Witness Name: Nadra Ahmed

Statement No.: 1

Exhibits: 7

Dated: 23rd January 2025

UK COVID-19 INQUIRY - MODULE M5/Care/01

WITNESS STATEMENT OF NADRA AHMED, CBE, EXECUTIVE CO-CHAIR NATIONAL CARE ASSOCIATION

I, **NADRA AHMED**, of 4, Beaufort House, Beaufort Court, Sir Thomas Longley Road, Rochester, Kent, ME2 4FB will say as follows: -

Introduction and answers to questions 1-5

The National Care Association (NCA) was formed in November 1980, is recognised as a leading authority in the field of social care, with over four decades of expertise and frontline experience. Its core mission is to support small and medium-sized care providers, who constitute the largest segment of the social care sector.

Led by our Co-Chairmen, Nadra Ahmed CBE and Ian Turner OBE, the National Care Association operates with a small, dedicated team of staff, overseen by a volunteer Board of Directors elected from its membership. These elected Board members are volunteers who are, or have been, care providers. The Non-Executive Directors, based across the country, are passionate and committed to supporting the National Care Association in delivering high-quality services, advice, and guidance to its members.

Biographies

Ian Turner, OBE, Executive Co-Chairman, National Care Association

Ian read Pure and Applied Mathematics at Newcastle University before joining International Computers Ltd (now part of Fujitsu) in the early 1970's. He worked as a programmer, then within operating system support, marketing, project management, and sales management. In 1984 he bought a property and converted it into a Nursing Home. He has now developed this into six Homes with 270 beds, all within East Anglia, offering Nursing and Residential Care to older people, and those living with dementia. During 2014/5 Ian was seconded into the DH/LGA team implementing the Care Act. Ian chaired the Registered Nursing Home Association for the past ten years. In 2023, the RNHA merged with the National Care Association, and Ian became Executive Co-Chairman of the NCA.

Nadra Ahmed CBE, Executive Co-Chairman, National Care Association

Nadra has been Chairman of NCA since June 2001. She has been involved in the field of social care for over 43 years and until 2005 was the Registered Manager of two private care homes for older people, having developed and run services since 1981.

Nadra has served on numerous government task forces, and she was the Vice Chairman of Skills for Care for 11 years having been appointed at its inception. Nadra is a trustee of Parkinson's UK among other charities. In 2023/24 she was the Deputy Lord Lieutenant of Kent and a Kent Ambassador.

In 2006 she was awarded the OBE for her services to Social Care. She is a regular contributor to journals and speaks at national and international conferences throughout the world. She is also regularly called upon by the major media networks to represent the views of social care providers. Nadra is driven by a desire to ensure the delivery of quality services to the most vulnerable members of our society. She works across a number of government departments which have an impact on the social care world giving evidence and expert advice to parliamentarians.

In 2023 she was awarded the CBE for her services to Social Care.

NCA today provides support through the recent merger with the Registered Nursing Home Association to our 1,023 members. Recognising the time and resource constraints faced by SME providers, the NCA works tirelessly to streamline resources and minimise duplicative oversight and monitoring functions, allowing for a greater allocation of resources to frontline care delivery.

The Association ensures that its members and their 30,000+ service users, receive relevant and timely information to navigate the ever-changing landscape of the sector and

provides access to subject matter experts who can address specific queries and concerns.

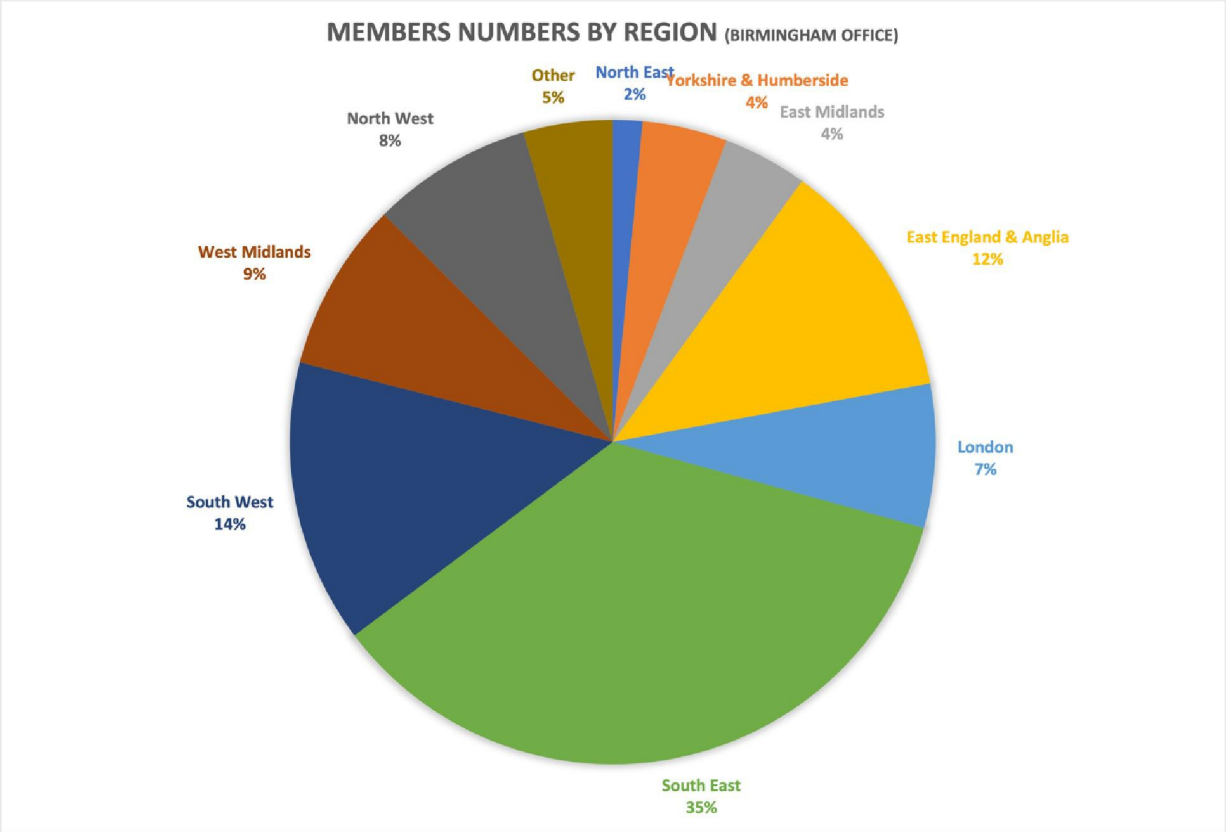
More detailed information of the membership is provided below:

a. Bed/Staffing Capacity of SME Providers:

- The NCA does not collect specific data on the bed or staffing capacity of its 1,023 members.
- However, small and medium-sized enterprises (SMEs) in adult social care are generally defined as care providers with fewer than 250 employees or fewer than 50 beds.
- On average, smaller care homes tend to have around 20–40 beds, while medium-sized providers might have between 50–150 beds.

b. Locations of Members Who Provide Adult Social Care Services:

- The geographic distribution of NCA members is largely represented by the following breakdown (based on the pie chart provided):
  - **Southeast England:** 35% of members are located here, making it the largest region.
  - **Southwest England:** is our second largest region with 14% of members located here.
  - **Midlands (East and West):** 13% of members
  - **East of England:** 12% of members



c. The Range of Adult Social Care Services Provided by NCA Membership:

NCA members provide a wide range of services, including support for adults with physical, sensory, and learning disabilities, individuals with mental health challenges, and elderly people. The breakdown of the service models is as follows 92% are nursing homes, or residential are homes. 8% of the membership provide services through home care (domiciliary care) or supported living provision.

d. The Range of Recipients of Adult Social Care Supported by NCA Member Organisations:

The range of services provided by NCA members includes diverse client groups, including adults with physical, sensory, and learning disabilities, individuals with mental ill-health, and elderly people.

e. **The Range of Adult Social Care Staff Employed by NCA Member Organisations:**

- The NCA does not collect detailed demographic or employment contract data regarding staff employed by its members.
- Staff roles in adult social care settings typically include:

- **Care workers** providing day-to-day support and personal care.
- **Registered nurses** (especially in nursing homes) offering medical care and support.
- **Support workers** assisting individuals with disabilities or mental health needs.
- **Administrative and management staff** overseeing operations and compliance.

- While specific demographic data on ethnic minority or disabled staff members is unavailable, the sector overall employs a significant proportion of women and individuals from diverse ethnic backgrounds.

The NCA's comprehensive offering encompasses practical support for the operational challenges faced by its members daily, a profound understanding of strategies to maximise quality of care, and the effective use of political influence to inform policy decisions at both national and local levels. The NCA works across all key social care stakeholders including the Treasury, BEIS, DHSC, DWP, NHSE, CQC, LGA, ADASS and the providers of care and support services.

Our organisation's purpose extends beyond advocating solely for care homes and older adults; it embraces a broader narrative that recognises the vital role of independent care providers across the care economy. The NCA is committed to ensuring the recognition and value of social care services, which support individuals at various stages of their lives, and the pivotal contribution of the SME sector.

Prior to the pandemic

6. How common was it for members to have in place contingency plans to deal with pandemics or epidemics in respect of emergency stocks of key medical equipment and supplies, including PPE, prior to the pandemic.

Before COVID-19, it was not universally common for care providers to have detailed contingency plans tailored specifically to pandemics or epidemics. Therefore, the National Care Association (NCA) members did not commonly have contingency plans for pandemics or epidemics, including emergency stocks of essential medical equipment and PPE, prior to the COVID-19 pandemic. While general care and support business continuity plans were encouraged by the Department of Health and Social Care (DHSC), the Care Quality Commission (CQC), local authority and NHS commissioners, they often focused on regular operational disruptions such as severe

weather, fuel shortages, or flu outbreaks, rather than the scale of continuity management and logistic support for a major pandemic.

7. Is the National Care Association aware of any policies or guidance issued by DHSC or any other Government Department, arm's length body or regulator which required the care sector to have in place contingency plans for stocks of key healthcare equipment and supplies?

Before the pandemic, we were aware of various policies and guidance issued by the Department of Health and Social Care (DHSC) and other government bodies that required care providers to have contingency plans (as per the Q6 response). Specifically, local authorities, healthcare commissioners, and the Care Quality Commission (CQC) held expectations for care providers to maintain business continuity plans, to have robust emergency plans in place. However, these expectations did not always explicitly cover pandemic-specific preparations, such as stockpiling PPE, until the COVID-19 pandemic underscored the necessity for such measures.

During the pandemic, **Exhibit NA/01 [INQ000508373]** provided the first guidance on continuity of supply and preparedness steps for care providers. These plans required care providers to identify critical aspects of operational sustainability. For example, information included, stock of medicines and disposable gloves, moving and handling equipment used in care premises, alongside an outline how to maintain these in the event of an incident.

8. Did the National Care Association liaise with local authorities, NHS bodies or government bodies or departments regarding the likely demand for PPE during the pandemic? If so, please describe how this was estimated and communicated onwards.

Yes, Ian Turner and Nadra Ahmed participated in meetings with the Department of Health and Social Care (DHSC), where they engaged in discussions with NHS Supply Chain representatives working on the PPE Portal, alongside Adult Social Care representatives. However, DHSC managed the coordination of these interactions. They also assisted with the drafting and co-signed several sector wide letters as members of the Care Provider Alliance (CPA) sent to:

The Prime Minister Boris Johnson and the Health Secretary Matt Hancock on the 27th March, **Exhibit NA/02 [INQ000507429]** the main asks of this letter were:

- Ensure all people discharged from hospital are tested prior to entering care settings

'Social Care staff MUST have the PPE of the correct specification and quantity in order to protect staff and deliver safe care'.

- Instruct local authorities to pay providers

On 9th April 2020, **Exhibit NA/03 [INQ000507430]** the CPA wrote a letter to all 650 local MPs in the UK, making an urgent call for action on:

- Securing PPE supplies

- Increasing COVID-19 testing capacity for people discharged from hospital

- Providing funding to local authorities from the £1.6bn government support package

Also, on 9th April 2020, **Exhibit NA/04 [INQ000507431]** the CPA wrote a letter to Helen Whately MP, the Minister for Care, regarding a meeting that had taken place the week of March 16th, to which the CPA had not received a response.

The outstanding issues raised included:

- Securing adequate PPE supplies

- Increasing capacity for COVID-19 testing

- Providing funding directly to care providers

In addition, discussions took place through the Adult Social Care Task and Finish Group – Personal Protective Equipment, and later through the COVID Adult Social Care Working Group of Stakeholders (CAWGS), established in September 2021. CAWGS combined several existing social care task and finish groups. Additionally, DHSC organised PPE customer experience panels for the PPE Portal, which were facilitated through these meetings.

9. Did the National Care Association carry out any surveys or consultations amongst its membership during the pandemic regarding: YES

The NCA supported members to respond in August 2020 a survey by:

The PPE Demand & Strategy team at DHSC. This was to assess the amount of PPE across the social care sector to get a better idea of the historic and current financial costs, as well as demand for PPE. This was to inform planning to meet those needs and prepare for different circumstances that may arise in the future. The PPE team were seeking extracted information from invoices for all PPE purchases, from all sources, for the periods:

-1 October 2019 – 31 October 2019

- Any two-month period between 1 May 2020 and 31 July 2020.

Providers were invited to return completed spreadsheets with details to ppefuturedemand@dhsc.gov.uk, if possible, by the 4th August. The request dated 30th July 2020 can be found within this **Exhibit NA/05 [INQ000508374]** along with the **Exhibit NA/06 [INQ000486994]** for reporting. This gave care providers 3 working days to compile information for the PPE demand team.

The subsequent results of this survey were not shared with NCA directly.

The National Care Association undertook a Covid-19 survey in October 2020; this had over 100 responses in the date range [1/10/2020—13/10/2020] and the majority of respondents 98% were residential care homes, 2% were home care services.

The results highlighted;

On the questions regarding access to emergency funding and staff vacancies:

"Almost 30% of providers have not received funding from the additional Covid-19 monies made available to LA's to support services."

"More positively 86% of providers have received funding from the Infection Control Fund."

"40% of providers currently have staffing shortages"

On access to PPE the NCA survey showed:

"96% of providers say they are able to readily source PPE and 74% have successfully used the PPE portal"

On access to testing our survey showed:

"98% of care services are managing to get regular testing"

These areas of evidence sought by the enquiry were not collected by the NCA survey:

(ii) the quality and fitness for purpose of PPE that was provided by central government, local authorities or distributed through Local Resilience Forums;

(iv) infection and prevention control guidance regarding the use of PPE during the pandemic

10. What was the impact of free PPE being made available to the care sector on your membership?

Our members initially welcomed the introduction of free PPE, as it provided much needed relief. However, this relief was soon tempered by disappointment, as the supply was widely seen as insufficient, and deliveries were delayed. Until the PPE portal became fully operational, access to free PPE through the NSDR and Local Resilience Forum (LRF) systems was inconsistent and often inadequate in many areas. For example, in the initial stages when free PPE was distributed, members of NCA reported concerns about whether the PPE provided met the required safety specifications. Members reported that masks received in May 20202 had expiry dates of 2019 on the external packaging. Challenges arose with accessing PPE through the National Supply Disruption Response (NSDR) **Exhibit NA/07 [INQ000508377]** and Local Resilience Fora (LRF's), as well as delays in the rollout of the PPE Portal were due to lack of comprehensive contact information for all care providers in their areas, particularly those operating nationally rather than regionally. There was no centralised social care contact database for LRFs or the NSDR to draw upon.

Nonetheless, the availability of free PPE was crucial to protect care recipients and workers, safeguard staff wellbeing, and alleviate fears about risks to their families.

Free PPE also helped reduce operating costs for NCA members given that the local authority and health commissioned fee rates paid were not enough to cover these operating expenses. The establishment of the free PPE distribution system ensured the availability of essential supplies and helped prevent price hikes and profiteering that had occurred in parts of the social care PPE supply chain early in the pandemic.

11. Did members raise any concerns regarding PPE with the National Care Association or its members during the pandemic? If so, please set out what these were, whether the picture changed over the course of the pandemic, and what action the National Care Association or its members took, if any, to escalate or meet those concerns.

Yes, members of the National Care Association raised concerns regarding PPE during the pandemic. In March 2020, the Department of Health and Social Care (DHSC) provided each CQC registered care provider with 300 face masks. For a 40-bed residential care home, these 300 masks provided just 36 hours (about 1 and a half days) of protection for staff and residents. However, this was far from sufficient to support care providers responding to the course of the pandemic or to implement operational guidance effectively.

Concerns emerged from NCA members regarding the appropriate timing for mask usage and what alternative types of masks could provide adequate protection for staff. While these issues were raised in March and April 2020, guidance from Public Health England (PHE) was only issued in early autumn 2020, several months after the initial mask distribution. During this period, NCA was actively engaging with DHSC through the PPE task and finish groups to address these concerns.

PPE supplies remained slow to reach the sector throughout the first outbreak of the pandemic, into the summer and autumn of 2020. In response, the National Care Association worked closely with DHSC on the development and launch of the PPE Portal, which became available in May 2020. However, access to the portal for the entire sector took considerable time. Non CQC registered providers initially had no access and were directed to Local Resilience Forums (LRFs), where the level of support was inconsistent across the country. The National Care Association and its members continued to work with DHSC to escalate these concerns and improve access to PPE throughout the pandemic. It was early 2022 before the supply chain had reached a level of efficiency to support the care sector.

12. Did the National Care Association or its members raise any concerns regarding PPE with DHSC, local authorities or any other government body or department during the pandemic? If so, please set out what concerns were raised, how they were raised, and what response was received.

Yes, these are outlined in response to question 8. These concerns were communicated via emails, phone calls, and meetings with care providers and senior civil servants at DHSC. However, the phone calls were not formally minuted. Any meetings between NCA and public bodies were minuted by the public bodies themselves. Often the responses to concerns raised by NCA were taken away for consideration by civil

servants and answers would be provided via revised guidance or sector communication bulletins.

For example, from early November 2021 NCA asked about the continuation of free PPE. On the 14th of January 2022, the Department for Health and Social Care confirmed "that free personal protective equipment (PPE) for frontline health and social care staff in England will be extended for another year free of charge until 31 March 2023 or until infection prevention and control (IPC) guidance is withdrawn or significantly amended."

13. To the extent that the National Care Association is aware of its members' experience, what was the impact of changes made to IPC Guidance for use in the care sector during the pandemic on:

(i) the confidence of staff in using PPE;

Before the pandemic, PPE usage in the care sector was limited, with guidance primarily focused on mask-wearing for procedures like suction, which was uncommon. As the pandemic progressed, frequent changes to PPE guidance, often without clear communication from PHE, UKHSA, NHSE, and DHSC, eroded confidence, not in PPE usage itself, but in the reliability of the guidance. For example; the guidance around glove use, including a mistake in October 2020 specifying nitrile gloves when many providers were using vinyl.

Much of the guidance was written from a clinical perspective, with little consideration of how care services operate. These concerns were raised directly with policy teams drafting the guidance (see response 13(ii)). The main issue for staff was not a lack of confidence in using PPE but rather a lack of trust in the evolving guidance and concerns about whether there would be enough PPE to meet their needs.

(ii) the amount of PPE required within the care sector;

The guidelines for PPE usage during the pandemic were complex and frequently changing. While the NCA participated in meetings with PHE and DHSC to provide feedback on PPE guidance drafts, the time for comments was often very short, sometimes with one hour or an afternoon to review, making it difficult to provide comprehensive input. Once feedback was gathered, the communication clearance process within DHSC could take 2-3 weeks, during which outdated guidance had to be followed by care providers.

Changes in PPE guidance directly affected the amount of PPE required. For example, during Easter 2020, a small, easily missed note was added to existing guidance, indicating that the UK was experiencing “sustained community transmission.” This triggered the use of "Table 4" in the PPE guidance, which significantly increased the amount of PPE care providers needed. Unfortunately, this change was not communicated properly to care providers or suppliers, and adequate PPE supplies were not made available to meet the new requirements.

(iii) the ability of staff working in the care sector to source and purchase compliant PPE?

Sourcing and purchasing compliant PPE was particularly challenging during the initial stages of the pandemic (spring/summer 2020). The government’s Infection Prevention and Control (IPC) guidance for PPE was inconsistent and often delayed due to lengthy approval processes. Also, many PPE suppliers and distribution systems set up by the government were unfamiliar with the social care sector's specific needs, making it difficult for providers to secure enough quantities of compliant PPE. This lack of understanding extended to third-party distribution and supplier networks, which struggled to access CQC registered care facilities and meet the sector’s demand.

14. Did the National Care Association liaise with the DHSC or any other government body or department regarding IPC guidance and changes to that guidance during the pandemic? If so, what points did the National Care Association make, with whom were they raised and when, and what response was received?

Yes, these are outlined in response to question 13. These concerns were communicated via emails, phone calls, and meetings with care providers and senior civil servants at DHSC. However, the phone calls were not formally minuted. Any meetings between NCA and public bodies were minuted by the public bodies themselves. Often the responses to concerns raised by NCA were taken away for consideration by civil servants and answers would be provided via revised guidance or sector communication bulletins.

Lessons Learned

15. Please provide a chronological list of any internal or external reviews, lessons learned exercises or similar produced or commissioned by the National Care Association or that the National Care Association has been involved with relating to any of the issues in the Scope for Module 5 since January 2020. This should include:

a. A summary of the conclusions and recommendations of those reviews, lessons learned exercises or reports.

The National Care Association (NCA) has not conducted a formal review or commissioned any specific lessons learned exercises related to the issues in Module 5. However, NCA believes that future pandemic preparedness should consider how the shape and nature of any future pandemic may look very distinct to those seen in Covid-19, for example the infection risk could be children and younger people.

Therefore, we recommend a level of flexibility within care sector emergency planning to include the following but not limited too:

- The care sector should be integral to pandemic planning both at National and local levels, with a flexible approach that avoids a "one-size-fits-all" strategy.

- This approach must fully involve care providers across all service types, including services for people with disabilities, mental health needs, and elderly individuals.

The data held on the care and support sector's shape should be logged within a central government function. Emergency planning sessions seen between DLUC and DHSC show gaps in understanding and how the funding distribution would come to the sector.

- Clearer definitions and support for social care "key workers" are needed, along with improved coordination to track who requires both publicly funded and self-funded care.

- Social care pharmaceutical, PPE, medical equipment, and virus testing supplies must be prioritised alongside the NHS, with streamlined supply chains and escalation routes for shortages.

- Early, clear guidance on PPE specifications and infection control is essential, with sufficient stockpiles and reliable distribution, avoiding over-reliance on inconsistent local systems.

- Lead time for changes in infection control guidance is necessary, and planning for potential FFP3 mask rollout should be prioritised for future outbreaks.

The NCA highlights the need for better collaboration between the Government, NHS, suppliers, providers, and local authorities to ensure the continuity of care and supply of essential goods and services.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

Dated: 23/01/2025