 12 months.

Now, it would be very unfair of us to say we're not going to now look at that complaint because it's out of date, when the hold-up for that complaint was nothing to do with the complainant. It was to do with a legal process that meant that they weren't able to raise that complaint. So that would be an example of that.

Another example would be somebody who has been unwell and unable to raise a complaint within that space of time.

Q. What about a young person who has left care and been out of care for over 12 months and wants to complain about abuse, would that be covered by exceptional circumstances or not?

A. It would be, but it might not be a complaint for us. It might be a matter for police or for social work or for police to investigation.

Q. If the alleged abuser was still on the staff of the provider, would that be of interest to you?

A. It would absolutely be of interest to us, yes. It might not be an investigation of a complaint. It might be taken as intelligence that we would then act upon. We might then be either speaking to the provider about that. We would certainly be looking to see whether the police were investigating that matter. So, yes, it would be definitely something we'd be interested in and

it wouldn't necessarily be that we would say, "Because that's over a year old we're not interested in it". But depending on the circumstances, it might not end up as a complaint investigation. It might be some other kind of action. We might go and inspect, for example.

Q. Insofar as the police are concerned, would you liaise with the police if such a complaint was made to you?

A. Yes.

Q. Do you have a process whereby that happens?

A. Yes.

Q. Can I ask you to look at this document, CIS-000009243. We are looking at a document that reads:

"What you can do if you are unhappy about a care service."

If we just read down, I think that's as far as that goes.

LADY SMITH: The document has eight pages to it, Mr MacAulay.

MR MACAULAY: Yes, this may not be the document I wanted to look at first.

What is the target audience of this document?

MR SLOAN: Is it okay if it scrolls down a wee bit?

MS HAPPER: It would be good to see.

This is our general complaints leaflet, so it's not specifically designed for children and young people.

LADY SMITH: It's all care services, isn't it, as we see from the "use the service complaints procedure" paragraph.

MR MACAULAY: Okay.

The other document then I want to look at, again it may be a generic document, is it CIS-000009308. If we scroll down:

"How we deal with concerns and complaints about care."

Is this a generic document?

A. Yes.

MR SLOAN: Yes, yeah.

MR MACAULAY: Would this document be open for access to a child or young person in care?

A. It would be, because it would be on our website, yes. I'm not sure how accessible that would be for them, but it would be available for advocates or Children's Rights Officers or -- yes.

MS HAPPER: Or parents.

MR SLOAN: Or parents and carers.

Q. The other document I want you to look at is CIS-000009278. This document is dated 13 June 2019, it's headed "Complaint procedure". Again, is this a generic document for all services?

MS HAPPER: Yes.

MR SLOAN: That's an internal document.

MS HAPPER: It's an internal document for staff to use.

Q. Staff in --

A. In the Care Inspectorate.

MR SLOAN: Yes.

Q. We looked earlier at paragraph 8.5, you do say there that anonymous and confidential complaints are accepted?

MS HAPPER: Yes.

Q. Is that without qualification?

MR SLOAN: No -- well -- no, it isn't without qualification. Confidential complaints will be accepted, but with anonymous complaints then there is a degree of discretion that's used about whether the nature of the allegation means that a meaningful complaint investigation can take place, because sometimes there isn't the level of information that allows a complaint investigation to take place. In those situations that would revert back to the caseholding inspector as intelligence.

What we would then do is write to the service provider with the detail of that saying:

"Look, we have received these concerns. There isn't enough there for us, through the nature or the narrative, to investigate a complaint. However, you should be made aware of it and take any actions that you

feel are necessary."

Q. What you say at 8.6(c), on page 33:

"Clarification that the Care Commission would only investigate anonymous complaints where the principles of openness ought to be over-ridden in the interests of people receiving care."

So there is that qualification?

MS HAPPER: Yes.

MR SLOAN: Yes.

MS HAPPER: I don't know if this would be helpful to understand the context, but we have been doing a bit of thinking about the difference between anonymous and confidential complaints, because we were getting quite a high number of anonymous complaints, which soak up quite a lot of staff time in trying to work out what they are.

There has been a rise in those since the kind of advent really of social media, so things come through Facebook and so on. Sometimes a series of complaints, anonymous complaints that come often through the night, where somebody says something and then an hour later they say something else and something else and it's building.

But we were still left even after all that work to look at it without enough information, as Andy says, to

really assess that information or be able to take that forward as a meaningful investigation. So we have tried now where we have contact with people, if it comes via social media and we can't access the person, there is very little we can do about that. But where we have contact with the people -- we used to say: do you want this to be anonymous? And people often said "yes".

Now what we do is we explain to them that it doesn't have to be anonymous but it could be confidential, because sometimes that's people's worry, that they don't want to be exposed for being the one raising the complaint. It's early days to see whether that's going to make a difference, but we're hopeful that that may make a difference to reducing the number of anonymous complaints and making sure that we can still investigate those and get full information but still protect the safety, the anonymity, of the person who has --

LADY SMITH: Am I to understand you are drawing a distinction between people who complain in circumstances where you know who they are, but you are giving them an assurance of anonymity so far as disclosure to the outside world is concerned or indeed disclosure to the service --

MS HAPPER: Yes.

LADY SMITH: -- but there are others who are wholly

anonymous and I suppose that will, as you say, be in circumstances where you have no means of going back to them and asking for further information for clarification purposes or otherwise.

Do you also experience anonymous complaints coming in gratuitously offensive language?

A. Yes.

LADY SMITH: What do you do about those?

A. If they're anonymous there's nothing we can do about it, other than delete them.

LADY SMITH: Delete them.

MR SLOAN: My team has experience where we would clean them up though and make sure that that -- if there is some piece of narrative there that can be made into an objective concern, that we would still pass that on to the service, and that's been a recent development in the last couple of years, is to make sure that while we may be withdrawing complaints, services and the providers still know them. Because they may have another piece of the jigsaw that we don't have, that helps them in either their quality assurance or their performance management of staff, for example.

LADY SMITH: But these are very difficult circumstances?

A. Yes.

LADY SMITH: Thank you.

MR MACAULAY: Helen, you are going to go on to give us some sort of sense of the volume of complaints, particularly from young people, and you do address this in the report.

I think the point you make is that the volume of complaints received from services for children and young people has always been very low compared to adult services?

MS HAPPER: It is low and we don't know all of the reasons for that. It may be that young people have other routes to complain to. They have anonymous boxes in services. They have Children's Rights Officers and so on, so maybe they have other routes which they can express concern.

It may be that their view of the Care Inspectorate is just that they don't know who we are, why would you ask, why would you raise a complaint with an organisation you don't know? They don't understand our role particularly.

It may be that children are afraid and they don't trust us or it may be that we are not making ourselves accessible enough to young people. In terms of that latter question, that's why we're doing that work, around we have started a text to complain medium, so that young people can text us rather than having to write or phone us. We investigate all complaints that

come directly from children and young people, as opposed -- we do triage services but we make contact with children and young people rather than -- where that's not always the case for adults and older people services. So we are trying to build trust there.

We are, as Andy explained earlier on, putting a lot of effort into our profile and presence when we're in an inspection, hoping that young people talk to each other and as well as that might just plant a seed that in future they might be able to come and speak to us about something.

Also we are using our young inspection volunteers to try to help us think through better ways of communicating, we'll see whether that makes a difference. I mean I hope it will and I hope it will drive up the number of complaints, because I do believe that there are complaints there to be made. But we also have to make sure we don't just rely on complaints from young people as a source of -- we don't take false assurance from the fact that a low level of complaints means there is nothing to be concerned about.

Q. You do provide the statistic on page 34 that complaints research from 2019 showed that less than 1 per cent of the 1,400 children and young people in residential care settings raised concerns?

A. Yes.

Q. It's very, very low?

A. It's very small.

Q. If we move on to the next section in the report, that's on page 35 and the heading is "The role of the Care Commission/Care Inspectorate and its responsibilities for enforcement against care services".

Again, you are looking at what powers have been provided to you by the legislation and the regulations. We have talked about improvements, there is also a power to impose conditions. Can you just explain that to me, what happens in practice?

MR SLOAN: Well, a service will have its registration certificate and it will have a number of conditions of registration placed on it. That's mostly just to do with the numbers of young people that are allowed to be accommodated in the service and its care service type.

But there may be situations where we may want to place a condition in terms of the operation of the service in terms of for example we may want to limit the numbers or limit the age range of young people that could be accommodated at a service at that time. So that would be a condition that we would therefore impose to make sure that the service operated within those more constrained conditions.

Q. We have touched upon improvement notices. If an improvement notice is not complied with, what then happens?

A. If the improvement notice is not complied with, the next stage of the process would be to -- well, if it's not complied with, because we would have undertaken monitoring visits to assess whether the requirements in the improvement notice were being met. If they weren't being met, then we would then move to a proposal to cancel the service's registration.

From that point we would then move -- there are rights of representation to the provider, a right to appeal to the Sheriff.

The next stage of the process would be a decision to cancel the registration of the service.

Q. Cancellation means effectively the service closes down?

A. It ceases to operate.

Q. You also indicate that you can apply directly to the Sheriff for an order to cancel registration, would that be in an emergency situation?

A. Yes. I think it's where there are serious risks to the health, welfare and well-being of users of the service, so the threshold for that is high.

Q. I think it's been tested in court in fact --

A. Yes, though not with children and young people ...

Q. -- in connection with Moore House School?
A. Yes.
Q. I think we heard from Professor Levitt about that.
The test is high. There will be a serious risk to the life, health or well-being of persons. If you can meet that test, then you can obtain an emergency cancellation of the service?
A. That's correct.
Q. Has that ever happened in the past?
A. Not in children --
MS HAPPER: Not in Children's Services, it's happened in Older People's Services.
Q. There are other provisions that allow for cancellation. For example, I think in a section of the 2010 Act, if a person is convicted of an offence, a relevant person, being a manager or -- then that would lead to cancellation of the service?
MR SLOAN: I'm not sure if that would lead to cancellation of the service.
There may be aspects in relation to the fitness of the provider or the manager, which would then lead to enforcement activity, which could lead to the cancellation of the service, yes.
There is also --
LADY SMITH: So that then would involve SSSC?

A. For the individual, yes.
LADY SMITH: The fitness for the individual?
A. Yes.
MR MACAULAY: If I just read this out from the 2010 Act, section 64:

"The Care Inspectorate (SCSWIS) may at any time after the expiry of the period specified in the improvement notice given in respect of a care service propose to cancel the registration under this chapter of a care service, on the ground that any person has been convicted of a relevant offence in relation to the service."

That is in the context of where there has been an improvement notice, presumably telling the service to remove the person convicted?
A. Yes. So it would be within the process of an improvement notice, that is correct.
Q. The offences are offences that are often offences under the Act or the regulation or an offence which, in the opinion of the Care Inspectorate, makes it appropriate that the registration should be cancelled. So you do have a degree of discretion or exercise of judgment when it comes to consider what offence might qualify to justify going down the cancellation route?
A. Yes, yes.

MS HAPPER: Yes.

Q. You move on then in the report to a section that's headed, "The Care Inspectorate's responsibilities for safeguarding and child protection". I think both of you are happy to contribute to this particular section.

You begin by making the point at 10.1 that the protection of children is a key consideration in all inspections of services for children and young people; is that right?

MS HAPPER: Yes.

MR SLOAN: Yes.

Q. And:

"Child protection is a 'core assurance' that the inspectors will explore at every inspection."

MR SLOAN: Yes.

Q. How do you set about doing that?

A. Well, our inspection procedures, which I think we submitted, that involves -- again, it's about the triangulation of evidence. We'll look at the documentations and records that relate to child protection, whether that be the Child Protection Policy, allegations of abuse, restraint records, safeguarding records, allegations of misconduct within the documentation that relates to child protection.

We are then looking at the staff training records,

to look at the inputs that they've had in relation to child protection and safeguarding and associated aspects. Child protection in its widest sense, we'll be looking at, for example, the training on restraint and the training on whistleblowing or whatever.

Then we're looking at, as we talked about the triangulation, the interviews with staff about their knowledge and understanding and confidence, about the implementation of those aspects of safeguarding.

Then we are speaking to children and young people about their experience of feeling safe, their confidence in staff actions. If they had a concern, their sense about whether there is bullying in the service, whether they believe that staff would act on that and then speaking to the external professionals about do they feel that the service is notifying them of those incidents, that visitors are welcome to the service, that the young person that they've been speaking to has been reporting about the dynamic and the feel of their safety within the service.

That's how that core assurance is built up.

Q. How common in your own experience, Andy, would it be that a child would say to you, "I don't feel safe, because I am being bullied by another child"?

A. I would say that's uncommon, yes.

Q. One thing you say in the report is that a child or young person would be asked if they had a particular person that they trusted. What would be the thinking there? Would you then be moving on to say: do you want to speak to that person?

A. No. I think that's really about their home life and whether they feel secure in terms of having a trusted individual who they can turn to if they have a concern about their safety or any aspect of either where they live or their family life outside.

Q. You are focusing on two areas there. You are focusing on the institution itself and whether or not there is a trusted person that the child could say to you, "I trust him", is that right?

A. Yes, that's correct.

Q. Again, looking to your own experiences, what has been the general reaction to that sort of enquiry?

A. The general reaction is that young people say yes, that they do have somebody, and will actually name somebody. It's usually their key worker actually. I think services have got better over the years at matching key workers or making sure that staff that have a shared interest or whatever are matched to that. I think that's one aspect of practice that's improved over the years and I think usually when we go out to services

that's who the young person will identify.

Q. At 10.4, you again mention the health and social care services and how keeping and feeling safe has a central part in these standards?

A. Yes.

Q. You set out, on page 38 through to page 39, the standards that have a bearing on that?

A. Yes.

Just to say as well, that was just really just a sample of some of the standards that relate to safety. There are ones about young people -- about going missing, about harming yourself et cetera in the other Health and Social Care Standards.

Q. Moving on to the next section, section 11, page 39, this section is seeking to explore the Care Inspectorate's knowledge of the nature and extent of abuse in the relevant establishments.

Can I perhaps just put the obvious to you that your knowledge -- what would your knowledge be of the nature and extent of abuse prior to April 2002, when the Care Commission was established?

A. I think it would be extremely limited. When I started in January 2003 it really was related to the information that existing inspectors had who had transferred over from Local Authority inspection units and the knowledge

that they had and any documentation that was taken.

Q. Do you know what liaison took place in that changeover between Local Authorities and the Care Commission?

MS HAPPER: I don't know the details of the liaison. What I am aware of is -- what I'm led to believe is that there was very, very little information, written information, handed over about services and that it was very patchy. So some Local Authorities had more information than others. The Care Commission, I believe, started with very little information.

Q. Are you saying they inherited very little by way of records for example?

A. Yes.

Q. Then looking to the state of knowledge of the Care Commission and the Care Inspectorate, what you say in the report in relation to this connection is that the state of knowledge cannot be described as "full", is that correct? That is the top of page 40?

MR SLOAN: Yes.

Q. Just so I can get a sense as to what you're saying there, because the question here is the Care Inspectorate's knowledge of the nature and extent of abuse in these establishments.

Are you saying you have some knowledge of some abuse, but you are convinced you don't have knowledge of

the extent of abuse?

MS HAPPER: I'm sorry, I'm not sure I'm understanding your question.

Q. You use the word "full", which suggests to me that you have some knowledge of abuse in these establishments, but you accept that it cannot be a full knowledge?

MR SLOAN: Yes.

MS HAPPER: Yes.

LADY SMITH: Because you are dependent on notification to you from the provider.

A. Exactly, and things that were dealt with and they're not passed on we have no knowledge of.

MR MACAULAY: You go on to say that in the main, the information you have received has been from the care provider?

A. Yes.

Q. Not from the children or young persons?

A. Yes, that is correct.

Q. Is that right?

A. That is correct.

MR SLOAN: That is correct, yes.

Q. The next section, 12, page 40, you are providing an evaluation of the effectiveness of regulators. Here you are looking at the Care Inspectorate and the Care Commission in preventing and/or detecting abuse of

children accommodated in the relevant establishments.

You go on to try and put some context to that issue. I think, Helen, this is an issue you can address, is that right? What is your response to that broad proposition?

MS HAPPER: I think it's important to understand that the Care Inspectorate sits as one plank in a network of people who try to create safety around a child. The Care Inspectorate does not have a role to investigate complaints -- allegations of abuse, for example. The investigating authorities for abuse are the police and social work services.

We do have an important role to play as one part of a network of trying to create a culture and an environment in which abuse is less likely to happen and if it does happen can be picked up and referred to the appropriate investigating authorities as quickly as possible.

Q. You say at 12.1 that there is really an inherent challenge in evaluating the effectiveness of the Care Inspectorate in finding evidence about the extent to which the existence of a regulatory body can prevent instances of abuse. Has any research been made to look at that?

A. No. There is very little evidence anywhere that will

support the kind of proposition that inspection of any kind, regulation of any kind, which is really a preventive matter, it's a preventive mechanism. It's very difficult to get empirical evidence about what is being prevented.

There is also in social care and social work, it's not possible to have control groups of things. You can't set up experiments where you can say, "We'll do it with this and then we will do it without and we will see whether that makes a difference".

What we do know is that deregulation of things doesn't normally create a lot more safety. So that's perhaps some evidence.

I think what's really, really important is for us to understand that as part of that network to create safety that there are things that we do know can make a difference. We know that for example, as we've talked about, children find it very difficult to talk about what's happening to them, but they are more likely to talk about what's happening to them if they have trusting relationships with people. So we can move forward secure in that knowledge and try to do what we can to build trust.

We know that spending time in services with people who are oriented to what it might feel like to be there,

rather than what it might feel like to deliver the service, we know that that's very important. That's why we're trying to make sure that we skill and equip our staff and support our staff to have that perspective all that time and to be asking that question all the time.

These are the kind of bases on which we'll move forward, rather than because we have empirical evidence that this is going to make that difference.

LADY SMITH: Helen, earlier you said what you do know is that deregulation of things doesn't normally create a lot more safety, so that's perhaps some evidence.

What is the evidence on which you base that statement?

A. We haven't deregulated social care and social work. We haven't abolished regulations, but we know that there are other examples of deregulation of the banks for example or building control, where people then feel they can cut corners and they can indulge in perhaps riskier practises. On that basis it's really a political decision about whether we have regulators or not, whether we choose to regulate social work and social care.

But we believe -- we have to believe that -- that the fact that we exist helps to create a safer culture, that regulation of the workforce creates an environment

in which it is more difficult for people who would be minded to abuse children to get into the workforce for example.

That our process for registering services will take some people out of putting themselves forward to deliver a care service when they're not fit to do so, because we have a process that weeds some people out.

LADY SMITH: I suppose, if you take building controls for example, we're talking about deregulation without adequate risk assessment of the impact of not having those controls and then seeing examples of the risks materialising that you were supposed to have been avoiding in the first place.

I can see that. You also touch on creating an environment that is unattractive for those who are not by their nature inclined to want to keep to the rules, do the best they can, do the best for the service, according to its particular focus and outcome?

A. It's important to say we don't set out to make things difficult for people. We're not trying to make things more difficult for people, but we certainly have a process that will encourage people to really think carefully about all that's involved in delivering and providing a childcare service. Because it's not easy, it's going to be very challenging and we don't want

people to get into it unless they are fit to do so and are prepared to meet all those challenges, because that will not benefit children.

MR MACAULAY: In this process of self-evaluation, what you do say, moving on from page 41 to page 42:

"We aim at all times to contribute effectively to a culture of safety and quality in the delivery of care and social work services."?

A. Yes.

Q. That is your aim?

A. Yes.

Q. One of the difficulties with that is that, as you say, people who abuse can go to extraordinary lengths to prevent detection?

A. Yes, yes, they can.

Q. In a context where those who are being abused are vulnerable children or young persons?

A. Yes.

MR SLOAN: Yes.

MR MACAULAY: My Lady, that might be a good time to stop for today. We are back tomorrow.

LADY SMITH: Yes.

Back tomorrow, starting at 10 o'clock.

MR MACAULAY: Yes.

LADY SMITH: Very well.

Thank you both very much for all you have given us today. That's been tremendous.

I'll rise now and sit again tomorrow.

(4.02 pm)

(The Inquiry adjourned until 10.00 am on Wednesday, 27 September 2023)

I N D E X