Monday, 30 June 2025

(10.30 am)

Opening remarks by THE CHAIR

LADY HALLETT: Good morning. Today we begin the public hearings into Module 6, investigating the impact of the Covid-19 pandemic on the care sector across the United Kingdom. That impact was devastating. Those who were receiving care were amongst the most vulnerable to Covid-19 and many thousands died.

From my very first meeting with bereaved families members, I realised just how important this investigation into the care sector is to many of them. The investigation has gathered about 160 written statements, and over 200,000 pages of evidence, including the Every Story Matters record, which brings together some of the tens of thousands of experiences that have been shared with the Inquiry.

The hearings will last for five weeks, and about 55 witnesses have been selected to give oral evidence. They include eight bereaved witnesses.

All of the material, both written and oral, will be considered and analysed before I reach my conclusions.

As ever, we have a lot to get through and so I shall keep my remarks brief. In all our modules we start the hearings with an impact film to remind everyone why the

work of this Inquiry is so important.

I'm very grateful to all those who contributed to making the films and I do understand how difficult it must have been for them. As with the previous impact films, this one is extremely powerful and moving. The contributors refer to sensitive topics such as bereavement, the impact of visiting restrictions on them, and on their loved one, and the abiding sense of guilt they feel about not being with their loved ones when they died.

There will be those who find it too distressing to watch, so whether you are following online or in the hearing room, please remember, only keep watching if you feel able to do so, and make sure you know how to access support if you need to do so.

The same applies to the evidence sessions.

The Inquiry's website provides links to organisations which may be able to help, and for those here at the hearing centre we have the Hestia counselling team ready to assist.

I will pause in a moment to allow those who are in the hearing room who wish to do so to leave for a few minutes -- the film lasts about 22 minutes -- and those who are following online to press "mute" or exit the live stream.

After the film has been played we shall reassemble and Ms Jacqueline Carey King's Counsel, Counsel to the Inquiry, will begin her opening submissions. She will set the scene, provide some background, and explain the issues we will be examining in this module in more detail.

Very well. If those who would like to leave the hearing room would like to do so now. Nobody is leaving, so could we play the film, please.

(Impact film was played)

LADY HALLETT: Thank you.

Ms Carey.

Opening statement by LEAD COUNSEL TO THE INQUIRY for MODULE 6

MS CAREY: My Lady, as that video has just demonstrated, Module 6 is undoubtedly going to be emotive and distressing for many people participating in and following these proceedings.

With over 43,000 deaths involving Covid-19 in care homes across the UK between March 2020 and July 2022, how could it not be?

For the relatives who lost loved ones, care workers who witnessed the deaths of people they cared for and tried to protect, and the care workers themselves who contracted the virus, some of whom died, there is an

understandable desire to examine how mortality on this scale happened and make recommendations to how the UK might prevent this from happening again.

May I start my address by saying a few words about care homes, and the people who died in them.

A care home is not a hospital. It is a person's home. Just as you and I feel safe when we go home and put the key in the front door, the same should be true for people living in care homes. They are, however, very different environments, where disease can spread easily and quickly, and the need to protects the elderly and other residents in care homes from influenza and other respiratory illnesses has long been recognised, as those diseases are a major cause of hospitalisation, morbidity, and death amongst older people.

Older age was the most powerful factor that increased the likelihood of death from Covid-19 early in the pandemic. In England alone, people who were aged 80 or older were 70 times more likely to die than adults under 40. And the risk to the elderly is compounded by the frailty and the comorbidities for which they require care.

However, it was not just the elderly who were in need of protection. You will also hear that in the first two peaks of the pandemic, before the widespread

availability of vaccines, people with learning disabilities were seven to nine times more likely to experience a Covid-19-related death than people without learning disabilities.

People with dementia were disproportionately negatively affected in the pandemic. Over 25% of all deaths from Covid-19 in 2020 were in people with dementia, a group who made up only 2% of the total adult population.

Professor Sube Banerjee will tell you that although part of this increased comorbidity will have been due to their essential frailty and other physical health problems, people with dementia and the death rate in people with dementia remains much higher than people without dementia, even when you take account for those effects.

In his opinion, it is likely a substantial element of this mortality is attributable to the way that older people and people living in dementia in particular were treated in the pandemic.

In many ways, my Lady, the numbers of deaths speak for themselves, but what the data and the graphs don't and can't do is to convey the impact of the pandemic on the people giving and receiving care.

It is not surprising that nearly 47,000 people

shared their accounts of the adult social care sector with the Inquiry's listening exercise, Every Story Matters. Those accounts have been analysed and, along with listening events and targeted interviews across the UK, they have been compiled into a Module 6 Every Story Matters record, published today, and I'll be referring to some of the passages in the record throughout this opening.

My Lady, at this stage, can I invite you to admit the Every Story Matters record into evidence.

LADY HALLETT: I do.

MS CAREY: Thank you very much.

In addition to Every Story Matters, one of the impact statements provided by a care home worker in a -- in a Durham care home, vividly describes what happened in her care home. And I should warn your Ladyship, and indeed those listening, this account may be distressing.

And care home worker says this:

"My care home experienced the first positive case of Covid-19 in early May of 2020. My colleagues and I were devastated because we saw the residents as extended family, having cared for some of them for over nine years. Once Covid-19 was in our care home, it spread like wildfire, and we could not do anything about it -- at one point, 67 out of 87 residents tested

positive, as well as a high percentage of our staff -- probably about one-third of the staff at the time. We were all terrified we would take the virus home to our families."

My Lady, she continues:

"A significant proportion of my time during the outbreak was spent facilitating Zoom calls between residents and their family. Sometimes so they could say goodbye to their loved ones when they were at the end of life ... they were unable to do it in person. I often cried alongside them. On one shift, five residents were all at end-of-life at the same time, and I, with colleagues, was going between the rooms to check they were still breathing and they were clean and comfortable, knowing that each time I left the room and next time I returned, they might have died. I recall in particular a resident whose daughter was devastated that she couldn't hold his hand when he was dying. I sat with him in a Zoom call to his daughter and I told her daughter to put her hand up to the screen, and I lifted his hand up to the screen of the iPad she was using. I said to his daughter that it was the closest thing to holding hands that I could do for her. It a memory which has stayed with me, and I will never forget.

"My care home eventually lost 25 residents to

Covid-19 in just three weeks. The care home was completely overwhelmed by the virus."

And that, my Lady, is just one of many accounts from carers who looked after people in receipt of adult social care.

Now, while estimates vary, can I invite you to show on screen INQ000587857.

This, my Lady, just gives you an overview of the number of care homes and residents. You will see that the figures are as at July 2020, and so do not necessarily reflect the precise position in February and March 2020 as we entered the pandemic. But they are, in my submission, a useful indication and summary of the position across the UK.

My Lady, I won't go through them all but if you just look at the top nine, the number of adult care homes in the UK as at July, there was just over 18,000 care homes. There were 537,000-odd beds available, and if we just go down to the penultimate row, the number of care home residents was just over half a million.

Now, whilst a major focus of these hearings is the impact of the pandemic on care homes, it's important to note at the outset that in fact the majority of care provided to those who need it is provided in people's own homes, either by care workers who come into the home

or by unpaid carers, family members and friends, often referred to as either home care or domiciliary care. During the first year of the pandemic there were at least 690,000 people providing domiciliary care in the UK, and at least 580,000 people in receipt of domiciliary care.

And if one looks at the numbers of people providing care, given by family and other unpaid carers, the 2021 censuses in England, Wales and Northern Ireland, and the 2022 census in Scotland found that there were approximately 5.8 million people providing unpaid care in the UK. Among those unpaid carers, 59% are women and about 1.7 million people provide 50 hours or more of unpaid care per week. Taken together, that is many millions of people either being cared for or providing care.

And that is why the scope of Module 6 and I'm going to invite it on screen in a moment, includes reference to care provided in care homes and in people's own homes.

My Ladyship will see there, I hope, on screen the provisional outline of scope, and as you scroll down, it sets out eight areas of focus during these hearings. Clearly the impact of the pandemic on people's experience of the care sector, including unequal

impacts, will be considered; I'll say something about the structure in a moment; key decisions are going to be looked at; the management of the pandemic in adult and residential care homes; DNACPRs, Do Not Attempt Cardiopulmonary Resuscitation notices; changes to the inspection regimes; clearly we'll be looking at the deaths related to the infection of Covid-19; and infection prevention and control measures, IPC for short, for those providing care in the home, including by unpaid carers.

Inevitably it is not possible for me to make reference in this to all of the evidence contained in Module 6. As your Ladyship said at the beginning, there are some 160 statements obtained by Module 6 and 217,980 pages of evidence have been disclosed to date.

It's clearly not going to be possible, either, in Module 6 to look at all the settings in which social care is provided. But I hope to help you in your task will be the submissions, questions, and assistance provided by the 27 Core Participant groups. I won't introduce them all, forgive me, individually. Indeed, I know many of them are known to your Ladyship from their involvement in other modules. All of the Core Participants have provided statements to you and many will be giving evidence over the coming weeks. We are

very grateful to them all for their contributions.

My Lady, may I say something about the structure of the adult social care sector across the UK because it covers a diversity of people, settings and needs, including but not limited to those who are older or living with disability or with physical or mental illness. It includes people who require personal care, such as support for washing, dressing, getting out of bed in the morning.

Care is provided by a mix of public and private bodies, including agencies operating at a local level. And just to give you a very high-level outline of the structure in each nation, in England, the Department of Health and Social Care is the lead organisation for adult social care, with responsibility for national policy and funding in England. The Ministry of Housing, Communities and Local Government oversees the commissioners of state-funded social care, which is namely the local authorities, including district councils, county councils and the like, of whom there are 317.

In Scotland, it is the Scottish Government who is responsible for the strategic framework of adult social care, and the 32 local authorities and territorial health boards who are required by law to plan and

deliver adult community health and social care services.

In Wales, the Welsh Government sets national policy through the Department of Health and Social Services, and the 22 local authorities in Wales have responsibility for planning and commissioning social care in Wales, as well as a duty to safeguard individuals.

Each of the Welsh local authorities plan and deliver the statutory responsibility differently, for example some provide care directly whilst some commission services from the private or voluntary sector.

And my Lady will know from other modules that in Northern Ireland there is an integrated system of health and social care. The Department of Health (Northern Ireland)'s responsibilities include developing appropriate policies, determining the priorities, securing and allocating resources, and setting standards and guidelines. They promote in Northern Ireland what is sometimes referred to as a "whole system approach".

The five health and social care trusts are responsible for providing both health and social care services in their areas, and you will know that that contrasts with the position in England, Scotland and Wales, where the provision of social services remains the responsibility of the local authorities.

Whether one is looking at either local authorities or the health and social care trusts, they are all responsible for assessing people's needs and for ascertaining if individuals are eligible and funding that care. And although it varies nation by nation, much social care is self-funded.

Most social care services are delivered by independent sector home care and residential care providers, which are mainly for-profit companies but include some voluntary sector organisations, and indeed many people will have care organised and purchased by their local authority, although, again, many people with disabilities, for example, directly employ individuals, sometimes referred to as "personal assistants", to provide their care and support.

And so what of the pre-pandemic state of adult social care?

My Lady, the evidence suggests that the adult social care sector was fragile pre-pandemic and lacked resilience. And whilst it's not within the remit of this Inquiry to solve these longstanding systemic issues, there can be no doubt that there were existing financial strains affecting providers, there was a low-paid workforce with a high turnover of staff, which in turn affected staff movement between care homes

and private homes.

Just to give you one example, Frontline Migrant Health Workers Group will tell you that many of its members were paid just on or around the National Living Wage, which back then, in 2022, was £8.72 per hour. They were on zero-hours contracts, which meant they had to work across multiple care homes or at people's homes. So the understaffing that was prevalent at the outset of the pandemic was exacerbated once workers were required to self-isolate and/or became ill with Covid themselves.

In England, the sector approached the pandemic with 112,000 vacancies from a workforce base of about 1.5 million people. There were turnover rates of between 30 and 40%. In care homes the turnover rates of care staff was 39.5%. There was also limited mandatory requirements for training, widespread use of zero hours, as many as 42% of the workforce in home care were on zero-hours contracts.

In Scotland, Jeane Freeman, the Cabinet Secretary for Health and Sport, has acknowledged in her statement the longstanding issues and concerns to address those, including pressures around staffing and resourcing, the funding and the way that adult social care contracts were set up.

In Wales, in January 2018, there was a Parliamentary

Review of health and social care in Wales. Vaughan Gething, the then Minister for Health and Social Services acknowledged in a written statement the following year that, and I quote:

"The simple message at the heart of the Parliamentary Review was that our current system of health and social care is not fit for the future. Change is not simply desirable; change is essential."

In Northern Ireland, you will hear there were vacancies in domiciliary care in each of the five health and social care trusts, and indeed, your Ladyship may recall in Module 2C, you heard from Robin Swann the Minister for Health, he was frank when he told you he believed the social care sector was underfunded and exposed. He said this to you:

"When I came into office in January 2022 [sic], I perceived our domiciliary care, our social work, to be the Cinderella service because I do think they've been undervalued and underrecognised up until that point."

That is just a brief summary but it does provide you with some context for the issues you are going to examine in the coming weeks.

My Lady, one of the key decisions for Module 6 to examine is the policy to expedite discharges of the medically fit patients from hospitals. Your Ladyship

will know from Module 3 that this decision was taken across all four nations of the UK in mid-March 2020 because it was feared that hospitals would be overwhelmed with people needing treatment for Covid-19, and there was a need to free up bed capacity.

In addition, given the anticipated increase in numbers of Covid-19 patients, there was concern that hospitals would become a place where non-Covid-19 patients would in fact catch the disease.

Your Ladyship may wish to consider, however, whether the focus on freeing up hospital capacity came at the expense of protecting vulnerable people in the community receiving adult social care.

Before I address you about the impact of the hospital discharge decision on care homes, I should emphasise that not all patients discharged were in fact discharged to care homes. In Scotland, between March and June 2020, around 63% of patients were discharged from hospitals back to their own homes. And according to NHS England, the vast majority of people in England, 95% of people in fact, were also discharged back to their own homes.

There is, however, evidence in England that people were being discharged back to services that did not meet their needs. Indeed, one of five directors of adult

social services believed that in general, people were not discharged to the right place during the period of rapid discharge from hospital in the initial stages of the pandemic, and there is concern that this may have left some people without, for example, services that might help them regain their independence.

The pandemic, also saw the introduction of temporary changes, sometimes referred to as easements, made to the way that local authorities carried out assessments of people's care needs in England, Scotland and Wales.

In particular, changes meant that assessments did not need to be undertaken with the same level of detail. Financial assessments did not need to take place, and care and support plans did not need to be prepared or reviewed. Now, those changes were intended to enable local authorities to prioritise who was at most need of care at a time when resources were stretched and the number of care staff were depleted either through ill health or the need to isolate.

The modifications, easements, were time limited, and intended to be used as narrowly as possible, and the evidence suggests in fact they were very rarely used. However, the mere fact that easements were introduced caused concern about who would be prioritised and there was a concern that there was a lack of clarity about the

circumstances in which these emergency powers could be used.

For example, the Homecare Association state that the easements meant that care arrangements would change with limited notice, and that sometimes essential support was reduced or withdrawn.

Your Ladyship will know from other modules that testing capacity was extremely limited, particularly so at the start of the pandemic, where testing was limited to people who had symptoms, and so it was not possible to test all patients who were discharged from hospital into care homes until mid-April of 2020, precise dates varying in each nation.

But my Lady, there is undoubtedly concern that decision to discharge patients to care homes without knowing their Covid-19 status led to Covid-19 entering care homes and, in turn, contributing to the large increase in deaths that we looked at earlier. And of course, a negative test was not a panacea. Putting aside the issue of false negatives the test could only indicate the absence or presence of Covid at the time the test was taken.

A number of studies have looked at the impact of the discharge decision on infection outbreaks in care homes, and over the course of the hearings, you will hear

evidence that although some care home outbreaks of Covid-19 were introduced or intensified by discharges, hospital discharge does not appear to have been the dominant way in which Covid-19 entered most care homes. Now I emphasise "dominant", my Lady, because the evidence does not support the contention that discharge did not seed infection into care homes at all.

You will hear genetic evidence that suggests the majority of outbreaks were introduced unintentionally by staff members living in the wider community. In Scotland, for example, a Public Health Scotland study on discharges between 1 March and 31 May 2020, found that care home size had the strongest association with outbreaks of Covid-19, concluding that the risk of a care home outbreak increases progressively as the size of the care home increases.

And studies by a number of the public health agencies found that in general terms, Covid-19 outbreaks correlated with high levels of community transmission. But my Lady, it's important to remember that if studies place reliance on tests carried out in March 2020, the limited amount of testing needs to be borne in mind when considering what weight to place on those findings.

Your Ladyship will hear more about this from the public health bodies when they give evidence and,

indeed, from Professor Laura Shallcross who was instrumental in setting up the Vivaldi Study. Now, the Vivaldi Study was set up in England to help understand more about Covid-19 infections in care homes.

Based on all the data collected, the Vivaldi Study concluded that reduced transmission of Covid-19 from staff was associated with adequate sick pay, minimal use of agency staff, an increased staff-to-bed ratio, and staff cohorting with either infected or uninfected residents.

The Vivaldi Study also concluded, on the other hand, that increased transmission from residents was associated with an increased number of new admissions to the facility, and poor compliance with isolation procedures.

Professor Shallcross will explain why it is difficult to ascertain using Vivaldi data the extent to which discharges from hospitals resulted in Covid-19 entering care homes. Professor Shallcross is clear that whilst Vivaldi provided evidence that did show the importance of staff movement between care homes in transmission infection, Vivaldi did not provide evidence about which was the main route or routes of transmission.

Of course, the fact that it now appears to be the

case that hospital discharges were not the dominant route by which Covid-19 entered care homes, that does not mean the discharge decision -- sorry, the decision to discharge patients without a Covid-19 test should not be scrutinised.

Given that it was well known before the pandemic that care homes were vulnerable to outbreaks of infection, it's obvious that there were no easy decisions here, but if you cannot test everyone at the outset, and you don't know for certain yet how the virus transmits, whether it's by droplets or aerosols or contact transmission, whether it's symptomatically or asymptomatically, but you do know that residents in care homes are much more likely to die if infected, then the importance of good infection control measures becomes all the more crucial.

And testing is an important part of infection prevention and control. Testing both the providers and indeed recipients of care, it enables, for example, Covid-positive patients and residents to be isolated and staff to take the appropriate precautions.

Inevitably, the introduction of testing regimes differed across the UK. And to just take the testing of patients being discharged from hospital as one example of different dates, my Lady, in England it was

15 April 2020 when the action plan stated that all admissions to care homes would be tested whether the patient was symptomatic or not. It started with patients discharged from hospitals, and the action plan also said that all admitted residents, whether symptomatic or asymptomatic, should be isolated whilst waiting for a test result.

In Northern Ireland it was four days later when guidance was issued that said that patients discharged from a hospital to a care home must be tested for Covid-19 48 hours in advance.

In Scotland, it was at 21 April that the Cabinet Secretary announced that Covid-19 patients discharged from hospital to care homes should provide two negative tests prior to discharge and that other new admissions should also be tested.

In Scotland, both sets of patients were advised to be isolated for 14 days.

And in Wales, whilst it was on 15 April 2020 that the Welsh Government contacted Public Health Wales stating it wanted to include testing on hospital discharge, it wasn't until 22 April that care home providers and local authorities were informed that testing would be undertaken before hospital discharge. They were told on that day the relevant guidance would

be updated, and it was a week later, on 29 April 2020, that the Welsh Government hospital discharge guidance was published.

The advice required a negative test result before any individual was discharged from hospital to an existing placement or care package, including those receiving support in their own home and it may be your Ladyship will want to examine the reason for the delay in the issuing of that guidance during the course of these hearings.

The first major IPC (infection prevention and control) guidance was issued on 25 February 2020. Now, at that time, there were only 13 cases of Covid-19 in the UK. By the time the next set of IPC guidance was published on 13 March, there were 798 cases and 11 people had died. And by 2 April 2020, when the admissions guidance to care homes was issued, the number of cases had grown to 33,700-odd infections and nearly 3,000 people had died.

The number of people infected with the virus and, indeed, dying of the virus was therefore rapidly changing, as was the scientific understanding about how Covid-19 spread. And your Ladyship may need to assess how the emerging scientific understanding was reflected in that IPC guidance.

To give you just one example, the March guidance provided separate guidance for residential care homes and home care, but both pieces of guidance advise that where neither the carer nor the person being cared for had no symptoms, then no PPE needed to be worn. You will want to consider that advice in light of what was known about asymptomatic transmission at the time.

That brings me on, my Lady, to PPE, personal protective equipment.

Much of the care provided, whether in care homes or home care, involves close contact, which involves very real difficulties in being able to either isolate a resident or to abide by social distancing. So the need for stringent and effective IPC measures is obvious. Given that ventilating care homes is a challenge, its particularly hot or particularly cold surroundings pose a risk to those residents, there was an inevitable reliance on PPE to prevent the spread of Covid.

Unlike in healthcare systems, in the adult social care sector, PPE was generally bought by social care providers from wholesalers.

Prior to the pandemic, PPE was not used in large quantities and certainly was not used with a frequency that it was used during the pandemic. Large reserves of

PPE were not kept, and of course the buying power of the social care provider often depended on the size of the provider.

Your Ladyship will know that from February 2020 onwards there was an international clamour for PPE.

And I have no doubt you will have well in mind the evidence given in Module 5 about the efforts to procure PPE, but as far as the adult social care sector is concerned, some insight into the ability to obtain PPE can be gleaned from surveys that have been conducted by the Convention of Scottish Local Authorities, or COSLA as they are known for short, and by the Local Government Association and the Welsh Government Association.

Now, in Scotland the survey produced mixed results because the respondents were asked how easy was it to access PPE in the first six months of the pandemic? 45% of the respondees said care providers found it very or fairly difficult to access PPE; 11%, however, said they found it very or fairly easy.

The position is slightly different in England. The Local Government Association survey found that almost nine out of ten local authorities reported that care providers found it either very difficult or fairly difficult to access PPE. And in Wales, 55% found it either very difficult or fairly difficult to access PPE.

So where PPE supplies were scarce, there were issues surrounding the guidance given to the sector, about the circumstances in which it was to be used, issues about how it was distributed. You will hear that some providers had orders requisitioned by the NHS Supply Chain, and there were wholesalers who refused to sell to non-NHS organisations. Scottish Covid Bereaved, for example report that many privately owned care homes were left to source their own PPE with several of the Scottish Covid Bereaved members reporting care homes relying on community support to provide PPE, and in some cases homemade facial masks and fabric masks were provided.

One member of Scottish Covid Bereaved said:

"They were short of PPE, I remember someone had donated PPE and a manager had posted a thanks on Facebook and said if anyone had any more they'd happily accept it."

Each nation provided free PPE eventually to the adult social care sector, the start and end dates of that provision varied, as did the methods by which the PPE was distributed.

There were also issues surrounding whether the care workers were trained to use PPE, from the end of April 2020, for example, NHS England offered IPC

training to all registered care homes including training others to train. And I know you will be familiar with issues surrounding the quality of PPE from the healthcare module but it bears repeating, there are examples of PPE not being fit for purpose, with, for example, mask straps breaking and the like.

You will hear about the various funding programmes put in place to support the adult social care sector. There were many, and I won't give you a list of all. But just by way of example, in Wales, there was a local authority hardship grant, an initial £40 million in April 2020, and in later that year, a carers support grant was set up.

In Northern Ireland, at the end of April, £6.5 million of financial support was announced for the independent sector providers, and, depending on the size of the care homes, care homes received a payment of either £10,000, £15,000, or £20,000.

The Scottish Government provided the Covid-19 financial support for adult social care providers scheme. It was designed to support resilience in the sector, reimburse additional costs related to Covid-19. It was an initial £50 million announced on 12 May and a further 50 million announced in November of 2020.

In England, the Infection Control Fund was one of

a number of funding streams, including the Rapid Testing Fund, the Workforce Capacity Fund, that was announced by the government.

In May 2020, the government gave local authorities £600 million through the Infection Control Fund to support adult social care providers. It was designed to reduce the rate of Covid-19 transmission, and support wider workforce resilience. And it was intended, if I may put it more bluntly, to be used to recruit staff, pay for transport so that workers didn't have to use public transport, and provide accommodation for staff who chose not to live at home.

Importantly, the fund was to be used to ensure that staff who were isolating would receive their normal wages, and thereby mitigate the risk that a Covid-positive worker would nonetheless come to work because they simply could not afford not to work.

There were further grants to the fund thereafter, such that the total ring-fenced funding for infection prevention and control came to almost 1.75 billion.

Now, my Lady, notwithstanding the various measures and funding regimes in place, whether in fact there was a "protective ring" thrown around care homes, as Mr Hancock stated at a Downing Street press conference on 15 May, is likely to divide opinion, and doubtless

something for Mr Hancock to address when he gives evidence later this week.

It's not so much a question of whether there was protective ring, for, as Mr Hancock acknowledged in Module 2, there was no unbroken circle around care homes, but why that phrase was said, upon what evidence it was based, and whether he believed it to be true, may be of some import to this module.

Finally in relation to infection prevention control guidance, there are concerns that the guidance was initially and primarily designed for hospitals, so not always suitable and applicable for care homes. The focus was then on guidance for care homes, which was therefore difficult for people to apply for those providing domiciliary care. The Nuffield Trust, for example, noted that policies to limit staff movement introduced in September 2020 didn't adequately take account of the fact the nature of domiciliary care, where people are often moving between home and home, providing different care at different times.

It also failed to take account that it was a largely low-paid sector, with staff often working more than one job.

There are concerns about guidance for unpaid carers which was not always easy to locate and some of the

specific guidance for unpaid care seemingly lagging behind guidance for other providers of care.

One of the important IPC measures that you will want to consider is that in relation to visiting restrictions. My Lady, they were imposed to try and prevent the spread of infection, but there can be no doubt that the impact of the restrictions was keenly and deeply felt by the residents, their loved ones, and the staff that had to apply them. For many, particularly at the start of the pandemic, this meant that many family members died alone without the comfort and care that being present at the end of life can bring. One daughter of a care home resident who died from Covid-19 said this:

"He'd been there two weeks and then we had the call to say he had Covid. Five people in the home had tested positive. Ten days later, he'd gone ... I couldn't speak to him, I couldn't Facetime him -- there was no signal. A shocking way to go on his own. I rang the care home for records. They rang back and said they held his hand."

Carers to Every Story Matters recounted how difficult it was for them. One domiciliary care worker said:

"It was horrible. We were the ones sat there

holding their hand as they were dying. We were the ones ringing the family to say 'Your mum's passed away this morning'."

The isolation that came with the visiting restrictions had a significant negative effect on many recipients of care. Professor Banerjee, the Inquiry's expert on dementia, will tell you that the cognitive function of people with dementia deteriorated more quickly than it would have done before the pandemic. Some people with dementia develop worsening neuropsychiatric symptoms, such as depression, anxiety and agitation, and care staff have reported that some residents simply didn't understand why they couldn't see their family, they couldn't understand the pandemic more broadly, which led to the residents becoming upset.

Care staff also reflected that visiting restrictions seemed to accelerate decline. One person noting, "Instead their dementia got worse due to no visits."

And that decline in loved ones with dementia echoes accounts given to Every Story Matters.

One care home worker said this:

"Her dementia declined rapidly when lockdown happened and she'd got no family support. So, she'd not got her family coming to see her. She just kind of lost all will. She wasn't bothered. She really declined.

And yes, you can speak to them over the phone. But she didn't understand that it was her daughter or her son or her grandchild she was speaking to, because she couldn't physically see their face."

Another contributor said this:

"My mother's death in the care home -- alone and confused about why her only child appeared to have abandoned her. It absolutely kills me to think about it. I felt and still feel angry, powerless and distraught. The restrictions caused utter confusion to a dementia patient, and only heartache. It affected my mother's mental health, causing her dementia to worsen, leading to a sharp decline and ending in her death alone without me alongside her."

My Lady, when those involved in devising the visiting restrictions give evidence to you, I very much doubt that any of them are going to say anything other than that they found the decisions about visiting some of the most difficult they had to make. Each decision maker had to weigh up the harm caused by allowing visitors against the hard caused by restricting visitors.

And you will hear that as the pandemic progressed, the rules changed. There were care partners introduced in Northern Ireland from September 2020 which allowed

the identification of a person to assist in maintaining each resident's physical or mental health. In England and Wales, restrictions were eventually amended to allow a differing number of visitors to enter care homes and, indeed, since the pandemic, in April 2024, legislative amendments were made to make sure that subject to exceptional circumstances, people staying in a care home, hospital or hospice, can receive visits from people they want to see; that people living in a care home are not discouraged from taking visits outside the home.

And the Scottish Government has developed legislative provisions on visiting. It's known as Anne's Law. Within the Care Reform (Scotland) Bill, if enacted, it will impose a duty on the Scottish ministers to exercise an existing regulation-making power so as to require providers of care home services for adults to facilitate visits.

Whether the changes in the policy and law subsequently made would mitigate the harm caused by the restrictions, however, remains to be seen.

May I turn to a different topic, my Lady, and changes to the regulatory inspection regime. Each nation has a regulator which monitors, inspects, and regulates the social care sector, and the providers,

with the aim of ensuring that health and social care services provide and improve the safety and quality of care. The regulators have a wide set of powers, including the powers of inspection. And in March 2020, each nation's regulator ceased its routine inspection activity, some inspections still took place, where there were safeguarding concerns, but the decrease in number of inspections can be seen in the table I'd like to put up on the screen now. Thank you.

There are slightly different ways in which the data is reported, either by accounting year or financial year, hence why we've set it out slightly differently, but if one looks at the figures for 2019, you can see that in England there were 8,155 inspections that year and the following year, when we started the pandemic, it dropped to 4,793. Go across, Northern Ireland, had 1100-odd down to 683. Scotland, 1100-odd, 603. And in Wales, the figure dropped from 862 to 178. They are, on any view, significant decreases in the number of inspections carried out.

Thank you. That table can come down.

But once the routine inspections had all but ceased each regulator put in place measures to try and monitor the sector. In England, this included calls to care home registered managers to see whether and how they

were managing Covid-19 risks. There was a mixed response to these calls. One manager of a care home described how their first contact with the CQC was not until July 2020 when they had a Teams call with an inspector to assess how they were managing, and that care home felt that that was simply too late.

Another manager of a care home, however, found the calls reassuring.

In Wales from the end of March, Care Inspectorate Wales introduced weekly check-in calls not check-up calls. There was an additional system set up in May 2020 to enable inspectors to look specifically at services where there'd been Covid-19 outbreaks to identify those services where people may be at risk, and to agree actions for oversight and potential inspection or further action. And a manager of a care home in Wales described that Care Inspectorate Wales calls were supportive.

In Scotland, the Care Inspectorate increased levels of contact with providers and introduced a red, amber, green assessment as a warning system to notify where there were difficulties with staffing levels and the provider might be reaching crisis point. Care Inspectorate staff monitored and responded to those calls daily and over weekends to ensure that services

got the support they needed.

And in Northern Ireland, the RQIA established a services support team which acted as a single point of contact for providers to raise issues and receive the most up-to-date advice, guidance and support from those inspectors.

For many, though, the lack of inspections has caused a great deal of concern. John's Campaign, for example, considered that the CQC had abdicated responsibility during the pandemic and that oversight and regulation were lacking.

Similar concerns have been raised by representatives and members of each of the four bereaved groups, worried, whether, without the usual checks and balances, the proper procedures were followed.

As one member of the Covid bereaved families for Wales has stated:

"With little or no GP attendance, [with] few inspections of services, and with no relatives going in to see what was happening, members are left feeling traumatised by the way their loved one died. They are left wondering if they could have been saved."

Now, within that quotation is a reference to attendance by healthcare professionals on care homes and during the evidence we will examine access by and to

healthcare professionals, including the impact of increased use of remote attendance.

My Lady, may I turn to a topic with which you will be familiar, and that of Do Not Attempt Cardiopulmonary Resuscitation orders, DNACPRs for short. You will be familiar with the very real concerns about the way decisions about DNACPRs were taken and communicated with both patients and their families.

You've heard in Module 3 about the way in which these decisions should be made. A DNACPR form is used to record a patient's preference not to undergo CPR in the event of a cardiac arrest, or where the treating clinician considers that CPR would be futile in all the circumstances.

A notice is signed by the clinician, not by the patient. And so although you have heard many references to DNACPR orders, a DNACPR notice is not legally binding, nor is it an order. It is a form which records a clinical decision for an emergency where the patient lacks capacity to be involved in decision making.

Module 6 will consider issues relating to DNACPRs, including concern that there was application of blanket DNACPRs. This was a matter raised by a number of contributors to Every Story Matters, and the listening exercise heard reports of DNACPRs being applied across

a care home, or to people with a particular type of health condition such as dementia. To quote just one contributor:

"One local doctor rang around families just to say they've put their DNACPR on their loved one because of a learning disability or old age, having never even met the people."

You will recall hearing similar evidence from the Older People's Commissioner for Wales, Ms Helena Herklots, who gave evidence in Module 2B. Your Ladyship will recall that she told you about a letter sent by a GP surgery in Wales to a patient with serious health conditions, the letter stating they would be "unlikely to be offered hospital admission" if they became unwell with Covid. They certainly would not be offered a ventilator bed. The letter stated that completion of the DNACPR form "will mean that in the event of ... deterioration in your condition because of Covid, the emergency services will not be called and resuscitation attempts to restart or heart or breathing will not be attempted."

That letter said that one of the benefits to completion of a DNACPR form was that scarce ambulance resources can be targeted to the young and fit who have a greater chance of surviving the infection.

That letter you may consider is contrary to UK-wide guidance. It's been published since 2016, which makes clear that DNACPRs should be made on an individual basis and during the pandemic, there was a number of people and organisations, including the Chief Medical Officers, the Chief Nursing Officers, who wrote to GPs, trusts, and health boards, deprecating any blanket policy and reiterating the need for individual decisions in consultation with the patient and their families.

Notwithstanding those letters, and that deprecation, there remains a concern that DNACPR guidance was not followed, and it may be difficult to ascertain now why this occurred, whether it's that some healthcare professionals were unaware of the guidance, or there was a sense of panic at the start of the pandemic which led to such letters being sent. Doubtless, also, the visiting restrictions will have meant that communicating with families about these decisions, discussions which we all agree should be done sensitively, were not able to take place in the way that they would have been done in non-pandemic times.

Sometimes you may hear these discussions were not taking place at all.

Clearly, with such a large number of people dying during the pandemic, there was a rapid increase in the

need for palliative and end-of-life care. The Inquiry's experts into end-of-life and palliative care, Professors Sleeman and Barclay, will tell you about a study conducted in 2021 with care home managers and staff which said that the care homes and staff found it very difficult to deliver what they considered to be high-quality personalised palliative and end-of-life care to people with and without Covid-19.

And, my Lady, it's likely that those findings will echo evidence that you will hear in the coming weeks.

My Lady, a final few remarks from me.

As the evidence unfolds, there may be a question mark about the extent to which the structure of adult social care was properly understood by decision makers. You may also hear the suggestion that the NHS was prioritised at the expense of adult social care. Whether and the extent to which that suggestion is accurate will be something for your Ladyship to consider.

You may think that, whilst there was undoubtedly a need to make sure people could receive the medical treatment they required, there was equally a need to consider how best to protect residents in care homes, given the well-known vulnerability of people living in those enclosed settings.

A number of witnesses and Core Participants are concerned about the extent to which governments engaged with them about issues affecting the adult social care sector. All acknowledged that the start of the pandemic was a time where decisions needed to be made quickly about a novel disease and that people were working night and day, but there are a number of organisations, my Lady, with a wealth of knowledge about the day-to-day implications of policies and guidance who say they were overlooked when they either tried to raise concerns or indeed made offers to help.

I started this address by referring to the high numbers of deaths of people who were in receipt of social care. But the risk to social care workers was also significant. The Inquiry has received numerous accounts of workers going over and above their daily work to try to care for and indeed protect those they were looking after, at not insignificant personal risk.

As you know from other modules, Covid-19 disproportionately affected people from ethnic minorities, and so whilst data on the ethnicity of social care workers who died is not easily ascertainable, even when adjusted for sex and age, a Health Foundation report found that in May 2020, social workers were more than twice as likely to die

from Covid-19 compared to the general population.

And indeed from 9 March 2020 to the end of February 2022, there were some 1,290 deaths of social care workers in England and Wales involving Covid-19 alone.

The impact on those working on the front line must not be forgotten. A survey of the adult social care workforce conducted in July and August 2020 found that 81% of the workforce said that their workload had increased, that their work-life balance had decreased. 53% of those working in care homes indicated their general health had worsened. 60% recorded an increase of incidents where their work had made them feel depressed or gloomy or miserable. And 89% of people working in care homes in that survey reported increased feelings of tension, unease and worry.

Indeed, as the Every Story Matters records laid bare, one senior care worker in a residential home for people with dementia in Wales told ESM that she worked 23 consecutive days, during which time she dealt with PPE shortages, unexpected hospital discharges in the middle of the night, and residents feeling frightened and abandoned. She said healthcare professionals were unable to visit. She said it made her feel abandoned. She considered quitting several times. And she said

this:

"It was hell, I thought about quitting, I felt like we were on our own, health professionals didn't want to know, mental health teams, dietitians, continence nurses didn't visit any more."

She said the long-term emotional impacts of the private equity remain.

"I could go on and on ... people say it seems so long ago but for me it still feels like yesterday, I feel sad for the ones we lost ... they didn't get the end-of-life care they deserved, I feel sad for the good staff we lost because they were scared of getting Covid, my heart breaks for the families that didn't get to say goodbye and I'm sad for me, being stuck with the memories of the worst things I've ever had to endure with barely any support from those that should have."

Finally this, a word about the hearing timetable. In addition to all the written evidence obtained by the Inquiry, over the course of the next five weeks you will hear from approximately 55 witnesses. Witness availability due to summer holidays means it will not always be possible to examine any given topic in one neat tranche of evidence, but I am confident, my Lady, that at the conclusion of the hearing you will have heard from a number of key decision makers and from the

groups, organisations, and people impacted by those decisions. In particular, the hearings will start and end with hearing impact evidence from members of the four Covid bereaved groups.

In addition, we will publish tomorrow the corporate statements from the bereaved groups setting out their concerns and I know that will be expanded upon in the addresses you will hear from them later today.

Those statements include many accounts from their members about the devastating impact of the pandemic on them and their loved ones, and I know that you will have those statements at the forefront of your mind as you hear the evidence.

My Lady, that's all I propose to say by way of opening. I wonder if it may be a convenient moment to take our mid-morning break.

LADY HALLETT: It is. Thank you very much indeed, I shall return, and I hope Mr Weatherby is going first, at 12.10.

MS CAREY: Thank you, my Lady.

(11.54 am)

(A short break)

(12.10 pm)

LADY HALLETT: Mr Weatherby.

Submissions on behalf of Covid-19 Bereaved Families for Justice by MR WEATHERBY KC

MR WEATHERBY: Thank you, my Lady.

Alasdair Donaldson was a senior policy adviser at the British Council until he was posted to the DHSC adult social care policy team, where he commenced work on 30 April 2020. He described "complete chaos", his words, in the department on his arrival, with no one knowing who was doing what or where responsibilities lay. And even later, he says, HR was unaware of how many people it was employing, even to the nearest thousand.

In his statement, at paragraph 133, he says this:

"My reluctant personal conclusion from what I directly witnessed is that the Civil Service I am proud to be part of catastrophically let down the people it was supposed to serve. Whitehall and policymakers should not shy away from the fact that they presided over something that was more than a natural disaster, inevitably exacerbated in places by a few incompetent or reckless errors. Rather, the Government public health response to Covid involved a series of catastrophic policy errors, and an overall system performance that was -- with notable exceptions -- a profound failure, perhaps the greatest Governmental policy failure of

modern times."

Then he continued with this:

"This failure resulted in the unnecessary deaths of tens of thousands of British citizens -- including a generational slaughter within care homes -- many of those victims dying horrible deaths, often without the solace of their loved funds. Understanding the true causes of this failure is I believe owed to the victims, their families, to history and to the future."

The importance of this is not only that he was a significant member of the DHSC ASC policy team, but he was responsible in large part for the Vivaldi Study, which was, as we've heard, an important project set up in May 2020 to gather and analyse data from care homes in order to direct policy.

Mr Donaldson rubbishes Matt Hancock's contention that the Vivaldi Study supports the suggestion that discharge of thousands of untested patients to care homes in March 2020 did not contribute significantly to outbreaks or mortality rates. He described such a position as "untrue", and makes the stark point that because those discharged at the time were untested the study could not have reached any such conclusion. Absence of evidence is plainly not evidence of absence.

He comments that common sense and basic epidemiology

would point in the opposite direction, that just at the time that hospital infections were rising exponentially, discharging untested patients would create a clear and obvious risk to care homes. The fact that there were other obvious risks did not diminish that.

Mr Donaldson also takes on the work done by PHE to review the policy's impact, pointing out that those within PHE had skin in the game, and that it was marking its own homework.

Although Mr Hancock wants to rely on this PHE work, he's rather stuck by a WhatsApp exchange with his junior care minister, Helen Whately, dated 13 July 2020 in which he describes data relied upon by PHE from March as "crap" and that government should have "zero tolerance for it".

No doubt you'll look closely at the March 2020 decision to discharge patients to care homes without testing, but currently you'll be doing so without hearing from Mr Donaldson or Lord Simon Stevens, head of NHS England at the time. We've asked you to review that decision and call on those witnesses with important evidence and just --

LADY HALLETT: Just pausing there, Mr Weatherby, I haven't yet made up my mind about Mr Donaldson.

MR WEATHERBY: Yes.

LADY HALLETT: I haven't made up my mind about Mr Donaldson.

MR WEATHERBY: I'm happily corrected. I was going to say we'll renew that request today, but no need.

For countless families, the decision to discharge untested patients to care homes or to receive domiciliary care at that time was unfathomable. It's cold comfort to hear the unevidenced assertions of Mr Hancock or Professor Harries that it wasn't significant or that discharges were not the dominant cause of infections in care homes. Every death was devastating.

If there'd been adequate testing capacity, would anyone have been discharged to a care home or to receive domiciliary care from workers who would then care for others without being tested? Of course not. Would care workers themselves have been tested earlier and more often? Of course. If there'd been a properly functioning ASC sector, would there have been so many people requiring social care stuck in hospital at the time? Obviously not. Had there been proper pandemic planning and capacity, would care homes have had better isolation provision, better staffing levels, dedicated staffing provision, support for staff needing to isolate, proper and sufficient PPE, would the risks have been much reduced? Of course.

Was sufficient done to free up provision in private healthcare settings? Was the right approach taken to limiting or stopping elective healthcare in the eye of the emergency? The reality is that with no preparedness and lost weeks from January to March, the government panicked. Under the dithering leadership of Mr Johnson and Mr Hancock, it was not only the failure to plan and prepare and resource before the pandemic, but the lost weeks from January to March, when performative government trumped candour. It was more important for them to pretend that we were okay than to act with speed and strength to catch up as far as we could.

This is not mere rhetoric. From WhatsApps we know that by early March Mr Hancock, and his junior minister Helen Whately, only knew about two local authority pandemic plans for ASC. They'd taken no action on large-scale asymptomatic testing. There was an acute shortage of tests and PPE. I could add a lack of clear central guidance on IPC and a lack of support funding for homes and staff alike.

Although the phrase "generational slaughter within care homes" may sound hyperbolic or rather colourful language, it chimes with the experience of thousands of our families.

In an earlier module we heard that former

Prime Minister Johnson told senior advisers that Covid was "just nature's way of dealing with older people", and Patrick Vallance recorded in his diaries that Mr Johnson appeared "obsessed with older people accepting their fate".

Meanwhile, Mr Hancock was asserting that a protective ring had been placed around care homes, an assertion he now tries to spin out of by suggesting that it was "clearly a piece of rhetoric".

By definition, people drawing on care and support were like more likely to be vulnerable people to Covid because of age, comorbidities and disability; they were not just casualties of some natural selection process. And as we'll see from the evidence in Module 6, they were not protected by some ring of steel, real or imagined or rhetorical.

In some settings those receiving social care fared well. In others, catastrophe outbreaks led to multiple deaths. This was not mere chance but largely down to themes which are now familiar to the Inquiry: lack of planning, lack of resourcing generally, the slow injection of emergency pandemic funding, lack of testing, and PPE capacity.

It's not for this Inquiry to investigate whether, of itself, the fragmentation of the ASC sector and the lack

of strategic overview or policy or resourcing during normal times was or is sensible. But it is for this is Inquiry to look at whether this provides a viable framework through which emergency planning and operations can work.

In England alone, ASC services are the responsibility of local authorities outsourcing to more than 18,000 providers, with the centre, the DHSC, responsible only for the legal framework and policy by which local authorities are to discharge there duties.

We know, for example, that this framework resulted in a position where ministers did not know even how many care homes there were by March 2020. I think it's fair to say that they knew how many hospitals there were, so why the lack of such basic knowledge in social care? Chris Llewelyn of the Welsh LGA provides an answer. He says: social care is viewed as a secondary service or "add-on", not the critical frontline service that it really is.

A system which relied upon staff caring for a number of residents could not overnight pivot to one where dedicated staff could look after individual residents. In many settings, staffing levels meant that there was considerable reliance on agency workers, who moved between homes, and with domiciliary settings that would

be the norm. Although some care homes no doubt managed to create isolation areas, these were people's homes, not designed for siloed living, and for many this was impossible because of the physical accommodation, staffing and resources.

We'll hear a more nuanced view from Sajid Javid, who will assert that ASC requires a joined-up approach between care providers, local authorities, the NHS, UKHSA, MHCLG and the DHSC. No doubt there's truth in that, but if so, where is the evidence of any functioning pandemic collaboration between all those agencies, or multi-agency interoperability plans?

If the UK in its constituent parts failed to prevent infection across many settings, failed to have proper staffing provision, failed to have sufficient testing and PPE, it's perhaps no surprise that it failed on visitation too.

Many others will speak to this issue, but it's of huge importance to the families, many of whom lost loved ones whom they were prevented from seeing for weeks and months prior to their deaths, many living with dementia and other conditions or comorbidities which made isolation from loved ones so much more unbearable.

As in all other modules, we urge the Inquiry to focus on how the response to the pandemic in the

ASC sector tackled or even acknowledged existing discrimination and inequalities. We've cited some of the available and shocking data in our written submissions, but mortality rates for ethnic minority staff were massively disproportionate to their white colleagues. Care workers were overwhelmingly women, and with lower than average socioeconomic status, including many in precarious positions.

What was done? What was planned? What policies were brought in to address these disparities?

It's well established that those with learning disabilities, autism, dementia, as well as those with physical disabilities, fared particularly poorly during the pandemic. What exactly was done to address these obvious issues in planning or the early stages of the emergency response or thereafter? It appears very little.

As with all these questions, what's the position now, in 2025? Have lessons been learned? And if so, do they inform what went wrong in 2020?

If lessons have not been learned, are we really destined to fare just as badly and disproportionately with respect to racialised minorities and disabled people as before?

Finally I turn to the lived experience evidence from

the bereaved families. You are to hear from two of our family members, Jane Wier-Wierzbowska and Linda Ann Dinsdale, and a number of others from the other bereaved groups. You've determined that the Inquiry will not hear from the CBFFJ UK organisational witness, Jean Adamson, but take account of her detailed witness statement, which in turn not only details her own experience but sets out the experiences of a number of others.

As you'll have seen, the statement draws attention to the consequences of having a fragmented system and calls for unified national care systems within each of the four UK jurisdictions, to enable proper emergency planning and response.

We urge you to make that a key recommendation for Module 6, but we add to that a rebalancing of the health and care sectors so the latter is no longer a poor relation. Better data, better regulation, proper emergency and pandemic planning, which includes resourcing, support for staff, adequate IPC, testing and PPE.

We urge you to recommend that tackling racial and disability discrimination in the sector not only needs to be a higher priority in normal times, but an integral part of emergency planning. It was plainly neither when

the pandemic struck.

Jean's statement on behalf of CBFFJ UK draws attention to the consequences of fragmentation, lack of strategic oversight, planning and proper resourcing. For CBFFJ, moving forward, the key issue is that without national care systems there will be absolutely no basis through which any other recommendations you make will work.

CBFFJ calls out the callous way that family members were treated by politicians and policymakers, referring to them as "bed blockers" and people nearing the end regardless of the virus. This theme was exacerbated by the experience of many family members regarding inappropriate DNACPRs and blanket visitation policies.

The statement reflects that those in charge of policy lost their moral compass in dealing with those receiving or case. Jean's dad was a Windrush pioneer who came to this country in 1956 to rebuild post-war Britain and worked on London Underground. Aged 98 and in a care home, he was not a statistic or a number.

Aldred Cleophas Adamson was a dignified senior citizen who should not have been a lesser priority because of some actuarial calculation. In his case, untested patients had been discharged into his home, less than a month before he died, without precautions

being taken, a matter expressly raised by his family at the time.

Arthur Argyle died in May 2020. His daughter Sarah had to fill gaps in his care resulting from chronic low staffing ratios which impacted on him being shielded from infection.

On 26 May 2020, Cath Sexton was the last of 24 people in her care home to die from Covid in a three-week period. Her daughter considers it probable that this was linked to the policy to discharge untested patients from hospital in March.

Marie Erwood removed her mother Margaret Jean Smith from a nursing home, having been told by the manager that they'd been required to take untested patients from the local hospital, and having raised concerns about an apparently symptomatic care assistant who'd returned from Italy caring for her mother without PPE. Unfortunately, Margaret had already contracted Covid and died two days after returning home.

By contrast, there's evidence of care facilities which managed to provide care safely. Amos Waldman's grandma, Sheila Lamb, sadly died in a care home in April 2020. At the time Mr Waldman was himself becoming a trustee of another care home which cared for adults with both learning and physical disabilities.

In Jean's statement she sets out Mr Waldman's detailed explanation of the measures taken by that care home which managed to remain Covid free until November 2020. It includes an earlier lockdown than the 23 March national one, proper PPE provision, dedicated staffing provision, full testing and support for staff who were self-isolating.

Mr Waldman's account is one of many which show that care home devastation was far from inevitable. It was avoidable with planning and early proactive management. His account also highlights that many of the families we represent are not only bereaved but health or social care or domiciliary carers themselves. The catastrophe in the care sector was not of their making and it did not need to be. The bereaved, their loved ones, and carers deserved better.

Thank you, my Lady.

LADY HALLETT: Thank you very much, Mr Weatherby.

Ms Campbell.

Submissions on behalf of Northern Ireland Covid-19 Bereaved Families for Justice by MS CAMPBELL KC

MS CAMPBELL: Thank you, my Lady.

In preparing to address you today on behalf of the Northern Irish Covid Bereaved, I revisited the submissions that I made at preliminary hearings in this

module in March '24 and February of this year, and on each occasion I indicated that it would be difficult for me to overstate the importance of this module to the Northern Ireland bereaved, not least because you will recall that some 90% of our client group have concerns about the treatment of their loved ones in the Northern Ireland care sector in the course of the pandemic.

Further light is shed on that 90% figure when it is understood that although deaths per hundred thousand remained lower in the north than in England, Scotland or Wales, a figure upon which we know the Department of Health appears to place some positive reliance, between March 2020 and June 2022, persons aged 75 and over accounted for almost 74% of Covid-related deaths in Northern Ireland, and care home residents alone accounted for 51% of all Covid-related deaths.

The figures, my Lady, are shocking. And at the first preliminary hearing, I observed, as you indeed have this morning, that having spoken to many Northern Irish Bereaved you know that they have a great deal to say about how and why those who ought properly to have been protected by the health and social care system in the pandemic became its primary victims.

I observe that the Northern Ireland Bereaved had been patient in biding their time in earlier modules,

and that in Module 6 their time would come when they would have the opportunity to add value through their evidence and through their individual lived experiences as well as the work they have undertaken collectively to identify and expose systemic failings.

But, my Lady, that time has not come, at least not in full. We welcome the decision to hear from Agnes McCusker tomorrow and from Gregory McQuitty in week 5 of this module and we know that their evidence will receive the due care and respect it deserves. But the recently communicated decision not to call corporate evidence from the Northern Ireland Covid Bereaved has been a disappointing blow, and one which, it's fair to observe, has left their faith in the Inquiry a little shaken, at a time when the module of the greatest significance to so many of them has approached.

It has left some with trepidation, and others with a feeling of marginalisation which we hope will be assuaged as the evidence is called, is heard, and is challenged.

My Lady, Tom Black and Martina Ferguson set out with care in the corporate statement not only their individual experiences, but the many systemic failings within social care in Northern Ireland. That statement we know will be published tomorrow, but in the absence

of oral evidence from them, we trust that the issues that they raise will form the platform for many questions to be posed to witnesses from whom you will hear, because, my Lady, so many of the themes that you have heard about in earlier chapters of this Inquiry, in earlier modules, find their conclusion in this module.

And sadly, that conclusion is that in large numbers, the most loved, the most valued, and the most vulnerable people members of our society were exposed to and died from this deadly virus.

The story of Covid might always have been a tragedy but it is made all the more so because when that story is told, it is apparent that so many of those we lost need not have died, had our government been more prepared, had they reacted with more focus and urgency to protect those in most need, had they listened more, and therefore led better, had there been more coordination and better cohesion, and had they learned more from one wave to the next. And nowhere is that clearer than in the world of social care.

My Lady, you were reminded this morning that in Module 2C Robin Swann told you that at the outset of the pandemic, the social care service in Northern Ireland operated as a Cinderella service. It was, he told you, undervalued. It received insufficient financial

resources and the contribution of its workforce was under-recognised.

We, of course, agree, but would go further. It was not and indeed is not adequately protected by safeguarding legislation. It was not and is not adequately protected by discrimination legislation. The sector regulator had long been exposed as substandard. It was completely lacking in resilience, because of a longstanding staffing crisis, and it was not a government priority, regularly overshadowed by concerns for acute or healthcare services.

But my Lady, all of that was well known before the pandemic, as it is now, meaning that the question to be explored in this module is: knowing that it was a Cinderella service, would it then more than ever become a government priority? And the answer, exposed through the evidence in this module, is no.

That much is made clear by the continued prioritisation of health over social care, notwithstanding the integrated nature of our health and social care system. By the early abandonment of domiciliary care, the initial failures to supply the independent sector with PPE, unclear, late and then duplicative guidance for the sector, the withdrawal of regulatory inspections, persistent failures to consult

and engage, a casual dismissal of concerns around DNACPR, and a failure to learn from one wave to the next. The Commissioner for Older People of Northern Ireland indicates in his statement that the approach taken by the department demonstrated a clear focus on protecting the NHS. As a result of that, the care sector was initially abandoned to struggle.

One inference, he tells us, to be drawn from the prioritisation of one section of the community over the other is an ageist approach in which the value of an older person's life is deemed less than that of a younger person.

The language of abandonment appears in other aspects of the evidence. In a recently disclosed statement from a homecare provider across the north we read that:

[As] read] "As the pandemic approached in February 2020, there was a belief that the Department of Health would abandon us, and true to form, when so-called guidance was produced for the domiciliary sector on 17 March and 7 April 2020, and it was indicated that PPE was either not required for domiciliary care at all, or, in circumstances where Covid was confirmed, basic PPE would suffice."

That same statement observes:

[As read] "It seemed as though we were to be

abandoned by the Department of Health. We were unimportant to the public sector. It was hugely demoralising."

My Lady, you've heard some of that before in Module 2C, 3 and 4, but what comes into stark relief from the evidence in this module is that any contention that those in charge did not know, had not had sufficient warning, or had not been told, can't stand up to scrutiny. Throughout March 2020, the sector and, as you know, families of those within the sector, had been repeatedly spelling out its needs to the department. Not limited to PPE, it included clear, prompt guidance, urgent decision making, with clear points of contact and allocation of responsibility, concerns about hospital discharge, the need for early consideration of visiting restrictions, particularly around end-of-life care, and a DoH that was prepared to engage and work in partnership.

You have heard, and will continue to hear, concerns about guidance issued late in the day, often, as you've heard, on a Friday, but the evidence in this module shows the consequences of that. That same statement from the homecare services provider recalls that:

[As read] "Guidance was often received late, especially on Fridays. One memorable Friday we received

five different sets of guidance, all on the same issue, all late in the afternoon."

That evidence is echoed in the statement from a spotlight care home in the Western Trust, in which it's observed that:

[As read] "The Public Health Agency, the Western Trust, RQIA, all these departments, were sending endless emails with attachments. There was far too much repetition, far too much detail, much of which was hard to understand. It was extremely time consuming."

My Lady, it's the opposite of the clear lines of responsibility and the bold and clear decision making that the sector had long requested, and as a consequence it heaped additional pressures on those working within it and added to the confusion and distress of those living within it and their families who supported them.

My Lady, prior to the pandemic, it's reported that 26% of nursing and care homes in Northern Ireland struggled to meet basic requirements of infection prevention and control. Yet, at a time when it might be thought to be never more important, not least because of the discharge of untested patients from hospital environments, the RQIA, on the direction of the CMO, halted inspections of reinsurance homes.

This is a topic, again, that we touched on in

Module 2C, when the CMO urged you to accept that the abandonment of regulatory inspections, for, we note, at least a six-week period, nonetheless meant that there was sufficient eyes and ears on the ground.

The alternative is that the worried reaction to this abandonment from families, from social workers, from COPNI, and even from care homes themselves, was in fact well justified.

Whatever the official language used, the evidence indicated that it was indeed abandonment, with only three in-person inspections throughout April 2020, and seemingly none of them in relation to buildings that housed residents.

We observe that, even on this important topic, there is little evidence that the Department of Health listened in real time to concerns from the public, only U-turning when faced with judicial review proceedings.

And it is, of course, of significance that inspections were withdrawn at a time when so many untested patients were being discharged into the care sector, upon which heightened responsibility for IPC measures were now being heaped.

On this, you will hear evidence of the Herity report, and assertions within it that it did not support the suggestion that the discharge of patients

from hospital was a "substantial cause of [Covid] outbreaks in care homes". Because of the patients discharged into the care sector over two weeks in March 2020, we are told that only some 1.1% tested positive within two weeks of discharge.

We invite you, my Lady, to look at that assertion with care, and to observe in doing so that the assertion that only 1% of those discharged tested positive belies the reality that the very significant proportion of those hundreds of people were not in fact tested at all.

My Lady, the persistent failures that we have observed to consult, engage and listen, don't end in Northern Ireland in early or even mid-2020, and we urge in this module that your team allocates sufficient time to events in autumn 2020. Again, it will be important, in doing so, to consider the evidence that you have already heard, and you will recall in Module 3, our Chief Nursing Officer told you with some confidence that Northern Ireland led the way with the introduction of care partner guidance.

Is that self-praise justified when the wider evidence is considered? The fuller story of the implementation of care partner guidance includes persistent and unresolved problems from its announcement in September 2020 well into 2021, at least in some part

because trusts and the independent care sector complained it was imposed without any prior consultation. And it certainly appears from the evidence that that guidance having been issued, there followed a deliberate and extended decision to ignore pleas for engagement with the sector about its implementation.

Letter after letter was written by the independent health and care providers to the Minister of Health, seeking engagement to resolve tension and dispute that had arisen, as you'd heard in Module 2C, on the doorsteps of our care homes, and letter after letter was apparently ignored, such that in correspondence of 16 November, almost two full months after the guidance had been issued, the IHCP observed that it was driven to conclude that:

[As read] "The views of the minister, the views the minister had expressed about working in partnership and about the value of the sector are not being translated into behaviours. We are concerned [they say] about the damage that this is doing to relationships between the independent providers of care and the Department of Health."

How are those frustrations to be reconciled, we ask, with the contention from the minister and the department

in evidence to this module that throughout the pandemic they engaged extensively with the sector?

Even that expression of frustration in November 2020, or those that came in the weeks and months afterwards, did not generate a response. Why? In issuing care partner guidance, did the department prefer to pit families against care homes, washing their hands of responsibility for what was happening on doorsteps or outside windows? Or was there, by then, a ministerial attitude, which you might have observed burgeoning in autumn 2020 Executive meetings, of "if you're not with us, you're against us".

In evidence to this module, the minister complains that as the pandemic approached, there were other -- sorry:

[As read] "As the pandemic progressed, there were other ministers who publicly criticised the Executive response by unfortunately using me and the Department of Health as the proxy for that criticism."

To what extent is that correct? Or is there another view: that such criticisms as there were, and are, are justifiable? And that in rejecting them, the response of the department was, and is, too defensive and insufficiently reflective.

My Lady, a refrain you've heard thus far from the

department and from the Minister of Health is that it was lonely at the top. And that may well be true, but a relevant question in response is: to what extent did the departmental isolation become self-imposed? Faced with constructive criticism, were the walls of the silo deliberately built up?

My Lady, in conclusion, the next five weeks represent to a very significant extent the Northern Ireland Government's swan song, but for Geraldine and Trevor, who featured on the impact video, or Agnes and Gregory, from whom you will hear, and from Martina and Tom, who penned the statement and many, many, more, it is the last opportunity to challenge that narrative, to learn the right lessons, and to force positive change for the future.

And my Lady, as ever, we are ready to work with you and your team to ensure that robust recommendations can be made and meaningful change can be measured. Thank you.

LADY HALLETT: Thank you, Ms Campbell.

Ms Mitchell?

Submissions on behalf of the Scottish Covid Bereaved by DR MITCHELL KC

DR MITCHELL: I'm instructed by Aamer Anwar on behalf of the Scottish Covid Bereaved.

While every module in this Inquiry is important, for many of the bereaved, this module, investigating the impact of the pandemic on the privately and publicly funded adult care sector throughout the United Kingdom is of particular importance.

For those who lost loved ones in care and nursing homes, the inevitable grief that follows any loss was compounded in many cases by the inability to spend those precious last few hours together, and feelings of having left family members to die alone.

Those who could not be with loved ones in their final moments hold a grief that will not and cannot rest. Many bereaved have been left -- many of the families of the bereaved have been left wondering how their loved ones came to contract Covid in the first place, whether they received the care they needed, whether they were unthinkingly made subject to Do Not Attempt Cardiopulmonary Resuscitation orders, and whether the system, which they trusted to care for the most vulnerable, was fit for purpose.

Firstly, though, we'd like to give some thanks. While the Scottish Covid Bereaved heard politicians talk of a protective ring being placed around care homes, the reality was far different.

The bereaved wish to understand whether promises

were made without the knowledge of what was happening in our hospitals and care homes. The bereaved will not shy away from making criticisms where they are due. However, the bereaved acknowledge those who stepped up during the pandemic to try and provide care and support to some of the most vulnerable. There is no small irony that those caring for the most vulnerable were also those who had their own vulnerabilities, underpaid, many women, for whom, for example, PPE as not properly fitting, many on zero-hours contracts, and those from ethnic minorities, who continued to work in terrible conditions, not of their own making, to try and provide care and comfort to those in most dire need.

The Scottish Covid Bereaved wished to thank them all. Their personal sacrifices and quietly heroic efforts have not been forgotten.

The bereaved are keen to assist the Inquiry when attention turns to the recipients of care, or the lack of it, and the effects on families caught up in the care system during the pandemic. For many, the horror of the pandemic was compounded by a nightmarish misnamed care system which was underfunded, understaffed, and underprepared.

The bereaved consider -- the Scottish Covid Bereaved consider that staffing levels and bed capacity

immediately prior to the pandemic were already unfit for purpose and that, sadly, remains the case. These pre-existing problems were compounded by the pandemic and the fact that the deaths -- sorry, were compounded by the pandemic and the Scottish Covid Bereaved consider that deaths relating to Covid-19, of both recipients of care and staff, are in part based on those pre-existing problems.

We wish to flagged four matters. One, key decisions. As the chair will already be aware, a key issue for the bereaved is the decisions made by the Scottish Government in respect of the care sector. This includes decisions relating to the discharge of people from hospitals, and to adult care and residential homes in the early stages of the pandemic.

There are so many questions surrounding the state of knowledge of the key decision makers, whether there was sufficient information about, and consideration of, the possibility of asymptomatic transmission; whether there were was sufficient testing; whether care and nursing homes were being provided with sufficient PPE and appropriate PPE; whether there were sufficient facilities to allow for the safe discharge of patients from hospitals into care and nursing homes.

We are obliged to Counsel to the Inquiry, Jacqueline

Carey KC, who has met with us and listened to our concerns and taken time to ensure that important issues to the Scottish Covid Bereaved will be addressed.

In this module the Inquiry may well hear, by now, a frequent refrain from Scottish Government ministers and civil servants that equality impact assessments were carried out. The bereaved are looking forward to hearing how these assessments were carried out. An equality impact assessment carried out by civil servants at home or at a desk in Edinburgh without any input from those receiving or providing care, or with experience in the sector, may well be of little benefit in formulating policy.

We've also heard that equality impact assessments were carried out retrospectively. It will be important to find out if that was done, how it was addressed, if the decisions were found to come up short.

Two. Adult care and residential homes. The management of the pandemic in adult care and residential homes is also a critical issue for the Scottish Covid Bereaved. The Inquiry has the statement of Donald Macaskill, the Chief Executive of Scottish Care, who discusses staff feeling a sense of clinical abandonment during the first stage of the pandemic, when they struggled to access GPs and struggled to get GPs to

attend care homes and to treat and care for residents.

In addition, the Scottish Covid Bereaved want to know about infection prevention and control used within homes, the availability of PPE in the homes, and to hear the experiences of staff in relation to this matter.

The Scottish Covid Bereaved are also concerned about communications with families and adequacy or otherwise of discussions and decisions about care and treatment, including the use of DNACPR notices.

Three. Visiting restrictions. The Inquiry will no doubt hear of visiting restrictions in care and nursing homes and measures that were put in place to facilitate contact. We're keen to hear the evidence in relation to this matter. We wish to know whether restrictions were necessary and if so, whether they lasted for the correct amount of time or longer than was necessary, and what consideration was given to those with particular vulnerabilities such as dementia or hearing loss, when consideration was given to whether modern means of technology were sufficient to allow for meaningful contact with families.

Four. Inspection regimes. The Inquiry has already heard some evidence about the regulatory inspection regimes within the adult care sector. The Bereaved look forward to hearing more about these regimes, how they

were carried out, whether they changed during the pandemic, and ultimately whether or not they were fit for purpose.

Finally, the Inquiry will hear, again directly from some of the Bereaved, who share their experiences. We thank them for sharing the most private and difficult part of their lives so that we may learn from it.

As important as disclosure and disclosed documents are, the evidence of those who experienced the care system firsthand as patients and as loved ones of patients is crucially important in understanding what can be done to do better the next time.

To this end, the Scottish Covid Bereaved are ready to assist in any way they can.

Those are the submissions of the Scottish Covid Bereaved.

LADY HALLETT: Thank you very much indeed, Ms Mitchell. Very grateful.

Mr Stanton, would you like to take us up to lunch?

Submissions on behalf of Covid-19 Bereaved Families for Justice Cymru by MR STANTON KC

MR STANTON: Thank you, my Lady.

The opening statements on behalf of the Covid-19 Bereaved Families for Justice Cymru is as follows: a letter from March 2020 to vulnerable patients in

Wales, highlighted earlier by Ms Carey, informed them that it was unlikely that they would be offered hospital admission, that they certainly would not be offered a ventilator bed, and they were encouraged to complete a DNACPR so that, and I quote, "Your friends and family will know not to call 999 and so that scarce ambulance resources can be targeted to the young and fit".

This letter was roundly condemned for its lack of sensitivity, but it is in fact an accurate reflection of what happened to many elderly and vulnerable people in care homes. The letter promised "We will not abandon you" but abandonment was exactly what was being communicated and it raises the question: how on earth were elderly and vulnerable people considered expendable in this way?

Through the awful experiences of care home residents and their families we are provided with a microcosm of everything that was wrong with the pandemic response in Wales, and with a system that allowed many elderly and vulnerable people to suffer lonely, avoidable deaths in unnecessary pain without appropriate medical treatment.

The group's members are horrified to have learned just how dangerous care homes were during the pandemic, with the people most vulnerable to infection locked down in the least safe environments in the country, with

excess deaths at over 100% in the peak months of the pandemic, and deaths rates following infection as high as one in three.

These dangers were well understood within Welsh Government, and a published statement of Helena Herklots, the Older People's Commissioner for Wales, describes a meeting on 28 May 2020 with the Chief Medical Officer for Wales, Sir Frank Atherton, who, when asked whether care homes were safe, replied that if he was working at home, he would take a relative into his own home from a care home.

For such a statement to come from the most senior Welsh government adviser on matters relating to health is a damning indictment on the safety of care homes in Wales, and Ms Herklots was so concerned about the situation that, in the same month, she referred the Welsh Government to the Equality and Human Rights Commission for investigation.

The Commission found that a number of decisions in the Covid-19 response may have resulted in failures to adequately protect the right to life, including decisions about hospital discharges, admissions to care homes, prioritisation of testing, and access to necessary healthcare and treatment, and their report states that representative groups have described how the

combination of decisions in the pandemic response either ignored care home residents or treated them as expendable.

My Lady, with that introduction, I have seven specific issues to cover in this opening statement. First, deaths and infection rates in care homes in Wales.

Many deaths of care home residents in Wales were not diagnosed or recorded as caused by Covid-19 because of the lack of available testing, and because the symptoms were not recognised. As Professor Tim Spector told the Inquiry in Module 7, the only symptom in many elderly people was acute confusion.

In these circumstances, the group considers it a reasonable position to attribute all excess deaths within care homes in waves 1 and 2 as Covid-19-related deaths.

A report of the Technical Advisory Group in Wales identified a 12% increase in excess deaths in Wales in all settings in 2020 against a five-year average. Terrible though this data is, it was even worse in care homes. In 2020, deaths in Welsh care homes increased by 26%, more than double the increase in the general population, and in the peak months of waves 1 and 2, excess deaths were at or over 100%.

The individual experiences of the group's members echo the national picture. One member lost her father in circumstances that 50% of the residents, 26 out of 52, died from Covid-19. Another member whose parents were resident in separate care homes lost them both within five days of each other. Other publicly reported examples include a care home in Wales that managed to stay virus-free until the second wave, when 24 residents were infected with Covid-19 and seven died, which broadly supports the case fatality rate of one in three.

Second, failures of preparation and to learn lessons for improvement, including between waves 1 and 2. The appalling circumstances in which so many vulnerable people lost their lives is a direct consequence of a lack of preparation and capacity within the health and social care system in Wales, in particular, a lack of hospital capacity, a lack of testing capacity, and insufficient quantities and types of PPE.

Despite the size of the social care sector and the increased vulnerability of care home residents to infectious diseases, the UK and Welsh pandemic planning exercises gave almost no consideration to this vital area of preparedness. Shockingly, many of the planning exercises do not even mention social care at all.

According to the ONS report of 11 May 2021, among

English regions and Wales, the highest proportion of care home deaths in wave 2 was in Wales, which supports the view of the group that there was a complete failure to learn the harsh lessons of wave 1.

The huge loss of life in wave 2 was not inevitable, but the continued disregard for the safety of elderly residents sealed the fate of too many.

The Welsh Government's primary concern and first instinct is always reputation management at the expense of candour and learning lessons. This tendency is offensive to the bereaved and prevents them from gaining closure, and it is most clearly evident in the next and third section, that of testing failures.

A comprehensive testing regime is essential for controlling known high levels of nosocomial infection in care homes, yet testing policy in Wales was a catalogue of chaos and reactionary decisions. On 8 April 2020, Wales rejected the need for a negative test prior to hospital discharge based on a claimed lack of testing capacity.

However, the average number of untested patients discharged to care homes for the remainder of April was just ten per day, equating to 1% or less of available testing capacity.

Despite the incredibly serious risk of seeding

infections within vulnerable communities it was decided that this tiny number of tests could not be spared. Worse, and adding insult to injury, Wales wasn't even close to using its full capacity in this period. For example, just 57% of available tests were used on 20 April.

When testing on discharge was eventually introduced on 29 April, some two weeks after the UK Government, it established the pattern, that continued throughout the pandemic, of decisions taken in Wales some two or three weeks after England.

Routine testing was not introduced in Welsh care homes until 16 May, almost three weeks after England on 28 April. However, in their oral closing in Module 7, the Welsh Government maintained that there had been no delay, and that it was not until new advice was provided by SAGE on 12 May that the case for routine testing was made out.

The Cymru group does not accept this position. It was well known that Covid-19 was spreading within care homes asymptomatically at levels of 50% from at least 3 April, the date of the CDC report. And SAGE meetings, at which the Welsh Government were represented, warned on the dangers of nosocomial asymptomatic infection on no fewer than seven occasions between 14 April and

7 May, including, on 16 April, at SAGE 26, that testing is an important part of controlling transmission in hospitals and care homes, and on 23 April, at SAGE 28, that a testing strategy to reduce the spread in care homes is required.

Meanwhile in Wales, the former First Minister, Mr Drakeford, was making bizarre statements in the Senedd on 29 April and 6 May that there was no clinical value in routine testing in care homes.

Moving forward to the second wave, in December 2020, as the situation worsened, the Welsh Government reversed its testing strategy and actually reintroduced the practice of discharging hospital patients in a care homes without a negative test.

Covid deaths in care homes had at this time increased from 21 in October 2020 to 217 in December 2020, and nearly doubled in January 2021 to 417. This backwards step demonstrates reckless disregard for the safety of elderly and vulnerable people, and is a glaring example of the inability of the Welsh Government to learn from its mistakes.

Against this background of dithering, false statements and U-turns, it was difficult for the bereaved families in Wales to hear the explanation offered by Mr Drakeford in his recent oral evidence in

Module 7 that:

"... we planned first and then we announced. And sometimes that makes us look like [we're doing things later] than was happening elsewhere, but I believe that our method was more effective."

What was more effective, the group asks, about repeated delays in the implementation of essential safety measures which endangered the lives of so many of the most vulnerable people in Wales?

Further, the Welsh Government was not planning how to implement routine testing in care homes before their introduction on 16 May. It was denying that there was any clinical value.

The Cymru Group believes that the real reason for failing to introduce routine testing in care homes was not scientific uncertainty but a lack of testing capacity and concerns about the impact on staffing levels, both of which were the responsibility of the Welsh Government, and for which the science made a convenient scapegoat.

Fourth, the failure to take a precautionary approach. The lack of regard for the dual risks of asymptomatic and airborne transmission, and the absence of a precautionary approach, is evident within the announcement of the former Minister for Health and

Social Services, Vaughan Gething, on 16 March 2020, that no PPE was required if a patient or healthcare worker in social care did not have symptoms of Covid-19 and that higher levels of PPE was unlikely to be needed in a social care setting.

Despite the lack of protection provided, the Welsh Government was well aware of the risks. For example, on 24 March 2020 in the Senedd, the former First Minister Mark Drakeford warned about the risk of asymptomatic transmission to vulnerable people.

These are complicated issues, but in short, the group's position, as already made clear by Ms Carey, is that there was sufficient scientific knowledge from the very outset set of the pandemic that the virus may transmit at high levels asymptomatically and via aerosols to have necessitated much greater focus on preventing nosocomial infection within extremely vulnerable care home communities through adequate PPE, comprehensive testing regimes, and other IPC measures, particularly ventilation.

The failure to do so undoubtedly contributed to high levels of nosocomial infection and deaths.

Fifth, inadequate PPE and IPC Guidance. The Welsh Government became responsible for the provision of PPE to care homes on 19 March 2020. By 7 May 2020, seven

weeks after the arrangement began, only around two-thirds of the social care sector's PPE needs were being met by the Welsh Government. There was also a failure to provide the right type of equipment, with IPC Guidance dictated by the inadequacies of the PPE stockpile and the limitations of PPE procurement rather than by considerations of safety.

Sixth, suspension of vaccinations in care homes. A major concern of the Cymru group is the decision of the Welsh Government to intentionally delay the provision of vaccines to care home residents, contrary to the advice of the Joint Committee on Vaccination and Immunisation. Given that the fatality rate for an unvaccinated care home resident may have been as high as one in three, and that the benefits of vaccination were so significant and pronounced, it beggars belief that any responsible government should have sought to delay this provision as the Welsh Government did.

The importance of adhering to the JCVI priority cohorts was explained by Professor Lim in his evidence during the Module 4 hearings. He said that if we vaccinated 20 people who were residents in an old age care home, we would protect one life. The same number needed to vaccinate to save one life in the 50 plus cohort is 8,000.

The reasons for the delay that placed so many people at unnecessary risk of death was the failure to procure the necessary refrigeration, despite knowing of this likely requirement since August 2020, another glaring failure of preparation and further evidence that older people in care homes in Wales were deprioritised.

Finally, seventh, the failure to provide appropriate medical treatment medicines, and equipment. The Inquiry is going to hear from witnesses and has other evidence before it of appalling neglect, including the routine application of do not attempt resuscitation notices, the removal of in-person consultations, which disproportionately impacted elderly residents of care homes, the outrageous refusal to provide hospital treatment, an example of which is detailed within the witness statement of Helen Hough, who describes an ambulance team refusing to take a resident to hospital and their instructions that they were not supposed to transport anyone from a care home.

And the fact that care homes were not equipped to provide oxygen therapy and good quality palliative and end-of-life care, which led to many residents enduring unnecessary suffering of which the Inquiry has many harrowing accounts.

My Lady, I conclude with the words of Helen Hough in

her email to the Welsh Government on 4 April 2020 in which she stated:

"I do hope when ... this is over, this is all thoroughly investigated, because I and many other managers will be stating what a diabolical shambles this is in Wales ..."

Thank you, my Lady.

LADY HALLETT: Thank you very much indeed, Mr Stanton.

Very well. We shall break now, and I shall return at 2.10.

(1.07 pm)

(The Short Adjournment)

(2.10 pm)

LADY HALLETT: Mr Friedman.

Submissions on behalf of Disability Rights UK, Disability Action Northern Ireland, Disability Wales and Inclusion Scotland by MR FRIEDMAN KC

MR FRIEDMAN: My Lady, we act for Disability Rights UK, Disability Action Northern Ireland, Disability Wales and Inclusion Scotland.

The long-term flaws of the adult social care system were starkly revealed in the pandemic in two extreme ways: care settings became life threatening, care services to sustain everyday basic quality of life were withdrawn.

Of those extremities, DPO ask you to consider four matters: knowledge, labour, law and the home.

First, knowledge. Most disabled people know something to that too much of society remains in denial about. That across the life cycle, we all live in care. We are all being cared for, caring for someone, or relying on others to provide care.

The quality of the care we need and that we give may be variable but its importance, when it becomes due, is universal, which is why a state that is unresponsive to the human condition to care and be cared for not only lacks resilience but renders people vulnerable.

DPO agree with the various descriptions of the care sector being complex, fragmented and fragile. However, what that language bears the risk of obscuring is that the system has been constructed that way.

A SAGE statement in May 2022 confirmed that no UK country can routinely identify who is resident in care homes, who is receiving social care at home, and who works in or visits a care home or a person's home.

All the Inquiry modules thus far have revealed profound weaknesses in data collection and analysis, but in the care sector, the evidence reveals a system where the recipients of care, the way they live, and the way that many of them died, was ignored by design.

In this long-tolerated state of known unknowns, central government during the pandemic then allowed care inspectorates to suspend routine inspections, records relevant to the wellbeing of disabled people remained unreliable or non-existent, the state of institutionalised ignorance extended to do not resuscitate notices, withdrawal of services, unpaid carers, fatalities, and critical aspects of the labour force.

Our second observation is about employed care workers. If anyone is remotely serious about future prevention, then the fatalism over how the virus sped through incessant movement of the workforce between care settings must be shaken off. The hazard arose from the nature of the labour market and pre-pandemic reticence about regulating the market, even though it concerns the protection of life and basic human dignity.

The risk of asymptomatic transmission was known about early. But the risk of symptomatic transmission was also known about, because this exploited workforce, on insecure contracts and breadline incomes, was too small to meet surplus need.

The experts on the social care taskforce and the adult social care directors could not conceive of a system in which staff were compelled to remain in one

setting because they knew that the system would collapse. Care homes would go under. People would be abandoned. It was decided that the lesser of evils was hazardous movement of staff.

Even if too little too late, the four nations realised the importance of discrete financial incentives. Each of the four made decisions to introduce them. Only in Westminster did the Treasury block the adoption of discrete sick pay and/or lump-sum payments. However, none of the four nations contemplated altering the nature of the economy, of temporarily nationalising the labour supply, of moving workers from other sectors into this service, of establishing central and regional directorates that could have drawn on diverse management and other expertise, including the DPO and third sector.

A £500 payment to the workforce and limited market interventions were never going to expand the labour pool enough to reduce the terrible burden of the unintended risks it carried. The failure now to examine how the state can take command and better integrate the different parts of the system would amount to eyes-wide-open acceptance that Covid-19's extreme outcomes would be repeated.

Our third point is about law. The DPO complain that

the very first thing that the government did to plan for disabled people during the pandemic was to legislate to take their rights away. They did this by the modification of the obligations to assess and review care and support needs, but can I add to what was said this morning: importantly, there was also modification of the duty to meet pre-existing eligible needs as recognised under care and support plans, and provided the local authority could be satisfied that withdrawal did not breach the very high threshold of relevant human rights in this context, which is the severe pain and suffering of inhuman and degrading treatment, or otherwise risk to life, then the withdrawal could be made.

So what schedule 12 of the Coronavirus Act allowed for was the suspension of care services to meet, for example, needs of basic hygiene, toileting, and social contact for people who needed it for fundamental reasons of wellbeing in their future.

Via the government's guidance documents for the so-called easements, local authorities that suspended their services were required to report the matter for monitoring purposes, which is why one of the most troubling aspects for this module is that only eight local authorities in England lodged reports to

acknowledge that they were operating under the emergency law, and in Scotland, a further four by survey admitted to doing so.

What that can only mean is that local authorities embarked on mass violations of the law when they reduced vital support but without revoking the easement provision. You have, my Lady, DPO, Bereaved Families, care providers and Every Story Matters, all speaking to vastly reduced services across the country and the human toll this took. Some local authorities reduced their services to basic life and limb protection, social contact services were drastically cut leaving people with dementia, learning disabilities and learning difficulties and mental ill health totally isolated for long periods.

The singular benefit of easements was that the law required reasoned, recorded, and open decision making about withdrawal of services and disclosure of that fact to central government, but across the system, that is the one thing that local authorities near uniformly appear not to have done. Government then helped to misrepresent the human cost by finding false consolation that only eight reports were made. Rather than taking steps to enforce the law, the result is one of the singularly worst failures of accountability, and indeed

illegality, across the period.

Which brings us to our final point. The person that the government primarily imagined when it told people to stay at home was someone who could financially, physically and logistically afford to stay there. Only in afterthought did it imagine the disabled people who could only do those things with the benefit of care or the unpaid carer who could not leave the home without leaving a disabled person in jeopardy. Notwithstanding the commitment to human dignity and independent living contained in International Human Rights Law, there is something about our ableist state that cannot conceive of disabled people actually living at home.

So when government contemplated social care, it far too often focused on care homes and not domiciliary or supported care settings. PPE, asymptomatic testing, food acquisition, the risk of labour but also the risk without it. All these things were afterthoughts, grafted on to government responses far later than for hospitals and residential settings, if at all. All of which culminates in the paradox of unpaid carers, who were too often the final afterthought for government.

In each of the Inquiry's remaining modules, it is going to be reminded that caring, from birth through to grave, is the most valuable commodity in any society.

Without it, survival is not possible.

The relevance of that to this module is that the capacity of the state to leverage unpaid and very low-paid care, in an unaccountable and unregulated way, is the core reason why the adult social care system remains fragmented and vulnerable, rather than integrated and resilient. It was made that way.

And the way it is, including how it makes preventable suffering inevitable, and the way it could be, to facilitate caring and being cared for as an essential social value, is above all about choice.

Thank you.

LADY HALLETT: Thank you very much indeed, Mr Friedman.

Next, I think, is Ms Jones. Oh, there you are. Thank you.

Submissions on behalf of John's Campaign, the Patients Association, and Care Rights UK by MS JESSICA JONES

MS JONES: My Lady, I act for John's Campaign, the Patients Association, and Care Rights UK.

Over the course of the pandemic, our Core Participant group provided support to thousands of people as they struggled to safeguard the care that they or a loved one needed, as they tried to make sense of the ever changing rules on whether they could be with the person they loved to give essential care and

comfort, and for family carers, as they tried to deal with their feelings of moral distress at being prevented from acting in ways that they knew to be right.

But despite the consistent efforts of our Core Participant group and others, adequate support for people relying on social care was simply not available. Rules were applied inconsistently and inhumanely, oversight mechanisms fell away, and a one-size-fits-all approach to decision making was taken. Each of these exacerbated the harm and distress suffered by people who draw on care and those who love them.

My Lady, we think harm is most likely to be avoided when people are included in the decisions that are made about them, when those with relevant lived experience are listened to and consulted, and when the focus is not on institutions but on the people those institutions are established to serve.

Instead, the stories that our groups heard during the pandemic were of people feeling marginalised, overlooked, neglected, powerless and undervalued.

We welcome the publication today of the Every Story Matters record, which contains many of these personal accounts.

And to give just two more of these examples, Doug Pauley, a 47-year old disabled person living in

a care home, has given a statement to the Inquiry in which he says that the guidance on leaving care homes seemed to him to be perverse. It made him feel strapped, discriminated against, powerless and isolated. It suggested, he says, a fundamental misunderstanding of the lives of people living in care homes and a failure to consider how their needs and preferences ought to be appropriately balanced against the risks.

The lesson that Doug draws from the treatment of people in care homes during the pandemic is, and I quote:

[As read] "I am expendable. My life will be treated with nothing like the same value and respect as other people's."

A similar experience was had by Francis, a 100-year old who lived in a care home. She said that lockdown was worse than living through the war:

[As read] "I felt trapped, lonely, depressed and forgotten. For over a year I only saw my family by appointment, through glass, at a distance. For 65 days, I was isolated in my room with no fresh air, no exercise, and no one to chat to. I felt like a caged animal."

My Lady, the impact on people living in care homes was profound, and it was also deeply distressing for

their loved ones. Francis's daughter Linda has said that she felt anger and frustration at the government's ineptitude and disregard of the human rights of residents in care homes. She said:

[As read] "I believe that the relatives of people in care homes during lockdown will live with a legacy of guilt, anger, hurt, and emotional turmoil that will never be erased."

Much of the written evidence that you have received in this module, and the personal accounts given so powerfully in the impact video that we watched this morning, are testament to truth of that statement.

Similar issues were also faced by people in mental health units, supported living settings and those receiving care at home. Common to all of them was that unnecessary suffering was caused when decision makers failed to recognise the diversity, humanity and worth of people who rely on care, and when they failed to include them in the decisions that were made about them.

Against that background, my Lady, I wish to draw the Inquiry's attention to the following five issues, which we ask you to have in mind along with the other issues raised in our opening written submissions, as you take evidence over the coming weeks of hearings.

Firstly, a fit-for-purpose social care system must

be person-centred in its structure, its focus, and in the way in which care is provided and regulated.

This means that blanket policies will never be appropriate. They must at all times be responsive to individual needs and circumstances, and they must ensure compliance with existing legislative duties which are intended to protect people's human rights and wellbeing.

As Liz Saville-Roberts MP said at a Prime Minister's Questions in January 2022, when discussing her fears for her mother who had dementia:

"... the human rights of disabled people, sick people and the elderly are not fair-weather luxuries ..."

But in our experience, my Lady, they were treated as such.

When we look at the visiting restrictions that were imposed on people in care homes, together with compulsory confinement and periods of isolation that would not be thought acceptable in the penal system, it is clear that there was an inexcusable failure to treat people who rely on care as humans with needs and priorities beyond the narrow aim of infection control.

Our second issue is that, as Counsel to the Inquiry opened with this morning, adult social care is delivered in people's homes. Whether that be their family home or

a residential setting such as care home or mental health unit. Decisions about and affecting adult social care should never lose sight of the fact that all of these places are people's homes, and decisions about them should be approached with just as much care and caution as decisions taken about the general population.

Politicians showed an understandable desire to impose lockdown conditions on the general population for as short a period as possible, and to permit social mixing again as soon as it could be reintroduced. But the relationships and wellbeing of people who live in care homes were not given comparable consideration and the draconian restrictions to which they were subject were unjustifiably maintained long after restrictions on the general population were relaxed.

Thirdly, we have particular obligations to people at the end of their lives, to provide them, as far as possible, with a dignified death and the comfort of their loved ones. That means ensuring proper access to palliative care and welcoming the presence of family members throughout the end-of-life period, which should be interpreted consistently with the CQC and NHS definitions and not limited just to the final hours of someone's life.

The failure to ensure at all times that dying people

could have those they loved with them was a serious departure from the values that should underpin our care sector and it's one that has caused deep and enduring guilt and anger.

Fourth, my Lady, we recognise that unpaid carers are the backbone of the adult social care system. Their numbers swelled during the pandemic, and the burden on them increased as they filled gaps in care created by lockdown restrictions, but they received little recognition and even less practical support.

They were sidelined from care teams and excluded from settings where their loved ones lived even though they are often the true expert in their needs and they perform an essential role as advocates and supporters in ensuring the provision of person-centred care.

In our view to, formal legal right to a care supporter for everyone using health and care services is now essential.

Fifth, proper monitoring and oversight are crucial to ensure safe, high-quality care. The suspension of regulatory inspections at the same time that loved ones and visiting professionals were excluded from settings resulted in a marked deterioration in the quality of care in many places.

Susan Lyons describes in her statement to the

Inquiry how it has subsequently become clear that her daughter Sarah, who lives in a care home for disabled adults, faced significant neglect during the pandemic, being left for hours in incontinence pants, deprived of the one-to-one care that she needs, and left without access to necessary communication aides resulting in a massive and lasting deterioration in her language and social skills.

Hers is just one of many stories like this.

My Lady, I want to close by drawing your attention to the content of an open five nations letter written in March 2021 by John's campaign, together with other allied organisations across the UK and Ireland. They summarise the situation then as follows:

[As read] "After a year of fear, distress and countless separations, family members, from our five in nations want to reassert the larger picture of what a society should be. Over the months of the pandemic, the deepest ties of love, the things that make us glad to be alive, have been treated as unimportant. Spouses, life partners, parents and children, have been treated as inessential to each other. Their wishes have not been considered, their voices have not been listened to. Residents of care homes have been shut in and those who love them have been shut out. This is not the society

we wish to pass on to the next generation or grow old in ourselves. The test of a democracy is how it gives respect and choice to all of its members, young or old, in health or in sickness."

My Lady, as that letter underscores, the treatment during the pandemic of those who rely on adult social care does not reflect the values that should guide and underpin our society. The Inquiry has the opportunity, through these hearings and your subsequent report to reassert the larger picture of what a society should be, and address what a functioning, person-centred social care system within that society should look like.

We hope that the evidence you receive through this module and the recommendations you go on to make will provide a robust basis for the reform that is so urgently necessary, and we look forward to continuing to work with you to achieve that.

LADY HALLETT: Thank you very much indeed, Ms Jones.

Ms Weston. My seating plan has gone walk about -- oh, there you are.

MS WESTON: [No microphone]

LADY HALLETT: Are you recording?

Submissions on behalf of the Frontline Migrant Healthcare Workers Group by MS WESTON KC

MS WESTON: My Lady, I appear on behalf of the Frontline

Migrant Health Workers Group, together with Annabel Timan, instructed by Joe Latimer of the Public Interest Law Centre.

The frontline group we represent is made up of three worker-led organisations: the Independent Workers Group of Great Britain, the United Voices of the World, and Kanlungan, all of which are third-sector organisations and charities picking up the pieces of a social care system neglected by government.

My Lady, these organisations give voice to care workers, the majority of whom are migrants, who look after the most vulnerable people in our society. They provide care in charities, providing supported housing and care to people with learning difficulties. They are also foster carers who support young adults as they age out of the children's social care system, and advice workers helping the disabled access the support they need in a system starved of resources.

They work in care homes, respite centres, and they go into people's homes to enable them to live independently. They are agency workers, night and day workers, domestic workers employed in private households, comforting, caring, and performing the very most intimate and personal tasks with respect and sensitivity for the dignity of those for whom they care.

Their employment is frequently tried to immigration status resulting in their being banned from the welfare safety net by a No Recourse to Public Funds condition attached to their visas or because they are undocumented.

My Lady, we are grateful for this opportunity, first, to note that this public Inquiry presents our nation with an essential opportunity to shine a forceful light on problems in the social care sector and how they impacted on the pandemic measures. Second, to highlight some of the evidence disclosed by Module 6. And thirdly, to make some brief observations about what Module 6 could achieve.

Turning to the evidence, the evidence that Module 6 has produced so far has been illuminating and damning but for frontline migrant care workers, unsurprising.

Firstly, at the outset of the pandemic, the evidence shows the lack of understanding in central government of how the sector functions and just how fragmented and precarious the sector is.

Those in government charged with intervening to protect and support the sector simply didn't have an understanding of the mechanics and variety of funding arrangements for the sector in practice. The self-funded, the local authority funded, the NHS funded,

all of the increasingly-opaque business models, non-profit, profit-led, charitable, and though almost completely diminished, local authority owned.

And then there's the delivery of care in both domestic and institutional spaces, and then stretched across this landscape was the equally fragmented and wholly inadequate oversight measures. See for example, the Dash report on the ineffectiveness of the CQC.

In this landscape, the evidence shows that business model matters. My Lady, models dependent on artificially cheap and insecure labour have no place in a resilient care sector. The pandemic has taught us that a social care sector which fosters and encourages exploitative and unsafe business practices is a dangerous one for both workers and service users.

The Inquiry will hear from witnesses such as Professor Shallcross, whose work illuminates the additional risks to service users posed by a care sector driven by profit. Evidence from frontline members includes accounts of working in completely unregulated and so-called black market care homes.

Professor Ian Hall in his statement at paragraph 247 notes anxiety about scapegoating care workers as transmitting disease because of the lack of understanding in government and in the public, that it

was not they but their working conditions which were the problem. He points to a lack of data about the movement of care workers between different care environments.

Counsel to the Inquiry has rightly highlighted, in opening, the lack of attention given by government to the domiciliary care sector in its pandemic response. This is reflected in the evidence of domiciliary care workers and their managers. This, from Julie Parkinson, member of the National Association of Care and Support workers. She says:

[As read] "At times I was overwhelmed and bewildered with the amount of guidance we received. I felt that the guidance was tailored towards care homes rather than domiciliary care and therefore was often not appropriate, or even relevant for our line of work. It seemed as if any reference to domiciliary care was only tacked on to guidance that had clearly been designed for care homes, not with us in mind."

My Lady, it should have been obvious to government that workers with more than one job or care homes reliant on bank and agency staff were vulnerable to the spread of infection, that domiciliary care workers undertaking 20-minute visits house to house would be an issue that needed to be addressed. But the paradox they faced, that government faced, my Lady, was that this

peripatetic insecure workforce was the fundamental bedrock of a care system wholly dependent on the cheapest possible labour.

The agency workers we represent were unpaid for the time it takes to get between jobs, and domestic workers describe how they were often required to provide care around the clock without breaks, with no one to speak for them, my Lady, out of sight.

The problems laid bare by the pandemic could not be solved by short-term firefighting. They were fundamentally related to long-term downward pressure on pay, on the funding settlement between central and local government, of consequences of trying to outsource this fundamental aspect of our society to a market which, at best, was poorly understood and, at worst, wholly subject to the effects of profit extraction.

The Covid-19 social care support taskforce recognised this early on, in August 2020, and advised government explicitly that it was time to "kickstart" some of the longer-term changes by investing in some urgent infrastructure elements around occupational health, recruitment, retention and pay. But as we learned from Vic Rayner's statement, the government ignored these requests.

My Lady, Bella Ruiz, impact witness on behalf of

UVW, recounts how staff members at the care home where they worked would come to work when sick, without taking a Covid test. They simply could not afford to do otherwise, my Lady.

She says:

"... at this time [everyone] got very sick. Some would say, 'I feel sick, I don't know if it's Covid or not but I have to pay my bills' ... On their part, management weren't really trying to find out if people were sick, they [just] wanted us to work. They just said if you have Covid, please stay at home but they did nothing to make this possible."

But care workers were amongst the lowest paid, who, without financial support, might continue to work at risk rather than isolate. The fear of loss of income, is not only obvious, but was specifically raised at least as early as 6 March 2020 in text messages between Mr Hancock and his team. Perhaps most unconscionably of all, this inadequate pre-pandemic position resulted in bad decisions taken during the pandemic in order to save face.

On 13 April 2020, minutes of the Covid-19 Strategy Ministerial Group state that a commitment to providing full pay to care workers from day one of sickness would "cause difficulty for the government, as it would be the

first time the government acknowledged that Statutory Sick Pay was not appropriate".

The Vivaldi Study subsequently proved this to have been a fatal decision, my Lady, as empirical evidence of the link between a lack of adequate sick pay and the spread of the virus in care homes emerged during the summer of 2020. Like the TUC and others reporting at the time, the frontline experience is that the money later earmarked for supplementing sick pay simply did not reach the care workers.

My Lady, I turn to the potential for Module 6 to have real impact on the future of the adult care sector.

The Frontline Group seeks recommendations to ensure that this fundamental lack of resilience in the care sector is recognised, understood, and addressed in the public interest. We are an aging population and change is imperative. Frontline's key suggested recommendations are set out at paragraph 181 of its Rule 9 witness statement, but we briefly flag here the following: an urgent review of the system of sick pay in the UK, my Lady.

Next, the removal of existing barriers to migrant workers being able to move place of work or employer so that workers can challenge exploitative conditions or leave workplaces where they exist and easily switch to

other employment.

Thirdly, a review of the 'hostile environment' approach to immigration control is also essential. Fostering a system of reliance on very low-paid, undocumented workers wards them away from essential public services, my Lady, like vaccination and healthcare.

My Lady, trust in health professionals is paramount to ensuring that people take steps to stop the spread of disease, and ensuring that misinformation is quashed, so care workers must be able to report poor practice and wrongdoing without worrying about their own job security or their consequent ability to remain in the country for migrant care workers with visas tied to their employment.

We ask the Inquiry to recommend: the implementation of a firewall which prevents data sharing between public bodies contacted for assistance and the Home Office; end the criminalisation of working while undocumented; and support safe reporting pathways to work inspectorates, immigration enforcement and the police.

My Lady, to finish, the government must acknowledge, understand and address the clear adverse implications of such an insecure and exploited workforce for the success or failure of pandemic protections for the most

vulnerable, both in care homes and in the community. Business models dependent on the artificially cheap and insecure labour have no place in a resilient care sector.

Lastly, there must be acknowledgement of the value to all of us of the vital work done by migrant care workers during the pandemic. They were disproportionately affected by the virus, disproportionately affected by the follow-on implications. My Lady, a workforce as important as this must never be left so unprotected again.

My Lady, on behalf of Frontline, those are my submissions.

LADY HALLETT: Thank you very much, Ms Weston. Very grateful.

Mr Payter, there you are.

Submissions on behalf of the National Association of Care and Support workers by MR PAYTER

MR PAYTER: My Lady the National Association of Care and Support workers, NACAS, was established in 2016 as an independent professional body to advocate for care and support professionals, promote their value, and provide them with crucial support and resources.

Before NACAS, there was no dedicated professional voice for care professionals. Its 15,000 members work

across the entire spectrum of adult social care, from care homes to home care, whether employed, self-employed, or on zero-hour contracts.

NACAS is grateful for this opportunity to assist Module 6 of your Inquiry, particularly through the evidence from its chair, Paul Featherstone, which is underpinned by surveys and accounts from its diverse membership.

The role of this Inquiry in shaping the future of adult social care, including how it responds to future pandemics cannot be overstated.

Care work has been historically undervalued by politics and society, often rooted in its association with gendered roles, older people, and the persistent false view that it's unskilled and economically unproductive. This lack of care defined both pre-pandemic preparedness, and the initial pandemic response in the adult social care sector.

As Cathryn Williams of the Association of Directors of Adult Social Services eloquently put it:

"There is a collective hope that the Inquiry will make a mark in recognising just how essential social care is for all our lives and start to build a new social contract about we live, work, and care for each other."

My Lady, to truly understand the pandemic's impact, one must grasp what it means to be a care professional. As Mr Featherstone reflected in preparing our written submissions, he said:

"Being a care professional is a privilege that few fully understand unless they have experienced it firsthand. It is an honour to be entrusted with someone's care, to be allowed into their home and their life in such an intimate and essential way. It goes beyond the traditional sense of just providing support or fulfilling duties; it is about forming a bond, building trust, and offering a sense of independence, no matter the limitations that exist due to age, illness, or disability."

"But that challenge is what makes it so rewarding. There is an inherent growth that comes with this work -- personal growth, that stretches you beyond what you thought you were capable of. You learn to be patient, to be present, to find solutions in difficult situations. You learn to read people's needs without words. To comfort with actions, to support with empathy.

"Being a carer also meant being an advocate -- someone who ensures the person you care for has access to services and resources they need. It can feel like

a fight at times, advocating for their rights, navigating systems that can be complex and overwhelming. Yet in these moments, you realise the true impact you're making: not just in individual lives, but in the broader landscape of care and support.

"The role of a carer can often feel like it goes unnoticed by society, it is often the silent work, the behind-the-scenes care that is rarely recognised or celebrated. Yet it is one of the most essential roles in any community. We become the quiet backbone, holding up families, supporting health systems, and ensuring that people can live with dignity."

"The privilege of being a carer is not just in what you do for someone else, but in what they do for you. They teach you compassion, resilience, and the true meaning of selflessness. They show you how to live fully, even when life is difficult. They remind you of the power of presence, of human connection, and of what it means to truly care."

My Lady, that inherent sense of duty and commitment was the very foundation upon which the adult social care sector relied, even more acutely during the pandemic.

And, my Lady, as you have heard, care professionals are often vulnerable. The overwhelming majority, 83% are women. Individuals from global majority backgrounds

and migrant workers are significantly overrepresented. One in five live in poverty and many earn less than the real living wage. Domiciliary carers often earn less than the statutory minimum wage when travel time and fuel costs are considered.

It was on this precarious foundation that care professionals suffered the terrible impact of Covid-19 with existing inequalities severely exacerbated. They witnessed the traumatic deaths of colleagues and those for whom they cared. The ONS analysis shows that the mortality rate for social care professionals was the highest by occupation in the UK, two to two-and-a-half times larger than the general population with even higher risks for staff from global majority backgrounds.

Care professionals toiled with staff shortages, a lack of PPE, inadequate testing, confusing guidelines and limited political societal recognition, with little mental health support.

As NACAS members reported in their own words, my Lady "I felt like I was having a mental breakdown from all the stress and worry."

"Staff were overworked, not having breaks, working extra and double shifts, made to cover larger areas and not given the time they needed with the client. Staff were completely mentally and physically exhausted, some

were crashing cars, falling asleep at the wheel."

"I have never seen deaths like that in my life. Covid made me feel helpless, let alone fearing for my life."

My Lady, we invite the Inquiry to recognise the immense sacrifices made by care professionals and their incredible resilience in continuing to deliver high-quality care under the most adverse conditions.

A core reason for the sector's precarious state was inadequate workforce capacity. That is a direct result of structural issues, low pay, poor working conditions, unmanageable workloads, a lack of status and limited opportunity for training and progression.

Pre-pandemic the sector faced a 7.8% vacancy rate, about 122,000 places, and a 30.8% staff turnover rate annually. By March 2022, vacancies had soared to an unprecedented 10.7%, equating to 165,000 positions.

That is an ongoing workforce crisis that has been exacerbated by a long period of austerity.

The structure of the sector significantly impacted the pandemic response too. As you have heard, it is large, complex, fragmented, and for the most part, unintegrated with health services. Consequently, when the pandemic arrived it was not clear who was responsible for different aspects of the response in

adult social care, hindering co-ordinated action and meaning there were very few levers available to drive change at scale.

Crucially, my Lady, you may find that central government demonstrated a troubling lack of understanding of the sector. SCIE has observed that the government's understanding of the sector's readiness, capacity, and capability, appears to be incomplete, poorly understood, or overlooked. This led to a delay in addressing adult social care concerns particularly as compared to the NHS. A striking example being procurement officials, expressing disbelief that 4 million aprons would be needed daily for social care, failing to even grasp the sheer size of the 1.6 million-strong workforce.

My Lady, the Inquiry is invited to investigate the root causes of that lack of understanding which the evidence suggests could include a lack of institutional knowledge, insufficient reliable data, the misperception of adult social care as merely an adjunct to the NHS, and the exclusion of adult social care voices from key decision making.

On that latter point, my Lady, there was a complete absence of adult social care voices when critical early decisions were made. There was no dedicated Director

General for Adult Social Care until June 2020, and no adult social care voice in SAGE until mid-2020. That exclusion meant that adult social care was invisible, and key decisions were made without adequate consideration of their impact on the sector.

Decisions that were made were often characterised by inaction, delay, and fatal misjudgments, and we draw your attention, my Lady, to four issues of particular concern to NACAS members.

First, flawed guidance. The February 2022 adult social care guidance published by PHE was fundamentally flawed. It, in short, advised business as usual. It stated it was "very unlikely that anyone receiving care would become infected", that "face masks do not need to be sworn by staff" and "there is no need to do anything differently."

That guidance remained in effect until 13 March, effectively lulling the sector and its staff into a false sense of security during a critical window despite evidence of asymptomatic transmission emerging as early as January and February of that year.

It, my Lady, set the tone for the guidance that followed, which was often issued too late, lacked specificity, was frequently inexplicable and contradictory, and updated so often the sector struggled

to keep pace.

Second, the hospital discharge policy. The policy to discharge patients from hospitals to release capacity in the NHS, while understandable in its aim, was, you may find, emblematic of an overfocus on the NHS at the expense of adult social care. Care homes overwhelmingly felt pressured to accept discharge patients without knowing their infection status. The lack of planning and consultation meant that adult social care was not prepared to manage the increased demand and risks.

The evidence, including the Vivaldi Study, clearly shows the policy was a source of ingress into care homes. Attempts by some to divert responsibility to care professionals, attempts that have been stripped of the context of the misleading advice that was given to the sector, have been deeply damaging, leading to abuse, discrimination, and feelings of being degraded among NACAS members.

Third, my Lady, testing and PPE provision. The adult social care, particularly domiciliary care, was forgotten about or deprioritised for PPE distribution and testing.

At the pandemic's outset, confusion reigned within government over who was responsible for the supply to the adult social care sector, leading to the NHS and the

sector competing for the same supplies.

PPE that the social care sector would have sourced for itself was even diverted to the NHS, leaving the sector feeling like an afterthought. This left care workers insecure, vulnerable, and forced to rely on donations or makeshift items. The lack of suitable PPE and testing may explain, in part at least, the disproportionate morbidity and mortality rates for care professionals.

Fourth, my Lady, mandatory vaccination. This policy, introduced in July 2021, mandating vaccination for adult social care professionals in England and care homes, was, you may conclude, unnecessary, unfair, and ultimately counterproductive. It was not adopted by devolved nations, did not apply to health workers, and ignored widespread concerns across the sector.

The government's own risk assessment estimated 40,000 staff might leave their posts. At the point it was revoked, 19,000 professionals were estimated to have lost their jobs, further exacerbating the severe staff shortages in the sector.

And the policy disproportionately affected women individuals from global majority backgrounds and may have undermined wider vaccination support.

My Lady, finally, NACAS extends an invitation to the

Inquiry to consider an important potential recommendation throughout the evidence: that is, achieving parity of esteem between the adult social care sector and the NHS, including through the professionalisation of care work.

The Nuffield Trust has identified a growing interest in professionalisation as a solution to the workforce shortages. Registration and adherence to common professional standards would create a strong professional identity, attract new entrants, and encourage retention by offering career progression.

England is unique in the UK for lacking a professional body responsible for regulating social care workers that is mandated and accountable to government. Examples from the devolved nations show clear benefits: increased knowledge of the workforce, improved retention, and a positive impact on the quality of work and confidence among both workers and service users.

NACAS believes that recognising the complex reality of care work, addressing systemic vulnerabilities and embracing the professionalisation of the care workforce are vital steps towards building a resilient, valued, and effective sector ready to respond to a future pandemic.

Thank you, my Lady.

LADY HALLETT: Thank you, Mr Payter.

Professor Rayner.

Submissions on behalf of the National Care Forum by PROFESSOR RAYNER

PROFESSOR RAYNER: My Lady, this the opening statement of the National Care Forum, and I am its chief executive.

The National Care Forum is the membership body for not-for-profit care and support providers in England who provide a diversity of services across all age groups, including residential and nursing homes, supported living, extra care housing, domiciliary care and day services to hundreds and thousands of people.

The National Care Forum dedicated significant time and resources throughout the pandemic to support and represent the experience of its members, highlighting the operational realities of delivering social care and support and how they related to government guidance, engaging with the government and other stakeholders, and advocating on members' behalf as they battled Covid-19.

My Lady, before I go further, I want to acknowledge the loss of life of all those with a connection to adult social care, including people accessing care and support, and care workers.

Care workers, people accessing care and support,

their families and loved ones, were all deeply impacted, and in addition, many continued to grapple with ill health and the legacy of those years.

In this opening statement, I want to give voice to the myriad of ways in which social care providers supported communities and their most vulnerable citizens to ensure their care and support needs were met, in the face of huge challenges.

I want to highlight the isolation and systemic misunderstanding and disadvantage that the adult social care sector experienced repeatedly throughout the pandemic.

I also want to be clear that the UK Government did in fact receive a huge volume of information and expertise that NCF and our members provided repeatedly, directly from the front line of delivery, which highlighted in real time the risks facing social care and support services and what was needed to minimise, where possible, their impact.

We're also concerned that much of what the Inquiry has heard to date does not adequately recognise the skill, professionalism, and dedication of the social care workforce, particularly in the face of the pandemic.

The responsive adult social care and support

providers in the face of limited resources, limited support from wider system partners, and increasing restrictions, was only possible because the people who make up social care, the frontline staff, the managers, the support team, the senior leaders, alongside many others, all came together to find a way through and deliver care and support.

Many took on jobs and activities they wouldn't normally do, everyone was working together to ensure that quality care and support was maintained. And they did this because social care is inherently relational. It is about supporting people. They did this because they care. This is vitally important for the Inquiry to hear.

My Lady, I want to use the remainder of the ongoing statement to outline significant concerns we had with regard to the impact of the pandemic on the adult social care and support sector and the key decisions made by the UK Government during that period which made the response more difficult. These are more fully laid out in my witness statement.

I first want to highlight pre-pandemic preparedness. While outside the timescales of this module, it is important for the Inquiry to remember that social care went into the pandemic ill prepared, with over

100,000 staff vacancies, a precarious financial situation following a decade of austerity, and the lack of any investment by the state in digital, data and physical infrastructure.

The risks around capacity were highlighted as urgent as recently as 2016, during Exercise Cygnus.

Second, throughout the pandemic response, there was a concerning lack of understanding of adult social care by policymakers, leading to an unhelpfully narrow public policy and resource focus on care homes for older people, with little consideration of the breadth and diversity of care and support settings and services which all needed a helping start from the start of the pandemic.

As a direct consequence, guidance and policy created during the pandemic were marked by a lack of understanding of the diversity of adult social care and support services and the people using those services.

The flow and communication of guidance from government and key stakeholders were poor and chaotic. And this was exacerbated by unclear chains of command, particularly the role of national versus local decision makers. Changes in the guidance itself were often communicated last minute, sometimes over bank holidays, and often late on Friday nights.

Changes in the policy relating to key elements of social care and support were often communicated by press release or the daily briefings, with this landing sometimes days and occasionally weeks before the final guidance was issued, leading to a mismatch between public understanding of the situation and the guidance that care and support providers were being instructed to follow.

All organisations had to grapple with multiple, interdependent, sometimes contradictory pieces of guidance, which were updated at different times. This was particularly challenging for smaller providers, who formed the bulk of the adult social care sector.

I want to move on to the disregard shown for the people accessing or working in care, and support from government and the wider health system in relation to key areas including testing, PPE, vaccination, accessing of community and specialist health services, and many other areas.

The advice of social care experts was often ignored or marginalised. This is in spite of repeatedly highlighting key issues including the breadth and depth of social care and support, the need to ensure that guidance was possible to implement for small organisations, the inability to access community health

services, and the impact on those receiving care and support and the care workforce, the inappropriateness of blanket guidance around areas such as isolating people living with dementia or other complex needs, the need to balance the risk of harm from Covid through enabling visiting with the risks of harm resulting from separation and isolation from loved ones, and many more key issues.

To support these perspectives, we gathered and shared rapid evidence, sought out independent expertise, and provided examples of how to mitigate risks, always building on the critical stream of information we received, day in, day out, from the front line through our close work with members.

I also want to draw the Inquiry's attention to the funding of social care during the pandemic. The drip feeding of funding support was unhelpful, insufficient, inefficient, and bureaucratic. Whilst all funding was greatly needed, it came after very significant advocacy from the sector and was provided only in the emergency -- in the form of emergency, short-term, time-limited funding, which was never sufficient to meet the publicly described need.

This short-termism meant providers were unable to put long-term protective measures in place.

My next point relates to collection and use of data, which was highly problematic throughout the pandemic for adult social care.

Infrastructure around data was lacking before the pandemic, and during the pandemic, data collected from providers via Capacity Tracker was used to meet policy aims, such as the freeing up of hospital beds, rather than to prioritise resources for providers who were including data that showcased their lack of PPE, and shortages of staffing.

In addition, collective data received by government in relation to new variants of data that would have flagged the need for additional capacity was not shared with providers. It is important to recognise that staffing and capacity became increasingly difficult due to the direct impact of the pandemic with organisations dealing with rapid increases in vacancies and sickness levels. This was compounded by guidance which required isolation but came without sufficient financial support.

In addition, specific cross-sector recommendations relating to the social care workforce in the summer of 2020 were not adequately addressed by the government.

Finally, the pandemic has revealed the deep-seated inequalities in our health and social care system. Due to its composition and the people who access care and

support, this is a sector where several inequalities intersect along ethnic, gender, age, disability, and socioeconomic lines.

My Lady, as outlined earlier, this will only change if the apparatus of government actually understands and values the people who work in social care and the lives of people who receive care and support.

In conclusion, the points I have outlined can be summed up in three ways:

(1) Social care was overlooked in key decision making moments.

(2) Social care was misunderstood by decision makers and the wider public. Social care is a diverse, interconnected system of care and support services for all ages, with a workforce larger than the NHS.

(3) Social care was disadvantaged, especially in comparison to the NHS. The focus of decision making appeared to be narrowly on protecting NHS hospital capacity rather than citizens in all communities.

Our participation in the Inquiry is motivated by our commitment to ensuring that everyone involved in care and support does not have to go through this experience again. It is essential that clear operational and implementational lessons are learned and applied across pandemic planning preparedness and response.

Those are our opening submissions, my Lady.

LADY HALLETT: Thank you very much indeed, Professor Rayner.

Dr Townson.

Submissions on behalf of the Homecare Association by DR TOWNSON

DR TOWNSON: My Lady, I appear on behalf of the Homecare Association, the only UK body that speaks exclusively for providers of home care, also called domiciliary care.

I'm grateful for the opportunity to assist the Inquiry, and through it, the bereaved families, people who draw on care, and the dedicated workforce who supported them.

At any one time across the UK, about one million adults rely on professional home care, more than double the number in care homes. Around six million more receive informal, unpaid care, and a further two million have unmet care needs. That's at least nine million people needing or receiving support at home, compared with just over half a million in hospitals and care homes. Yet public attention and resources have often focused elsewhere.

There are some 740,000 professional homecare workers in England alone, more than the 698,000 in care homes, delivering support in ordinary homes across every

community. They help people live well at home, uphold rights, prevent hospital admissions, and enable safe discharge but before, during and after the pandemic, home-based care was often invisible in policy, data and debate.

Our evidence reinforces what my colleague Vic Rayner has just said: there are three overarching themes. First, home care was overlooked in key decisions. Ministers and officials focused on protecting the NHS, and later care homes, with insufficient awareness of the scale and importance of care delivered behind closed doors.

Second, home care was misunderstood. Decision makers treated social care as synonymous with residential care for older people overlooking the diversity and complexity of services delivered at home.

Third, home care was disadvantaged compared to the NHS and care homes, access to PPE, testing, vaccines, data, guidance, funding and professional respect all lagged behind.

The pandemic exposed a number of structural weaknesses and I draw your attention to five.

First, fragile foundations. Years of underfunding and insecure commissioning left homecare providers without reserves. Covid-19-related costs added about

25% to hourly delivery costs while fee rates barely changed. Funding intended to keep the sector going, often failed to reach home care.

Lack of leadership and expertise. Social care, and especially home care, was largely absent from SAGE, COBR and ministerial briefings. It took over a year for a SAGE Social Care Working Group to appear on any public list. These blind spots cost lives.

Reduced access to other professionals. National instructions to minimise face-to-face contact led many professionals, GPs, district nurses, social workers, housing teams, and regulators to withdraw to remote working. Homecare workers were often the only professionals entering homes, sometimes asked to carry out tasks such as wound care, insulin injections, verification of death, without adequate support.

One provider told us a district nurse threw dressings over the threshold and ran away.

Poor communication and lack of data. There was a paucity of official data about home care and no reliable national channel to reach all homecare providers, making coordination nearly impossible. And deep-rooted inequalities. The largely female ethnically diverse low-paid workforce received little sick pay protection, some had to choose between infection control

and paying the rent.

The practical consequences were severe. Access to healthcare was restricted. The message to stay at home, protect the NHS, save lives, led many to delay or avoid seeking help. While only 7% of deaths at home were officially attributed to Covid-19, by mid-2022, hospital deaths from non-Covid conditions had fallen by over 100,000 while deaths at home from causes like dementia and cancer soared. PPE and testing were hard to access. Eight in ten homecare providers could not secure PPE in April 2020.

Business as usual orders, paid for by homecare providers, were diverted to the NHS. Workers fashioned makeshift protection from fabric and bin bags, while government guidance said they didn't need it.

Routine asymptomatic testing for homecare staff only began in January 2021, ten months after it started in the NHS. People were transferred from hospital without tests, transferring risk and responsibility to families and homecare workers.

Vaccinations saved lives but the policy to make it a condition of deployment risked them. It threatened to remove up to a fifth an irreplaceable workforce at the height of staff shortages. Around 18,700 workers left the sector in anticipation before the policy was

withdrawn.

Emergency funding was distributed inequitably. At least 75% of the first infection control fund went to care homes. Home care received the scraps under the table. Funds were often denied to providers without council contracts excluding many who delivered NHS commissioned care or self-funded care.

Some councils, like Hertfordshire, distributed funds equitably to all providers but this was the exception.

Movement restrictions were unworkable. Home care, by its nature, involves workers moving between households. Restricting this would have required far more staff at a time when vacancies were four times higher than the wider economy and staff turnover already exceeded 25%. Other countries used cohorting, enhanced PPE and testing rather than blanket restrictions.

Guidance was chaotic. Initial advice claimed community transmission was low and masks increased risk. Neither was true. Guidance changed frequently, often late on Fridays and without adequate consultation. One flawed instruction in September 2020 forced providers to scrap vinyl gloves overnight for scarce nitrile stock. It was reversed weeks later after confusion and cost.

There was a regulatory vacuum. The Care Quality Commission paused inspections. This left homecare

providers without oversight, and people without assurance. Some services have still not been inspected for more than 7 years.

The human cost of the pandemic was devastating. Thousands became isolated with deteriorating health and no access to essential care. Those receiving professional home care fared better because care workers became their advocates, lifelines, and sometimes their only human contact. Care workers made difficult judgments alone and often were the only people present to comfort someone at the end of life.

Families rightly ask: whose lives did the government intend to save when those most at risk could not access the healthcare they needed?

The Inquiry can help future responses to be fair, effective, and inclusive. We urge the Inquiry to recommend embedding social care expertise at every level of emergency planning, science advice and operational command; creating a standing national social care forum with equal status to the NHS; guaranteeing equal access to PPE, testing, vaccines and sick pay across health and social care; requiring integrated community services, including continued face-to-face input from GPs and district nurses supported by safe PPE and clear protocols; building a modern data infrastructure that

captures everyone receiving or delivering home care; valuing and protecting the workforce with sustainable funding that supports fair pay, training, technology, and resilience; ensuring emergency funding reaches all providers automatically and equitably; and developing policies especially for home care, recognising its distinct nature from residential care.

As I close, it is important the Inquiry recognises that during lockdowns, many home care workers walked through silent streets before dawn so people at particular risk could live safely and with dignity in their own homes. They filled the vacuum left by others, sometimes at cost to their own health or lives. Their courage steadied the nation. We owe it to them and to those they served to build a system that will never again leave people unseen and unsupported. I stand ready to assist the Inquiry further.

Thank you, my Lady.

LADY HALLETT: Thank you very much indeed for your help, Dr Townson.

I think we'll break now and return at half past, please.

(3.17 pm)

(A short break)

(3.30 pm)

LADY HALLETT: Mr Jacobs.

Submissions on behalf of the Trades Union Congress by MR JACOBS

MR JACOBS: My Lady, these are the submissions of the Trades Union Congress. I'm instructed by Thompsons Solicitors and I appear here with Ms Ruby Peacock and Ms Natalie Lucas.

In these opening submissions, we focus on the experience of those who worked in the pandemic in the adult social care.

The social care sector is, at its core, a social care workforce, a cast of many thousands who provide care and support, and in many cases a home and company and companionship for those who depend on the sector. Undoubtedly, working during the pandemic in adult social care was, for many, a traumatic experience.

We are grateful to Ms Carey King's Counsel this morning for recounting the experiences of Ms Kitchen, a wellbeing coordinator who covered care shifts in a residential home.

The experiences she described of caring for large numbers of Covid-positive patients, providing end-of-life care, and managing end-of-life meanings with family members over Zoom were traumatic but common.

The account of the distress of not being able to hug

family members, who themselves felt like extended family, gives an insight into the value of care work, which is often so inadequately reflected in pay and conditions of work.

My Lady, this was the trauma of an already beleaguered and vulnerable workforce.

It is a workforce which, as we have heard, depends on a high proportion of migrant workers who face additional vulnerabilities and a significant proportion of black, Asian and minority ethnic workers.

The challenges for workers of proximity to death and exposure to a novel virus were exacerbated in myriad ways by some of the structural issues faced by the sector.

There were common experiences for social care workers of not only a lack of PPE, but a sense of being at the very back of the queue, of generally being a low priority, a mere adjunct to the NHS, of working in an environment that felt essentially hidden from central government and from regulators, of not being able to self-isolate without significant financial difficulty, of feeling abandoned with terribly unwell residents in pain, without being able to bring in and lean on proper medical expertise and treatment, of working amid staff shortages and the pressure to cover more and more shifts

at the expense of personal wellbeing; of not being able to raise concerns about poor health and safety because of being in precarious employment.

My Lady, that latter concern was reflected so powerfully in the impact film this morning, the account of workers not being able to raise concerns for fear of losing their jobs.

When we talk in general terms of precarious work, it is these sorts of difficulties which are the lived realities which result, to the detriment of the safety of those who provide adult social care and those who depend on it. And we wholeheartedly endorse the observations made before the adjournment by the Frontline Migrant [Health] Workers Group and others about an exploited workforce.

My Lady, as to the state of the social care sector and these structural difficulties, you will not find a single witness before you who says anything other than that the system of adult social care going into the pandemic was under-resourced, fragmented, and generally neglected. That those are the characteristics of social care is not sensibly in issue. It has been examined to a point in Module 1 and the Department of Health and Social Care in its own opening written submissions does not shy away from those features.

And it is not surprising that, in the opening statements today, some core themes have emerged. It begs the question, my Lady, what to do with a problem like adult social care.

There would appear to be a risk that Inquiry calls for change merely sit atop an already large and dusty pile of reviews and committee reports which have, over many years, realistically, called for change in the structures of adult social care.

But a justified fear as to the prospect of change simply makes it all the more important that this Inquiry sets out the issues in the barest and starkest of terms.

This Inquiry cannot itself devise the national systems necessary to support the operation of adult social care. But it can set out what such national systems should be able to achieve in order that the response in the next pandemic can be more effective.

A central point must be strategic action on the social care workforce. The sector came into the pandemic with 120,000 vacancies and high staff turnover. For reasons we and others have touched on, it is not just a question of numbers of workers; it is a question of the conditions of work. Some of the features of precarious work, of not having the financial support to stay away from work when ill, of working various shifts

across various homes, and of vulnerability to unsafe working practices need to be addressed.

It needs ultimately to be a more valued, better paid, and less insecure workforce.

Some action was taken by way of the May 2020 Infection Control Fund, but the lack of structure for oversight of the operation of the sector meant that it was, in substance, an expenditure with little sense of where the fund actually went. Minutes of a Covid-O meeting in December 2020 state:

"The fund was designed to support the restriction of movement of staff between care homes, but its weak processes meant that funding was not reaching those who needed it most."

Evidence disclosed to this Inquiry demonstrates that in October 2020, only 25% of employers were paying staff who needed to self-isolate their full wages. Some homes had refused to sign up to the fund because they feared setting a precedent of paying full sick pay beyond the pandemic. It also shows that the Department of Health and Social Care did not have the ability to check whether care home staff who tested positive in the weekly testing programme were being paid their full wages.

PPE and preparedness, over which there must be some

national operational oversight, needs to be transformed. A poll carried out by Survation on behalf of GMB in April 2020 found that fewer than half of social care workers felt that they had been provided with adequate PPE.

Contributing to unsafe working conditions was an absence of effective regulation in the sector during the pandemic, and we echo what has been said on that by others.

Essentially the lesson should be that amidst the dangers of a pandemic, regulators should step not back, but forward, and assist in ensuring the safety of those who depend on and work in social care.

And you have heard accounts this morning which make clear that regulatory input can be supportive.

The policy of vaccination as a condition of deployment was especially distressing for social care workers, and it compounded the effects of structural racism and worsened the understaffing crisis. Workers described to the TUC the vaccine mandate as being pressurised, forced, like blackmail.

A residential care worker in the North of England describes "It felt like a betrayal, like we were useless, and incapable of keeping the people we support safe."

What the TUC says is that more ought to have been done to build trust and share information about the vaccine. A survey by the TUC and UNISON found that 58% of social care workers reported not being provided with enough information about the vaccine.

My Lady, these are some of the important issues to be considered in this module. They are important in shedding light on and improving the position not only of those reliant on adult social care but those who provide it. They are workers who continue to provide care during the pandemic at great sacrifice, and they are owed the careful and robust consideration of this Inquiry. My Lady, thank you.

LADY HALLETT: Thank you very much indeed, Mr Jacobs.

Mr Boyle.

MR BOYLE: My Lady, as you know [no microphone]. Four nations of the United Kingdom.

LADY HALLETT: Can we just check the -- the usher is coming to help.

Submissions on behalf of the Royal College of Nursing by MR BOYLE KC

MR BOYLE: It's on now. I'll begin again.

My Lady, as you know, the Royal College of Nursing is the representative voice of nursing, across the four nations of the United Kingdom. It is the largest

professional union of nursing staff in the world. It has more than half a million registered members, including nurses, student nurses, midwives, nursing support workers, and healthcare associates.

The Royal College's members work not just in NHS hospitals, but also, and significantly, for the purposes of this module, in specialist health facilities, in care and nursing homes, in the community, visiting patients in their own homes, or the homes they share with their loved ones, and in the independent healthcare sector.

Given the extent of its membership and the extraordinary breadth of the experience which its members have across the adult social care sector, the Royal College hopes, and is in fact confident that you, my Lady, will factor into your work through this module, and ultimately your recommendations, the voice of the Royal College on behalf of its members.

The written and oral testimony of the Reverend Charlotte Hudd and Claire Sutton will hopefully assist you in that regard.

Regrettably, and perhaps surprisingly, given the breadth of its expertise and the experience it can call upon, the voice of the Royal College has not always been welcomed, listened to, or engaged with by those in power.

You have our written opening, so I propose to address you briefly under three headings. Firstly, workplace capacity, staffing shortages, and underinvestment. Secondly, disparity of treatment between social care in the community and the NHS. And thirdly, the impact of the pandemic on nurses and care workers in adult social care.

First topic then, workplace capacity, as to which you've heard a good deal already. Years of underinvestment in community care and the care home sectors meant that adult social care was left exposed when the pandemic hit.

The Royal College had consistently highlighted over a number of years the absence of effective workforce planning for nursing. The impact of this failing was already manifesting itself pre-pandemic, and endures to this day in high levels of vacant posts and escalating expenditure on agency staff.

The failure of the UK Government to tackle the issues facing the nursing workforce, including in recruitment, retention, and burnout, remains a serious risk to the country's ability to robustly tackle future pandemics.

Currently, in England, there is not yet a credible system for understanding workforce shortages and

responding to increasing demands in both population and service.

Persistent systemic workforce issues and underinvestment put nursing staff and patients at risk. Over five years on, the adult social care system remains fragile, as Counsel to the Inquiry described it earlier. That is alarming.

The Royal College is calling for a strong legislative underpinning of government accountability for workforce planning and supply across health and social care. In England and Northern Ireland there is no law related to nurse staffing, unlike the Nurse Staffing Levels (Wales) Act of 2016, and the Health and Care (Staffing) (Scotland) Act of 2019.

The college is calling for legislation in each UK country to guarantee nurse staffing levels across all sectors and settings.

Put simply, nursing should no longer be viewed as a cost burden; rather, a profession, a workforce to be invested in, and valued for the benefit of us all.

Second topic, disparity of treatment between social care in the community and the NHS.

Historically, there has been an artificial and unhelpful divide between adult social care and the NHS, with unequal access to resources, guidance, and

workforce. This had led to an unfair perception that adult social care was in some ways secondary to, or less important than, acute hospital care.

The description by Mr Weatherby KC from one of the witnesses of the government's not knowing how many care homes were in existence is an example par excellence of that disparity.

This perception appeared to continue throughout the pandemic, with care homes feeling under pressure to take untested discharged patients and, as you heard from the impact video, on occasion, those that had in fact tested positive. And that to prevent the NHS from being overwhelmed, but which ultimately may have resulted in higher levels of deaths in care homes than would underneath wise have been the case.

We have all watched the damaging and long-lasting impact of that from the moving accounts of relatives in the presentation at the commencement of this session.

The inadequacies in the management of the discharge processes were then compounded by the inadequacy and lack of availability of PPE for staff in the social care setting, which in turn was coupled with the comparative lack of availability of testing in social care facilities as compared to larger NHS facilities.

Throughout the pandemic, the Royal College conducted

a number of surveys where members repeatedly reported that perfect storm of inadequacy and disparity across the health and social care sector.

In terms of infection prevention and control, as a profession, health and social care workers deliver the vast majority of physical and psychological care to patients in all care settings. Over the years, they have led the way in reducing the transmission of infection by prioritising IPC measures in their clinical practice. These measures are fundamental to the safety and wellbeing of the profession and the patients.

The Royal College and its members is uniquely placed to understand the importance of IPC methods to reduce the spread of infection, and in so doing, to protect the patients from avoidable harm.

It was extremely disappointing that the voice of nursing was absent from discussions regarding the creation of IPC Guidance for the care sector.

The Royal College invites you, my Lady, to recommend that nurses need to be engaged with and play a significant role to help shape and influence policy for the provision of social care and its guidance that affects the communities they care for.

Final topic: impact on nurses and care workers. The concerns which the Royal College has to ensure there is

future-proofing of suitably resourced and equipped staff working in safe environments in adult social care are real, given the impact the pandemic has had on the physical and mental health of so many of its members.

Many lost their lives just by turning up for work. Many lost their careers through the impact of the pandemic on their mental health. Many continue to suffer the effects of Long Covid, which has blighted their ability to work and perform the public service which they so cherish and which our society so desperately needs.

These consequences and the inevitable impact on the safety of those they care for should never happen again. And the Royal College, my Lady, as has been the case in other modules, stands ready to assist this Inquiry to try to achieve that aim.

LADY HALLETT: Thank you very much indeed, Mr Boyle.

Mr Allen.

Submissions on behalf of the Local Government Association and Welsh Local Government Association by MR ALLEN KC

MR ALLEN: Good afternoon, my Lady. As you know, in -- as in other modules, I represent the interests of the Local Government Association and also the Welsh Local Government Association.

The two associations work very closely together and

welcome the opportunity, again, to be Core Participants in this module.

Together, they represent the collected voice of local government with 100% of the Welsh authorities and over 99% of the English principal local authorities as members.

The two associations have a role in ensuring communication between government in England and Wales and their members, the local authorities who have the statutory duties in care, slightly different duties in the two parts of the United Kingdom.

Both associations are very well aware of the terrible toll felt by so many involved in the adult social care sector, as a result of the pandemic. The two chief executives have filed witness statements, Joanna Killian for the Local Government Association, and Chris Llewelyn, who was referred to earlier, for the Welsh Local Government Association.

In this short opening, I don't want to reprise the themes that have already begun to come quite clear in the openings that you've heard so far in any great detail, but just to provide a little more context to that which has already been mentioned.

First, looking at the position in England, I think the size of the adult social care provision really needs

to be seen in a number of different ways. First, the financial side of it has yet to be mentioned.

In 2019 to 2020, fiscal year, the total core spending of local authorities in England was 46.6 billion and of that, 37%, about 16.7 billion, was spent on adult social care. That is a huge number, but it doesn't represent the full national cost of adult social care, since much care is self-funded.

The figures that the LGA has is about 23.5% of people accessing domiciliary care are self-funded, and for care home residents, the figure is about 37% or 137,000 people.

You've heard already a little bit about the jobs that are involved in adult social care. The figures we have for England are about 1.65 million jobs, of which about 7% to 8% were vacant. There were about 1.52 million people actually working in the sector.

In short, that means there was a gap of some 112,000 people that were needed but were not there when the pandemic struck.

12.3% of those vacancies were in the nursing sector, 8.2 were ordinary -- I say ordinary, but non-nursing careworker roles.

And you've heard already that this workforce is considerably larger than that of the NHS, some 300,000

more jobs.

A little bit more about the statistics. It's an overwhelmingly female workforce, 82%, whereas the national economically active population is about 47%. It's disproportionately older, some 27% were aged 55 or above, compared to 20% nationally.

And it is also very largely brought -- a very large employer of the BAME workforce. 21% identify as being BAME, against 14% nationally. And of those, it's interesting, drilling down, to note that 12% identified as black compared to 3% nationally.

Then what about the demand? How does that look in terms of transactions? We don't have the figures exactly for the period during the pandemic, but this will provide, I think, some context for you. In 2023-2024 we know that councils received just under 2.1 million requests for support from new clients, about 0.66 million requests from people aged 18-64 and 1.43 million for people over 65.

This works out at about 5,700 requests per day. And it was probably considerably larger during the pandemic period.

The bare recital of the scope of their duties, the demand, the persons involved, doesn't do full justice to the stress in the sector. As has been noted in other

submissions that have been made, of course we know that this was a period of very considerable cuts in local government funding.

But LGA wants to say, and to have it heard loud and clear, not only in this hearing but to the public at large, that the pandemic imposed a huge physical and emotional toll on all those who worked in adult social care because of the stresses. And the consequences can be seen in a number of short points: care provider instability, deleterious impacts on the nature and quality of provision, serious detrimental impacts on recruitment and retention, greater strain on unpaid carers, inadequate investment in prevention, and high levels of unmet and under-met need.

One matter much mentioned today already, but one which we can add a little bit more complex to, is what is known in the LGA as the perception problem. This is the perception about adult social care. What it is. You may find it interesting to know that very shortly before the pandemic, the Local Government Association commissioned a public survey of more than 1700 people and found that nearly half the respondents had little to no understanding of what social care actually meant.

44% believed social care to be provided by the National Health Service. Over a quarter believed social

care was provided free, paid for through national taxation. And finally, I should note on this point that there was so little understanding of this sector that in some cases, those who had interacted with adult social care were not even aware that they had done so.

And this perception problem is really important in understanding the way in which this issue has been addressed. With the public so ignorant of what adult social care actually means, notwithstanding the huge demand on it, national politicians have had little incentive to really get to grips with those issues. And you've heard a lot about those issues already and that particular problem.

The LGA's role, as I've told you throughout this, was to be the intermediary between its members and government, and in the witness statement of Ms Killian you'll see much that is discussed on this and you've already had the Local Government Association's general survey of the local government -- of local authorities which was conducted in conjunction with the Inquiry team.

Ms Killian's statement gives some sense of the range of engagement of local authorities. It is, I think, one of the longest statements, over 300 pages long, covering much of the topics that have been mentioned, but I'll

just summarise them: government response, PPE shortages, testing protocols, workforce challenges, vaccination efforts, vaccination as a condition of employment, Care Act easements, grant conditions and funding, data collection and reporting, infection control and testing, PPE, visiting restrictions and impact on recipients. And that's not all.

And that will give you some idea of the involvement of the English local authorities and, indeed, it's very similar to the position in Wales.

To whom I just turn shortly now to add a few more statistics to give you a bit more context of the problems that you will have to deal with over the next five weeks of this Inquiry.

The Welsh Government Association's statement points out also many of the problems that occurred before the pandemic, noting in particular a growing demand for services due to an aging population, and the increasing complexity of care needs, and the strain that just came from that. It mentions also the workforce shortages, with significant difficulties in recruitment and retention, with low pay, which has already been mentioned, limited career progression for care workers and how that contributed to instability in the sector.

Of course, also the significant funding challenges

and their effect on undermining the sector's stability and effectiveness have been mentioned. Financial sustainability during the pandemic and the role that local government played in that are very important indeed.

So adult social care in Wales, like in England, faced problems of urgent workforce challenges, recruitment, retention, morale, status, and the need for better progress, all of which created problems during the pandemic when the pressure and stresses were so greatly increased.

I want also to mention the effect --

LADY HALLETT: Sorry, Mr Allen --

MR ALLEN: -- very shortly.

LADY HALLETT: I'm sorry to interrupt, Mr Allen, I'm afraid I've allowed you considerably more, given that I thought that maybe the time allotted wasn't exactly generous.

MR ALLEN: Ms Thelma Stober said I could have a minute of her time, so would you allow me just to --

LADY HALLETT: You've already had several minutes. I have to be fair to everybody, so if you could bring it to a close I'd be very grateful.

MR ALLEN: All right.

Well, my Lady, I wanted to mention the relative statistics that the Welsh Local Government Association

particularly draw to your attention, between the position of the social care workers, the mortality rates in social care, how they were roughly double the mortality rates of those in the NHS. A factor of great importance.

My Lady, thank you for the time that you've given me and I will rely on my written opening statement to contribute to the rest.

Thank you.

LADY HALLETT: I'm very grateful, Mr Allen. I do understand. Obviously, given the role of the local authorities --

MR ALLEN: Not at all.

LADY HALLETT: -- I do understand why there was a certain amount of you wanted to put before us.

Ms Stober.

Submissions on behalf of the Association of Directors of Social Services by MS STOBER

MS STOBER: My Lady, on this occasion, I represent the Association of Directors of Social Services, referred to as ADASS.

ADASS is a charity whose members are current and former local government directors of adult social services and their senior staff in England. ADASS also has a president that is appointed on an annual basis.

ADASS is very well aware of the terrible toll felt by so many involving the adult social care sector as a result of the pandemic, in whatever role.

ADASS hopes that this module can do very important work, and in its recommendation to ensure better preparation so that this never happens again.

My Lady, ADASS makes the following important point for the Inquiry to take into account in its investigation, and in its recommendations.

You've already heard, my Lady, that social care sector was in a very poor state due to decades of austerity and severely underfunded, misunderstanding and undervaluing of people needing and working in care, a lack of appropriate emergency planning, and significant workforce recruitment and retention issues.

A lack of infrastructure and resilience at the beginning of the pandemic led to too few people desperately developing policies, practices, and guidance at too rapid a pace, and having to make it up as they went along.

There was -- again, you've heard, my Lady, there was, and still is, a significant lack of understanding of the complexity and essential nature of social care by the public and by many in the NHS and central government.

Social care was an afterthought before the NHS. Again, this is something we've heard today in the Inquiry. The focus on prioritising the NHS and maximising capacity in acute hospitals overshadowed people needing and caring -- working and needing caring.

Rapid discharge from hospitals to care homes without testing, PPE or staffing capacity to provide time for recovery, rehabilitation, re-enablement, and then assessment of people's future care needs, had tragic results. There was insufficient consideration of the impact on people with learning disabilities, and unpaid carers. National plans were either too late or policies were announced publicly before social care sector was aware of it and able to respond.

The need for data quickly meant that local and regional systems were over-ridden and the use of an NHS system designed for a different purpose.

ADASS hope that planning for future pandemics will have greater focus on the social and psychological, as well as the clinical vulnerabilities of the population, ie the need for both protection and connection.

There was insufficient consideration of quality, basic safety and safeguarding in relation to the numbers of people behind closed doors at home or in institutions which effectively became closed institutions with the

known associated risks of neglect and abuse.

Finally, my Lady, the focus on hospitals and the clinical perspective arguably prioritised people of working age, deprioritising those needing and working in social care, and exacerbated inequalities, the impact of which is still being felt today.

Thank you, my Lady.

LADY HALLETT: Thank you, Ms Stober. I appreciate what a difficult week this must be for you. My thoughts are with you, all other survivors, and those bereaved by the London bombings on 5 July 2005. So please convey my best wishes to everyone --

MS STOBER: Thank you, my Lady.

LADY HALLETT: -- who is still here. Thank you.

Ms Murnaghan, I think you're at the back, weren't you? Did I see you? Yes, I did.

Submissions on behalf of the Department of Health in Northern Ireland by MS MURNAGHAN KC

MS MURNAGHAN: [No microphone] my Lady, I appear for the Department of Health in Northern Ireland.

Firstly, the Department was like to place on record its thanks to all of those who supported the delivery of adult social care in Northern Ireland. We recognise that some of the most acute pressures were experienced on the front line, and to that end the Department would

like to acknowledge those in care worker roles. Their dedication in caring for some of the most vulnerable in the most difficult of times is evidence of their commitment and compassion and we feel must be commended.

My Lady, I would like to start by briefly summarising the relevant adult social care delivery structures that operated in Northern Ireland.

Adult social care services are delivered in Northern Ireland in a mixed economy of care in the statutory sector, the private sector, and the voluntary sector. Statutory services are directly provided by the HSE trusts. Private sector organisations and individuals own and run services for a profit.

Many of their adult social care services are provided under contract with the HSE trusts. The voluntary sector comprises organisations, some of which are registered as charities, which operate in a non-profit making basis but who also provide services under contract, again with the HSE trusts.

At the start of the pandemic in Northern Ireland, there were 482 nursing and residential care homes, which approximated to just over 16,000 beds.

The challenges faced by the adult social care sector during the pandemic cannot be overestimated. It is accepted that the Northern Ireland social care system

was already in a very fragile state by the beginning of 2020, and that provides the backdrop to the sector's response to this pandemic and makes the scale of that response all the more deserving of acknowledgement.

My Lady, the Department has provided a statement to the Inquiry which sets out some of the measures that it put in place to help support the sector in responding to these challenges. These measures included putting in place dedicated plans, guidance and policies for the management of Covid-19 in residential and nursing care homes.

However, the Department would like to acknowledge two key points at the outset, one being actions and decisions often had to be made at pace with the best information available at that time, and secondly, that given the rapidly evolving nature of the pandemic response, it was not possible to engage and consult with all stakeholders to the extent that we otherwise would have wanted to have achieved.

My Lady, the Inquiry today has heard quite a bit about the staffing pressures which were identified in Northern Ireland as a key challenge for the sector early on.

The Department responded to this issue by putting in place arrangements to ensure that the HSE trusts worked

in partnership with care home providers to monitor and help deal with staff shortages. In a six-month period in 2020, the trust provided over 27,000 hours of staff time to the independent sector that was totally free of charge. The Department understands that no other jurisdiction in the United Kingdom did this.

There was similar cooperation evident in the context of PPE supplies for the sector. Recognising the difficulties experienced by the independent sector providers in sourcing PPE, the Department, at a very early stage, in March 2020, decided that PPE would be provided to care homes and the independent sector without charge.

Alongside this, the Department provided additional funding and investment in the care sector. The full extent of this is detailed in our statement, but there were three financial support packages in the single year of 2020, April, June and October, which amounted to approximately £45 million. We also made available enhanced sick pay for both care home and domiciliary care workers. The provision of this sick pay helped to ensure that staff who tested positive for Covid were adequately supported to take the necessary time off work, thereby reducing the risk of transmission to other staff and residents in care homes.

The Department also worked closely with the RQIA to utilise their experience in supporting care homes, domiciliary care providers and supported living services. A key outworking of this support was the establishment of the RQIA sufficient support team as an additional mechanism of support for those in that sector.

My Lady, of course another topic which this module will deal with is the question of visiting restrictions. The Department acknowledges the very real challenges in managing infection control and balancing that with the need to protect the health and wellbeing of residents. Whilst restrictions were a necessary protection, the Department also recognises that they undoubtedly impinged on residents' quality of life and the ability of families and others to visit their loved ones.

Many significant restrictions were applied but the Department always aimed to ensure that there was some form of visiting available, even if only virtually.

And to that end, my Lady, in 2020 and 2021, care homes were provided with funding for the purchase of tablets or communication devices, wi-fi coverage was provided, and this was designed to ensure that virtual visits could be facilitated.

In September 2020 the Departments announced its Care

Partner Scheme which was, again, another measure to try and alleviate the long-term separation from loved ones. The Care Partner Scheme arrangements were not mandatory nor were they underpinned by legislation. However, when issues of compliance were identified, the Department worked with the trusts and the PHA to try to maintain contact with care home management to identify solutions and encourage implementation.

By September 2020, approximately 60% of care homes had the Care Partner Scheme in place.

Another issue, of course, my Lady was the question of discharge from acute hospital settings to a care setting. There were a number of factors which influenced decision making regarding discharge. Amongst them was the risk of keeping care homes residents in hospital longer than was clinically necessary, especially at the time of increasing risk of nosocomial infection.

The Department, however, was conscious that the risks associated with discharging residents back to a care home who may have already acquired Covid-19 existed particularly at a time when testing was so limited.

In Northern Ireland, section 14 of the Coronavirus Act, introduced in March 2020, referred to early

discharge. However, I would highlight that this aspect of the Act did not extend to Northern Ireland. Rather, Northern Ireland maintained its policy that discharge of patients was always based on clinical decision making alone.

Testing for Covid-19 was part of a package of comprehensive measures for care homes in Northern Ireland, recommended by the Department from early in the pandemic. The expansion of testing in care homes proceeded in a phased way based on advice from the initial testing based on those who displayed symptoms to routine testing of all residents and staff.

Another mechanism, of course, for control, was the vaccination programme which began on 8 December 2020 and the initial phase of that programme focused on care homes and staff. We have made the point before, my Lady, that the JCVI had identified care home residents as a top priority. However, our then Minister of Health determined that they should be the top priority. And Covid vaccinations were delivered to care home residents on the very first day of that programme.

By 26 February 2021, Northern Ireland again led the UK by having offered all residents and staff in care homes two vaccine doses, and at this time the Department had agreed that trust mobile teams would be redeployed

to residential and supported living settings to assist in that programme.

Care home workers again, my Lady, were considered a very high priority for vaccination. Although they themselves were not vulnerable to severe disease, they had high exposure and interacted with a number of the most vulnerable.

My Lady, in closing, the Department would wish to reiterate that the pandemic required difficult choices, requiring careful balancing of multiple interests under significant time constraints, and in the midst of immense uncertainty. The Department is acutely aware that these decisions undoubtedly had a profound effect on the population, not least those living and working in the care sector.

The Department welcomes the opportunity to provide this opening statement, and hopes that, along with all of the other evidence to be submitted to the Inquiry, it will help in the consideration of issues pertaining to this module and we remain committed to the work.

Thank you very much, my Lady.

LADY HALLETT: Thank you very much indeed, Ms Murnaghan.

Ms Khalique. There you are.

Submissions on behalf of the Welsh Government

by MS KHALIQUE KC

MS KHALIQUE: Prynhawn da. Good afternoon, my Lady. I act for the Welsh Government. The Inquiry will hear powerful evidence about the impact of the pandemic on the social care sector and the families in Wales. It will also hear from witnesses involved in the Welsh Government's response to the pandemic in the social care sector.

The Welsh Government welcomes the Inquiry's examination, and acknowledges that there are key lessons to be learned both in identifying good practice and recommendations for improvements. I will address, in brief, seven particular matters.

My Lady, you have our written submissions.

First, the Welsh Government, as you've heard, is responsible for social care policy, whereas local authorities are responsible for the operational delivery of social services. During the pandemic, existing government infrastructure and systems were supplemented with bespoke groups specifically established to manage the challenges of the pandemic. The Welsh Government also continued to maintain important relationships with external organisations across the sector.

Secondly, hospital discharge. On 15 April 2020, the decision was made by the Welsh Government that hospital patients should not be discharged into a care home until

they had tested negative for Covid-19.

This was confirmed in letters to all registered providers and responsible individuals in adult social care services, in Wales on 22 April, and to all chief executives of local health boards in Wales, amongst others, on 24 April. The Welsh Government guidance followed this on 29 April.

The Welsh Government acknowledges that in the state of urgency that existed at the time these decisions were made and implemented, that guidance ought to have been published sooner.

Thirdly, PPE. The Inquiry has heard in previous modules that the provision of appropriate and high-quality PPE was a significant challenge. The pre-existing pandemic stockpile in Wales was supplemented by NHS Wales Shared Services Partnership, which procured and distributed additional PPE on behalf of the Welsh Government.

From March 2020, the partnership rapidly expanded its existing NHS-only provision and commenced supply of PPE to local authorities for onward distribution to the social care sector.

By March 2022, the partnership issued over 1.3 billion items of PPE to the health and social care sectors in Wales, and around 550 million of these were

issued to the social care sector.

Nonetheless, the Welsh Government has accepted, as you've heard in Module 5, that the move to centralised NHS-led procurement for the social care sector could have been put in place earlier in March 2020, which might have quickened the improved availability of supplies for the sector in those very early days of the pandemic.

Fourthly, testing. On 2 May 2020 the Welsh Government introduced targeted asymptomatic testing in outbreak hotspots and larger care homes which were at greater risk of outbreaks. From 16 May 2020, asymptomatic testing in care homes was introduced, and made available to all care homes.

These decisions were taken in light of the developing knowledge of asymptomatic transmission. The Welsh Government sought to take an evidence-led approach and made decisions based upon the advice and scientific evidence available to it at the time.

In December 2020 the Welsh Government published its Coronavirus Control Plan - Alert Levels in Wales, the social care services for adults and children.

This plan established clarity in testing arrangements and the ability to foresee testing expectations when alert levels changed.

Fifthly, care home visiting restrictions. The Welsh Government sought to carefully balance the need to protect vulnerable care home residents with the need to promote family and social contact, and residents' wellbeing.

The Welsh Government produced non-statutory guidance to support providers when making decisions about visits within the legislative restrictions and encouraged providers to respond on a case-by-case basis. This guidance was regularly reviewed and updated in response to the changing level of risk.

The Welsh Government also sought to mitigate the impact of visiting restrictions, for example in November 2020 it introduced the visiting pod scheme to support outdoor visits during the winter.

Sixthly, the Welsh Government acknowledges the critical role played by the social care workforce and is grateful to staff across the sector for their valuable contributions and consists. It took steps to support staff, including via the development of bespoke workplace risk assessment tools, the provision of a wellbeing support line for staff, and the creation of a special payment scheme in which eligible social care staff received a one-off additional payment.

The social care workforce responded positively to

vaccination, and the minimum thresholds of those vaccinated greatly exceeded those recommended by SAGE, with 92.3% of care home workers having received their first dose by 16 July 2021.

The Welsh Government also acknowledges the significant role played by unpaid carers. The carers support grant was established which remains in place today. In addition, the one-off special payment scheme to social care staff was extended to unpaid carers.

Seventh, on the regulation of the care sector, Care Inspectorate Wales engaged extensively with stakeholders to ensure that the voice of the sector was heard by policymakers. It adapted its registration process and issued revised guidance during the pandemic.

The Welsh Government implemented learning from the first wave of infections promptly, for example, the Care Homes Action Plan was developed to address the challenges faced in the first wave. And the Welsh Government also evaluated how policies would affect different groups. It engaged with community groups, stakeholders representing diverse populations, and specific measures were taken, for example a social care subgroup of the Black, Asian and Minority Ethnic [Covid-19] Advisory Group was established. Funding was allocated for learning disability health checks, and

significant work was done to assist those with dementia, their families and carers.

Finally, on funding, the Welsh Government ensured that resources were made available to local authorities to meet changing demands. In April 2020 you've heard that a Local Government Hardship Fund was established which allocated £40 million to help adult social care providers meet the additional costs.

In September 2021, £48 million was approved to support a social recovery fund.

The Welsh Governmentally regularly evaluated the need to provide additional financial support and how best to ensure that the social care sector met the needs of the Welsh population.

Finally, learning and reflection on the part of the Welsh Government took place during the pandemic. Key reports and plans, including a social care recovery framework were published, and the Welsh Government, my Lady, were committed to protecting the Welsh population.

It fully supports the need for the Inquiry to identify lessons that can be learned, and improvements that can be made.

My Lady, thank you.

LADY HALLETT: Thank you very much indeed, Ms Khalique.

Mr Rawat ...

Submissions on behalf United Kingdom Health Security Agency by MR RAWAT KC

MR RAWAT: Thank you, my Lady.

My Lady, I appear today with Lissy Verrall-Withers on behalf of the United Kingdom Health Security Agency, or UKHSA, as we've been referring to it.

Your Ladyship is very familiar with the work of the UKHSA and of its predecessor organisations, particularly Public Health England, and that arises obviously because of our involvement in earlier modules.

Today, I want to touch upon how Public Health England and then UKHSA provided support to the adult social care sector during the pandemic, but use my time primarily to focus on four themes which bear upon the important question of how of the resilience of the sector can be improved for a future pandemic.

As your Ladyship has heard from Counsel to the Inquiry, and indeed from other representatives, the structure of the sector is a complex one. In our written opening statement, we set out some reasons for that complexity, but given what your Ladyship has heard, I will not repeat those here.

Professor Susan Hopkins, chief medical adviser to UKHSA, has provided the corporate witness statement for

this module which sets out the work done by UKHSA and by its predecessors.

PHE and then UKHSA had, and has, a discrete role in terms of the support provided to the sector which can be summarised as, first, conducting research into pathogens; secondly, collecting data in relation to outbreaks of infectious diseases and specifically those in care homes; third, contributing public health advice to guidance owned and published by government departments; fourth, producing guidance in relation to infection prevention and control measures; and finally, providing direct support to care settings and to local partners through regional health protection teams.

The corporate witness statement also sets out UKHSA's reflections on the pandemic, and what can be done to better support the sector going forward.

The following themes can be distilled from those reflections. First, the importance of national to local collaboration. It has been recognised that certainly in the early stages of the pandemic, there was a lack of strategic oversight from the centre. That changed, and how local and national bodies now collaborate must continue to develop and deepen.

In April 2022, UKHSA set up a dedicated adult social care team, which is a permanent function that continues

as a source of advice and evidence on public health threats to the sector. As commissioned by the Department of Health and Social Care, this team leads on UKHSA's contribution to national guidance, which is usually published by the Department.

As our written opening statement and indeed our corporate witness statement explains, the team engages with the sector in various ways, not only through working with the Department of Health and Social Care, but also by engaging with the Care Quality Commission, the NHS, as well as local government and providers of adult social care.

Then there are the regional health protection teams that I've already mentioned. They are available to provide specialist health protection advice and support. They work with the local teams in the NHS and in local authorities as well as with providers.

For UKHSA, the health protection teams are also important, first, because they work with the national team to monitor outbreaks and undertake surveillance and, second, because of their involvement in a range of local bodies and because of the relationships they have with, for example, directors of public health.

Such participation makes for better information sharing both at local level and back to the centre.

My Lady, mention of information sharing takes me to the next theme, which is data.

It remains the case that there is a lack of comprehensive population and health data at a national level about those who work in the sector and who access its services. And given its role, access to realtime data is obviously beneficial to UKHSA. The more granular the data, the better the understanding of risk across different settings.

How we as a country can make best use of data in pandemic preparedness is a point that UKHSA has raised before. The fragmented structure of the sector makes developing a coherent data strategy challenging. However, the UK health data infrastructure is developing rapidly and a range of data sources now access and use NHS data.

There is, therefore, an opportunity to take a strategic national approach to the use of data, beginning with care homes as regulated entities.

My Lady, this is, however, not just about physical infrastructure. During the pandemic, some data systems were set up at pace in response to that emergency, and they may not be appropriate for the next emergency.

Reimagining how data is shared and used will depend inevitably on government decisions to funding. But it

also raises profound questions about security and privacy which must be addressed in parallel. Governance and the potential need for statutory regulations are important considerations which are best addressed in peacetime.

Our third theme, my Lady, is research, and specifically research into the sector. Mention has already been made of the Vivaldi Study and you will be hearing evidence about those studies. You will also be familiar from Module 3 with the Easter 6 study.

There is a need to improve the evidence based on how non-pharmaceutical interventions, or public health and social measures as they are now termed, can be best used in the sector.

Such interventions bring both benefit and harm, and a decision to implement such an intervention is never an easy one. Factors such as the impact of isolation from family, how existing health needs can continue to be met, how non-permanent staff are deployed, need to be given weight. The better the evidence base, the better the guidance and the more focused the intervention.

Our final theme is science. The response to a future pandemic will require a strong domestic science and research base, and the benefits of scientific research are as relevant to the sector as they are to

the rest of society. Sustaining our strength in science and research requires not only funding but the maintenance of international links and collaboration between public and private. Critically, there must be a recognition that encouraging innovation means that not every initiative will immediately succeed but is nonetheless of value.

My Lady, you have our written opening statement and you have the commitment of UKHSA to continue to assist this Inquiry with its important work. And those are our submissions on behalf of UKHSA.

LADY HALLETT: Thank you very much indeed, Mr Rawat.

Mr Mitchell, I think I saw you back there.

Submissions on behalf of Scottish Ministers

by MR MITCHELL KC

MR MITCHELL: Thank you, my Lady. This the opening statement on behalf of the Scottish Government.

I appear today along with junior counsel Kristian Whitaker, and we are instructed by Caroline Beattie and Heather Auld of the Scottish Government Legal Directorate.

In this Inquiry it is often said that Covid-19 did not discriminate, yet the Scottish Government recognises that some suffered more than others. Nowhere was this more true than in the adult social care sector. In care

homes, families lost loved ones, carers strove to provide care in often difficult circumstances, and were themselves at times exposed to the virus. Some lost their lives.

Without hesitation, the Scottish Government acknowledges the profound impact on the sector. It passes its sympathies and condolences to the bereaved, it pays tribute to the workforce and to unpaid carers.

Today we look at aspects of the impact and we explore the rationale behind, and the effect of the discharge of patients from hospital into care homes.

One of the reasons people in Scotland made so many sacrifices was to protect those most at risk from the worst effects of Covid-19. Scotland's ASC workers, including those providing care in residential, nursing and domiciliary care settings, worked tirelessly to support the most vulnerable.

Unpaid carers also faced significant difficulties, as many had to step into the gap to support vulnerable friends and family members during the initial lockdown.

And thus the number of people providing care increased and many existing carers took on more intensive caring roles, while also losing the opportunity to take breaks from caring.

The Scottish Government was aware of the issues and

risks that workers faced, and sought to protect and to support them. Similarly, it engaged with unpaid carers and representative groups to understand the issues and to provide guidance and support.

In addition to IPC, a range of practical, wellbeing and financial measures were put in place from early on in the pandemic.

The pandemic adversely impacted end-of-life care in many ways, described in the witness statement of Judith Kilbee of Scottish Covid Bereaved. Examples include family members not reaching their loved ones in time for end-of-life visits. The Scottish Government recognises that restrictions on visiting caused much pain and surging, yet the complex considerations that surrounded decisions on issues such as visiting are reflected in the findings of the UK CMO technical report which stated that reducing risk of transmission in care homes involved some of the most complex trade-offs of risk to individuals of any part of the pandemic.

It is important to have regard to the actual guidance that was produced by the Scottish Government in contrast to the measures that individual care homes chose to put in place. For example, the Scottish Government's position from the outset was that essential and end-of-life visits should be supported.

As more became known about the virus and protections were put in place, there was agreement on the need for gradual opening of care homes to support wellbeing.

The Scottish Government has taken steps to ensure that people can remain connected to their loved ones even in outbreak situations. This includes the Care Reform (Scotland) Bill approved by the Scottish Parliament earlier this month. Amongst other provisions, it imposes a duty on Scottish ministers to provide providers of care home services for adults to facilitate visits. This is known as Anne's Law.

Through engagement with Disabled People's Organisations, the Scottish Government learned of issues and took steps to resolve them. For example on 28 April of 2020, the Cabinet Secretary for Health and Sport set out details of a range of measures to improve the position for people whose care home packages had been removed. Further, by the end of September 2020, the Scottish Government had made £57.6 million available to support local authorities in ensuring that people were able to access food and essentials.

Turning to discharge from hospital into care homes.

Background and context have to be considered. To remain longer than necessary in a hospital environment exposes patients, particularly the elderly and those

with comorbidities, to risks to their health and wellbeing. A delayed discharge occurs when a patient aged 18 years and over and clinically ready for discharge cannot leave the hospital because they do not have access to the necessary care, support, or accommodation, or funding is not available, for example to purchase a care home place.

In early 2020, two priorities therefore loomed large. First, in light of the expected demand in hospitals, to mobilise and to create capacity within the NHS; and second, to ensure that the appropriate safe and supported discharge of patients for whom hospital was already an increasingly high-risk environment.

It should be understood that in contrast to its relationship with the NHS, the Scottish Government does not have direct statutory responsibility for the delivery of adult social care. It cannot direct providers of social care. It cannot and did not compel care providers to accept admissions from hospitals.

The Scottish Government did ask local authorities to put additional effort into reducing delays, in discharging those assessed as clinically fit.

It would be wrong to suppose that the request presented a stark choice between hospital and a care home. Rather, it recognised the pressures on local

health and social care systems of both seeking to prevent avoidable hospital admissions and trying to facilitate the safe and appropriate return home of people who were clinically ready for discharge.

Looking at the effect of discharge, we submit there is little evidence that it increased the risk of the introduction of Covid-19 into care homes. Great efforts were made to ensure that the process of discharge was conducted safely. For example, in guidance directed at social distancing, in the need for clinical screening prior to discharge and in periods of isolation. Further, not all patients were discharged into care homes, between March and June of 2020, around 63% were discharged back to their own homes following a period of delay.

A report by PHS concluded that no statistically significant association had been found between hospital discharge and the occurrence of a care home outbreak, although a small effect could not be ruled out.

By 21 April 2020, testing capacity was sufficient to allow the Cabinet Secretary for Health and Sport to announce in the Scottish Parliament that Covid-19 patients discharged from hospital to care homes should first provide two negative tests. Other new admissions should also be tested. Both sets of patients should be

isolated for 14 days. Knowledge surrounding asymptomatic transmission had developed. There was a real appreciation within the government, the Scottish Government, as to the vulnerability of the care home population.

The aim was to provide maximum support and oversight for a sector largely operated by private sector providers, in relation to which statutory powers of direction were not available.

My Lady, plainly, there is much that could be said about the many issues that the Inquiry will explore in this module but time does not allow today. Those who are interested may read our written opening statement.

In conclusion, we finish by again recognising those who suffered, and who continue to suffer, and by again paying tribute to those who delivered all forms of social care during the pandemic.

Thank you.

LADY HALLETT: Thank you very much indeed, Mr Mitchell.

That completes the oral submissions that I shall be hearing today. We've got through a very great deal in our first opening day and tomorrow we'll start hearing the evidence, and obviously I wish to assure everybody, those who have made oral submissions and those who haven't, that I shall bear very much in mind the

contents of all the submissions that have been made, both oral and written.

So thank you very much. 10.00 tomorrow.

(4.43 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X