IN THE UK COVID-19 PUBLIC INQUIRY

BEFORE BARONESS HEATHER HALLETT

IN THE MATTER OF:

THE PUBLIC INQUIRY TO EXAMINE THE COVID-19 PANDEMIC IN THE UK

Submissions on behalf of Covid-19 Bereaved Families for Justice UK and NI Covid-19 Bereaved Families for Justice For the Module 6 preliminary hearing on 5 February 2025

Introduction

1. These submissions are provided on behalf of Covid-19 Bereaved Families for Justice UK ('CBFFJ UK') and NI Covid-19 Bereaved Families for Justice ('NI CBFFJ') in advance of the Inquiry's Module 6 preliminary hearing on 5 February 2025.

2. As the Chair is aware, the goal of CBFFJ UK and NI CBFFJ has always been, and remains, to establish the truth of what happened to their loved ones who were being looked after by the Care Sector, to participate effectively in that pursuit of the truth, and, in so doing, to ensure accountability and to prevent future deaths. As with the Inquiry's preliminary hearings in Modules 1, 2, 3, 4, 5 and 7, CBFFJ UK and NI CBFFJ set out below initial submissions as to how that vital aim – to conduct a fearless and effective inquiry that establishes the truth and involves the bereaved in a meaningful way – can be achieved.

3. As requested by the Inquiry team, we have confirmed that the CBFFJ UK and NI CBFFJ representatives intend to make oral submissions at the preliminary hearing.

Rule 9 requests

4. It is recognised that in sending Rule 9 requests to organisations such as the Department for Health and Social Care ('DHSC'), the Inquiry may well receive multiple statements in response from relevant individuals. In addition to those individuals specifically named on the Inquiry's list of Rule 9 requests, we have included a list of those witnesses whose evidence we submit may be important to the Inquiry's task of investigating the response to the Pandemic in the Adult Social Care ('ASC') Sector. In so doing we make two particular points: the evidence needs to properly cover the position and experience of each of the four nations/jurisdictions, and there is a need

to ensure that there is sufficient evidence from staff and service-users, as well as government, administrations and providers:

(a) Rosamond Roughton, DHSC Director General for ASC until July 2020 and then Director for ASC;
(b) Sir David Pearson, Chair of the DHSC Social Care Sector Covid-19 Support Taskforce from June 2020;
(c) Prof. Jane Cummings, Former Chief Nursing Officer and DHSC Director and Senior Adviser for ASC testing from May 2020;
(d) Fran Leddra and Mark Harvey, Joint Interim Chief Social Workers (England);
(e) Kate Terroni, CQC Chief Inspector of ASC;
(f) Michelle Dyson, DHSC Director General for ASC from September 2020;
(g) Jonathan Marron, DHSC Director General of the Office for Health Improvement & Disparities;
(h) Dame Ruth May, Chief Nursing Officer (England);
(i) Dr Éamonn O'Moore, Senior Reporting Officer in the ASC Team at PHE;
(j) Prof. Catherine Noakes, specialist advisor on the environmental transmission of Covid-19 who attended the SAGE Social Care Working Group ('SCWG');
(k) Liz Jones, National Care Forum Policy Director who attended the SCWG and absented herself from the 2022 'Consensus statement on the association between the discharge of patients from hospitals and COVID in care homes' **[INQ000107084/21]**;
(l) Prof. Christina Pagel, member of Independent SAGE;
(m) Liz Kendall MP, Shadow Minister (Health and Social Care) from 10 April 2020 until 4 September 2023; and
(n) Dr Heather Payne Chair of C19 MEAG Wales.

5. The Chair is also invited to make Rule 9 requests of the following organisations:

(a) Local Government and Social Care Ombudsman, Public Services Ombudsman ('PSO') for Wales, Scottish PSO, NI PSO;
(b) Welsh LGA[1];
(c) The Health Foundation;
(d) Mencap;
(e) Amnesty International (to speak to its report 'As if expendable' **INQ000509643**);
(f) Age Cymru, Age NI, Age Scotland, Age Scotland Orkney and Age

[1] We understood this had already been requested as per the CTI update note of 6.11.24.

International;[2]

(g) Wales Carers Alliance;

(h) Scottish Human Rights Association; and

(i) Health and Social Care Alliance Scotland.

6. In relation to Northern Ireland, the Chair is aware from other modules of the precarious nature of Adult Social Care in Northern Ireland. The sector is the poor relation of an already over-stretched and underfunded health service. Legislation is fragmented and outdated, causing significant confusion amongst those relying on Adult Social Care and their loved ones[3]. A very significant burden of Adult Social Care falls on unpaid and unregistered carers, with the value of unpaid care growing by over 40% during the last decade (significantly higher than the equivalent rise in England (30%) and Wales (17%) during the same period). In total, unpaid carers in Northern Ireland are estimated to save the equivalent of 80% of the Department of Health's entire day-to-day spending budget for 2023-24[4]. As at 13 October 2020, there were 482 registered care homes in Northern Ireland, of which 434 (90%) were independently owned and operated and 48 (10%) were publicly owned and operated.[5] Moreover, while there may be no data to quantify the numbers of migrant workers in the Care Sector in Northern Ireland (for reasons that the Chair has already heard in previous modules), the experience of NI CBFFJ members is that many care homes are heavily reliant on staff from our migrant communities. It will be important to reflect all that and more in the evidence obtained from Northern Irish sources.

7. NI CBFFJ acknowledges that r.9 requests already issued to NI actors, departments and organisations are likely to cover some or all of the topics above. However, we note that r.9 requests do not appear to encompass evidence from:

(a) The Office of the Chief Social Worker;

(b) The experiences of migrant workers.

8. As to the Office of the Chief Social Worker, the Inquiry will recall the evidence of the NI CNO, Prof. Charlotte McArdle in M3, that she worked very closely with the Chief Social Worker in the policy guidance and directions that were given to the whole

[2] Caroline Abrahams's statement covers the position in England. Ms Abrahams tells the Inquiry, *'Our partners in each of the nations including Age Cymru, Age NI, Age Scotland and Age International are available to provide any nation specific or international perspectives as required.'* **INQ000509808/2§3**.
[3] Evidence of Eddie Lynch in M2C, see also INQ000250244 (M2C).
[4] https://www.carersuk.org/reports/the-economic-value-of-unpaid-care-in-northern-ireland.
[5] Inquiry Report on the Impact of Covid-19 in Care Homes INQ000191288_0006 (M2C).

community[6]. The Inquiry will also be aware from the M6 joint statement of Martina Ferguson and Tom Black of efforts to engage with the Office of the Chief Social Worker on behalf of residents of care homes during the Pandemic (§§159, 167). Given the combined nature of the Health and Social Care system in NI, it is important that this module obtains evidence reflecting the work undertaken by and the experiences of the Chief Social Worker during the Pandemic.

9. The Inquiry heard concerning evidence in M3 about the lack of data relating to our migrant communities and the consequential difficulties in reflecting their experience during the Pandemic. However, that is not to say that it will be impossible for the Inquiry to capture evidence of their experiences – which is particularly important in this module given the representation of migrant workers in the care industry. We contend that the Inquiry should approach organisations advocating on behalf of migrant communities for their assistance – both to gain such evidence as there is as to the collective experience of migrant workers, and if possible, to obtain evidence from migrant health care workers themselves. There are a number of such organisations in Northern Ireland and we are ready to assist the Inquiry in the identification of relevant sources of information.

<u>Gathering evidence from individual residential care and nursing homes, and domiciliary care providers</u>

10. We note the Inquiry's intention to gather 'spotlight' evidence from a selection of care homes in urban and rural areas across the UK '*at random'* **[CTI note, §5]** and appreciate that we suggested a similar approach in our submissions for the preliminary hearing on 19 March 2024. Having observed the process in Module 3, however, we have considerable reservations.

11. In Module 3, evidence was obtained from directors of several hospital trusts across the UK. Although 22 providers gave written evidence, only four were called to give oral evidence. Because of the lack of consultation on the selection process and the lack of 'on the ground' evidence from frontline workers and service-users, such evidence was from only an institutional and management perspective and was at odds with the experiences of many CBFFJ UK and NI CBFFJ families. The lack of meaningful opportunity to compare and contrast this evidence with the experiences of staff, patients and loved ones, caused concern to the families we represent and undermined the laudable object of the spotlight approach. If the Inquiry is going to adopt a similar

[6] Transcript 18.09.24, P:12:L10-14.

approach in Module 6, we urge the Chair to ensure that the evidence is not self-serving and is adduced from the different perspectives of administrators and providers, staff and service-users, and that there is a transparent process of selection informed by consultation with Core Participants.

12. The task of selecting spotlight evidence in M6 would be particularly complicated given the very high numbers of care homes across the UK, their different sizes and the very diverse nature of those care homes (e.g. residential homes supporting older people with semi-independent living, nursing homes for people requiring medical support, homes caring for people with dementia, homes for those with learning or other disabilities, homes focusing on recuperation and support pending a return to independent living, homes offering temporary or respite care). The picture is further complicated by the differences between private and publicly owned care homes (see §6 above). On that basis, and given the collective experience of CBFFJ and NI CBFFJ, if the Inquiry is to pursue evidence from spotlight care homes and if that evidence is to be of any value to the Inquiry, we contend it will need to come from a very significant number and range of sources, and spotlight the care of people with specific conditions, such as dementia and learning disabilities.

13. As set out in the CBFFJ UK Rule 9 response, some care homes responded brilliantly to the Pandemic and went above and beyond to keep residents safe but that is sadly not true for all care homes. As recently as October 2024, the Area Coroner for Devon, Plymouth and Torbay is reported to have found that '*Safety measures were not "effectively or consistently" followed in a care home where seven people died during the COVID-19 pandemic*'[7]. Unless the Inquiry spotlights care homes where both good practice and outcomes occurred, and where poor practice was known or suspected *and* obtains sufficient disclosure and accounts from staff members and users to enable that evidence to be properly scrutinised, it is submitted that the evidential value of this exercise will be extremely limited.

14. If the Inquiry chooses to adopt this approach, it is invited to request position statements from providers, staff and users, in advance of detailed evidence so that the choice of examples, and the Rule 9s can be targeted. This approach takes account of the limited time remaining to gather such evidence, and will assist in honing the parts of the evidence gathered which should be adduced and scrutinised orally, thereby taking

[7] Sky News (17.10.24) 'Staff failed to follow COVID safety rules at Devon care home where seven residents died – coroner', available at: https://news.sky.com/story/staff-failed-to-follow-covid-safety-rules-at-devon-care-home-where-seven-residents-died-coroner-13235311.

account of the timetabling. CBFFJ UK and NI CBFFJ families are able to provide the Inquiry with examples of providers who managed an excellent response and those where there were concerns. In addition, the Inquiry is invited to obtain evidence not only from providers who operate care homes but those who provide domiciliary care services to get the most value from the evidence, and to ensure the latter is not overlooked. The movement of staff between settings and parity of guidance and resource for domiciliary and/or unpaid carers are central issues which can be effectively and proportionately included.

Disclosure to Core Participants

15. We appreciate that the Inquiry is working with '*material providers to ensure, in so far as is possible, that disclosure in Module 6 is not compromised/unduly delayed'* **[CTI note, §9]**. Noting the issues that Thirlwall LJ encountered in obtaining documents from the CQC[8], the Inquiry is asked to provide assurance that all material providers, particularly the CQC, are complying with their disclosure obligations in Module 6.

16. We note there have been six M6 disclosure tranches to the date of these submissions, which includes documents disclosed in previous modules. There is plainly a significant way to go in terms of disclosure. Whereas we recognise that disclosure will continue through the process, we repeat our submissions from earlier modules that the Inquiry should set a date by which the bulk of M6 disclosure should be made – we submit this should be 30 April 2025. Disclosure is only meaningful if it is made in good time for the Inquiry and CPs to properly consider it and undertake further follow-up work as necessary. The purpose of setting a date two months prior to the hearing start date is to concentrate the minds of material providers, and the Inquiry itself, on the need to make disclosure in sufficient time for proper preparations to be made.

17. We note the LGA surveys which relate to E&W, and that COSLA surveys relating to Scotland are to follow. We note with concern that no mention is made to similar evidence relating to NI. Furthermore, whilst such surveys are likely to assist the Inquiry, we submit that there is a need to consider other perspectives, including from provider, staffing and service-user organisations.

Expert evidence

18. We are reviewing the draft expert reports on dementia, learning disabilities and end of

[8] The Thirlwall Inquiry (14.11.24) transcript of Week 9 Day 4, P1:L4-P2:L11, available at: https://thirlwall.public-inquiry.uk/wp-content/uploads/2024/11/Thirlwall-Inquiry-14-November-2024.pdf.

life care **[CTI note, §10]** and will provide our observations by 31 January 2025. In the meantime, the Inquiry is again invited to obtain evidence on the impact of racism, ageism and sexism as it relates to Module 6. Although ableism is covered to an extent by the report of Professor Chris Hatton and Professor Richard Hastings, further evidence is required on the impact of structural and institutional racism, ageism and sexism during the Pandemic, which affects both the people who draw on care and support and ASC workers, and is alluded to by relevant witnesses but not covered in detail **[for e.g. The King's Fund INQ000502030/12§34-35 and Age UK INQ000509808/21-23§57-60]**.

19. In particular, the Inquiry is invited to instruct an expert to speak to the disproportionate impact of the Pandemic on female carers (both paid and unpaid). Nadra Ahmed tells the Inquiry that a significant proportion of women and individuals from diverse ethnic backgrounds are employed within the Care Sector **[INQ000515683/4§11]**. We have outlined the UK Government and Devolved Administrations' heavy reliance on unpaid carers at §6 above. As set out by Simon Bottery on behalf of the Kings Trust,

> *'The 2021 Census found that 10.3% of females in England provided unpaid care compared with 7.6% of males. Similarly, the Health Survey for England 2019 found that women (20%) were more likely to have provided unpaid care than men (14%). The Health Survey for England found that the proportions of men and women providing care increased with age and were highest among men aged 65-74 (19%) and women aged 55-64 (34%), and lower among older age groups.'* **[INQ000502030/14§39]**

20. In her M2 report, Dr Clare Wenham described the *'disproportionate unpaid care burden'* on women as being one of the '*key challenges to gender equality in the UK*' **[INQ000280066/3§3]**. According to Dr Wenham,

> *Reducing public services and welfare directly and indirectly exacerbates gender inequality, and are a form of gender discrimination. Women, as carers, mothers, and the majority of older people, are more reliant on public services and welfare than men: affordable, accessible, and quality public services thus function as a means of redistributing unpaid care work from women to the state. Furthermore, women make up two-thirds of the UK's public sector employees, so reductions in public services and pay freezes impact women's employment security and opportunities, and their financial freedom. Without quality public services, women spend more time and energy engaging in care work that benefits the whole of society, but without the support of that society.'* **[INQ000280066/4§7]**

21. Prof. Sube Banerjee draws the Inquiry's attention to gender-based health inequalities

in the context of dementia with female family carers providing '*70% of care hours for people with dementia'* **[p.17§11]**. It is estimated that unpaid carers save the NI Department of Health £5.8 billion per year[9]. That saving disproportionately comes from female carers; mothers, wives and daughters who have taken on additional caring responsibilities, often to the detriment of their professional opportunities and / or personal wellbeing.

22. The potential financial, physical and emotional impacts of providing a high level of care are obvious. Female carers who give up employed work or reduce their hours find themselves financially disadvantaged in 'real time' due to loss of income and in the future due to the consequential impact on pension contributions. In April 2024, the ONS reported that the probability of an unpaid carer being in 'not good health' grows with the hours of care provided and in 2021 the risk of one or more A&E attendances was higher for female carers who were providing increased hours of unpaid care, compared to female non-carers.[10] In her book *'Invisible Women: Exposing Data Bias in a world designed for men'* Caroline Perez observes that '*female carers also tend to receive less support than male carers so then end up feeling more isolated and being more likely to suffer from depression – in itself a risk factor for dementia'* **[p.71]**.

23. CBFFJ and NICBFFJ contend that expert evidence on the impact of the Pandemic on women is essential in M6 given the Care Sector's heavy dependence on the valuable contribution of female caregivers.

24. In addition, noting that the Inquiry was considering obtaining expert evidence on the impact of the Pandemic on those with mental health difficulties at the preliminary hearing on 19 March 2024 **[CTI note for 19.3.24 hearing, §33c]**, the Inquiry is invited to obtain a report from a mental health expert to speak to the elevated risk of death among people with Severe Mental Illness during the Pandemic and, in particular, the elevated risk of death for Black Caribbean/Black African people. The Inquiry is invited to instruct Dr Jayati Das-Munshi, lead author of the 2023 article in the British Journal of Psychiatry, 'Severe mental illness, race/ethnicity, multimorbidity and mortality following COVID-19 infection: nationally representative cohort study'[11] and Principal

[9] https://centreforcare.ac.uk/updates/2023/11/unpaid-carers-saving-ni-health-service/
[10] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/socialcare/bulletins/unpaidcareexpectancyandhealthoutcomesofunpaidcarersengland/april2024.
[11] Das-Munshi, J. et al. (2023) 'Severe mental illness, race/ethnicity, multimorbidity and mortality following COVID-19 infection: nationally representative cohort study', The British Journal of Psychiatry, 223(5), pp. 518–525, available at: https://doi.org/10.1192/bjp.2023.112.

Investigator on the COVE-IMM study[12].

A word on language

25. We note that in one of the expert reports, reference is made to *'carer burden'*. This is not a phrase that CBFFJ UK and NI CBFFJ families would use to describe the impact of caring for their loved ones as it tends to suggest that their loved ones were in some way a burden or inconvenience, which they in no way were. In the same way that phrases such as 'suffer with dementia' should be avoided and phrases such as 'people with dementia' used in preference, the Alzheimer's Society suggests that 'impact' or 'effect' should be used instead of 'burden'[13] and we would invite the Inquiry to adopt and encourage the use of this phraseology by all witnesses.

Provisional List of Issues document

Relevant Period

26. The Inquiry's ToR, the Provisional Outline of Scope, and the Provisional List of Issues all include the structure of the Care Sector, staffing levels and capacity in the four nations/jurisdictions as at 1 January 2020 (and by implication pandemic planning). The LoI document asserts that the relevant period for M6 is 1 March 2020 to 28 June 2022, suggesting that there will be no evidence relating to January and February 2020. In our submission, whatever the evidence as at 1 January 2020 regarding resilience and planning, the UK Government, DAs and local authorities, and care providers themselves, ought to have begun rapidly preparing the Care Sector for a public health emergency of pandemic proportion; including by urgently optimising capacity, planning for widespread testing, PPE procurement and plans for distribution, identifying isolation facilities, producing tailored IPC guidance, and addressing the movement of staff, clinicians and visitors. A similar approach should have been advanced regarding domiciliary care services.

27. It is submitted that in order to understand *why* the Care Sector was impacted as it was and *why* it had to respond as it did, it is necessary to investigate both the position as at 1 January 2020, and the period from **1 January 2020 until 29 February 2020**. Examining that period is unlikely to add significantly to the work of the Inquiry – it is

[12] https://www.kcl.ac.uk/research/covid-19-ethnic-inequalities-in-mental-health-and-multimorbidities-cove-imm-study.
[13] Alzheimer's Society (2018), 'Positive language An Alzheimer's Society guide to talking about dementia', pp.9 and 16, available at: https://www.alzheimers.org.uk/sites/default/files/2018-09/Positive%20language%20guide_0.pdf.

submitted that very little meaningful planning for the Care Sector or action appears to have happened during those two months.

28. Even at this early stage of disclosure, at least eight specialist organisations[14] speak of the '*neglect'* of the Care Sector before and during the Pandemic. This is not a new phrase to this Inquiry; Dr Jennifer Dixon told the Inquiry in Module 1 that the Care Sector had suffered years of '*political neglect'* **[INQ000183420/6§17]** which is cited in the Module 1 report at p.122§5.82 footnote 127.

29. In our submission, February 2020 is the month when years of political neglect crystallised. Those years resulted in there being a lack of strategy and adequate resourcing for the Care Sector, a dearth of operational and practical knowledge of the Sector within DHSC **[INQ000273807/121§9.3 and INQ000176785/9-10]**, a lack of central leadership including there being no Director General for ASC for four years prior to the Pandemic, and no notion of a plan for an infectious disease pandemic other than flu. This resulted in there being an underappreciation in Government of the urgency of the need for sector-wide planning and preparation in January and February 2020 and the continued prioritisation of the NHS throughout the Pandemic.

The need for a unified ASC Sector with centralised leadership and adequate funding

30. As outlined in the CBFFJ UK Rule 9 response **[INQ000474426/2-3§3.2-3.4]**,

> 'In Modules 1 and 2, the Inquiry was variously told that the Care Sector was *'fragmented'*, *'alienated'* and *'neglected'*. It was told that the Care Sector was, and still is, a Cinderella sister to the NHS. The stories of CBFFJ UK members which we have outlined below showcase just some of the services that come under the vast umbrella of 'Adult Social Care'. In our view, a unified care service is necessary to avoid the catastrophic death toll that the Care Sector experienced during the Covid-19 Pandemic in future.
>
> It is shocking to our members that the UK Government and Devolved Administrations did not have sufficient plans or resources in place to help the Care Sector respond to a pandemic, given the knowledge from Exercise Cygnus. It is more shocking still that it took until April 2020 for the UK Government to publish a specific action plan for the Sector. It is breathtaking that the then Health Secretary did not know how many care homes there were in England in March 2020, and devastating that there were no data on deaths until after that point. It is incredible that there was no centralised plan or

[14] The King's Fund: **INQ000502030/29§7**; NI Human Rights Commission: **INQ000505789/7-8§2.9**; Age UK: **INQ000509808/11§32**; Disability Rights UK: **INQ000520998/5§13**; Disability Action NI: **INQ000520343/21-22§69**; Care Rights UK, John's Campaign and The Patients Association: **INQ000514104/36§97**.

provision for Personal Protective Equipment or other Infection Prevention and Control measures.

If there is nothing else to be learned from the destruction caused to the lives of people receiving care from and working in the Care Sector and their families during the Pandemic, the Care Sector can no longer be ignored. The Pandemic has spotlighted the urgent need for a national care service that is anchored to the centre of Government and equal to the NHS. Guidance and contingencies alone are little use when the elements of the system are so hard to pin down.'

31. The UK is now five years on from the start of the Pandemic and it appears that the ASC Sector is in no better position to respond to a pandemic. In order for the Inquiry to identify lessons from the response, it rightly proposes to examine the structure, capacity and staffing of the ASC Sector across the four nations/jurisdictions. In order for recommendations to be meaningful, it must be prepared to examine and report on the broader picture of ASC organisation and leadership across the UK, which will necessarily touch on issues of funding and the impact of Austerity. The Inquiry should not shy away from making the findings and recommendations which properly flow from this evidence.

Listening exercise - Every Story Matters

32. The Inquiry has heard directly from a number of bereaved family members across each of the modules completed to date and is now in a better position to assess the importance of this evidence to the context of the subject matter under consideration. Although the Inquiry has commissioned an ESM report for M6, we submit that this is no substitute for hearing directly from family members. Our observation is that such evidence ensures that everyone involved in the Inquiry remains focussed on the real life effects of the Pandemic and the failures of resourcing, planning, and decisions taken.

33. Given the number of people who died in care or nursing homes, or whilst receiving domiciliary care, and the number of issues which M6 covers, we submit that the Inquiry should call a greater number of such witnesses in M6, and to that end we will submit a schedule of willing family members with a range of accounts to assist the Inquiry.

Public Hearings

34. Module 6 is currently listed for 24 working days from 30 June 2025 until 31 July 2025. Taking account of opening and closing submissions and not sitting on Fridays, it will hear only 17 days of evidence in Module 6 compared with 37 days of evidence in

Module 3. It is submitted that to conduct a sufficient inquiry to discharge the ToR, **the length of hearing for M6 should be at least equal to that of M3** for three reasons:

(a) Firstly, to allow sufficient time to interrogate the systems for providing ASC across the four nations/jurisdictions and the variations in response. At the end of 2019/20, 630,065 people were estimated to have been drawing on long-term support in England alone **[INQ000502030/11§Table 6]**. Also in England, there are currently 18,000 ASC providers across 39,000 settings **[INQ000502030/13§36]**. In Northern Ireland in October 2020 there were 16,110 registered care home beds, a figure vastly overshadowed by the estimated 220,000 unpaid carers[15] propping up the ASC Sector. Given the fragmentation of the Sector and the sheer number of people it serves and relies upon, it is submitted that 17 days is unlikely to be sufficient to investigate even a proportionate amount of evidence about the impact of the Pandemic and response to it across the four nations/jurisdictions.

Not only is the Care Sector fragmented but so too was the response. Numerous State bodies were involved on a UK, devolved, and local level. The need for improved coordination is a central issue when considering recommendations for the future, which will necessarily take time to unpick.

(b) Secondly, to enable the Inquiry to interrogate (i) the extent to which the impact on the ASC Sector was adequately considered when key decisions were made and (ii) the production and proliferation of guidance to the ASC Sector and the ways in which contributions were received from ASC specialists, people who draw on ASC and their carers, and Scientific Advisory Groups. As outlined in the joint statement from Care Rights UK, John's Campaign and The Patients Association, the guidance on visiting alone was updated more than 30 times **[INQ000514104/53§125]**.

(c) Thirdly, to allay any fears that the Care Sector might be treated with lesser priority than the NHS in this Inquiry. It will be clear to the Chair from the evidence already received that there have been longstanding concerns that, despite being inextricably linked to the NHS, the Care Sector was and continues to be overlooked by Central Government.

24 January 2025

[15] https://centreforcare.ac.uk/wp-content/uploads/2023/11/valuing-carers-northern-ireland_.pdf, p.3.

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