Witness Name: Jenny Harries
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UK COVID-19 PUBLIC INQUIRY

MODULE 6

WITNESS STATEMENT OF PROFESSOR DAME JENNY HARRIES

Section 1: Introduction

I, Professor Dame Jenny Harries, of the UK Health Security Agency, 10 South Colonnade, Canary Wharf, London E14 4PU, will say as follows:

1.1. I am the Chief Executive ("CE") of the UK Health Security Agency ("UKHSA"). Prior to taking that role, I was Deputy Chief Medical Officer ("DCMO") for England from 15 July 2019 to 31 March 2021. On 27 January 2025, I announced my forthcoming retirement from the post of CE of UKHSA. I will be stepping down at some point in the early summer.

1.2. I make this statement in response to a Rule 9 request from the UK Covid-19 Inquiry ("the Inquiry") dated 22 October 2024. This is the 11th witness statement I have submitted to the Inquiry. Accordingly, where appropriate and at the Inquiry's invitation, I have either repurposed, repeated or adapted material from my previous witness statements insofar as it is relevant to the content of the Rule 9 request received from Module 6.

1.3. This statement covers my time as DCMO. As the Inquiry is aware, UKHSA is a distinct and separate organisation from the Office of the Chief Medical Officer ("OCMO") and UKHSA has been asked to make a corporate witness statement for Module 6. In making this statement, I have relied upon my personal recollection of events, as well as the records which are available to me. I have had access to some material held by OCMO from my time as DCMO and have been assisted in identifying relevant

documents by searches performed by my legal team. However, not all the documents that would once have been in my possession or control remain so.

1.4. In this statement, where it is necessary in order to provide relevant context, I have on occasion referred to meetings at which I was not present, or to documents prepared or advice given by others. Some of the requests made of me in the Rule 9 fall entirely outside my direct knowledge. In certain instances, other individuals or bodies will be better placed to assist the Inquiry with its work than I am. Where I feel this to be the case, insofar as I am able, I have indicated accordingly.

Section 2: Professional Background

2.1. My background is as a clinical doctor with specialist training in public health medicine. I hold a medical degree ("MBChB") and Fellowship of the Faculty of Public Health ("FFPH") by examination alongside other formal qualifications. These include a BSc in pharmacology, a master's degree in public health ("MPH"), a master's degree in business administration ("MBA"), a postgraduate diploma in health economics evaluation and a postgraduate certificate in strategic planning and commissioning. I am also a Fellow of the Chartered Management Institute, a visiting Professor of Public Health at the University of Chester and an Honorary Fellow of the Faculty of Occupational Medicine ("FFOM"), the Faculty of Public Health and the Royal College of Paediatrics and Child Health ("FRCPCH").

2.2. Before my appointment as DCMO, I was Regional Director for the South of England within Public Health England ("PHE") from 2013 to 2019. Alongside this, I was interim Deputy National Medical Director for PHE from 2016 to 2017 providing specific support for strategic incident response. From April 2017 until I commenced the DCMO role, I also formally held the strategic incident Deputy Medical Director role at PHE. I have been a member of several national advisory groups including the Joint Committee on Vaccination and Immunisation ("JCVI"), the National Advisory Committee on the NHS Constitution, the NHSE Clinical Priorities Advisory Group and the Women's Health Taskforce. Prior to joining PHE, I worked as a Director of Public Health in Norfolk & Waveney, Swindon, and Monmouthshire. I was additionally a Chief Officer in the former two Local Authorities ("LAs").

2.3. These roles involved me leading the UK public health response to several significant health protection incidents, including the Novichok poisonings (2018), the first cases

of mpox in the UK (2018), the Zika epidemic (2016) and other global crises such as the Hurricane Irma response (2017). I was the National Programme Director for Ebola screening and established the UK returning workers programme, initially operational from 2014 to 2016, as well as being Senior Responsible Officer ("SRO") for the subsequent development of the High Consequence Infectious Disease ("HCID") programme. I have significant professional experience of infectious disease management and of emergency response strategy and operations at a local, national and global level.

2.4. My previous roles in hospitals, health boards and in LAs afforded me experience of both health and care services, their commissioning and delivery, as well as the functions of local councils, in particular in relation to community public health and the devolved nations' health systems. I gained experience of the commissioning process for adult social care ("ASC") when working to contract and assure services alongside Directors of Adult Social Care in English LAs. I have further first-hand practical experience of ASC from work I undertook for the Department of Work and Pensions performing disability assessments as well as assessing cases for continuing healthcare support for Welsh Local Health Boards. Lastly, I worked early in my career as a healthcare assistant and have had to directly commission residential and domiciliary care services for family members, including for my father in the period immediately prior to the pandemic.

Section 3: The role of the Deputy Chief Medical Officer

Responsibilities as DCMO

3.1. In early January 2020, my responsibilities as DCMO were primarily in respect of the health promotion and health services portfolio. This included responsibility for advice on non-communicable diseases, preventative medicine (primary, secondary and tertiary), pharmaco-public health, and professional registration. It also included specific responsibilities for advice on screening, reproductive health, specialised commissioning, workplace health and rare diseases. The health protection portfolio, which in normal times includes the surveillance, monitoring and emergency response to infectious diseases, was held by Professor Sir Jonathan Van-Tam.

3.2. The CMO, Professor Sir Christopher Whitty, led the work of the OCMO during the pandemic. There was however a natural division of labour between him, Sir Jonathan and myself, with each of us focusing on the areas to which we could bring our previous experience to bear. The CMO is an expert in infectious disease, whilst Sir Jonathan had direct experience of vaccine development and the pharmaceutical industry. As covered above, my previous experience included health and care services, their commissioning and delivery, local council functions (in particular community public health), and the devolved nations' health systems. This experience in LAs allowed me to proactively move to support and address those areas I believed were important, but in which there was less 'hands-on' experience within the Department of Health.

3.3. It is perhaps important to state that as DCMO, I had no formal oversight, decision-making or operational responsibility for ASC. From my prior roles, I was familiar with many of the routine operational aspects of ASC, including how providers should respond to infectious disease outbreaks or how they might go about maintaining their services. However, decisions regarding the response by the ASC sector to the pandemic would ultimately fall to the providers themselves, their commissioners (mostly LAs or individuals) or the Minister for Care. My role in respect of ASC was to advise on the medical and public health aspects of the COVID-19 emergency response. In this regard, I provided advice in much the same way as I did when, for instance, advising the Department for Education ("DfE") in relation to COVID-19 considerations in schools, or Government generally in respect of non-pharmaceutical interventions.

Role of the OCMO and DCMO

3.4. The OCMO's role, and by extension my own as DCMO, was advisory – to provide medical and scientific advice to Government. In providing such advice, the CMO and DCMOs would liaise with each other whenever possible to ensure that we gave consistent advice in a manner which was easily understood and to triangulate that advice. We drew on available publications, emerging research data and our own professional experience. As is usual in the medical and scientific communities, we would challenge each other's provisional views before reaching a consensus. The intent was always to provide the best practical advice on the basis of the current evidence within the timeframe available. My contact with the CMO and Sir Jonathan

was effectively daily (or more) from the onset of the pandemic until I ceased to be DCMO. Whilst we would advise on operational aspects of the response where we felt able to do so, we had no operational functions.

3.5. It is important to stress that the sheer volume of requests coming into the OCMO meant we were often required to give advice at exceedingly short notice to exceptionally tight deadlines. In compliance with good medical practice, where a topic or area arose over which I had limited prior knowledge and/or experience, I would whenever possible try to ensure this was considered by those with more appropriate experience.

3.6. As DCMO, it was usual for me to provide advice at ministerial or departmental level. I had less direct or frequent involvement with the Cabinet or the Prime Minister, such meetings usually being attended by the CMO. My primary ministerial engagement in respect of ASC was with the Secretary of State for Health and Social Care ("Secretary of State"), the Rt Hon Matthew Hancock MP, and the Minister for Care ("MSC"), Helen Whately MP. That contact would predominantly happen through email and in face-to-face meetings.

Other working relationships

3.7. In addition to my contact with individuals in the OCMO, I engaged with other senior figures as follows:

(i) Public Health England: I worked with PHE predominantly on guidance as part of the 'triple lock'. From 25 May 2020, the cross-government 'triple lock' clearance process was introduced so that all government guidance relating to public health was cleared through: (i) PHE; (ii) the OCMO; and (iii) the Government Digital service and No. 10 in a process coordinated by the Cabinet Office guidance coordination team **[JH11/001 INQ000224011; JH11/002 INQ000224012]**. Accordingly, my engagement with senior individuals in PHE was frequent in relation to publications, as well as specific topics requiring my professional input, challenge or linkage and where their representatives were also contributing to different meetings or groups, for example the SAGE Social Care Working Group ("SCWG"), the ASC Task force meeting or MSC-led routine meetings. PHE often led on technical aspects of the COVID-19 response or where it had specific expertise. It is also routine practice as well as

a requirement of continuing professional development amongst registered healthcare professionals to continuously learn with regard to new science, evidence and interventions. I would therefore engage *ad hoc* with key individuals to better understand a developing picture in a local area, the global epidemiology or the detail behind a recent research paper;

(ii) the Chief Nursing Officers ("CNOs") for England, Scotland, Wales and Northern Ireland: my main interaction was in the form of occasional exchanges of technical information on specific areas, particularly IPC guidance. This was predominantly with the CNO for England, Dame Ruth May;

(iii) the Chief Social Worker Officer for England ("CSWO"): I do not recall having significant contact with the joint CSWOs for England, Mark Harvey and Fran Leddra, prior to the start of the pandemic. Over time, my engagement with their office grew and I would exchange views with them via email. As their title suggests, I understood their role to encompass much broader aspects of social work, rather than being focussed solely on ASC;

(iv) Government Chief Scientific Advisor ("GCSA"): I worked closely with the Government Chief Scientific Officer, now Lord Vallance, throughout my time as DCMO. This was predominantly through face-to-face meetings and email or via the Scientific Advisory group for Emergencies ("SAGE"), which he co-chaired;

(v) Directors of Public Health ("DPH/DsPH"): I actively linked with Directors of Public Health, many of whom I had worked with previously during my time in similar roles at local and regional level. I valued their assistance in getting as clear a picture as possible of how communities were managing at any point in time and in different geographies. I proactively tried to include them in relevant national meetings to ensure their views and experience were fully considered and included within national guidance **[JH11/003 INQ000151538]**. I also linked closely with their representative body, the Association of Directors of Public Health ("AsDPH"), usually through its President. I established regular meetings between the CMO and DsPH, which continue to this day. I also chaired meetings where CMO could not be present;

(vi) Local Resilience Forums ("LRFs"): Local resilience forums are multi-agency partnerships made up of representatives from local public services, including the emergency services, LAs, the NHS, the Environment Agency and others. I had experience of their membership and work from my time as a DPH and in LAs and through Scientific Technical and Advisory Cells (STACs) when working in PHE. I do not recall any personal direct links with LRFs during the pandemic.

I would however have joined discussions where consideration was given to the interface of LRFs with ASC on particular issues, for example in relation to PPE distribution or establishing mechanisms for test kits to reach ASC workers. I would have had occasional discussions with individuals who were also members of their local LRF, one example being in respect of the establishment of quarantine facilities on the Wirral in February 2020;

(vii) NHS England: My main points of contact with NHSE were: (i) Professor Sir Stephen Powis on clinical matters; (ii) Professor Sir Keith Willet (subsequently Dr Michael Prentice), Dame Pauline Philip and Stephen Groves on urgent care and emergency response; and (iii) Professor Jane Cummings CBE and Dame Ruth May for nursing matters including infection prevention and control ("IPC"). I would have attended several meetings at which Sir Simon Stevens would have been present, for instance meetings at No 10 and those with the Secretary of State. There were also opportunities to engage prior to press briefings and many of those named above were part of the senior clinicians group chaired by the CMO;

(viii) bodies representing the interests of ASC workers, providers and the interests of those receiving ASC: I had no formal routine direct links with these groups but would regularly provide input to meetings led by others, for example roundtables or webinars led by MSC or the DHSC ASC team. In addition, I facilitated the inclusion of representatives from the ASC sector on the SAGE SCWG in order to ground the latter discussions in the context of their experiences and to improve the ASC sector's understanding of the breadth of scientific inquiry being used to support care home residents. The National Care Forum was represented routinely at SCWG meetings as were experienced researchers in dementia and the care of the elderly. Further, I attended the Social Care Taskforce which included representatives from the Care Provider Alliance, ADPH and others; and

(ix) the charity sector: my involvement with charity groups was similar to that above (see subparagraph viii). There were times when I would be asked to join meetings at short notice to provide support. In addition, I supported meetings with civil society and charity representatives chaired by the then Ministry of Housing, Communities and Local Government ("MHCLG") and provided support through my separate but overlapping work on clinical leadership of the shielding programme for the clinically extremely vulnerable by personally chairing webinars to support patient advocacy groups.

Section 4: Decision Making Structures

4.1. The CMO tended to cover meetings with the Prime Minister or Cabinet, although the DCMOs attended occasionally depending on the topic. The DCMOs often covered meetings with other government departments beyond the Cabinet Office and No. 10. I outline below the various committees and meetings involved in the response to COVID-19 and my involvement with each:

(i) COVID-O and COVID-S: the Cabinet Office organised ministerial meetings that were focused on "strategy" chaired by the Prime Minister and those on "operations" chaired by a Cabinet Office Minister ("COVID-S" and "COVID-O" respectively). Throughout the pandemic I attended both as required in my role as DCMO (and then later as CEO of UKHSA). As DCMO, my attendance would depend on our (i.e. CMO's and DCMOs') schedules and the topic being covered. I attended COVID-O more often than COVID-S.

(ii) SAGE: I first attended SAGE on 6 February 2020 and thereafter attended as DCMO as frequently as possible given other diary pressures. I was first asked to become clinical co-chair of the already-extant SAGE Care Home Working Group in July 2020 after the first pandemic wave and remained as such until I left the role of DCMO. With subsequent agreement from the group, I proposed its renaming to the "SAGE Social Care Working Group" on 10 September 2020 to formally recognise that the care matters which could benefit from the group's consideration were wider than care homes and that many of those contributing expertise were also providing advice to other vulnerable groups supported more widely by care services, such as prison populations or children with disabilities. From summer 2020, it operated proactively to provide rapid advice to support social care policy provision directly to the MSC as soon as robust evidence was available. This was in order to maximally protect vulnerable groups. I less-frequently attended other SAGE sub-groups as DCMO, but due to time pressures this was not routine.

(iii) The Inquiry has asked about the "the Covid-19 Daily Meeting". I take this to mean the Prime Minister-chaired morning meeting. I attended this as a standing invitee in my capacity as DCMO (and later as CE of UKHSA). Although data was initially provided by Cabinet Office colleagues, the Joint Biosecurity Centre subsequently led the data collation including modelling and there was broad continuity of the data presented between the Bronze/Silver/Gold Local Action Committee meetings (see below) and these Prime Ministerially-chaired meetings. My personal contributions would vary but, in addition to

ensuring robust data flows corporately once I had responsibility for some functions in JBC and UKHSA, might also include specific insights into key lines of enquiry — for example an update on urgent overnight work to understand the cause of an epidemiological spike in a particular geographical area, or to outline the operational handling of an outbreak, for example in a food factory.

(iv) Four Nations Meetings: There were meetings chaired by the Rt Hon Michael Gove MP, Chancellor of the Duchy of Lancaster, to exchange information and coordinate with First Ministers across the Devolved Administrations. In addition, there were meetings of Health Ministers, or their representatives, from across the Four Nations chaired by the Secretary of State for Health. I attended both as required in an advisory capacity in my DCMO role, largely to explain the current epidemiology and the scientific or evidence base behind different policy considerations. I also attended the frequent UK CMO meetings at which we shared information with our counterparts in the Devolved Administrations. On very rare occasions during the pandemic I was asked to support a Prime Ministerial meeting with leaders of the opposition for the same purpose.

(v) Meetings within the Department of Health and Social Care ("DHSC"): From late January 2020, there was a Permanent Secretary (Sir Christopher Wormald) led series of meetings on COVID-19, and then from February 2020 onwards, a Secretary of State for Health and Social Care-led series of meetings. I attended most of these routinely throughout the pandemic, initially as DCMO. Along with written advice, usually provided via email, they were the principal route by which OCMO advice fed into decision making in DHSC.

(vi) Meetings with the Minister for Social Care: During the early part of the pandemic as DCMO and from the summer, after the first pandemic wave, inputting also as co-chair of the SCWG, I would routinely attend most of the senior-level advisory meetings held by the MSC. This had the practical benefit of allowing developing or robust new evidence on mitigations for those receiving care to be considered for policy inclusion or for change at the earliest opportunity following new evidence.

(vii) Local action committees: I routinely attended the CMO-chaired Silver meeting and Health Secretary-chaired Gold meetings. These focused on local and regional epidemiology, its causation, interpretation, ongoing mitigations and, as appropriate, potential interventions. This included (after their introduction) the system of tiers and resulted in recommendations by the Secretary of State to COVID-O as to the measures to be adopted.

(viii) Other departmental ministerial and official meetings: I attended a range of meetings with Ministers across Government. These included the Department for Education ("DfE"), the Department for Transport ("DfT"), the now-Foreign, Commonwealth and Development Office ("FCO/FCDO"), the Department for Culture Media and Sport ("DCMS"), the Department for Business, Energy and Industrial Strategy ("BEIS"), the Government Equalities Office and the then-MHCLG. At the request of the Cabinet Office or Secretary of State respectively, I also briefed the Leader of the Opposition and other senior politicians from time to time on the current epidemiology and scientific rationale of mitigations that Ministers were considering or had agreed at the time.

(ix) Meetings with ASC stakeholders: I attended webinars with ASC providers during the pandemic and chaired aligned webinars to which stakeholders such as Age UK were invited on overlapping topics in my role as clinical SRO for the shielding programme. As stated above, I had very frequent engagement with the policy director of the National Care Forum who I invited to remain in the SAGE SCWG when I reviewed the structure during 2020. Although this was a meeting for scientific interrogation, there was value in retaining contemporaneous practical insight, as well as in the sector having an understanding of the group's findings when changes in policy might be needed ahead. The SCWG was also attended by representative professional experts such as the President of the Geriatric Society, Professor Adam Gordon and Dr Laura Shallcross, University College London, who led the Vivaldi research studies. I also attended meetings of the Social Care Sector COVID-19 Support Taskforce at which there were representatives from Carers UK, Unison, the Local Government Association, Healthwatch England, the Care Provider Alliance and the Royal College of Nurses amongst others.

Section 5: Chronology of key advice and analysis

5.1. In this section, I provide an overview of the key advice I provided in relation to ASC during my time as DCMO, save that my advice in respect of testing is covered below at section 6 of this witness statement.

The meeting of 11 February 2020

5.2. My first significant involvement in the ASC response was on 11 February 2020. Prior to that, I had had a short time away due to family bereavement. On my return, my

main involvement with the COVID-19 response was in respect of the repatriation of travellers from abroad, quarantine facilities and travel advice.

5.3. On 11 February 2020 there was a meeting in respect of the ASC response led by Sir Christopher Wormald, Permanent Secretary to DHSC. As of that date, there had only been 8 cases of COVID-19 in the UK. The UK would not have its first confirmed case of community transmission until 28 February 2020. The CMO's initial meeting with the Prime Minister regarding the outbreak had occurred the week before. To provide context, the focus of Government's operational efforts at this time was on the repatriation of travellers from abroad and the establishment of suitable quarantine facilities. The World Health Organisation would not declare a pandemic for another month.

5.4. Given the passage of time, I am unable to recall the ASC meeting of 11 February and so can only comment on the readout of it **[JH11/004 INQ000049363]**. The following features of that readout stand out to me. First, the tripartite plan notes that there was no substantive dedicated G6 (a role ranked below a Deputy Director role) or team in place for the adult social care response. That lack of dedicated resource in respect of ASC is further evidenced by the need to move over an EU exit team to work on putting in place the necessary staffing and resources, which was only available at that time until March. The most recent 'reasonable worst case scenario' ("RWCS") slides that morning had recognised that the pressure points from Operation Cygnus included ASC and community services but the remainder of the slides mentioned social care only briefly **[JH11/005 INQ000575554; JH11/006 INQ000575555]**. They did however observe that both the health and social care sectors would likely face higher levels of absence in the RWCS. They also noted that "*social care will need central oversight that covers local authority and private care providers*".

5.5. This commentary reflected the fact that DHSC had until 2018 been a health department (and indeed carried the name Department of Health). At the start of the pandemic it was, at least in my view, predominantly focused on healthcare rather than social care. In sharp contrast to the position with the NHS, ASC services were commissioned from a wide variety of independent and private providers over whom, from my understanding, central government exercised limited oversight or control. The bulk of ASC was commissioned by LAs and in my view there was limited understanding in DHSC of the interaction between ASC and local authorities, how

such services were commissioned locally, and in some regards about ASC generally. The Department's more detailed understanding related to regulatory matters concerning ASC, for example the activities of the Care Quality Commission ("CQC"). Relationships between DHSC and ASC providers were not well developed in the same way as they were with the NHS, which had much closer relationships with DHSC with and through NHSE. There was also a clear lack of centralised data relevant for the rapid assessment and response required in the event of a pandemic.

5.6. The ASC meeting on 11 February set out the three strands of the approach to COVID-19 in adult social care, namely: (i) raising awareness in the sector to promote prevention; (ii) preparing for the RWCS planning assumptions; and (iii) putting in place appropriate staffing and resourcing. The readout suggests that the initial intention was to manage the response in local authorities with a degree of national coordination rather than lead from DHSC **[JH11/007 INQ000151448]**. It also records my view that "*there are some difficulties around informal carers and domiciliary care, in particular a) around how isolation would work, b) the lack of information flow between private sector care providers and LRFs and c) what the triggers would be in RWC*". The Inquiry has asked me to expand on what I meant by those concerns.

5.7. First, I was very aware that there were hundreds of thousands of informal and domiciliary carers looking after even larger numbers of people who were being cared for outside residential care settings. These are people who, although living in their own homes, still require some social care support, some of which will be provided through formal care providers but with a large part provided through family or other community carers. That social support is vital in maintaining an individual's ability to safely live in their own home or to understand and take appropriate preventative action. Further, there was (and is) a large body of people who, although living independently, benefitted from critical social support in connected informal settings e.g. lunch clubs. Such individuals would struggle, physically but more likely mentally, if required to isolate and that support was withdrawn. For those dependent on receiving close personal care at home, having rigid restrictions e.g. an inability for others to visit someone else's home was potentially going to be very problematic. Put simply, you cannot safely isolate someone who needs assistance with their activities of daily living. There will always be a need to balance protection against infection with the necessity of their continued support. My response was to highlight these issues centrally and to seek to connect DHSC with those individuals in PHE who knew how

the care system worked and who routinely engaged with LA DsPH. That was intended not only to assist with consideration of safe domiciliary care provision but also to utilise existing work on supporting hospital discharge into the care sector to ensure systems with appropriate knowledge were effectively aligned.

5.8. Second, there were not, as there were for NHS healthcare providers, clear mechanisms for the flow of information and data from private sector ASC providers to government. The vast majority of care homes and ASC services are privately provided. Relationships were not developed in the same way even with the large private providers. Some informal or domiciliary carers would be 'sole traders' with essentially no relationship with DHSC and potentially unrecognised in the care system as a whole. There were very limited routine data flows out of ASC and no requirement to report the sort of service activity data on a daily basis that would be needed to understand the progression of a pandemic within an appropriate timeframe. I knew of no requirement to send that data to the LRF. The LA would have access to some data, including contract audit reports, but that was designed for a much slower moving management scenario than was needed by a pandemic response.

5.9. The proposal for information to flow via LRFs in my view demonstrated a lack of understanding of how the LRFs worked. From this, and from earlier work with critical incident management in relation to those returning from Wuhan, it seemed to me that many in DHSC were unfamiliar with the practical representation of those bodies which formed the LRFs. Nor was there an appreciation that there would be no additional resource should the pandemic become serious and that each senior representative would also be required to run their own part of the response system *in extremis*. In practice, and despite the formal Civil Contingency response arrangements, the LRFs could not be a full local solution because their membership e.g. the NHS, LAs or emergency services were likely to be overwhelmed with their priorities being elsewhere. They did however deliver some critical work for the ASC response for example ensuring LFD availability for non-residential settings, particularly in rural areas.

5.10. Third, I was concerned that if the RWC planning assumptions materialised, then it was unclear what the proposed triggers for activation of the response should be. This was a wider problem during the pandemic where different waves might affect different

geographies or cohorts of the population to varying degrees and it was therefore difficult to apply national rules as to how to act (to a large extent the later 'tiers' approach addressed this issue). Given the important balance between prevention and accessibility required in many settings, whether healthcare, residential care, schools or similar settings the application of principles – rather than triggers - to be applied in the local context was usually more effective.

5.11. Also at the meeting of 11 February:

(a) David Lamberti commented that there were *"likely three ways that the virus could enter a care home (infected people moved into homes; staff; visitors).* That was in my view uncontroversial and a statement of obvious fact – it simply identified the three main groups of people who would be entering care homes;

(b) the need to provide clinical guidance to cover what should happen when a case occurred in a care home was identified. I cannot recall who raised that idea but it was to my mind a sensible observation, as was the intention to explore the practical consequences of the options under consideration; and

(c) whilst the action in response to that need was recorded in the minutes as being for me to draft clinical guidance, that practical action would not have been my usual role as DCMO. My action in response was to link the PHE guidance cell who would have led on the actual drafting to the DHSC ASC team. Broadly speaking, as DCMOs we reviewed and commented on guidance produced by others rather than being responsible for the production of guidance ourselves. Given the differential understanding, I perceived my main role in the response at this point was to ensure that the correct people in DHSC were in touch with those in PHE (or elsewhere) who understood the ASC system and who would be able to assist in the production of the necessary guidance and in due course for me to review that guidance and advise DHSC or MSC whether there were obvious omissions or improvements that could or should be addressed **[JH11/008 INQ000575564; JH11/009 INQ000575565; JH11/010 INQ000575567]**.

5.12. More generally, as I stated in my Module 2 witness statement, it appeared to me that in the early phase of the pandemic few people in DHSC had direct or practical experience of having worked in or with care homes, the commissioning of care home services, understanding the local connections which would underpin the ASC emergency response (e.g. LRFs, LAs, DsPH) or the routine support they might

expect from local systems (e.g. Health Protection Teams in LAs or PHE). Certainly, as far as I could understand, no one seemed to appreciate that whilst there was some CQC regulation of registered healthcare providers in relation to preparedness and infection control, if the underlying architecture of ASC provision relied on a dispersed private business model there was inevitably very limited routine focus on detailed, connected or coherent pandemic response plans. This was akin to any other private business (e.g. a retailer) and was compounded by the number of ASC providers which were small or medium sized enterprises. The effect was that local pandemic plans within ASC settings tended to be underdeveloped (albeit given the number of providers, there are likely to have been instances of very good practice). Whilst, care homes and other care settings did already have guidance on outbreak controls, IPC and other practice relevant to routine care, particularly in the winter months, my perception was that the challenges associated with an event on the scale and with the interconnectedness of a global pandemic were less clearly understood.

5.13. I have been asked for my views on the extent to which the apparent limited understanding of the ASC sector by DHSC impacted on early strategic decision making by the UK Government. Whilst I think DHSC gave ASC due and timely attention in the early stages of the pandemic, in my view the lack of data and limited understanding of how the ASC sector practically operated meant that the ASC response required considerable and urgent efforts in that early period. Had similar efforts been made prior to the pandemic, they would have provided a solid platform from which to build the pandemic response. In short, a more balanced focus to DHSC's work which included ASC as opposed to just health would have provided a better starting point for both the ASC and hospital response to COVID-19. That said, the speed and scale of improvements introduced during the pandemic were in my view amongst the fastest and most meaningful in the course of the pandemic.

5.14. Although my role was advisory and not an operational one, I was emailed the day after the meeting of 11 February 2020 seeking my input into operational guidance for the ASC sector on how to respond to a confirmed COVID-19 case in a care home or private residence (the latter being in respect of domiciliary care) **[JH11/011 INQ000575558]**. I replied making the following observation:

"*The Perm Sec commissioned task from a clinical perspective probably has two main elements:*

- *One is about appropriate earlier containment phase handling of cases in the same way there is guidance for flu, particularly in nursing and residential care homes and vulnerable adults; also safe handling of people isolated in their home environments*
- *The second is about managing large numbers of cases in the face of an epidemic which would include decanting as clinically safely as possible large numbers of patients from wards to the community and social care sector and then potentially onwards to the domestic and third sector.*"

5.15. I also observed that the steer from the meeting the day before had been that the ASC response would be managed locally but with the benefit of national guidance.

5.16. I echoed those sentiments in an email I sent PHE on 12 February stating "*There is some early discussion in DHSC about wider planning across the health and care system for a pandemic (ie the mitigation phase) and I am going to work with Social care colleagues internally to identify clinical parameters around cohorting, decanting, residential care home closure etc. The ambition is that in general, although there should be national guidelines, it will be local system oversight to enable the infrastructure and partnerships already working together to best manage demand*" **[JH11/007 INQ000151448]**.

Discharges from hospitals to care homes

5.17. On 14 February 2020, after being asked to support the discussions on ASC planning in the RWCS, I contacted colleagues at NHSE and PHE to request further information on their pandemic preparations and how these would interact with the ASC sector **[JH11/012 INQ000151466]**. I was concerned that the two would be developed in isolation given the usual higher focus on acute hospital care. In that email, I observed that the interface between central government and the ASC sector had been weak in Operation Cygnus, something reflected in the June 2018 influenza briefing paper **[JH11/013 INQ000105391]** and again noted in the RWCS slides presented on 11 February **[JH11/006 INQ000575555]**. That reflected many of the observations I have made above as to the degree of interaction between the ASC sector and DHSC and the nature of ASC in the UK.

5.18. In that email I also observed that: *"I am very aware of the critical interdependencies between 'decanting' less ill patients from the acute sector out to community and social care systems… I do not have sight of any of the detailed planning I know you have been working on in NHSE".*

5.19. It is normal practice in the face of any emergency which is likely to put pressure on hospitals that a focus is applied to freeing up hospital capacity by discharging back home those patients who do not need to remain as inpatients and indeed who may be at increased risk by remaining in that environment. There are at any time many hospital inpatients whose acute medical problems have been resolved but who are waiting for social support in the community in order to allow them to be discharged. It was clear to me from both technical public health knowledge and practical experience of work in the acute hospital sector, that demand on hospitals would rise rapidly in the event of a severe COVID-19 wave and that there would be a foreseeable need to free up capacity by discharging these patients back into the community. To this extent, it was something which was always known to be a realistic possibility as soon as it became apparent that COVID-19 was likely to be a serious public health concern.

5.20. It followed that expansion of hospital bed capacity was planned almost immediately with the same view in mind. My concern was to ensure that the continuum of care was being adequately considered in a pandemic from the hospital front door through to discharge back into the patient's normal residential setting. For many of our elderly and frailest population this would be to a residential and/or nursing care setting. Such a policy would be entirely appropriate but would inherently depend on having the necessary capacity in residential and domiciliary care services – something which is often not the case even in normal times. I was trying to establish what NHSE were planning in this regard because I had heard of ongoing work on the issue but had not had sight of it. I was concerned that there needed to be link up between DHSC, PHE and NHSE to ensure that any NHSE planning would align with that for ASC. Hence my sending this email on 14 February 2020 to Professor Sir Keith Willett and Stephen Groves at NHSE.

5.21. Professor Willett responded pointing out that at any given time about 5% of NHS beds (approximately 5000 beds) may be occupied by patients awaiting either care packages or care home placements **[JH11/014 INQ000575562]**. It may be helpful to

repeat what I observed in my Module 3 personal witness statement about the logic of discharging patients when they are fit to do so.

5.22. Firstly, at times of extreme demand, there is a clear and obvious benefit to making beds available for the patients that need them. Put simply, if patients appropriately arrive at the hospital for care and cannot be accommodated, they are likely to become at greater risk of harm. When there is a sudden demand on bed capacity, for instance at the beginning of a pandemic or following a multi-casualty event, preventing this heightened demand from going unmet by freeing up beds through the discharge of medically fit patients is clearly logical.

5.23. Secondly, it is well established that keeping medically fit patients in hospital when they do not need to be there is detrimental to their health. There are a variety of reasons for this. Patients in hospital are inevitably more sedentary, and so at greater risk of various conditions including deep vein thrombosis and pneumonia. They are, at least to some extent, deprived of their autonomy and freedom, that deprivation in itself being undesirable without good reason. Patients in hospital are deprived of the benefits of their normal surroundings. For some elderly patients, those recovering from clinical states of confusion or infection, and those with dementia, it can be of particular importance to be in their normal environment. It is well evidenced that for some, physical and mental stress and deterioration can follow any reduction in their time spent with trusted, recognised carers. Further, being an inpatient exposes an individual to the risk of hospital acquired infections. This was all the more so in an infectious respiratory pandemic, where cases were foreseen to be necessarily actively admitted to the hospital on a recurring basis. Remaining in hospital when fit for discharge therefore exposes patients to an avoidable risk of harm. Even in normal times, prompt discharge once a patient no longer requires hospital admission should be seen as the norm and something to be encouraged.

5.24. Thirdly, it is important to remember the context in which decisions were being made in March 2020. As of 16 March 2020, SAGE was advising that there was a real risk of NHS capacity being exceeded **[JH11/015 INQ000075664]**. There was therefore an imperative to increase NHS capacity where possible and discharging those patients who were medically fit was a sensible tool to achieve this.

5.25. It follows that I think it would be unfair to characterise the Government's initial strategy as primarily focussing on issues of NHS planning and surge capacity to the detriment of minimising the risks and impact of COVID-19 on those working and in receipt of ASC. For the reasons outlined above, the desire to increase capacity was reasonable and would be the normal response to any major incident likely to stress the healthcare system's services (e.g. any mass casualty event). It also avoided having large numbers of vulnerable people unnecessarily in hospitals and so exposing them to the risk of nosocomial infection and other harms. Lastly, I did not consider it inherently an unreasonable ask of ASC to isolate infectious cases. Most providers would have been familiar with the sort of routine infection control policies in respect of respiratory, skin and gastrointestinal infections and would have some understanding of things like isolation and cohorting in that context. Insofar as the initial strategy in terms of ASC was underdeveloped, that was to my mind a reflection of a long-term systemic inattention to ASC.

5.26. The Inquiry has asked about the extent to which consideration was given to expanding the bed capacity of ASC services through the use of hotels, military establishments or other real-estate. It is logical that there would have been discussions about increasing bed capacity in all sectors, including ASC, in the face of a pandemic. However, I do not recall being involved in any detailed discussion on this issue. In general, I would observe that the limitations on the capacity of the ASC sector were driven by the availability of staff rather than premises. Regulation of ASC providers by the CQC was not part of my portfolio as DCMO.

Testing hospital patients prior to discharge

5.27. I understand that it has been suggested that those patients who were fit for discharge should have been kept in hospital or tested prior to discharge. It is important when considering such a suggestion to avoid hindsight and there were, at the time, practical difficulties which would have made the adoption of such measures unfeasible:

(i) there were, as of March 2020, very few tests available. They were primarily needed for diagnostic purposes to identify which patients had COVID-19 in order to provide appropriate clinical care. Tests were therefore not available to test people prior to discharge. Even if tests had been performed, there would then have been a period during which the individual could have

acquired the disease in hospital whilst awaiting their result after they were tested, even if that initial discharge test subsequently returned a negative result;

(ii) similarly, a negative test would only have identified that the individual was not positive at the time the test was performed. It could not differentiate whether an individual was incubating the disease at that time having already been infected and so would become unwell shortly thereafter. Those returning a negative result could reasonably have posed a risk of developing a positive test and of being infectious in the 10-14 day period following discharge and therefore onward isolation was of more importance in transmission control than a single negative discharge test; and

(iii) there was no appropriate place to accommodate such patients pending their test result. Whilst some patients may have been self-caring, others would have required significant nursing care in order to be kept safe (indeed, this is why many required discharge to nursing homes). This was at a time when there was a pressure both on the availability of beds and staff in hospitals.

5.28. It is also important to note that subsequent analysis has shown that the majority of infections introduced into care homes came not from the discharge of medically fit patients from hospitals but were unwittingly imported by staff **[JH11/016 INQ000234332]**. I will address this in greater depth below. There was therefore strong logic, subsequently evidenced, in rolling out routine testing approaches to health and social care staff as a priority testing intervention.

Mid-February to early March 2020

5.29. On 18 February 2020, I attended a meeting at which the urgent need to develop guidance and a RWCS for the adult social care sector was discussed. This involved further consideration as to the impact on adult social care should NHS pressures become so great that patients needed to be moved into community settings in order to relieve pressure on acute hospital beds **[JH11/017 INQ000151491; JH11/018 INQ000575561]**.

5.30. On 19 February 2020, I emailed DHSC in respect of the urgent need for ASC guidance in the event of a RWCS and for the ASC sector to plan in anticipation of the NHS needing to discharge patients to the community **[JH11/019 INQ000575563]**.

5.31. On 25 February 2020, guidance for social or community care and residential settings was published **[JH11/021 INQ000223341]**. Whilst I was aware that guidance was in production, I do not believe I was heavily involved in its drafting and it would have been normal for me not to be. Whilst I did ask to see it prior to its publication, and have clearly reviewed some of the clinically relevant content during development, I have not been able to establish if I reviewed the final version before its publication by PHE **[JH11/009 INQ000575565; JH11/022 INQ000575566; JH11/023 INQ000575568; JH11/024 INQ000575569]**.

5.32. On 3 March 2020, I emailed colleagues at PHE to highlight developments around a planned assurance process for social care resilience within the LRF organisational structures. I had requested and obtained support for a PHE regional director ("RDPH") representative with the right experience and background to join LA CEOs, Directors of Adult Social Services ("DASSs") and integrated care system representatives with support from the Association of Directors of Public Health ("ADsPH") in providing input to such a framework. The intention was to proactively ensure alignment and practical assurance across the health, public health and social care interface based on the practical reality of frontline organisation and operation **[JH11/025 INQ000151531]**. In that email, I set out my concern that there was *"very little understanding of the processes at LRF levels within DHSC"*.

5.33. I cannot recall precisely what prompted this comment given the passage of time. However, it is likely that the thrust of my concern was a perception that DHSC's intention was to simply seek assurance from the LRFs that social care provision was adequately prepared for COVID-19 in their areas. As I touched upon above, that did not recognise that LRFs comprise the same individuals who would be occupied by their day jobs in any pandemic and who would have no additional personnel resources should the RWCS manifest. The assurance was to be built from 2018 pandemic plans and where the majority focus was theoretical rather than practically exercised. They would therefore be poorly placed to provide robust assurance to DHSC on ASC matters of deep practical response capability. For that reason, I was trying to encourage the inclusion of practical public health input at a local and regional level to the assurance process being developed.

5.34. 3 March 2020 also saw the publication of the 'Coronavirus Action Plan' **[JH11/026 INQ000057508]**. My first sight of the finalised document was around 28 February 2020. I advised on a draft on or around 26 February **[JH11/027 INQ000047878; JH11/028 INQ000047879]**. Although I was not heavily involved in its initial development, I agreed with its principles.

5.35. On 6 March 2020, I attended a meeting led by the Secretary of State at which he stated that the impact of coronavirus posed *"a complicated set of problems on the social care sector due to the higher risk for older people and the need to be gripped as soon as possible"* and it was further noted that there was need to *"ramp up preparedness around social care"* **[JH11/029 INQ000049530]**. At that meeting:

(i) I contributed a number of key observations or concerns which focused on:

a) the recognition of significant vulnerability in both residents and staff and that average final length of stay for a resident in a nursing home setting is 7-12 months. For residential but not nursing homes, this is approximately 2.5 years. Both have wide variability;

b) the recognition that more clients are provided for in domiciliary settings than in residential care homes and therefore this also needed to be considered;

c) the importance of the workforce and understanding the context in which it operated. This included the known shortages, the likelihood of increased demand, that even in nursing and residential care settings most staff were not clinically trained, and the risk of 'double counting' staff given that many workers moved regularly between settings (e.g. hospitals and care homes) and hold down multiple jobs; and

d) that care workers were amongst the lowest paid and that without financial support they may continue to work at risk rather than isolate for fear of loss of income;

(ii) the minutes record: "*DCMO JH flagged that the majority of the people that we're talking about are receiving domiciliary care too. SofS agreed that we should be thinking about this in the following hierarchy: residential Home, nursing home, domiciliary care".* Given the passage of time, I am concerned not to speculate on the thinking behind statements attributed to others including the Secretary of State;

(iii) It was agreed that there was work to be done on the following: workforce; financial support; excess deaths; data; support for non-Covid-19 illnesses;

equipment e.g. PPE and oxygen; LRF readiness; collaboration with providers; communications and the Coronavirus Bill. The Inquiry has asked why this did not include IPC measures or the isolation of symptomatic residents in care homes. Again, given the passage of time to answer this question risks speculation, which is not particularly helpful.

5.36. On 8 March 2020 I received an email from Rosamond Roughton (Interim Director for Adult Social Care at DHSC) **[JH11/030 INQ000325228]**, outlining several concerns about the adequacy of the February 2020 guidance and the general concerns of the ASC sector. It would be for ASC providers to comment on the extent to which the guidance met the sector's needs. I can only observe that if it was being reported to her that there were concerns as to its sufficiency then the implication must be that it was not. I was aware that DsPH had raised a request for greater clarity in some of the guidance and I shared this with Ros Roughton and wider colleagues at the meeting led by the Secretary of State on 6 March **[JH11/030 INQ000325228]**. This issue was raised again two days later at the Permanent Secretary meeting on 10 March 2020 and I would note that with the continually developing nature of the pandemic at this time any published guidance became rapidly out of date **[JH11/031 INQ000575571]**. One issue was around the advice to avoid direct or close contact within 2 metres of another individual to reduce the likelihood of viral transmission. That reflected the inherent tension between on the one hand advising steps which were thought to be protective (in circumstances where the population in care homes was highly vulnerable to COVID-19) but on the other hand accepting that for many close personal care simply could not be withdrawn. Application of the guidance required a balancing exercise in extremely difficult circumstances. I summarised the issue in my email timed at 12.16 that day:

> "*Fully understand the face to face needs of individuals, but to be honest with a 30% best estimate mortality rate in care homes where assessed, we do need some really balanced consideration of this issue. It may be that we could identify units eg some dementia wards, where the personal contact is essential for behavioural interaction and wellbeing and demise imminent without it, and the risks of mortality from COVID-19 and mortality from condition are balanced and recognised. Not easy.*"

5.37. The Inquiry has asked about my response to that email in which I replied: *"... In the early part of the epidemic … we will have more care workers who are susceptible to illness themselves and at risk of passing it on. Once we are over the peak we should have a cohort of those who we know have had disease and could be safely reprioritised to care for the most vulnerable groups without fear of passing on the disease or contracting it themselves..."*. At that time, we did not have detailed data on which to base our recommendations. It was however reasonable to assume that once a care worker (or anyone) had had the infection and recovered, there would be some period, albeit potentially temporary, where there would be a lower risk of onward transmission or reinfection in that individual. That might allow for their return to work with a lower short term risk of passing on the virus or catching it themselves and could provide some assistance to what was anticipated to be very serious and acute problems with staffing in the first wave. In the event, that was borne out - our clinical experience was that reinfections tended to happen after a period of immunity following primary infection but this varied significantly with different variants. Reinfection rates were low after the initial wave but rose considerably with the arrival of the omicron wave.

5.38. On 9 March 2020, I had a meeting with colleagues at PHE in respect of new COVID-19 guidance for social or community care and residential settings and provided comments on it **[JH11/032 INQ000151562]**. I provided further input on guidance for those in supported living on 12 March 2020 **[JH11/033 INQ000151578; JH11/034 INQ000151579]**. On 13 March 2020, the February guidance on social or community care and residential settings was superseded by three pieces of guidance: (i) COVID-19: guidance on residential care provision; (ii) COVID-19: guidance on supported living; and (iii) COVID-19: guidance on home care provision' **[JH11/035 INQ000300278; JH11/035a INQ000325235; JH11/035b INQ000325234]**. That guidance was published in tandem with the decision taken at that time to move from 'contain' to 'delay' also. It was about this time that, separately, a formal scientific review of the high consequence infectious disease ("HCID") status of COVID-19 was undertaken and it was subsequently reclassified as not being an HCID. The Inquiry has asked me to consider the timing of the guidance in relation to both those points.

'Contain' to 'Delay'

5.39. I do not recall being actively involved in decisions around the timing of the publication

of this guidance and overarching control of publishing timetables sat with the Cabinet Office. I would have generally been keen to progress the publication of guidance in a timely manner. I can however make the following observations:

(a) first, although draft guidance had been prepared by PHE earlier, it appears that changes were being updated by DHSC ASC colleagues and that in the OCMO, I and possibly other colleagues were still making comments on the supported living guidance as of the evening of 12 March 2020 **[JH11/033 INQ000151578]**. I understand that what was initially one piece of guidance was ultimately divided into three separate pieces (COVID-19 guidance on home care provision; COVID-19 guidance for supported living provision; COVID-19 guidance on residential care provision). That tends to suggest to me that this section of the guidance was not fully signed off and ready for publication several days prior. Frequently, it will be better to wait until the guidance has been properly considered before publication rather than prioritising speed of publication over consideration of the guidance's content and implementation;

(b) it is of public health importance that messages land clearly. There has been a similar discussion as to the pros and cons of publishing guidance, particularly operational guidance affecting numerous different stakeholders, in Module 4 in relation to the vaccines programme. The same key points apply here – that there can be risks in both directions, going too early and going too late, and that an effective balance has to be struck on each occasion where the context is fast moving. This is a common problem in the communications relating to the management of many routine outbreaks of far lower complexity than COVID-19. I note that **[JH11/036 INQ000223344]** refers to five pieces of guidance being published in tandem. There can be logic and benefit in publishing guidance in parallel so that it lands with a greater impact. That can assist in raising awareness of the guidance in those on the frontline with the result that they are more likely to implement it; and

(c) delays in publication can be accompanied by pre-discussions with relevant third parties such as those who will be implementing the guidance. In and of itself that can be valuable if (i) their views are inputted into the guidance and (ii) they are then expecting the guidance at the time of publication and can have local systems better prepared for more rapid implementation with greater clarity. That in itself can also protect lives.

5.40. I am not aware that any interim guidance was published between 4 March 2020 and 13 March 2020. Indeed, the documents I have seen suggest to me that the guidance was not 'system ready' as of 4 March and continued to be developed **[JH11/037 INQ000575894; JH11/038 INQ000575895; JH11/039 INQ000575893]**. The Inquiry has asked whether, on reflection, any delay to the publication of the guidance may have placed the ASC sector at risk of harm. In my view that is impossible to know, but it does not necessarily follow that a delay (if there indeed was one given my observations above) placed the sector at greater harm, or overall provided benefit:

(a) appropriate clinical case management of those affected in the care home setting would have continued in a similar manner whether or not the new guidance had been published sooner. The case definitions, pathways into hospital care and management of an outbreak in a care home with specialist support from health protection team specialists in PHE Centres were ongoing and will have occurred independently of the guidance and irrespective of the date of its publication;

(b) whilst there was clearly community transmission at this time, the greatest risk would have been from ingress by staff and staff movements. Those risks were increasingly appreciated and mitigated later as the pandemic, and associated evidence, progressed;

(c) as I outlined above, the extent to which the updated guidance was recognised and complied with by ASC providers may have increased due to the prominence afforded to it by the concomitant move from 'contain' to 'delay'. Timing its publication with moves in the rest of the system has the potential to be very beneficial for awareness, risk understanding and adoption of the new interventions; and

(d) any specific harm or benefit occasioned by the delay is something of an unknown and would also vary dependent on a myriad of other factors such as patient cohort and geographical variation in and near the specific local setting described.

HCID

5.41. To assist the Inquiry, I have repeated some observations described in the second corporate witness statement provided by the CMO and submitted on behalf of OCMO for Module 1 of the Inquiry, with which I agree **[JH11/040 INQ000184638]**.

5.42. A novel emerging infectious disease is likely to be treated as an HCID whilst its characteristics are still becoming known. That is a sensible and prudent measure when case numbers are limited, and the disease's epidemiological properties are uncertain. It is sensible to act with an abundance of caution – there is much to gain if, with the benefit of growing evidence, the disease is found routinely to be characterised by the criteria relevant to an HCID, and the relative downsides of a cautious approach are few in circumstances where the number of cases are low.

5.43. Thereafter, it will be important to maintain an HCID designation where appropriate. Typically, this will be for diseases with a very high infection fatality rate. It is for this reason that certain haemorrhagic fevers, Ebola, MERS and pneumonic plague remain on the HCID list. These diseases often have a case fatality rate in the general population which exceeds 1 in 10, in many cases by some margin.

5.44. It is important however to differentiate the risks posed by a disease such as COVID-19. Whilst COVID-19 was a serious public health threat, its fatality rate was not of the same magnitude as those other diseases on the HCID list. The HCID list records high mortality and usually low UK prevalence infectious diseases. It is these types of diseases which categorisation as a HCID and (should cases arise) management in the HCID network are intended to address. Treatment protocols for those with an HCID requires ill patients to be transported to specialist units around the country for admission in appropriate accommodation. Managing patients in a HCID setting is highly resource-intensive, and the provision of such specialist beds is highly limited.

5.45. Given the above I do not consider that the recategorisation of COVID-19 as an HCID had any detrimental impact on ASC settings. Its recategorisation was an appropriate step in circumstances where COVID-19 did not fit the HCID criteria and one which enabled far greater testing and allowed patients to be managed appropriately.

Mid-March and April

5.46. On 16 March 2020, when case numbers were rising acutely one week ahead of the first lockdown, I was contacted by colleagues at DHSC regarding the potential future management of those in care homes who were elderly and likely to require onward residential care. As discussed above, this was because in the event of a catastrophic rise in case numbers it was likely that, to maintain hospital capacity effectively, less

acutely ill patients would need to be returned to their usual residential settings, including care homes where relevant as described above. Given no one currently planning the response had themselves previously lived through or managed a pandemic of this potential size and impact, I felt it was important that colleagues not trained in public health had in their minds what sort of numbers and interventions might need to be implemented in order to maximise protection within the services and resources available to the country. DHSC's working assumption was that appropriate discharges would require strict infection control once patients were transferred from the NHS. In response, I confirmed my understanding of this approach to manage overall clinical risk and capacity, being aware of the exponential rise in COVID-19 cases in the UK and having observed the early experience in Northern Italy and other countries where care demand had been overwhelmed **[JH11/041 INQ000151606]**.

5.47. In my reply, I confirmed the sender's impression that such discharges would require very strict infection control. That was not a reference to any specific guidance at the time – including that of the 13 March COVID-19: guidance on residential care provision **[JH11/035 INQ000300278]**.

5.48. The Inquiry has asked about my involvement in the Covid-19 Hospital Discharge Service Requirements published on 19 March 2020 **[JH11/043 INQ000049702]**. This was an NHS owned document and, save insofar as I tried to find out about its content so as to draw others with relevant expertise into the early development conversations, I do not believe I had significant input into its content or that I saw it to clear prior to publication.

5.49. As to the guidance titled 'Responding to Covid-19: the ethical framework for adult social care' published on 19 March 2020 **[JH11/044 INQ000106252]**, I had only short sight of this the day before publication and so was only able to provide brief comments **[JH11/045 INQ000575572]**.

5.50. Later, other guidance which supplemented this was developed by DHSC. This provided more detailed advice to care homes on the admission of residents and was presented to me albeit relatively late in development **[JH11/046 INQ000575573; JH11/047 INQ000109223; JH11/048 INQ000575576; JH11/049 INQ000575579; JH11/050 INQ000575580]**. I was concerned that the guidance needed to be clear,

consistent and safe and so, even though I was asked to clear quickly for urgent publication, I raised a number of detailed queries in parallel to MSC. In particular these concerned precise advice on isolation of residents. I continued to advise on that point up to 2 April 2020 where, working directly with PHE, I reviewed and advised on the isolation period in care homes and whether it should be required for 7 or 14 days **[JH11/051 INQ000151702; JH11/052 INQ000151703]**:

"The agreed position is as follows:

- *The 7 days isolation period will normally apply but*
- *The elderly and care home setting is a particularly vulnerable group of patients and the setting at higher risk of onward transmission and severe disease*
- *And the elderly immune response may differ from younger normally healthier individuals therefore*
- *A 14 day period of isolation (either when discharged well or to complete a period of isolation).*

In summary the 14 day period in this document is now agreed and Susan Hopkins has added a note.

It will match NHS discharge documentation which is due to be finalised shortly

It does raise a slight concern in my mind about consistency with some other settings advice already issued eg the elderly discharged direct to domiciliary care which we are now supporting should include 14 days isolation wherever possible (although many of them will be shielding or operating stringent isolation anyway)"

5.51. On 23 March 2020, I emailed DHSC and PHE identifying the need for decisions in respect of PPE in hospitals to take account of the impact on individuals who would be facing a similar exposure in the ASC sector. My email stated:

"Although I recognise I am sounding very much like a stuck record, I am really concerned that whatever adjustments are suggested to be made on the health side must be considered, before recommendation and implemention [sic]*, for impact and inequality for similar risk exposure on the care side. When these*

are done together it is the combined PPE requirement which needs to be considered for all similar risk exposures eg NHS acute, community, primary care plus nursing care, residential care and all domiciliary care including all private and non-state funded provision. It will be unhelpful to recommend a change to manage angst amidst healthcare workers if we then have insufficient supplies to implement fully right across all relevant similarly exposed workers, care or health" **[JH11/020 INQ000151633]**.

The Inquiry has asked whether that email received a specific response from DHSC or PHE. For DHSC, I can see that the email was acknowledged the following day **[JH11/052a INQ000593243]**. I and my team have been unable to identify a response from PHE in my emails over the following two days.

PPE

5.52. It is convenient to begin by explaining what role as DCMO I would have had in advising on PPE. As I described in my Module 2 statement, it is my understanding that in general central government does not commission care services directly and has not previously taken formal responsibility for PPE funding, procurement or provision on behalf of the care sector. At local authority level, this would likely only arise as part of a specific contract if the authority sought to exercise its responsibilities in this way. The national PPE stockpile, which I have previously understood to cover contingency for those services for which DHSC has taken routine formal responsibility i.e. NHS delivered and commissioned services, was overseen by DHSC colleagues. I had no personal link to the acquisition or general distribution of PPE but public health colleagues (i.e. from PHE) would advise on technical aspects of its makeup. Where my role could align would be in relation to considering the evidence base for guidance (for example that which PHE technical experts proposed), and new evidence that arose during the course of the pandemic, highlighting potential areas where there were research gaps and, wherever possible, trying to ensure alignment of rationale and advice both within the different parts of the care sector but also between health and care sectors. As DCMO this was again an advisory rather than operational role.

5.53. I was however aware of the importance of PPE availability in the face of a growing pandemic and worked closely with colleagues in PHE, NHSE and across the Devolved Administrations to try to ensure clarity of message and rationale. I also

contributed to discussions on stock distribution through LRFs to ensure more remote care workers were able to access PPE.

5.54. On 1 April 2020, I and others provided comments to DHSC on a "dear colleagues letter being drafted to go from the Secretary of State for Health to MPs to update on emergency response preparations. The content was centred on the acute health sector. Amongst other comments, I flagged both the omission in the draft, and the critical importance, of ensuring that care staff and the criticality of their work to the nation's response was recognised in all correspondence, planning and announcements **[JH11/053 INQ000151693; JH11/054 INQ000151694]**.

I noted in my email response:

"I would just like to reiterate that without the care system keeping clients/patients at home and accepting rapid discharges from hospital the NHS will quickly become overburdened however many ventilators, treatments or staff we have acquired. Therefore we need to ensure that care staff outside the acute sector are continuously mentioned throughout any public and formal correspondence — care homes are already anxious about accepting covid-19 discharges and we are not yet seeing epidemic size patient influx.

I have made some suggested tweaks on the attached copy but I do think we should be do an 'equality' check for NHS and care staff on each document — without their support the whole of the life-saving plan falls over."

In my comments in the draft letter I observed:

"*The out of hospital care sector, whether in care homes or domiciliary, will be critical in stopping patients appropriately going into hospital and supporting rapid discharge when acute bed capacity is critical. The two [workforces] are inextricably linked but we alienate one very regularly."*

5.55. My view was that staff in the ASC sector were just as important to the pandemic response as those in the NHS and that while the Minister directly responsible (MSC) would similarly flag these concerns, they were often forgotten about in wider communications or not as frequently given the appropriate level of consideration. I

also felt that there was a perception amongst care staff and organisations that they were not being recognised and this was something reinforced by them not being mentioned in press statements, Ministerial announcements or even public expressions of thanks. Often the focus was on the NHS and there was a risk of minimising the contribution of the ASC sector. It was for these reasons that I would often try to encourage a recognition of the efforts of the ASC sector by others and would try to do so in my own public comments.

5.56. In relation to my comments above, I have been asked by the Inquiry whether reiterating to the care sector in public and formal correspondence the importance of them accepting rapid discharges from hospitals may have put undue pressure on care homes to accept hospital discharges against their wishes. In my view that interpretation is erroneous. For my part, I sought to advocate for the ASC sector within government and more widely and for me a problem was that there was insufficient mention of the sector in correspondence. My own experience was that it was never the intention of government to pressure care homes to accept discharges; there was an understanding that care homes managers were responsible for accepting (or not) an admission, and this was a perception government was alive to and was keen to prevent **[JH11/048 INQ000575576]**.

5.57. It has become apparent to me that there is a typo at paragraph 5.21. of the witness statement I produced for Module 3 of this Inquiry **[JH11/055 INQ000489907]**. That paragraph reads:

> *"On 4 April 2020, I had a conversation with the Minister for Social Care in which the issue of hospital discharges to care homes was discussed as well as the potential for nosocomial infection within the care home environment. Following this, I made enquiries with DHSC, GO-Science and the NHS about whether the SAGE nosocomial subgroup was already considering the care sector specifically or was planning to do so. The GCSA replied confirming the intention was to consider care homes and other healthcare settings outside hospital."*

5.58. The GCSA's email to which I am referring can be found at **[JH11/056 INQ000151701]**. It can be seen that there was a delay in his response, and that the date of my meeting with the MSC referenced in that email was actually 1 April 2020. This is further supported by the invite to a meeting on that date **[JH11/057**

INQ000575575] and the date of the materials circulated in advance, namely the draft care homes guidance **[JH11/058 INQ000575577; JH11/059 INQ000575578]**. I apologise for this inaccuracy.

5.59. I have not been able to locate the minutes of the 1 April meeting with the MSC in the documents available to me. That is unsurprising as I would have expected any minute to be taken by the MSC's team and so to be held by DHSC. With the passage of time, I am unable to comment with certainty on the detail of that discussion but both the Minister and myself were keen to ensure clear and accurate guidance was provided to mitigate infection risks in care settings and the two key points of discussion are logically (1) ingress risk to care homes and (2) transmission risk within care homes i.e. nosocomial infection. The guidance we discussed, 'Admission and care of residents in a care home during COVID-19', was ultimately published on 2 April 2020 **[JH11/060 INQ000575581]**.

5.60. At the time of this discussion there was limited testing capacity and therefore a detailed understanding of the transmission risk within hospital or care settings was only just emerging. Over time and with in-depth research it became clearer where and how that was occurring and for care homes the Easter Six and Vivaldi studies were critical to its consideration. It is likely that my inquiry at this point was because the Chief Investigator for CO-CIN had raised a concern that he may have spotted early indications of nosocomial transmission occurring in hospital settings **[JH11/056 INQ000151701]**. My email to Lord Vallance was proactive because I was keen to make sure the intention was for similar investigation and modelling to occur for care settings data. I was assured it would do and therefore there was no need for me to establish a parallel approach, and in fact the subgroup which looked at this data became the SAGE SCWG and subsequently focused almost solely on care settings and functions. As DCMO I had no operational, managerial or clinical responsibilities for care homes. However, I would have been alert to any significant changes in infection rate in hospitals (as here) and in communities and the latter would have included outbreak control information in care homes provided via PHE and then on to the OCMO. Through this request to GCSA, I was proactively seeking to address risks or concerns, and in particular to ensure any appropriate parallel work ongoing in the health sector was followed through in the care sector.

5.61. Within four weeks, at the NERVTAG meeting of 24 April 2020, PHE reported the initial

results on what was subsequently known as the 'Easter six' study. This followed focussed proactive research to try and better understand the prevalence of infection in care homes **[JH11/061 INQ000120161]**:

> *"swabs were taken in six care homes in London over the Easter weekend. All residents and staff were sampled and a total of approximately 500 swabs were collected. The six care homes were at different stages of outbreak. One of the homes had only identified two cases and had very few symptomatics. It was found that 75% of the residents carried the virus and only 25-33% were symptomatic. Approximately 45% of the healthcare workers were also carrying the virus, with 25-33% symptomatic."*

5.62. Of importance was the fact that while symptomatic staff were self-isolating, they were being replaced by bank staff who moved between care homes. This initial investigation provided an early insight into the characteristics of care home outbreaks and interventions which were subsequently explored in much more detail in the Vivaldi research study, a joint programme of work between UCL, PHE/UKHSA and other investigators with the principal investigator subsequently reporting findings directly into the SCWG. These studies were vitally important in informing our collective understanding of COVID-19 in ASC settings and would have informed the advice I gave.

5.63. The Inquiry has asked to what extent the ingress of COVID-19 into residential care settings had been foreseen and considered prior to April 2020. It was logical that a virus which could be transmitted from person to person via the respiratory route was likely to ingress into care homes. What was not known initially was the extent to which the elderly would be disproportionately affected by COVID-19. The impact on care homes would have been far less had this been a virus which impacted the young rather than the old. Whilst ASC settings would be expected to manage respiratory or gastrointestinal infections routinely, IPC skills and capacity were probably weaker than in the NHS. In most geographies specialist IPC skills and training capacity previously offered by some public health teams had decreased since the transition of public health from Primary Care Trusts to LAs. Even in residential nursing settings, the majority of care was provided by non-clinical staff. These were recognised systemic weaknesses. More focus on IPC in care service settings could not only have provided better preparedness for a pandemic but would likely also decrease the

demand for hospital care and improve quality of life for both domiciliary and residential care users by avoidance of unnecessary infection on a more routine basis. I had also flagged the makeup and social vulnerability of many of the care workforce at a meeting on 6 March 2020 **[JH11/029 INQ000049530]** and the associated foreseeable challenges to maintaining robust infection control in the care workforce.

Summer 2020

5.64. On 12 May 2020, the SAGE SCWG presented a care homes analysis paper to the 35th meeting of SAGE **[JH11/062 INQ000215643]**. I attended that meeting. The minutes record:

> *"19. Extensive testing of both residents and staff is crucial both in care homes which have reported cases and those which have not.*
> *20. Preventing cases coming into homes should be a key aim, with avoiding transmission within homes also important.*
> *21. Workforce management and behaviours are key factors in transmission. SAGE reiterated the need to minimise, and ideally avoid completely, staff moving between homes. This presents a challenge to the operating model of many care home providers.*
> *22. Working conditions in the sector similarly present challenges, including disincentives to self-isolate. Addressing these issues is critical to reducing transmission.*
> *23. Infection prevention and control procedures are important and should draw upon expertise from healthcare.*
> *24. There are other settings where similar issues may arise, such as domiciliary care, hostels, and university halls of residence. Similar principles may apply in these settings.*
> *25. Further targeted studies, including to understand variation in scale of outbreaks between different care homes and the reasons for this, are needed. Serological data, viral sequencing, behavioural data, and data from devolved administrations will also be valuable.*
> *26. SAGE endorsed the paper from the Care Home Group subject to some changes to reflect SAGE discussion."*

5.65. On 21 and 22 May 2020, I reviewed and provided comments to DHSC on updated guidance for the 'Admission and care of people in care homes' **[JH11/063 INQ000151981; JH11/064 INQ000151982; JH11/065 INQ000575587**; **JH11/066 INQ000575588]**.

5.66. That work continued into early June **[JH11/067 INQ000575589; JH11/068 INQ000575590]**. On 4 June 2020, I provided further input, in particular reviewing the definition of an 'outbreak' in a care home and the relevant practical response. At the time, a single COVID-19 case triggered an outbreak response given the vulnerability of the population, as opposed to a more usual definition for other diseases of two or more confirmed cases connected in time place and person. I supported this enhanced approach **[JH11/069 INQ000152122]**.

5.67. On 8 June 2020, I was informed that PHE had reviewed their definition of 'outbreak' in light of my comments but had decided to adopt the standard epidemiological definition. However, they specified that practical outbreak management measures would still be undertaken if there was one confirmed case given the risk of spread in care homes. Single laboratory confirmed cases would be reported as incidents and two or more clinically suspected or laboratory confirmed cases would be recorded as an outbreak. Any suspected case was still to be reported to the local health protection team **[JH11/070 INQ000069606]**.

5.68. On 14 June 2020, I advised DHSC on the updated care homes visiting guidance and, in particular, on the proposal to amend regulations to facilitate care home visits in exceptional circumstances. This approach facilitated locally delegated decision making on whether to support care home visits in exceptional circumstances, a decision which also allowed more individualised approaches to particular residents for improved overall wellbeing, for example those with dementia. I sought agreement from DsPH before supporting these changes which included some oversight from themselves, the PHE Centres' Local Health Protection Teams and/or the Clinical Commissioning Group Infection Prevention and Control lead in order to be implemented safely. I informed the CMO that I supported this and he concurred **[JH11/071 INQ000069682]**.

5.69. On 16 June 2020, I provided DHSC with my views on a draft submission on care homes visits policy and reiterated **[JH11/072 INQ000152202]**:

"I think we should make it really clear to care homes that the 'relaxation' is the exception not the rule. Ie they need to have a really good logic, with full RA, each time it is relaxed rather than that there should be a free for all visiting policy developed.

I think this is what has been planned and that the safeguards in the process as described with DsPH etc will support this, but please can we make ultra-clear.

I have discussed with CMO and he is content for this to be in place with current epidemiology as long as I have been assured about the proposals. With the point above re exception not norm, and noting this is in the current epidemiology and evidence knowledge, then I am supportive noting that some residents lives will be at risk for reasons other than Covid-19 and we need to have a system which allows us to address this"

5.70. On 18 June 2020, the first meeting of the COVID-19 Social Care Sector Support Taskforce took place led by Sir David Pearson **[JH11/073 INQ000575591]**. Afterwards, I wrote to DHSC colleagues who had contributed to the meeting outlining my view that the existing ASC/health protection interface with DsPH and PHE was poorly understood and offering to input into the Task Force's work where I could be of assistance **[JH11/074 INQ000575592]** in particular to prevent unnecessary new work and duplication. As I have said, it was apparent to me that DHSC had a narrow understanding of LAs **[JH11/075 INQ000575593]** but the Task Force played a substantial role in remedying this in its work over the summer of 2020. I attended meetings of the Task Force, which reported to MSC, but was not heavily involved in the practical operational task delivery, which lay with DHSC.

5.71. Following the relaxation of restrictions announced on 23 June 2020, DHSC again requested my view on the draft care homes guidance and, specifically, whether the guidance on care homes visiting was too restrictive. I advised **[JH11/076 INQ000152294]**:

"The key points, by way of explanation are:

1. Those in the care homes are both individually at very high risk (ie clinically

vulnerable) but to compound this they are also in a very high risk setting – so not the same as those shielding at home and not living within the same lower community prevalence rates as others are. They are living within care home disease prevalence rates which are higher though difficult to define.

2. *There are two way legal positions to consider: the first is the liberty debate and harm from not being free to receive visitors – the second is that the government is accused of not having adequately protected those in care homes*

3. *These latter two points are oppositional so there is a clinical and legal balance point to be achieved. The clinical point needs to highlight strong disease transmission risk control and for care homes this effectively translates as prevention to avoid early fatalities so it should be quite strong."*

I went on to state:

"The first priority must remain preventing infections in care homes and this means that visiting policy should still be restricted with alternatives sought wherever possible. However, care homes should now develop their visiting policies based on a dynamic risk-based approach taking fully into account the significant vulnerability of residents in most care homes."

5.72. On 2 July 2020, I was asked by Lord Vallance to become co-chair of the SAGE SCWG. The role of the SCWG at that time was to provide expert modelling and evidence review functions to support science-based policy decisions intended to continuously improve the management of COVID-19 in social care service provision, with particular consideration of the context of the individuals involved and the settings in which many of those affected were living or working. The SCWG functioned slightly differently to most other SAGE sub-groups in one particular aspect, in that rather than providing its advice to the main SAGE committee on a regular basis, the SCWG more frequently provided advice directly to the Minister for Social Care but also additionally provided key position updates to the main SAGE committee as required or requested. This arrangement was arrived at so that robustly evidenced advice in respect of social care could be provided to the Minister for her decision and incorporation as appropriate into policy without delay.

5.73. I anticipate that the Inquiry will be seeking evidence of topic discussions, timelines and publications from all SAGE subgroups including the SCWG. Go-Science or DHSC may be better placed to assist the Inquiry in that regard.

5.74. On 6 July 2020, shortly after being asked to chair the SCWG, I advised DHSC and PHE further, following concerns from the Secretary of State on the proposed approach to allow visits in care homes on the basis of a local assessment. My view was that wherever possible visits should be limited to a single regular visitor in order to limit the risks of infection, and that if feasible DsPH should be involved in overseeing the introduction of care home visits because of their local knowledge and links to support robust risk assessment. Given the length of time some residents had been without recognised visitors however, there was a careful balance to be struck between protecting care home residents and not having overly onerous restrictions **[JH11/077 INQ000152376]**. Alongside these discussions, I asked the SCWG to begin work to see if balanced guidance in relation to visiting, visitors and risk of COVID-19 could be produced which specifically included wider exploration of quality of life considerations. That work resulted in the production of a consensus statement produced after evidence gathering in November 2020.

5.75. On 1 August 2020, I provided advice to DHSC on the guidance 'Admission and Care of Residents in a Care Home during COVID-19' **[JH11/078 INQ000575595]**. This updated the guidance of 2 April 2020. I broadly agreed with its principles **[JH11/079 INQ000575594]**.

5.76. Having taken up the co-chair role of the SCWG and aware that two studies had already been started in relation to hospital discharge to care homes, on 18 August 2020, I wrote to PHE to request prioritised, urgent, technical support on this particular issue as follows **[JH11/080 INQ000152704]**:

> *"I am writing as the formal chair of the SAGE Care & Care Home Subgroup to ask for your support in prioritisation of PHE analytical capacity for research into the impact of hospital discharge on care home infection rates.*
>
> *As part of the national winter Covid preparation planning we are trying to gain robust evidence on the role which hospitals may play on the transfer of infection*

to Care Homes. There is a strong causative narrative being articulated, particularly within the Care sector itself, but the reality is that there is limited evidence to drive policy in coming months. Some policy options could be major operational changes to protect our most vulnerable – for example the national development of a transitional care system – alongside other interventions such as changes in testing protocols, isolation facilities etc.

5.77. The purpose of this request was to get robust, unbiased evidence to understand the role hospital discharges may have been playing in causal ingress of COVID-19 into care homes. I cannot now recall having made a formal request for prioritisation of PHE analysis before this and I was trying to ensure that the research already in train was progressed rapidly.

5.78. On 19 August 2020, at a meeting of the Social Care Sector COVID-19 Support Task Force **[JH11/081 INQ000152728]** there was discussion including on preparing recommendations for future work to better understand risks and possible mitigations **[JH11/082 INQ000152730]** which was finalised at a further meeting on 26 August 2020 **[JH11/083 INQ000152726]**. One of the recommendations, which was allocated to myself acting on behalf of the SCWG, was to progress and finalise this research relating to hospital discharge and further consider the evidence base relating to risk of COVID-19 introduction through community admissions.

September 2020 and the Social Care Symposium

5.79. On 13 September 2020, I advised colleagues within DHSC and PHE with respect to the protection of care homes. I was seeking further urgent investigation given the significant impact the first wave of the pandemic had had, the rapid approach of winter and the relatively short window of opportunity to properly understand and take action on any risks that could be mitigated, in particular recent test data outlining a significantly higher ratio of infections in staff to those in care residents in a rising tide of case numbers. The document briefly summarised my broad understanding of some of the risks to care homes at the time based on the evidence available **[JH11/084 INQ000152802]**:

"• *There isn't currently any very strong evidence that hospitals are a causative risk factor in care homes through transmission of infection via discharge policies*

- *There isn't any strong evidence that visitors are a particularly high disease transmission risk (if any)*
- *We don't know what the risk of transmission is for other peripatetic professionals eg GPs going in and out of care homes*
- *We do know there is a strong association with size of care home and risk of outbreak*
- *We do know that once an infection is in a care home there is a much higher risk of further cases/fatalities ie an unaffected care homes tend to stay unaffected and rising case numbers and fatalities tend to get clustered in specific care homes.*
- *We do know that a large number of staff and residents will have asymptomatic disease where cases exist*
- *We do know that some staff are still fulfilling multiple care roles and operating between settings as an ongoing risk … and*
- *We have general information about ethnicity infection rates in the general population, the high proportion of care workers in lower SE groups and from BAME backgrounds and*
- *We know in the general population that the individual or family economic circumstances may impact strongly on the likelihood of a worker and their family complying with isolation advice.*
- *We know there are cases/outbreaks in care homes where no visiting has been allowed in recent weeks which still suggests the workforce is a particular risk*
- *We know that, even where there is robust testing availability, workers are showing testing fatigue. Clearly the policy questions coming from No 10 and the Minister for Care quite rightly focus on what action can we take to keep our care homes safe. My understanding of the latest data … on current cases in care homes was that:*
- *There were over 1,800 positive cases last week in care homes compared to just over 600 the previous week*
- *Of those with known staff/resident breakdown on Friday 60% were staff and 16% resident ie nearly 4:1 staff infection ratios. If this continues to pertain when remaining results are through we have an urgent need to understand in much more detail the characteristics of these staff cases and I am not clear who is working on this or where the information is being collated.*

I will be absolutely delighted if this is happening already but for me the key variables which must be traced back in the staff in order to focus urgent interventions are:

- *Age*
- *Gender*
- *Ethnicity*
- *Home postcode (for location and SE status)*
- *Geography ie travel corridors and breadth of work environment ie are individual workers travelling across the country to an employer at some distance*
- *Single or multiple employer/active workplace settings*
- *Family linked positive case ie at the same postcode and household*
- *Linked setting associations for staff cases eg active health workplace setting links, other employment setting links (eg food processing factories in worker doing multiple roles or in linked household members) or active social setting links"*

5.80. In this email, I attempted to summarise in very basic terms the evidence base available at the time. The key point suggested by the evidence was that although there were multiple risk factors for the ingress of COVID-19 into care homes, the main risk of transmission appeared to be from staff. Addressing the risk therefore required objective analysis followed by directly linked action. In my view:

(a) we had seen that every time community rates went up the care home rates would go up in parallel. That was inherently unsurprising but suggested that care homes could not be sealed from what was happening in the community. Put simply, rates amongst care staff would inevitably rise when community transmission was high and they would then act as vectors by which the disease could be transmitted into care homes;

(b) where care home workers were doing multiple jobs i.e. they went between care home and/or hospitals, there was a definite risk identified. This was confirmed in the Vivaldi study and was reduced once steps were taken to prevent people moving jobs; and

(c) not unreasonably given staff were working so hard to keep residents safe and such evidence could be misinterpreted, it was a sensitive yet important area of evidence to discuss with the sector in order to mitigate risk both for residents and the care workers themselves.

5.81. This work fed into a 'care symposium' which I organised as co-chair of the SCWG

and which was held on 21 September 2020. The symposium looked at the entirety of the developing research base and included genomic studies in particular and direct contributions from colleagues actively working on relevant studies at the time. The purpose of the symposium was to better understand viral ingress and transmission in care home settings. It was motivated by a desire to review the evidence base from first principles to ensure that the basis of our thinking and actions was rooted in science and that all possible mitigations had been applied.

5.82. The symposium drew together relevant experts to assess the extant information in an unbiased way and arrive at a consensus as to how infections were being introduced into care homes, to identify gaps in knowledge and policy opportunities, and to highlight where further research should be focused. This meeting resulted in the production of a consensus statement **[JH11/085 INQ000074994]**.

Participants at the symposium included: Professor Ian Hall of the University of Manchester OBE, Professor Bruce Guthrie of the University of Edinburgh, Professor Laura Shallcross MBE of UCL, Professor Shamez Ladhani of Imperial College, Professor Sharon Peacock CBE and Professor Maria Zambon of PHE and Dr Alasdair Donaldson of DHSC.

5.83. This scientific symposium therefore involved representatives from a wide set of perspectives including those performing research in the field and those with a specialist knowledge base from academia, the NHS and PHE, along with contributions from a National Care Forum attendee representing the sector. Evidence was contributed from specialists from many fields, including environmental, care of the elderly, epidemiology, genomics etc and considered many different outbreaks and individual cases. Presentations included observational studies, detailed genomic investigations and linked data set work from England and Devolved Administrations. The consensus outcome briefing note was agreed by the SAGE care subgroup. Ingress of the virus in many settings was assessed to be most likely from care staff, reflecting the rates of infection in their communities and the background science and understanding of this is recorded in a paper of 23 September 2020 presented to SAGE **[JH11/085 INQ000074994]**, which itself built on an earlier analysis of 12 May 2020 **[JH11/062 INQ000215643]**.

5.84. The key findings of the symposium were **[JH11/085 INQ000074994]**:

(i) evidence of staff-to-staff transmission had emerged in the genomic analysis (high confidence);

(ii) conversely, there was weak evidence on the role of hospital discharges and the impact of visitors. The evidence did not suggest a dominant causal link to outbreaks from these sources;

(iii) it followed that public health measures which reduced community incidence could be effective in reducing ingress into care homes; and

(iv) asymptomatic or atypically symptomatic presentation in residents' and staff meant that ingress may be hidden for a number of generations of disease.

5.85. The symposium also considered that the following may contribute to future improvements in care or response:

(i) that further research was carried out on:

a. the longevity and quality of antibodies;

b. the extent to which the physical layout of a care home influenced transmission;

c. the behavioural aspects of viral transmission risk, for example changes in ways of staff workingl; and

d. the factors influencing the severity of outcomes such as co-morbidities; and

(ii) that barriers and opportunities included:

a. ensuring flexibility of testing infrastructure, in particular to enable genomic analysis systematically as required:;

b. the difficulties in connecting data across organisations and studies due to information governance issues;

c. the opportunities for separate disciplines to better enable systematic research inquiry by linking their own data domains routinely so studies can build one on another; and

d. the recommendation to establish mechanisms for regular analysis of these combined data streams to give an up-to-date view on how the virus and different strains were spreading at a local/regional level.

5.86. On 30 September 2020, I further advised DHSC on the care homes visiting policy and confirmed I supported allowing two visitors but that increasing numbers above this point would provide increased infection transmission risk and less obvious social welfare benefit **[JH11/086 INQ000070891]**. Also on that date, following circulation of

a draft Post-Discharge Designation Scheme Submission, I advised DHSC regarding planned discharge destinations for COVID-19 positive patients going into adult social care and provided detailed comments on the guidance **[JH11/087 INQ000152890].** I recognised at the time that the objective of the intervention using designated settings was to enable safe post discharge recovery and isolation where the usual residential setting may not have been able to provide adequate assurance. I was however concerned about potential balance of risks and liberties:

"A key point I want to highlight, which is important for Ministers to understand, is that I cannot see what scientific evidence we could currently offer to support this policy in the event of a legal challenge given that we think:

- *Discharge from hospital to care homes has not so far been shown to be the major risk of outbreaks in care homes*
- *We are creating an intermediary setting with a number of potential personal harms to those who are 'transited' back to their usual residential setting including*
- *An additional isolation period of a further 2 weeks which is not being applied to any other population groups..."*

5.87. On the same day, I further commented to DHSC, NHS and PHE on operational aspects of the proposals for a post-discharge designation scheme, which was established to enable robust assurance of infection control processes for discharge of hospital patients from acute settings through use of designated transitional settings as part of the Adult Social Care winter plan. The assured settings were designed to deliver high compliance in managing the isolation period effectively and securely and I provided advice particularly on appropriate isolation periods and the time periods and setting required for different presentations and discharges for care home residents after consulting with senior colleagues in IPC, patient safety, public health and infectious disease modelling **[JH11/088 INQ000152897]**.

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5.88. On 9 October 2020, I provided further advice on operationalising the post-discharge designation scheme where CQC had oversight of the specific assured residential settings which were due to receive discharged patients. I also provided detailed comments on a draft letter addressed to the President of the Association of Directors

of Adult Social Services ("ADASS") aiming to ensure awareness of the changes and system wide support. In relation to operations, I strongly advised the requirement for the ability to track detailed data flows from the setting to allow appropriate surveillance, outbreak tracking, sender and receiver organisation knowledge and testing uptake and outcomes to be part of each contract **[JH11/089 INQ000152954]**.

5.89. On 2 November 2020, I gave further input to DHSC on care homes visiting policy including both clinical, practical, individual versus collective risk and broader well-being considerations. As a result of specific work I had started to commission within the SAGE Care subgroup **[JH11/090 INQ000215625]** as noted above, to try and estimate more precisely the quantitative and qualitative benefits and disbenefits of different approaches to visiting and isolation in comparison to infection risk, I was also able to cite a very high level, initial but non-robust finding from that work **[JH11/091 INQ000071437; JH11/092 INQ000153096]**:

> *"1. in terms of QALYs (Quality Adjusted Life Years) early indication on current evidence of infection risk is that the QALYs lost from 6 months of isolation appear to be substantially higher than the QALYs lost through risk of infection from visiting – but these are very, very broad indicators.*
> *2. In terms of ordering of clinical risk of the below options in the current pandemic from infection risk alone (ie not balanced with other harms such as isolation), the order you have put them in is the correct order for clinical risk, with visiting ban being safest and permitting visiting without testing the least safe.*
> *3. As long as the 'environment' is well managed, I don't think air tight visiting poses any real significant internal infection risk to residents – it may well pose other risks and critique, in particular issues of fairness*
> *4. Given that we have not been permitting visiting in Tier 3 areas, it feels illogical to move to in person visiting during Tier 4/national lockdown unless you are going to shift the whole framework of visiting to align differently going forward – I haven't seen such a proposal."*

5.90. Between 21 and 23 November 2020, I provided substantial input into the discussions surrounding the policy and measures for care homes during the Christmas period **[JH11/093 INQ000153292; JH11/094 INQ000153297; JH11/095 INQ000153303; JH11/ 096 INQ000575598]**. In general, exchanges focused on the clinical evidence base, practical and psychological considerations of different proposals and policy

consistency in relation to testing, isolation, visitor numbers, visitor modes and social bubbles.

5.91. Further to the Cabinet Office circulating draft guidance for care homes during Christmas and confirming that political special advisors were intending to change the position so that care home residents tested on their return and need not isolate for 14 days, I advised **[JH11/097 INQ000153315]**:

"…if you wish to change this element of safe return to care homes you will need to consider changing other admission policies also - In particular care home residents arriving from hospitals with negative tests or new entries from community settings.

This all seems quite risky to be changing on guidance without taking time to think through the wider implications when rates of disease in care homes are still rising in the second wave."

5.92. On 7 December 2020, I reviewed and cleared guidance on designated settings (care homes) with DHSC and PHE who had been working to finalise a position on retesting individuals within a 90-day window of testing positive for COVID-19. The guidance included the then current position that individuals who had tested positive for COVID-19 within 90 days of being discharged to a care home (provided they have undergone the 14 day isolation period), did not need to be retested or undergo additional isolation **[JH11/098 INQ000072055]**.

5.93. On 18 December 2020, I received an email from the Cabinet Office requesting my view on the policy position for care home visits in the proposed "tier 4" areas and more broadly and provided further advice. Amidst rapidly rising case numbers nationally, and given the relatively recent introduction of LFD visitor testing at that time, my conclusions were summarized as **[JH11/099 INQ000153503]**:

"… two reasonable options exist:

1. *To continue with the current approach given that we do not yet see signs of increased risk with visiting – I am not in favour of this as a general principle because of rapidly rising rates and the fact that new test and visit policy has not been embedded sufficiently for us to observe any direct effect*

2. *Use a variation of the plan B outlined, which seems proportionate to changing epidemiology. My concerns would be*
   a. *Potential inequality in access – possibly unavoidable*
   b. *Potential deterioration in condition of residents – I think there should be very strictly controlled exceptions if manageable practically ie a resident for whom life threatening or significant deterioration is known to be linked to lack of visiting should be treated as exceptional and the visitor should go through the current LFD risk reduction process.*
3. *For full outdoor visiting I don't think testing is required (probably also for visiting areas where there is a full screen and separate outdoor entry and exit routes. For any version of indoor pod type visiting where there is a small chance of infection transmission an LFD protocol could be used"*

5.94. Because of the significant community case numbers, I also spoke directly with MSC on this matter **[JH11/100 INQ000153506]**:

"I am very mindful that the epidemiology is changing so fast at the moment that the need for real caution is becoming paramount. In the London/SE/EoE LAs rates are now heading well over 1000 cases per 100,000 population – this is an entirely new recorded level of case numbers and immediately increases the risk of ingress to a care home. I have just spoken directly to MSC and have noted I would send the comments below".

5.95. On 29 December 2020, I reviewed and provided feedback to PHE on guidance for vaccination in care homes **[JH11/101 INQ000153536; JH11/102 INQ000153537]**.

5.96. On 28 January 2021, I advised DHSC colleagues on operational aspects of discharge from hospital to designated settings to ensure that appropriate clinical assessment was applied to each patient. This was to check for any signs of active COVID-19 as well as any signs of underlying conditions which would impact the individual's response to infection **[JH11/103 INQ000072592]**.

5.97. On 4 February 2021, I advised colleagues at DHSC that whilst vaccination for care home visitors should be encouraged, it would be very difficult for this to be made a condition for visitation for a single designated visitor **[JH11/104 INQ000269393; JH11/105 INQ000269392]**.

5.98. On 15 February 2021, further to discussions between DHSC and the Secretary of State on the roadmap to lifting lockdown measures, I was asked to advise whether care home visits could restart. My view was that a cautious return to care home visiting was a reasonable short term future ambition where vaccination uptake was good and once vaccine effectiveness had been assessed positively, prevalence was low, new variants were not active, and where IPC standards were well maintained **[JH11/106 INQ000153730]**.

5.99. Also on 15 February 2021, I provided my further views to DHSC with respect to mandating vaccination for care home workers **[JH11/107 INQ000153735; JH11/108 INQ000153736; JH11/108a INQ000153737]**. I considered that mandatory vaccination posed significant challenges despite my strong support for professional responsibility in all care workers to protect themselves and others through vaccination wherever possible. The challenges were both in terms of practical requirements to record and monitor uptake effectively; the clinical evidence underpinning mandation in terms of duration of effect and impact on transmission; and importantly the potential decrease in trust and uptake of vaccination more widely, particularly in a critical carer workforce, many of whom were from ethnic minority heritage. This included the potential for staff to feel stigmatised, and of a potential longer term detrimental impact of worsening health inequalities if vaccination rates subsequently reduced:

> *"Most of all I am concerned about the impact on wider vaccine uptake and subsequent health inequalities. If Covid goes well we could boost vaccine uptake for ethnic minorities in all communities and gain years of life now and in the future. If it goes wrong we lose children and parents and the communities spiral down with ever increasing inequalitie[s]"*

5.100. In early March 2021, I provided further input on updated DHSC guidance for visiting care homes **[JH11/109 INQ000072926; JH11/110 INQ000072943; JH11/111 INQ000072944]**. This set out how from 8 March 2021 every care home visitor would be able to nominate a single named visitor for regular visits.

Section 6: Testing in care homes

6.1. I begin this section with the following observation. There is a tendency to refer to testing as a single initiative. In reality, during the pandemic as is the case for all testing protocols, it is a series of activities often applied within numerous separate initiatives many of which had different individual objectives. Each initiative relied on different testing infrastructure detail and protocols and the context of its application was critical, for example the concurrent prevalence levels. The most obvious and prioritised testing application was in the clinical management of an individual patient. However, several other forms of testing were considered, implemented and evaluated at various points over the pandemic within ASC including: (i) discharge testing; (ii) resident testing; (iii) staff testing; and (iv) the testing of visitors. Depending on the context, testing can broadly be grouped to be either opportunistic (say for some visitor testing), responsive (for example in outbreak testing) or periodic and preventative (regular testing for staff and/or residents) and the type of test could be PCR or LFD. Where possible I will endeavour to set out which of these streams we were advising on and/or was in use at any given time.

6.2. Whilst I was not copied into the email, I am aware that in an email of 14 April 2020, the CMO's advice was that testing within care home settings was a priority following concern highlighted by a recent study of 39 care homes indicating potential high rates of nosocomial transmission **[JH11/112 INQ000068798]**. It should be remembered at this time tests were not available to symptomatic patients in the community (the population was being asked to isolate on the basis of symptoms). I therefore interpret CMO's comments broadly as suggesting that care homes should be a priority for some testing when capacity allowed, directed at residents and/or staff.

6.3. The Inquiry has asked for a summary of the details of the 39 care home study. I exhibit an interim report dated 13 April 2020 which outlines this early study and its findings. There was at this time significant interest in performing tests on those being discharged from hospitals into the ASC sector. Despite clinical support for discharge testing to be undertaken as soon as possible, testing was not initially available at the scale necessary to achieve the objective. Any system of testing prior to discharge from hospital into care home settings would have been dependent on there being sufficient tests available, as well as ensuring the appropriate process parameters - such as time of test, time period over which a test remained valid, turnaround time of

the test result etc — were agreed and evidence based. These were fundamental considerations for the SCWG work programme. **[JH11/112a INQ000587567]**

6.4. As noted earlier in this statement, I am not of the view that the inability to test patients being discharged from hospitals to care homes would reasonably have played a significant part in managing any potential transmission rates in care homes in the spring of 2020. This is for two key reasons: firstly because the strongest evidence for ingress to residential care settings was through staff arriving from their communities and secondly because the strongest mitigation was a robust isolation period regardless of whether the patient/resident had tested negative or positive at the point of discharge. Had those tests been available, and knowing what we know now, it would have been far more useful to prioritise the testing of staff in ASC settings, as ultimately happened later in the year following the September symposium.

6.5. On 15 April 2020, DHSC announced in its 'Action Plan for Adult Social Care' that it would move to institute a policy of testing all residents prior to admission to care homes beginning with those being discharged from hospital. This was to be the responsibility of the NHS **[JH11/113 INQ000233794]**. Either I or CMO would likely have reviewed this document, but I have been unable to identify from the documents now available to me what feedback was provided and given the passage of time cannot say what it was with certainty. Having reviewed the document, my view is that in general this was helpful guidance for ASC providers, not just because of the advice it gave but also because it collated in one place an updated explanation of some of the principles of COVID-19 mitigation and aimed to address the concerns held by some. Where I had previously commented on more detailed advice – for example on the length of the quarantine period – this had been incorporated into the text **[JH11/114 INQ000575582; JH11/115 INQ000575583; JH11/116 INQ000575584]**.

6.6. On 15 May 2020, the SAGE SCWG met to consider testing strategies for those in care homes. I have not had sight of the output of that meeting but have seen the summary in the witness statement of Dr Hall and can confirm that it reflects my understanding at the time **[JH11/117 INQ000056544]**[1]. The following day DHSC contacted myself and Dr Hall requesting advice on testing strategy. The response provided by Dr Hall, to which I was copied **[JH11/118 INQ000575586]**, reflects my

[1] The same also applies to his summary of the SAGE SCWG consensus statement dated 21 December 2020.

advice at the time. Unfortunately, the outputs from those discussions are not recorded in documents which are now available to me and it may be that the SAGE secretariat in Go-Science, is better placed to assist the Inquiry in this regard.

6.7. Importantly, modelling to understand the most effective testing regimens whilst minimising discomfort to residents (predominantly), but also to staff and later visitors, remained ongoing throughout the pandemic. Changes in test kits, testing fatigue, new variants or supply constraints were all considered as required to maximise effectiveness. The work of the SCWG was summarised in the "Technical report on the COVID-19 pandemic in the UK", to which I contributed ("the Technical Report") **[JH11/119 INQ000203933]**:

> "*To interpret study outputs and provide science advice informing social care policy decisions, the SCWG complemented work conducted by the Scientific Pandemic Influenza Group on Modelling Operations (SPI-M-O) to understand the impact of SARS-CoV-2 on vulnerable populations and settings such as care homes. Modelling approaches were used to understand the key determinants of ingress and transmission of SARS-CoV-2 in high-risk adult social care settings. A key focus was ongoing assessment of effective options for the most appropriate testing and isolation regimens for care home staff and residents to mitigate the risk of transmission of SARS-CoV-2 and to reduce hospital admissions and avoidable mortality due to COVID-19.*"

6.8. On 17 June 2020, whilst providing input to DHSC on a draft submission on care homes visits policy, we discussed precautions that should be in place to support changes in care homes visiting including whether to test regular visitors who may be involved in close and sustained contact/personal care and who could not maintain social distance requirements. I was aware there was a potential testing capacity issue but the key purpose of my intervention appears to have been to highlight that the recommendations regarding data collection for any visitor testing regimen had been omitted from the main visitor guidance and Ministerial submission. Given there were testing capacity constraints, DHSC informed me they were reviewing this to see how much they could deliver on testing suggestions later. I flagged the criticality of the data collection so that if a similar query arose in the future, whether for COVID-19 or other care homes risk, we would have a basic evidence base from which to build advice **[JH11/120 INQ000152203]**.

6.9. On 25 June 2020, the CMO and I were sent a note setting out the background and context for the repeat testing proposal in care homes. The CMO's response stated **[JH11/121 INQ000152301]**:

> *"1. SAGE said, and I obviously agree, that weekly testing of staff and residents, where resources allow has advantages, but frequency of testing can go down as prevalence goes down. They also said that modelling suggests testing only staff and returning residents may well be as good as testing all residents. I note that testing can if done properly be distressing for residents so should not be done without good reason.*
>
> *It follows that in areas of high community transmission, or areas [that] are having frequent outbreaks in care homes, weekly testing of staff and all returning residents does have a useful place, with some testing of residents. This complements wide testing where outbreaks are occurring.*
>
> *2. In areas of low prevalence and with few or no outbreaks testing frequency can decrease. At very low community prevalence there will be a relatively higher proportion of false positives, assuming a specificity less than 100% under operational conditions."*

6.10. The same day, I replied **[JH11/121 INQ000152301]**:

> *"I think what SAGE has proposed and what you have written below are not incompatible – they appropriately propose a differential approach depending on prevalence of disease. The latter has dropped considerably during the weeks where the SAGE sub-group has been meeting.*
>
> *I think there may be a short interim window where the testing frequency, the policy and the care sector expectations are brought together comfortably in a slightly stepped downward approach, probably over a period of a month. I will assume that is acceptable with you Chris unless advised otherwise. Managing confidence in care homes from a strong baseline position is likely to be an important bedrock for forward more localised outbreak controls."*

6.11. I agreed with SAGE's advice, as repeated by the CMO, not least because the modelling advice which had been presented to SAGE incorporated the work of the modelling group supporting the SCWG. In short, there was a direct alignment between the main report to SAGE and the ongoing work within the SCWG which was regularly advising on testing protocols.

6.12. Over the summer of 2020, COVID-19 incidence began to rise again. On 31 July 2020, due to an increase in COVID-19 prevalence which threatened our ability to provide sufficient national testing capacity for all contexts, I received an email from DHSC regarding the strategies which appeared to have been considered to meet the deemed operational testing requirements for care homes without clear clinical input. The options reported to have been considered included **[JH11/122 INQ000152630]**:

> *"1. Use weekend lab capacity for care homes.*
> *2. Accept longer turnaround times for care home asymptomatic testing to process tests in the lab at the weekend.*
> *3. Take forward sample pooling to further increase our capacity in the channel*
> *4. Look at whether we can procure further surge lab capacity – whether temporarily using NHS lab capacity or other commercial partners"*

6.13. I had not been party to the drafting of any documents on which decisions were being made and I could see no risk assessment or clinical evaluation of the likely health impact of the different models. It appeared to be a logistical assessment not a functional assessment and I was very clear that I could not support without further detailed information.

6.14. By this time asymptomatic care home residents and staff were being tested. Due to the surge in demand for testing with rising case numbers in the community, the Secretary of State appeared to have agreed to proposed changes in general logistical test handling which I was worried could potentially result in delays to test results for care homes when the value of the test was primarily to access appropriate clinical care and to isolate those who may infect others. This was therefore a time sensitive intervention. Whilst the pure operational performance of the testing system was not something I as DCMO had real sight of or responsibility for, there were already some delays to test results and so in my view we needed to be very careful about extending the processing time further. This was particularly so given the vulnerability of the care

home population. In my response to DHSC I reiterated **[JH11/122 INQ000152630]**:

"Just for clarity, my concerns regarding delay in testing are:

1. *Ensuring reliability of the testing process – ie we cannot have sample deterioration or inaccurate results because we have operationally needed to halt the laboratory process but have taken swabs some time previously. I cannot check this out from the detail but believe you were following up*
2. *Ensuring that any testing which is needed for good clinical management are not delayed – for example if there are positive cases within the batch which is delayed for 2 to 3 days, even if results are deemed reliable*
3. *Ensuring that testing protocol timetables still deliver an appropriate level of care home surveillance, particularly given the rising number of cases in some areas. This could potentially be handled by a 'shift' in the testing days to weekends as long as the interim days are covered and the move does not result in loss of surveillance to the section of the workforce which spends most time with residents ie weekday versus weekend staff cohorts*"

6.15. The focus of my advice was the safety and effectiveness of testing, not the management of capacity issues or their cause. There was in principle nothing wrong with sending asymptomatic tests from care homes to weekend labs so long as that did not impact on the overall phasing of the testing protocol to deliver safe surveillance. In particular, I was worried that positive tests would either (i) deteriorate whilst they waited and so give inaccurate results; or (ii) not be reported in a timely manner leading to people being exposed during the period of delay or not accessing appropriate care. My recollection is that advice was heeded by Government.

6.16. On 28 November 2020, I further advised DHSC and PHE colleagues with respect to measures for care homes during the Christmas period **[JH11/123 INQ000153358]**. This concerned the introduction of lateral flow devices to inform visits of people in care homes.

Section 7: Data flows

7.1. As I have identified, at the start of the pandemic data flows from the ASC sector into DHSC, and by extension to OCMO, were underdeveloped and poor. What data was available was mostly held by local authorities rather than central government. CQC data would be reported within DHSC and PHE routinely managed outbreaks of

infectious disease. Some local solutions were in use to assist with hospital discharge protocols. I personally had no direct data control or access and no direct management control or reporting lines over ASC data.

7.2. Care home outbreaks and infectious disease investigations had always been supported technically by PHE Centres' Local Health Protection Teams but there was no routine data system which could routinely track the epidemiology of an epidemic or pandemic in care homes. Some larger care home providers would internally track data for operational management purposes but this was not routinely shared with Government and so was unavailable to DHSC/OCMO in the early stages of the pandemic.

7.3. The extended use of Capacity Tracker was the first self-reported data system from which DHSC drew information and insights and published statistics in the early phase of the pandemic. Capacity Tracker was an existing system developed by NHSE and the better Care Fund to identify care home vacancies in real time in some areas of England. Cover was incomplete but its potential to be pivoted to wider uses was identified and its use for this purpose announced in the COVID-19 ASC action plan on 15 April 2020 **[JH11/113 INQ000233794]**.

7.4. Collated data included testing of staff, residents and visitors, vaccination rates and staffing levels. As the pandemic progressed, the MSC commissioned the Social Care Task Force under Sir David Pearson to rapidly develop a data set to track what was happening in care homes on a daily basis. Whilst DHSC would be better placed to comment on the detail of how that system came into being, I would see information from these streams at Ministerial meetings once it had come into effect. Data from ASC also began to be used regularly in the gold, silver, bronze reports once they were established and local information from PHE's LHPTs and DsPH/LAs would also be included. After becoming chair of the SCWG, I could request and obtain more focused information for example from specific research studies. There were also representatives of the care sector and of others using ASC data across all four nations on the SCWG and the data systems in Wales particularly were more comprehensively linked but with a much smaller demographic.

7.5. I had no formal responsibility or channels through which to receive the views of those working on the frontline of ASC about their ability to respond to the pandemic or

implement IPC measures apart from webinars or similar stakeholder meetings hosted by others but to which I would contribute technically. I would however learn from others reporting during Ministerial meetings, through my work with ASC colleagues in DHSC (e.g. the CSWO), the Social Care Task Force and from sector representatives e.g. in the SCWG meetings or in the September symposium. Some information also came directly from the DsPH, the PHE LHPTs and from individuals such as the ADASS president, with whom I had worked previously when a DPH, or the Chair of the Social Care Task Force.

Section 8: DNACPR

8.1. The Inquiry has asked about the extent to which I advised about DNACPR orders during the relevant period. I therefore repeat the following from my Module 3 witness statement **[JH11/055 INQ000489907]**.

8.2. I do not recall directly discussing or providing advice on the use of DNACPRs during the relevant period. I would not have expected to do so, as if there had been a use this would have been an operational matter. I recall it being anticipated that the difficult question as to how DNACPR might be managed in the event of a severe pandemic could arise, albeit to my recollection this was largely, if not entirely, in the form of informal discussions. There was a clear concern amongst all clinicians that the pressure of the pandemic had the potential to make what is an already difficult area of medical practice even more challenging. The issue was particularly relevant and a realistic one to raise in light of events in Italy, where health services had been overwhelmed. There was again a risk that if the issue was not considered, such decisions would ultimately have to be made at a local level, with the potential for differing and inequitable approaches. I do not recall any central guidance being delivered. Rather, there was thinking and guidance from relevant specialist groups within the medical profession.

8.3. By the autumn of 2020, I was aware of concerns reported in the media, about the use of DNACPR orders earlier in the year. Guidance from the winter onwards stressed the importance of personalised clinical decision-making, the involvement of individuals and their families, and that blanket DNACPR orders were never appropriate. The guidance is exhibited at **[JH11/124 INQ000090007]** and **[JH11/125 INQ000109755]**. To my mind this did nothing more than restate the proper position.

Section 9: Reflections, lessons learned and recommendations

Extent of the state's responsibility

9.1. As I have already mentioned, ASC provision in the UK is largely supplied by private sector providers. The effect of that arrangement is that central government has little direct ownership of, or day-to-day formal accountability for, ASC. That position stands in sharp contrast to the healthcare system which is subject to much greater oversight and indeed control by central government. One consequence is that while there are systems and controls in place for the quality of the service provision, the formal responsibility for management of the residential setting in a crisis, as with other businesses, lies predominantly with the business itself. This fundamentally reduces the levers immediately available to government to direct and influence the ASC sector's response at pace. It may also result in ASC 'process' having less routine visibility in central government. My own personal view is that it would be advantageous for those in senior positions in central government departments to have greater experience in, or familiarity with, the relevant systems within local government to aid such awareness at times of crisis or policy formation more generally.

9.2. It is an entirely political decision what the state wishes to take responsibility for at any particular timepoint and/or routinely. That is not an area which I, as an advisor, should intrude upon or would want to. However, it is reasonable to reflect on the vulnerability of the ASC sector to serious external stressors which has been highlighted by the pandemic, as well as the difficulties in building resilience in a fragmented system consisting of many private providers. In my view, the division of responsibility and the ownership of risks in respect of ASC as between providers, local government and central government needs to be given proper consideration. Similarly, those stressors, in particular the availability of and support for workforce which is so critical for ASC delivery, are driven and enabled by many different inter-departmental decisions in government.

9.3. I am not of the view, even in light of our experiences in 2020 and 2021, that the division of responsibility has been properly considered or resolved (although I am aware that Baroness Casey of Blackstock has been appointed to chair an independent commission into adult social care). Until such clarity on their respective responsibilities is achieved, it is likely that both providers' and Government's planning

for the next crisis will be inadequate. Preparedness exercises relating to ASC need to be better developed so as to stress test these arrangements. They also need to involve the breadth of ASC providers (i.e. from large private providers through to solo domiciliary carers).

9.4. That question of allocation of responsibility and risk is of even greater importance in circumstances where one branch of the state (i.e. the NHS) is so vulnerable to the knock-on effects of weaknesses in the ASC sector. In my view, the most significant lesson – something perhaps still not fully acknowledged or explored – is that ASC is part of a continuum of care alongside the health service, and that deficiencies in one have serious impacts on the other. That is true in normal times but was amplified by the pandemic.

Data

9.5. I have also observed that the data flows out of ASC to central government were poor in the early stages of the pandemic. In my view, it would have been helpful to have access to all of the data fields which were ultimately put on the Palantir platform from the outset. These should be collected at a national level and be provided routinely by providers, not only as part of any pandemic response, but also in support of the response to the typical infectious disease outbreaks which occur in normal times. That data includes:

(a) real-time data on: (i) patient flows; (ii) numbers of infections by staff member and by patient; and
(b) routine data on immunisation (of both staff and ASC residents) and the characteristics of the staff cohort.

9.6. In addition to the collection of data, for it to be used effectively there need to be adequate systems in place to support the coding of clinical data collected. This is important because it allows: (i) interrogation to ensure appropriate clinical support is in place; (ii) an understanding of treatment responses and steps to prevent further risk (e.g. the use of antibiotics and drug resistance over the longer term); (iii) accurate consideration of the onward flow of patients to hospital or other services and demands on the health system as a whole; and (iv) overall, a basis for robust research to improve care and crisis preparedness for those using ASC services in the longer term.

Reflections on the quality of guidance

9.7. The Inquiry has asked for my reflections on the quality of Government guidance which was produced during the pandemic. Ultimately, that is a question which only those who were required to implement the guidance can answer. There is a wide variety of both settings and users of ASC and therefore a significant challenge, particularly given the pace of a pandemic, was to assure the provision of high-quality information for all groups equally at all times. For example, young adult patients with learning disabilities will have very different needs to elderly patients in their last year of life. Uniform policies across ASC are thus unlikely to be appropriate, yet it is simply impossible to have guidance which covers the unique circumstances of every individual. As with most guidance, early involvement of stakeholders, whether ASC users or staff, creates better, more practical and relevant guidance. From my observations this is something which improved as time went on.

9.8. For my own part, both because of my previous experience in public health at a local level as well as the importance of adopting an evidence-based approach, I kept the needs of ASC users and those working in the sector in mind when asked to review guidance. I was not (and am not), however, an adult social care professional. My role as DCMO was to comment on ASC policies and guidance from a technical public health or clinical perspective. It follows that I could not claim to have addressed all the possible impacts of polices on those providing or in receipt of ASC. To give a simple analogy, when advising on policies for the hospitality industry it was my role to consider and advise on the public health aspects. I could not have advised on the economic or business consequences and it would have been inappropriate for me to do so. Likewise in respect of ASC, I am confident I gave adequate consideration to those public health concerns which fell within my remit, but it would be naïve not to think that there were broader impacts which fell outside my skill set and which I as DCMO was far less well placed to consider in my advice. I tried to draw in stakeholders with that expertise where I could in order to address that risk. Nevertheless, consideration of the breadth of policy considerations was properly a role for those designing and deciding on policy.

9.9. Earlier in the pandemic significant efforts were required to ensure that the various guidance produced for both the healthcare and ASC sectors was consistent in content and logic. I tried as best I could to keep abreast of the guidance being provided to the two sectors so as to identify any such inconsistencies, but

undoubtedly that could have been better managed had there been a greater understanding at the outset of the pandemic of the ASC sector within DHSC. That is not to say that guidance for health and ASC should be the same. In fact, quite the opposite, in that usually they will need to be tailored to the setting or sector. The critical consideration however is that they should be coherent and consistent in the principles being applied. This improved when it became clearer to all that DHSC had ownership of the guidance produced for the ASC sector and was ready to take it forward.

9.10. The process of consultation on guidance was, on occasion, hindered by leaks. That was counterproductive as it made consistent communications and policy design difficult and gave rise to confusion if the final policy did not resemble the pre-consultation draft. It similarly could also be detrimental to population messaging. There needs to be recognition by all sides that consultation is inherently beneficial even if there remains disagreement over the content of the policy. It is something to be encouraged but leaks from third party stakeholders in the early phases of development have an understandably damaging effect on Government's willingness to engage in consultation.

9.11. I would lastly make the following observations:

a) any individual's risk appetite is ultimately a personal decision. For instance, in respect of visiting, it would be quite reasonable for one individual and their family to prioritise social interaction, and another to prioritise self-isolation;

b) that personal autonomy is however complicated by the fact that decisions taken by one serve to impact on the risk of others. In care home settings an individual's behaviours and decisions have the potential to impact significantly and harmfully on those around them because of the particular risk factors for COVID-19: age and pre-existing ill-health, and the associated extreme vulnerability; and

c) the resolution of that tension (insofar as there is one) is not a strictly public health question as much as it is a broader one for society. It follows that guidance on care home visits was particularly challenging as it could never satisfactorily accommodate the competing views and priorities of all. Whatever position is adopted needs to acknowledge the fundamental tension between increasing access and reduction of the opportunities to transmit an infective agent.

Workforce

9.12. In my view ASC staff are one of the most important resources within a caring society. It is however a workforce which had (and has) inherent structural vulnerabilities. At a national level, capacity in the workforce is simply insufficient for the demands placed upon it from a naturally ageing population demographic. There are issues with recruitment and retention, exacerbated by poor terms and conditions.

9.13. Accordingly, there were on occasion documented cases of positive staff returning early to work or failing to isolate because in their absence vulnerable adults would not have their care needs met. In some instances, the financial position of the carer also served to encourage them to return prematurely to work when staff in other sectors would have isolated, supported by adequate sick pay. Issues with staff working in multiple roles leading to increased transmission were in part a product of the need for those staff to undertake multiple roles. Those factors had a measurable impact on outcomes in ASC settings.

Concluding remarks

9.14. The pandemic had a profound impact on those who worked within ASC, used its services or who lost loved ones who were being cared for within the sector. We must all remember that. As someone who has direct experience of the ASC sector both on a personal level and through my work over many years in public health, it is an impact that I have felt acutely. I very much hope that the recommendations that emerge from this Module will contribute to ensuring that the ASC sector is put in the best possible position to respond to another public health crisis. Building the necessary resilience requires continued partnership between providers, local and central government and appropriate recognition of the importance of care by all of society.

Statement of Truth

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

Signed:

Personal Data

Dated: 17.04.2025