Thursday, 10 July 2025

(10. 01 am)

LADY HALLETT: Ms Shotunde.

MS SHOTUNDE: Good morning, my Lady. May I please call Dr Chris Llewelyn.

DR CHRIS LLEWELYN (sworn)

Questions from COUNSEL TO THE INQUIRY

MS SHOTUNDE: Dr Llewelyn, thank you for coming back and giving evidence at this Inquiry, and thank you so much for your witness statement, which is dated 7 May 2025.

You are the current chief executive of the Welsh Local Government Association; is that correct?

A. That's correct.

Q. I will refer to it as the WLGA throughout my questioning.

A. Yes.

Q. You started your role as chief executive in January 2019, having worked at the WLGA since 2002; is that right?

A. Yeah.

Q. So you were in post during the pandemic?

A. Yes, that's correct.

Q. In terms of the Welsh Local Government Association, am I correct in saying that it's a membership body for local authorities in Wales, and although the membership

is voluntary, its members include all 22 local authorities; is that right?

A. Yes, that's correct.

Q. And you also state in your statement that its purpose is to promote, improve and support local government, and that it works to give local government a voice?

A. Yes, that's right.

Q. At paragraph 22 of your statement you state that, throughout the pandemic, the WLGA did not play any decision-making role but facilitated consultation and engagement between local authority leaders and senior professionals and the Welsh Government.

Did the senior professionals include people from representative organisations, such as Age UK or any of those sorts of organisations?

A. Such as --

Q. Age UK or Age Cymru?

A. Yeah, we would have worked with a range of public sector, voluntary sector, organisations, yes.

Q. You also state in your statement that the social care response saw the Association of Directors of Social Services Cymru provide professional and operational leadership whilst the WLGA provided political leadership. What do you mean by political leadership?

A. Primarily engagement with elected members. The way the

WLGA is constituted, we have a governance and decision-making structure which comprises elected members, an executive board, which is the 22 leaders of each of the 22 principal authorities in Wales, and a council which is made up or which comprises a proportionate representation of all of the 22 councils in Wales, so the larger councils have more members and the smaller councils have fewer members.

But as an association, we emphasise the primacy of politics, of the important role of elected members and the idea that democratic -- that public services are delivered through a democratic framework where there's local accountability. And in all of the evidence I think we've given to the Inquiry, we emphasise the lengthy -- the local accountability of elected members and of councils.

Q. Thank you. If I may put in your statement on screen, it's INQ000613908, page 20, paragraph 55.

Here you describe the state of the care sector in Wales just before the pandemic began. You state on 22 December there were 1,076 care homes services for adults and there were 570 domiciliary support services registered with the Care Inspectorate Wales, of which 23 were provided by local authorities.

You also describe the adult social care sector in

Wales as varied:

"... large and varied, consisting mostly of smaller private providers with narrow margins and limited financial reserves."

You state that 75% of care homes for older people in Wales are owned by a single owner who owns one care home, or an owner of less than five care homes.

You also state that only 8% of homes are owned by large group providers.

What impact did the size of providers in Wales have on their resilience in the pandemic?

A. I think there were quite a range of impacts. I think that the -- operating on such a small scale made -- gave a number of challenges to providers. There are -- in this sector there are workforce challenges across the -- you know, across all 22 authorities, across every aspect of the social care provision, and in this instance, within the smaller care homes, recruiting staff is always a challenge, and losing staff, whether through Covid or other sickness issues, was always going to be exceptionally challenging.

There were also challenges because of the size, the physical size and scale of the homes, in terms of dealing with visitors as far as infection control quarantine arrangements, isolation and so on. But

I think they're -- they're the most significant, but there were quite a host -- a large number of challenges.

Q. And you've described in your statement the state of the adult social care sector in Wales before the pandemic, and in it you've listed many issues including workforce recruitment and retention, the increasing demand on services and the complexity of people's needs, budget cuts, and under-appreciation of social work as compared to the NHS.

Some of the witnesses in this Inquiry have described the adult social care sector as the "Cinderella service" compared to the NHS.

Would you say that the sector was neglected before the pandemic?

A. Well, I don't know if I'd use the word "neglected". I think the sector as a whole -- before the pandemic and after -- during and afterwards, is undervalued and underappreciated. I think there is a desperate need for strategic workforce planning.

And although I think some of the challenges are understood, I think significant reform is needed, improved planning, additional resources as well, and a better understanding of the contribution that social care makes as a frontline service in terms of the process of prevention and early intervention.

We see, increasingly, governments within the United Kingdom, but elsewhere, as well, putting greater focus on prevention and early intervention, and social care is a way of delivering that and adding value to the work that the NHS does.

Q. So just on pre-pandemic preparedness and planning, in your view was the adult social care sector in Wales adequately warned and prepared for the impact of the pandemic in January and February of 2020?

A. I don't think any sector was appropriately prepared for the onset of the pandemic and I think because of the -- those structural issues that we've mentioned in the witness statement, I think that the sector was particularly challenged by the pandemic.

Q. I'm just going to pull up the Local Government Association survey. It's INQ000400522, page 21 and table 6.

All local authorities in England and also in Wales participated in this survey. As you can see in terms of preparedness of the care sector for the pandemic, 86% of Welsh authorities rated the preparedness as either not good at all or not very good.

There's also points in respect of capacity there, and resilience is a bit of a mixed picture.

Now, if we could turn to table 7 which is on the

next page of the same document, page 22.

Those local authorities who had stated that capacity or resilience was not good, they've stated a number of reasons why, with all of them saying workforce recruitment difficulties being one of them, funding pressures, rising demand for adult social care services, workforce retention issues, et cetera.

Now, in terms of pre-pandemic planning before this pandemic, who or which organisation was involved previously in that? Are you aware?

A. Well, there would have been a range of organisations. As an association, we -- our engagement would have been limited. I think we've discussed in previous modules our involvement in emergency planning at a strategic and at a national level, but we would have been less engaged at a service level.

Q. Do you think you should be more engaged in it?

A. I, you know, as I think we've said before, the before that local -- because of local government's involvement in the operation and delivery of services, the more involved local government is and the more involved at an earlier stage, the better the outcomes are likely to be.

Q. Are there any other organisations that you think should be involved in pre-pandemic planning?

A. One of the -- I think one of the good things about the

way we do things in Wales is that the public sector as a whole, both the public sector and the voluntary sector and, indeed, the private sector, there is a great focus on working in partnership. The Social Services and Well-being Act places emphasis on public sector organisations working in partnership. So I, in this, in relation to your question, I'd expect to see the Welsh Government, Public Health Wales, the NHS, the regulators, local government, WLGA as a representative body, and so on, all involved.

Q. And what about representative bodies for care providers? Do you think they should be involved as well?

A. Yeah, I think the more -- the greater the plurality of voices heard in that discussion then again, the more effective the outcomes are likely to be.

Q. Would you agree that recipients of care and unpaid carers should also be involved in some way or have a voice?

A. Well, yeah, again, you know, the Social Services and Well-being Act emphasises the importance of voice and control. As an association, we always emphasise the -- you know, I touched on the point earlier, but services being delivered within a framework of democratic local accountability. And the voice of service users is absolutely incredibly important because nobody

understand services better than they do.

We also emphasise the principles of social partnership as well, of engaging with those people who deliver services as closely as possible, as well, because the service users and then those who deliver them at an operational level are the ones that will understand the service best.

And if I can just add, I've been listening to some of the other witness statements -- or the evidence sessions, and I think that those who have been delivering services on a day-to-day basis, who were faced with the challenges of having to deliver services in a very difficult situation, making sense of guidance that was provided to them, gives an incredible insight into the challenges of the pandemic.

I think sometimes there's a tendency to look at things from a strategic and national level, and forget sometimes about the service user and the operational dimension to it all.

Q. And my final question on this point, in terms of pre-pandemic planning for care providers, how do you think that should be integrated? Because, of course, there's the possibility of it happening from the top down, but how do we ensure that care providers are fully prepared in the case of a future pandemic?

A. Yeah, I think there is a challenge there, because, you know, the -- it's a fragmented sector. There are so many different providers, as we've indicated in the survey. I think at the start of Covid there was something like 750 care home provides, which were just sole, individual businesses. Communicating with and engaging with them is difficult, but it is a challenge we have to overcome.

There's an emergency planning exercise being held in Wales in October this year, and it is, you know, important in these planning exercises that we do look at this experience and learn those lessons.

Q. I'm going to come on to discuss the Welsh Government and also Public Health Wales's understanding of the adult social care sector at the beginning of the pandemic.

You stated in your statement that:

"... officials in the Welsh Government's social care department had a good awareness of adult social care, the challenges pre-pandemic and those which occurred because of the pandemic."

However, you say that:

"There was less knowledge of [the] adult social care [sector] in other Welsh Government departments such as health and in other organisations [such as] Public Health Wales."

You then also go on to state that:

"Public Health Wales appeared to understand residential care, but domiciliary care less so."

Do you think Public Health Wales or the Welsh Government's understanding of the sector has increased since the pandemic?

A. I'm not in a position to comment, I don't think.

In terms of the -- within the Welsh Government, I'm aware that there is significant practitioner experience. You know, the -- I think the director of social care within the Welsh Government is a former social worker and has experience of working within local government, and I think that that's the case with other senior officials as well. Beyond that it's difficult. I'm not in a position to make an assessment.

Q. I'm going to move on to discuss key decisions and consultation within the Welsh Government. In your witness statement you stated that the Welsh Government held an emergency summit of local authority leaders on 12 March 2020. Do you remember if this was the first time that leaders or the WLGA were consulted on the adult social care sector's response to the pandemic?

A. To my recollection, it was, but I think in the submissions we've made hitherto, then there would have been -- we will have provided a record of all the

meetings and discussions that took place. And I think that that is probably as accurate an account as we've gotten. My recollection is that that was the first time.

Q. Do you think liaison should have happened sooner with the leaders?

A. You know, as I've said before, the earlier the engagement, then the better the outcomes would have been. There were concerns within the local government developing during that period. I think with the benefit of that hindsight, probably, yes.

Q. You've stated that from an adult social care perspective the Welsh Government's approach to joint working to manage the pandemic was commendable. However, despite the joint working with stakeholders, you and other witnesses have highlighted issues with the content of guidance.

What improvements do you think could be made in order to ensure that there's clear and useful guidance in a future pandemic?

A. I think in social care, but across in other services as well, I think there's a tension and possibly a dislocation between the people who write guidance and their theoretical or, in this instance maybe clinical, understanding of what's required to be contained in the

guidance, but then the importance of writing guidance in such a way that it's understandable, and can be operationalised with ease.

And again, from other witness statements, I've seen the challenge the people in social care settings faced with changing guidance, the need to -- the immediacy of delivering services, but having to interpret guidance there and then as it changed. So I think that the -- in developing guidance in social care but in other sectors, as well, the more engagement there is with people who work at the operational, the delivery side, then the more effective it's likely to be.

And we've said in other statements that we've made that the earlier that local government is engaged in developing guidance, then the better and more effective it will be.

Q. I'm going to ask you a couple of questions on the discharge of people from hospitals into care homes.

In your statement you state that the WLGA were not consulted on national policy or approaches to hospital discharge. Do you think they should have been?

A. It would have -- it's outside of our remit as an organisation, and we, as an organisation, don't have particularly relevant expertise, but I think -- I think we could have added value, and I think that our

interventions subsequently did add value.

Q. What value did you -- do you say you would have added?

A. Well, I think it's because of the understanding that local government collectively has in delivering services and the point I mentioned earlier in terms of being at the front line of service delivery, of being able to, both the provider and the user and experience, informing policy, and in this instance, in the absence of accurate, reliable and immediate data, because local authorities, both as officers and elected members, are rooted in their communities, in the absence of other data, then the information that they can provide and share, I think can add value and help to inform policy.

And in this instance, during the course of March 2020, we expressed concerns in different ways through different channels, because of that delivery end knowledge that authorities had.

Q. If I can pull up the LG survey again, that's INQ000400522, page 72, thank you. Table 56.

This table is asking the local authorities the extent to which appropriate IPC measures were in place for moving people between hospitals and care homes. And as you can see in terms of Wales, 45% of authorities said "to a small extent" and only 36% said "to a moderate extent".

In your view, do you think the Welsh Government sufficiently considered the ability of care homes to enact appropriate IPC measures before issuing the March discharge guidance?

A. Sorry, can --

Q. That's fine.

A. -- ask again?

Q. So I went -- the March discharge guidance of course was saying that people should be discharged into care homes or into their own homes.

A. Yeah.

Q. Now, at that time in March, there were issues with PPE, for example, a question mark whether or not there were isolation facilities in care homes, things like that.
Do you think that IPC measures were sufficiently considered by the Welsh Government before they issued the March guidance?

A. I think the focus was elsewhere and I think we've said previously because they focused on the NHS and capacity within the NHS, there were many aspects of social care provision which weren't taken into account.

Q. How do you think this could be improved for the next pandemic?

A. Well, I think, you know, that particular lesson needs to be -- learning the lessons of the experience is

important, but also, it relates to the earlier point about the ways that social care is valued as a service and as a profession.

So, you know, in terms of the -- within the sector, there needs to be a better understanding of infection control and prevention, but within a wider framework -- a framework which looks at recruitment, retention, training, qualifications, continuous professional development, elevating the sector as a whole, not just these particular instances. It relates to the -- you know, in terms of infection prevention and control, the training in terms of the use of PPE. I think it -- I think the underlying issue cuts across many of the -- almost all of the aspects of the -- that this module is focusing on.

Q. And many Core Participants have recommended that in a future pandemic there should be no discharges to care homes without testing or quarantining measures. I do note that, from 29 April 2020, the Welsh Government issued updated guidance on step-up and step-down care arrangements, so if someone was still positive they would either -- have to be taken to an NHS facility whilst they recover before being discharged.

What's your view on the recommendation of testing or quarantining before discharge?

A. Based on the Covid experience, I think that would make sense. It would depend -- I don't have any clinical expertise, but it would depend on the, you know, the particular pandemic, the circumstances or -- and so on, but I would have thought, based on the Covid experience, that would be a minimum expectation.

Q. And my last question on this, in England, the UK Government created designated settings, which were specific care homes that had isolation facilities to house Covid-19 positive residents. Would a similar policy be useful or possible in Wales or do you think the step-up/step-down arrangements were sufficient?

A. I think it would be something to consider and look at. We, you know, during the -- those early months of the pandemic, I think we just -- it was suggested using the Nightingale hospitals, which I think is a bit similar to your suggestion, but that's definitely something that's -- you know, to consider.

Q. I'm going to talk about -- ask you questions about personal protective equipment and, in particular, access to PPE.

The provision of PPE for social care providers was undertaken via the NHS Wales Shared Services Partnership. On a practical level, what was the role of local authorities in terms of distribution of PPE during

the pandemic?

A. The individual authorities distributed PPE to the social care sector within their areas, where there was direct provision, but to the other sectors as well.

Q. And I understand there were deliveries to the local authority joint equipment stores, which were then --

A. Yeah, there were latterly. It took a few months until it worked effectively, but I think by the end, it did. Some of them were -- Lee Walters, I think was the deputy minister at the time, did some really good work in chairing a working group which looked specifically at PPE and the NHS shared services. We eventually -- I think by mid-June we got to a very resilient position where the -- all the key partners were involved.

We -- I think we communicated on a daily basis with the Welsh Government procurement colleagues and with individual authorities as well, I think as is indicated in our written statement. It took a couple of months to get there, but we did eventually.

Q. Yes, in your statement you do say that by June 2020, relatively stable operational arrangements had been established in respect of PPE?

A. Yeah.

Q. Why did it take so long?

A. Because -- I think because initially, with PPE, the

focus was on the needs of the NHS rather than the care sector. And again, a lack of readiness and a lack of preparedness.

Q. What about PPE for unpaid carers? Do you have any suggestions or recommendations on how to ensure that unpaid carers have access to PPE during a future pandemic?

A. The -- I think the source will probably be through local authorities. Again, going back to the Social Services and Well-being Act, there is a responsibility on local authorities to cater for the needs of unpaid carers, as well. I think communication is probably an issue there, but I think that the -- through local -- local authorities have got a key role to play, and that would be the obvious channel.

Q. I'm going to raise some concerns that have been raised by Care Forum Wales in their witness statement, if I can pull that up, please, INQ000 -- you've got it thank you so much. Page 25 and paragraph 73.

As you can see from this paragraph, they do raise some concerns, one of them being, middle of the paragraph:

"A small number of providers with self-funding clients ... reported difficulties because the local authority had not made them aware of the PPE

arrangements [until] several months later or seemed to be supplying PPE in respect of funded clients only."

They also raise that PPE was distributed to local providers according to the proportion of the size of the authority rather than the size of the care homes within the authority, which led to delays in providing adequate stock to one of the largest care homes in Wales which was situated in the smallest local authority.

Were those issues known to the WLGA at the time?

A. I'm not familiar with this particular instance. You know, I'd have to see the evidence in more detail. I think inevitably, the supply would have been sensitive to demand, so where there was greater demand, then I presume there would have been higher levels of stock provided, but my assessment of the situation and understanding would be that authorities would distribute and deliver PPE to wherever it was needed, and there wouldn't have been any the selective process of distributing PPE.

That said, I think it has to be recognised that this was a very dynamic context, ever changing. Things were -- particularly, during the months of March, April and May 2020, things were moving very quickly and communication was -- it wasn't always possible to communicate as effectively and as directly as might

have -- as we might have wanted.
Q. Do you think there's any improvements that can be made in respect of that?
A. Well, I think there are always improvements, possibly, to the communications, shared understanding, and so on. As I mentioned earlier, it took us -- I think it took us a few months to get a good position with PPE. Hopefully in a future pandemic that wouldn't be the case but, as I say, it's always possible to improve communication.
Q. I'm going to move on and ask questions about testing for the social care staff and also residents.
Now, I'm not going to pull it up on the screen but the WLGA survey shows that 73% of Welsh local authorities found that care providers found it either fairly difficult or very difficult to access Covid-19 tests in the first six months of the pandemic.
The testing regime went through various iterations, various different --
A. Yeah.
Q. -- guidances as more and more testing became available, but what I want to focus on is the testing that local authorities were involved in. I understand that a scheme was developed between the Welsh Government , the WLGA, ADSS Cymru, and Data Cymru, for local authorities to identify 15 staff -- members of staff per council to

be tested from 1 April 2020?
A. Yes.
Q. Yes. To clarify, was this testing for symptomatic staff only at the time?
A. It was up to individual authorities to nominate up to 15 members of staff, and they had to do it -- it had to be done first thing in the morning, as well. I don't recall that it worked particularly effectively, the feedback arrangements didn't work, they weren't -- they didn't seem to be immediate and I don't think it was a satisfactory solution.
Q. No, and you state in your statement that the scheme covered both local authority, social care staff, and staff employed by commissioned providers?
A. Yeah.
Q. So including care homes who were symptomatic. What about providers that were not commissioned by local authorities?
A. I can't recall whether they were covered by it or not. You know, I can provide that information as a follow-up.
Q. Problems with testing process continued, in your statement, and it did not appear to have been implemented via Public Health Wales. So essentially that testing 15 members of staff a day, in your witness statement you state that there were problems with that,

and you said that it did not appear to be implemented via Public Health Wales or at least there did not appear to be an established process to feed this information back in real time.
So just for a clarification point, did the scheme not start on 1 April -- of the 15 members of staff per day?
A. It did start, but it didn't -- it seemed to have operational problems from the outset. And in particular, you know, the whole point of doing the testing is to get the results of the tests and the feedback as immediately as possible, and my recollection is there were significant delays, and that it wasn't really a practical solution.
Q. So let's say we have a future pandemic and it's a bit similar to this one in the sense that there's limited tests in the beginning, do you have any recommendations on how the testing regime for the adult social care sector should be implemented?
A. Well, it needs to be joined up end-to-end and everybody within the process needs to understand who does what and you would want it to be as simple and as streamlined and as understandable to everybody as possible.
Q. You'd stated in your witness statement that the process of identifying social care staff that can be tested was

complex and time consuming at that point.
Now, of course there is a register of adult social care workers that's been held by Social Care Wales, they have to register with them.
A. Yes.
Q. Do you think the fact that they now have to register would assist in trying to implement a testing regime like that in a future pandemic?
A. I think I'd have to look at it in more detail. My fear is that it might not, because of itself, having the registration of social care staff at a national level, I think I'd have to, you know, interrogate -- in terms of what I was describing in terms of the end-to-end process being as streamlined and simple to operate as possible, I think I'd have to interrogate how the registration of staff, how exactly that would improve the efficiency of the testing regime. I can see other advantages to the registration, but in terms of testing, I think that needs more enquiry.
Q. Thank you.
I'm going to ask some questions about other infection prevention and control issues. One of the issues that you've highlighted in your statement is the physical environment of care homes. You've mentioned that the ability to isolate Covid-19 residents

discharged from hospital, ventilation in care homes and communal bathrooms made it difficult to prevent the spread of Covid in those settings.

Do you think this was sufficiently taken into account by the Welsh Government or Public Health Wales when making key decisions or issuing guidance during the pandemic?

A. I'd be surprised if there was a sort of comprehensive understanding of the settings and the familiarity of the settings within the different sectors that you mention and this is why, again, we emphasise the importance of, in developing guidance, of getting operational input and involving local authorities as early as possible because they would have an understanding of the capacity within their area, and would be able to, you know, inform decisions about guidance.

I think it's highly unlikely that that level of understanding would be available at a national level.

Q. As far as you're aware, has any work been undertaken since the pandemic to consider the physical environment of care homes and maybe improve them?

A. I'm not personally conscious of any work that's been undertaken, but -- which isn't to say that that hasn't taken place. I wouldn't be involved in that level of detail. But it's conceivable. And, you know, I can

provide more information as a follow-up if that would be helpful.

Q. If it hasn't, do you think it should be?

A. Well, I think it comes back to the earlier point about the -- elevating the status of the service as a whole, and -- the challenge during the pandemic was of having over a thousand relatively small-scale providers, relatively small buildings with limited capacity for adaptation. I don't think that situation has changed significantly. And in -- as part of the reform that's needed within social care, it's one of the aspects of the service that needs to be taken into account.

Q. I'm going to ask you some questions about the hardship fund. As I understand it, the hardship fund was provided by the Welsh Government to local authorities to use and to distribute to other care providers to cover additional costs of the Covid-19 pandemic. How did that work on a more operational level, in terms of the money funding coming through?

A. The hardship fund worked as a whole very effectively throughout the pandemic period. It was developed in partnership with -- you know, with the Welsh Government. The then minister for local government, Julie James, was incredibly receptive to local government demands and expectations. And, I have to say, in terms of the

partnership working between local government and the Welsh Government, the accessibility of and willingness of ministers to work closely with the local government members and leaders, both of -- the First Minister, Mark Drakeford, and Julie James, as the local government ministers, were always accessible and would always listen to local authority concerns.

The hardship fund developed as a consequence of that dialogue. Initially in the first instance I think 40 million was made available, in the second year it was 48 million. That was distributed to local authorities, and then trickled down through the system to the different providers within each individual authority.

Q. Care Forum Wales have issued some issues regarding the distribution of those funds and if I could pull up their statement, it's INQ000517219, page 20 and paragraph 56.

You can see here that they raise some concerns from the second sentence onwards:

"Significant problems were experienced with regard to the distribution of the funding through the local authorities, which resulted in 22 different ways of working."

And:

"For instance, some paid a fixed rate which reached the sector fairly quicker, but meant that a provider in

Gwynedd received £50 whereas a provider in Cardiff received £80. Some paid a percentage increase. Some asked providers to supply evidence of costs with varying degrees of complexity/stringency that delayed funding reaching providers and added considerably to workloads in an already overstretched sector. Some did not pay separately for voids and those who did interpreted voids differently ..."

In other words, there seem to have been variations in how the funding --

A. Yeah.

Q. -- was provided --

A. Mm.

Q. -- with different local authorities.

Were you aware of those issues during the pandemic?

A. Yeah, I think it depends, though. You know, you can look at this -- some of these issues are contestable, and -- again, I'm not particularly familiar with Care Forum Wales, you know, evidence and the detail, but I think one of the beauties of the system is that local authorities could take account of particular circumstances in their authorities.

And, you know, I've mentioned a few times the principle of, you know, local democratic accountability, of -- that authorities, councillors and officers being

rooted in their communities and understanding their communities, being able to work with different partners as required.

The circumstances -- you know, Wales is a diverse country, the circumstances, urban areas, rural areas, are geographically, demographically, socioeconomically different, and there's a sensitivity in the system to take account of those differences.

You know, we've seen in some of the earlier slides, there are over a thousand different care home providers. Most of those are different, with different demands.

As a whole, I think the process of distributing funding worked incredibly effectively. There were guidelines set by the Welsh Government. They were flexible. All authorities worked within those guidelines. And of course, as well, there is the issue of financial probity and transparency as well, so all of that is important.

So I think -- you know, I think it's harsh to criticise authorities for acting within the constraints of financial probity and transparency in the way they distributed building funding.

Q. Let's say, for example, that one local authority decides to charge a fixed rate for something or provides a fixed rate for something, whereas another local authority

decides to do it by way of percentage increase, and that means that for, let's say, a care home in one local authority they end up getting more money than a care home in another local authority for the exact same thing. Do you think that's fair?

A. Yeah, but I'm not sure it's ... you know, you'd have to be certain that you were making relevant, immediate and direct comparisons. You know, it may be that in your example that neighbouring authorities funded different things differently. So I think -- I don't think it's possible to make those kind of direct comparisons, and my assessment is that overall, the process worked very effectively. And I don't recall at the time the concerns that are expressed here being raised.

Q. So just to confirm, would you say that there should still be, in a future pandemic, local authorities should still be allowed to set their own sort of processes and terms and ways in which they -- (overspeaking) --

A. Yeah, I think because of their understanding and sensitivity to local circumstances, I think that that's a good way of delivering the funding. And I think it's likely to be far more effective than a centralised national top-down approach to it.

Q. Concerns were also raised about the speed at which money was reaching providers, with Care Forum Wales having

stated that some funding was agreed for the sector by the Welsh Government in April, but they gave evidence in May that it was still not reaching the sector.

Do you -- were you concerned -- were you -- did you hear about any concerns about the speed of the funding reaching providers during the pandemic?

A. No, I mean, I can understand the frustration felt by different sectors, depending on their cash flow circumstances. But as I say, at the time, we felt that the authorities were, given the circumstances, were distributing funding very swiftly, effectively, and efficiently, in this sector, but in other sectors, as well.

Q. I'm going to ask you some questions about data, because many witnesses have mentioned lack of data at the beginning of the pandemic, and increases in data as the pandemic went on.

Now, you'd mentioned in your statement that on 29 April the Welsh Government wrote to local authorities setting out new reporting arrangements seeking weekly data collections from 4 May, and you also state that this data collection has continued post-pandemic but on a monthly rather than a weekly basis.

In terms of the data that's being provided monthly, do you believe that that data is sufficient for the

sector to be able to cope in a future pandemic or do you think there is more data that's missing that needs to be added to the monthly rota?

A. Data is always ... timely data, the acquisition and the provision of comprehensive and timely data, I think, is always a challenge. Since the -- as an example, since the pandemic, I think we refer in the witness -- in our statement to the Care Action Committee, and since the pandemic we've been meeting the Welsh Government on a monthly basis looking at different aspects of the interface between health and social care and discharges from the NHS, from hospitals to social care settings. And although it's onerous, that seems to be working well and addressing current needs.

So I think that collectively, we are in a better position than we were at the start of the pandemic. But some of the concerns we had, I think -- and I think it's reflected in our statement -- was about the -- some of the planning assumptions that the Welsh Government had, the work they did with some of the academic institutions, with the universities, and it would have been -- it would have been useful if those data had been shared with local authorities from the outset so that they could have a better understanding of the NHS and the Welsh Government's planning assumptions.

And, you know, there were other aspects of the data provision that we mention in the statement where we felt things could have been improved.

What is clear, and I think has been from other witness statements, as well, is the need to have a single source of data and to have an authoritative source, which everybody uses, can rely on, and is timely.

Q. And who do you think should -- which organisation do you think should hold or collect that data?

A. Well, I'd be less -- I think the ONS are used as an authoritative source of data. I think I'd be less concerned about who holds the data, so long as we had a shared understanding of the -- that it was authoritative, comprehensive, and timely.

Q. What about data on unpaid carers or adults who are in receipt of unpaid care from, perhaps, their family members or friends? Do the local authorities have enough data on them? Do local authorities know how many there are, for example, so if in a future pandemic they would know who to target for testing or PPE or guidance or anything like that?

A. Yeah. It's of the -- the position and the role of unpaid carers is quite a difficult and challenging one, and authorities -- it is a responsibility that they

have, but there's a statutory responsibility to take account of the needs of unpaid carers, but it is very challenging because, to a large extent, they self-identify, and very often people don't see themselves as being unpaid carers. So it's one of those areas where we need to be constantly vigilant and I suspect there's probably more work that can be done.

Q. Thank you. I'm just going to ask you a question on easements.

A. Yes.

Q. Now, those were, as you describe, mechanisms allowing local authorities to streamline arrangements for the assessment of needs and prioritised care so that the most urgent and acute needs could be met if services were under such pressure that a local authority would be unable to fulfil its statutory duties.

My understanding is none of the 22 local authorities in Wales implemented those easements during the pandemic. In a future pandemic, would you recommend that those easements still be put in place?

A. We were involved in discussion with the Welsh Government about the easements and the provision that they could be used, and at the time, I think we were receptive to the idea. But as you say, as it transpired, authorities didn't make any use of the easement. So again, it would

depend on the immediate circumstances of any future pandemic, but in this instance, as I say, we -- at the time, we thought it was a good idea.

Q. Now, in terms of lessons learned and recommendations, you've included a number of them in your witness statement, one of the main ones being that social care should be seen as a primary and equal part of an integrated health and social care system-wide approach and not a secondary service or an add-on.

What would that look like to you in a future pandemic, in terms of key decisions or resources?

So for example, if it was seen as an equal -- a primary and equal part of an integrated care system, would there have been different decisions on PPE, for example, or the discharge decision, or testing?

A. Well, hopefully on all of those, I think, it is -- the care sector needs comprehensive investment and reform. You know, I've touched on some of these issues already in terms of recruitment, retention, training, continuous professional development, terms and conditions, the remuneration, in terms of the welfare, the wellbeing and welfare provision of the staff, you know, for example with PPE, the donning and doffing of PPE is a central part of training within the NHS. But, you know, that isn't the case within social care. But investing in all

of those areas, elevating the status, improving the level of public appreciation and understanding of the role, as well, all of those things are important.

They go far beyond the immediate concerns, maybe, of this Inquiry in terms of the various government plans for the future of the NHS, a focus on early intervention and prevention. In all of those areas, social care is the front line of addressing those needs.

Q. And there is another recommendation that you mention in your witness statement:

"Consider the optimal response of, and role for, regulators in a pandemic situation."

Could you provide us with more information on what you mean by that.

A. Yeah, I think it would be useful to have a better understanding of, you know, of the role of audit inspection and regulation within the context of a future pandemic. Our approach, as an association, as local government in Wales, generally is that we think that regulation audit inspection needs to be far more integrated, joined up, streamlined, proportionate, that we need to declutter and reduce complexity as much as possible.

We -- the inspectorate and regulatory framework is quite wide. I would have thought there is potential

there to streamline, to look at the role of inspectors and regulators, but also various commissioners as well, look at potentially shared back office functions and so on. So I think there is considerable scope there which could lead to a more effective and efficient provision.

Q. And Dr Llewelyn, is there anything else that you would like to tell the Inquiry today?

A. Well, I just think the -- I've said this before, the role that local government and local authorities played in -- and the workforce especially, I think was exemplary. Authorities delivered -- in Wales the -- councils in Wales deliver between 650 and 700 different services 24 hours a day, every day of the week, throughout the year.

The challenge of doing that is immense. Doing it during the course of the pandemic on the back of the challenges of Brexit, Storm Dennis in the February of 2020, and continuing to deliver those services to -- I think sometimes it can be overlooked. The challenge in delivering services, of having to adapt and respond and to interpret guidance immediately, and whether or not the guidance makes sense or not, the services still have to be delivered.

I think sometimes it's -- the challenge of doing that is forgotten, and the success of local government

is their ability to continue doing that.

We've heard various witnesses, I think, talk about statutory responsibilities. One of the greatest things about local government is when they deliver services, the staff at the operational end, they look at what needs to be done and they do it. They don't consider: is this within our remit? Is this our statutory responsibility? If they think it needs to be done, they do it. And I think it was one of the features.

And, you know, as you can tell, you know, my sense within the WLGA is that it's undervalued, it's not appreciated. In this instance, in this module, the status of the social care sector needs to be elevated. And I think hopefully we will shed light on that during the course of the -- the further course of the Inquiry.

Can I just -- I don't know if it's opportunity -- can just add as well, I am conscious that there are members of bereaved families here, and I've given evidence to this Inquiry, I think this is the third time, and we have provided statements, but I am conscious that the bereaved deal with the consequences of the pandemic on a daily and on an hourly basis, and I do want to express my sympathies and ongoing condolences to them, as well.

LADY HALLETT: Thank you very much.

MS SHOTUNDE: My Lady, no further questions.

LADY HALLETT: Mr Stanton.

Mr Stanton is over there.

Questions from MR STANTON

MR STANTON: Thank you, my Lady.

Good morning, Mr Llewelyn.

A. Good morning.

Q. I appear on behalf of the Covid Bereaved Families for Justice Cymru, and may I say on their behalf, thank you for your remarks just made now.

At paragraph 80 of your statement you state that social care was less valued compared to the NHS and not considered as important despite its frontline role, and that's a point you've made repeatedly during your evidence this morning, describing it as, I think, undervalued.

Also at paragraph 80 you give some examples of how guidance and the procurement and provision of equipment was tailored to the NHS without proper consideration for social care.

Can I ask you, please, how did you push the Welsh Government during the pandemic to treat social care as a higher priority?

A. Yeah, thank you for the question. We -- our interface

with the Welsh Government was quite broad. So we, I think I've mentioned the sometimes daily engagement with Welsh Government ministers in different service areas. So in almost all of those meetings we would have been raising the concerns in terms -- that have been discussed today in terms of testing, PPE, and so on, and I think our elected members, in discussions with ministers, would have been promoting that idea of the need to -- for parity between the care sector and the NHS.

But we would have been doing it through other channels, as well. We work closely with some of the professional groups, the Association of Directors of Social Services, we would have been working with them in lobbying the government. I mentioned the fact that we worked with local partnership through the Joint Council for Wales, I think we've submitted correspondence between us as partner organisations with the Welsh Government.

There was a considerable amount of engagement between civil servants and the WLGA. We also worked closely with the special advisers. So there was quite a broad interface. And in all of those instances at every opportunity, then, we would be promoting the importance of social care.

Q. You mentioned earlier in your evidence on a number of occasions that there's a desperate need for strategic workforce planning. Do I take it, then, that no action has actually been taken, no positive action has been taken in that regard?

A. There have been discussions, and I think there is an understanding of the substance of the issue, but the reality is, in the 22 councils in Wales, there are workforce shortages in every authority area, in every service, from the strategic to the operational. So I think it is a big challenge for local government in every sector, but especially in social care.

And a lot -- a lot of it relates to the conditions of service and the remuneration within social care in that most other service areas are more attractive financially. And what happens is that the -- we rely on the commitment and the sense of vocation of the people who work in the sector.

Q. Thank you. Despite the efforts that you've described and the representations you've made to the Welsh Government, has any tangible action been taken by the Welsh Government to rectify the disparity that you describe?

A. Well, it's something we constantly lobby on. There is -- you know, there has been a recognition of the need

to pay at a level of the real living wage. There has been some progress, but we need significant further progress, I think.

MR STANTON: Thank you, Dr Llewelyn.

Thank you, my Lady.

LADY HALLETT: Thank you, Mr Stanton.

Ms Jones.

Ms Jones is just there.

Questions from MS JONES

MS JONES: Hello, Dr Llewelyn. I ask questions on behalf of John's Campaign, The Patients Association, and Care Rights UK, and there are two questions I want to ask you about today. The first is consultation with stakeholders and the second is the visiting guidance.

So, in respect of consultation with stakeholders, at paragraph 63 of your witness statement you set out a table of various organisations, including government bodies and care providers with whom the WLGA met and engaged, but the table doesn't include any reference to people who rely on care, and so my question is, did the WLGA take any steps to work with people who rely on care, or obtain their perspective about what was happening in adult social care?

A. We would have -- I think we would have expected individual authorities to engage in that discussion and

then to feed into our work. So we would have been more reliant on them.

It may be that it's something that I haven't emphasised during, you know, the course of my evidence, but we -- the WLGA is a relatively small organisation, so we rely quite heavily on the professional input of individual authorities, and which is why we work with professional networks like the Association of Directors of Social Services. And we also rely on anecdotal information and data that we gather from elected members.

I think I've emphasised the point that elected members, councillors, invariably live within their electoral wards, are closely associated with their communities, and engage very closely with the people that they represent.

So we would use those channels I think, to get information in this instance.

Q. Are you aware of any of the Welsh local authorities having formal processes for people who rely on care to raise issues that they may be having with their local authority, or are you expecting that more to happen more on the *ad hoc* basis that you --

A. Well, you know, I'm sorry, I'd have to check to see -- you know, I can provide that information as a follow-up.

That would be my expectation, but I'm not familiar enough at an operational level with the detail.

Q. Thank you.

In terms of consultation regarding the visiting guidance for care homes, are you aware of whether people who use social care, or their families, were consulted about the content of the visiting guidance, and if not, why not?

A. The visiting guidance provide -- delivered by individual care homes or the national guidance?

Q. And the national guidance.

A. At a national level, I'm not aware that there was any discussion or consultation, which is why we've -- you know, we've -- repeatedly we emphasised the importance of engaging with people at an operational level, you know, I think I've said, both in terms of the people who provide services and people who use services as well, because they understand those services better than anybody else.

The legislation that's in place talks about voice and about listening to service users, and it is something that we emphasise and prioritise, and would expect to see happening at every level.

Q. Thank you.

At paragraph 189 of your witness statement, you

identify that 16 (sic) of the 22 local authorities in Wales thought that the visiting guidance was either not very good or not good at all.

Were you aware of any specific concerns that local authorities had with the guidance that led them to those conclusions? And what, if anything, was done to respond to their concerns?

A. As far as the detail of the concerns, we -- on issues like this, sometimes we act as the interface or the conduit. It's easier for the Welsh Government to deal with us as an association than to have bilateral discussions with each one of the authorities and, in turn, with the providers. So we would have been -- all of those issues that were raised with us, we would have then been lobbying, as it were, the Welsh Government to make those changes.

And there were issues that we were always conscious of, and it relates to some of the other points that have been made about the particular circumstances of care homes and the provider settings.

But, you know, because they're so diverse, at the time there were over a thousand of them, each of those, the circumstances were very different, the physical circumstances and the infrastructure would have been very different, and their capacity to respond would have

been different as well. So we would have been communicating that to the Welsh Government as much as we could.

Q. Do you recall how any of that feedback was received by the Welsh Government and whether it was taken into account to make amendments to the visiting guidance?

A. We would have had a dynamic and ongoing dialogue. The Welsh Government would have always been receptive to those concerns and there is, you know, there is a trade-off or a balance between providing guidance which allows for local flexibility, but it, at the same time, addresses the clinical concerns and needs.

MS JONES: Thank you, Dr Llewelyn, those are my questions.

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

Dr Llewelyn, that completes the questions we have for you. You said you've helped us three times, I'm not sure that I can say it's goodbye and a genuine thank you -- well, actually, all my thank yous are genuine, but thank you very much for the help you have given so far --

THE WITNESS: No, thank you. It's a pleasure much.

LADY HALLETT: -- if it is so far, and if it's goodbye, thank you very much and goodbye.

I don't know if you're going back to Wales today. I don't think you're going to cool off if you are.

THE WITNESS: No, I hope, to be, yeah, it's unusual, I live in a green and lush land, and -- yeah. So no rain would be welcome.

LADY HALLETT: Thank you very much indeed. I shall return at 11.30.

(11.13 am)

(A short break)

(11.32 am)

LADY HALLETT: Ms Jung.

MS JUNG: My Lady, the next witness is Professor Ian Hall.

PROFESSOR IAN HALL (sworn)

Questions from COUNSEL TO THE INQUIRY

MS JUNG: Professor, your full name, please.

A. Yeah, it's Ian Melvin Hall.

Q. You are currently employed by the University of Manchester as Professor of Mathematical Epidemiology and Statistics; is that right?

A. That's right, yes.

Q. You've been in that role since 2021. Your primary areas of expertise are mathematical epidemiology, statistics and modelling, applied to public health, epidemiology, and adult social care; is that right?

A. Yes.

Q. You've contributed to a large number of major publications, a list of which you've provided to the

inquiry and some of which we'll be discussing today. And in your day-to-day professional work, is it right that you develop mathematical and statistical models of infectious diseases to learn how to better control them?

A. Yes, that's right.

Q. Is it right that, since 2006, you've also held various roles at Public Health England, although you're not currently employed by UKHSA; is that right?

A. Yes, that's right. Yes.

Q. You currently are honorary senior principal modeller in emergency preparedness, and prior to that, you held various modelling roles?

A. Yes, yeah, yeah.

Q. You've also been involved, both prior to the pandemic and during the pandemic, in various scientific and technical advisory groups to the government. I don't want to deal with all of them but the ones most pertinent to your evidence today are, firstly, the Care Home Working [sub] Group; is that right?

A. Yeah.

Q. Which started off, I think, as a task and finish group, as a working group of SPI-M-O, and then was subsumed, I think a week or so later, as a formal subgroup of SAGE; is that right?

A. Yeah, that's right. Yeah.

Q. You were also involved in SPI-M, and that is something that you've been involved in since 2006?
A. Yeah.
Q. And SPI-M is not a subgroup of SAGE but it's a standing advisory group to the Department of Health and Social Care, and is it right that that advises the government on pandemic risk and preparedness?
A. Yeah, modelling-wise, yeah.
Q. And modelling?
A. Yeah, there will be other committees like NERVTAG or -- yeah, that would advise on different aspects for pandemic response.
Q. Thank you.

Can I just ask you, in relation to your expertise and experience in adult social care, is that something that you had pre-pandemic, or is it something that's developed as a result of and since the pandemic?
A. I mean, it's -- it wasn't immediately prior to the pandemic. I mean, the only work I'd really done was the lit review and the modelling around enclosed societies. So, in that sense, we're treating a care home as an enclosed society. But, yeah.

Obviously, then, because of that experience, that's why the chair of SPI-M-O invited me to set up the subgroup on -- for care homes, that then sort of

cascaded from there.
Q. So just to check I've understood correctly, your expertise in adult social care came mainly from your modelling work --
A. Yeah, very much so.
Q. -- in relation to enclosed societies, which we will come on to deal with?
A. Yeah.
Q. Before we do, can we just briefly deal with modelling, please. The Inquiry has heard quite a bit of evidence on modelling in previous modules, so I don't want to spend too long on it, but just briefly, is this right, Professor, that if we simplify it right down and put it bluntly, are models a way of making educated guesses, using data and assumptions, about things that are not otherwise easily observable?
A. Yeah, a model is simply a simplification of real life that you have to make assumptions that hopefully are evidence-based to make them computationally tractable so you can understand them, run them, and then understand the outputs. The ... yeah. So that's the thing. I think the ... yeah.
Q. Thank you.
LADY HALLETT: Do you tell your students you only make educated guesses?

A. Well, I think the important thing, and this is what -- I was just trying to recollect was, it is -- yeah, we do, I think this is the important thing that students need to understand, that it is sort of an educated guess, but if you don't have a model you're just making it up as you are going along, really, in the sense that -- you need a model to give yourself a framework for decision making. And some -- yeah, and that's where it sort of ...
LADY HALLETT: And then you need the decision makers to understand the limitations on modelling --
A. Of course.
LADY HALLETT: -- in what you're trying to do.
A. And that's the hard bit. I always tell PhD students, maybe more than undergraduate students, that designing the model is the easy bit, it's building the interventions in that we, sort of, start to earn our money, as it were, or -- yeah, from an advisory piece, because that's where the nuance comes in.
MS JUNG: We touched on the limitations to modelling, but is it right that the quality of models depends on the quality of the data underlying it as well as the assumptions?
A. Yeah, very much the two go hand in hand. There's the sort of -- it's a fairly old trope but yeah, a model is

only as good as the data that underpins it.
Q. If I can just summarise a statement in the technical report, do you agree that for models to provide the best insight, good data is required? If data entering models are of poor quality, then the model results will be too. There needs to be a diverse range of data using different methodologies. When data has been lacking, assumptions were required to fill gaps. These unknowns may be biological, sociological or related to policy. And speed of data is also important.

Do you agree with that?
A. Yeah.
Q. And what do you consider to be good quality data?
A. I think it's very hard to define that succinctly. I mean, I think it -- it tends to be operationally ... it's just very difficult to come up with a clear definition of "good data".

If you can have multiple datasets to triangulate a finding, then it becomes -- and sort of self -- and validate or verify findings from one dataset to another, then that makes life a bit easier. So the -- yeah, diversity is very important. Yeah.
Q. Sorry, I think I asked a very broad question. But if we could look at in particular adult social care data that was available at the beginning of the pandemic, but also

as the pandemic developed, you say in your statement that it's quite difficult to categorise types of models, but -- types of models and data, but you --

A. Mm.

Q. -- summarise them into four broad areas.

A. Yeah.

Q. The first is disease epidemiology, and that's the information about the disease, so, for example, transmission routes, and so on. The second is information on social mixing patterns?

A. Yeah.

Q. So that would include, for example, how often people are coming in contact with settings and between each other --

A. Yeah.

Q. -- the movement between settings and so on.

A third is surveillance data from settings. So would that be, for example, if there'd been an outbreak --

A. How many cases --

Q. -- the health protection team would go in and collect information on the number of cases and things like that?

A. Yeah.

Q. And then finally, quality of life factors.

A. Yeah.

Q. And that would cover things like what is the cost of disease to an individual?

A. Yeah.

Q. Or the cost of the --

A. Or the cost of the intervention, yeah.

Q. And as far as adult social care data is concerned, were any of those missing, and what impact do you think that might have had on the response?

A. So the key one that it was missing, and sort of arguably still is missing, would be the social mixing within care settings.

There were efforts to look at that through the contact survey run out of the University of Leeds, and so that -- we spoke to them, and we are speaking to them on an ongoing basis. That's a very important study hopefully that we can, sort of, do in the future, and I've got a PhD student looking at some of that work, collaborating with the PI from that study.

There were operational challenges to collect that data in the pandemic, in sort of wartime, as it were, during the pandemic. Getting researchers into care homes isn't easy, and so you're reliant on, sort of, remote challenges. And so actually, the delivery of that data in the pandemic is challenging.

So, in terms of that from a lesson learnt, we really

must have protocols for such studies set up ahead of time, so that in the future we can make the ethics and the way of collecting data faster and more reliable in the future.

Q. And just to clarify, the contact study that you refer to there, is that one where they put Bluetooth devices --

A. It was, yes -- (overspeaking) --

Q. -- into care homes to see how much staff and residents came into contact with each other?

A. **(Witness nodded)**.

Q. But there were, as you say, operational difficulties during the pandemic --

A. Yeah.

Q. -- and so you're saying that that kind of research needs to be set up in advance, is that --

A. Yeah, and it must involve residents and staff in that, so you get a whole sense of the setting.

The -- and so without that sort of data you're sort of blind -- you're having to make assumptions about people just mixing randomly within the setting, which may not be true, and that sort of thing.

I think the surveillance -- sorry, did you want to follow up on that before I go into the other -- (overspeaking) --

Q. I was just going to ask, just on the back of what you

said, so where data was missing during the pandemic and therefore your knowledge had gaps, how did that impact on the quality of the modelling that was produced during the pandemic?

A. I think you have to couch your advice from the models in the light of the fact that there are gaps in the data. So some of the early work that we put in through sort of the May SAGE paper, there was modelling advice that went into that generated from London School of Hygiene and Tropical Medicine's modelling team, that was perfectly good modelling and they would have been assuming sort of random mix -- a certain type of mixing between staff and residents, but it was an assumption rather than data driven.

Q. Thank you --

A. Because of that, yeah.

Q. Thank you. So that's social mixing data.

A. Mm-hm.

Q. And what about quality of life factors --

A. Yeah.

Q. -- is that data available?

A. No, not in an easily modellable form. So this is one of the things that we learnt through the pandemic -- a couple of times on a couple of different commissions that that sort of quality of life, the traditional, kind

of, way from a health economics point of view would be to, sort of, do a quality-of-life questionnaire on people -- I think in care homes there is a more nuanced and, sort of, more -- a better way of doing that through, say, the ASCOT tool, and I think you've heard about ASCOT from previous witnesses. And I think that would -- but that -- that has been used but it hasn't ever been used from an infectious disease angle, so it's typically used for chronic infections or general quality of life in the setting, the, sort of, transient nature of an outbreak, I think you -- we need -- there needs to be further work done on collecting that sort of information to look at how quality of life is affected by the disease and the interventions, what the return to normality is after isolation, say, and, yeah.

So yeah, that data wasn't available.

We particularly found that -- when we were looking at whether visitors should be allowed back into care homes --

Q. Yes.

A. -- and I don't know if you want me to talk about that later or bring it up now?

Q. We will be covering that topic a bit later.

A. Okay, we can come back to that then.

Q. Thank you, Professor.

Can I just ask, you did mention health economists would normally carry out research in this area.

A. Mm.

Q. Did you have any, as part of the working group?

A. Yes, not in April, May, June. I invited Alex Thompson from the Centre of Health Economics in Manchester to join when we started looking at health -- at visitors, visitor isolation issues, and so he wrote some of the reports on that.

Q. Thank you.

A. And then later, we had economists from London School of Economics working with us on, say, the discharge piece and other aspects but that was probably a few months like, yeah, that was probably during the sort of alpha and post-vaccination types -- I can't remember the dates when they came on. It was a bit of an evolving piece.

Q. Don't worry about the dates.

A. Yeah.

Q. Thank you. The Inquiry heard earlier on that representative groups like the National Care Forum were able to carry out quite widespread surveys of their members. Is that something that you explored early on in the pandemic when you realised you were missing that data?

A. Yes. I think you can clearly see in the paper from

12 May we have a list of data sources, and the types of studies that we would need to fill in those data gaps. So we made -- so that was the main effort, from the start of care home, sort of, subgroup of SPI-M through to the adoption of SAGE, that first paper was really around how we fill in some of the data gaps, and enhance the modelling capacity, as well.

Now, what was -- and then we sort of looked at some of the ongoing research and we were, rather than having to fill those survey gaps ourselves, we were able to use studies like Vivaldi, eventually, to fill in those gaps. So we basically got other researchers to do that work for us.

Q. Thank you. Can I ask you about your work on enclosed societies, please.

A. Mm-hm.

Q. And it's right, isn't it, that after the 2002 swine flu pandemic you produced a couple of papers?

A. Yeah.

Q. And forgive me, when I refer to "you", I'm actually referring to you and your team at the University of Manchester, is that right, or at Public Health England?

A. Well, these papers were when I was in PHE.

Q. So these papers were at Public Health England?

A. Yeah, Public Health England.

Q. And you produced one in 2012, which was a literature review?

A. Yes.

Q. Could you tell us, please, first of all, what enclosed societies are and what the key findings of that research was, please.

A. Yes, so we took the definition of enclosed societies to be somewhere that had a population that was largely resident in the setting, and had limited -- and it's hard to define that -- that connectivity, but had limited connectivity to the external community.

I think the commission from the Department of Health to PHE was originally driven by a concern that such settings would have higher attack rates than the general community, which is what we then found.

Q. And that's what you found?

A. Yeah.

Q. And would care homes fall into the description --

A. Yeah.

Q. -- of an enclosed society?

A. Very much so. Prisons, cruise ships, naval ships, barracks would also be within the definitions for that paper.

Q. And was it just a high attack rate that you found within enclosed societies --

A. That was the commission -- (overspeaking) --
Q. -- or was there anything else relevant?
A. No, that was the key metric that we took out of the study.
Q. Thank you. And is it right that you also found that pre-pandemic Public Health England was essential when it came to trying to protect enclosed societies from those high attack rates? And that rapid intervention was essential, using control measures?
A. Yeah, I'm not sure that that -- that the direct output would have been -- yeah, rapid. I'm not sure those words would have been exactly what we used. But I think that's that sort of -- a heavy implication, if that's not the wording we used, so yes.
Q. Do you recall what kinds of interventions were mentioned in the literature as being effective in controlling transmission within enclosed societies?
A. Not off the top of my head. Um --
Q. Were they the sort that would reduce contacts between the -- (overspeaking) --
A. Yeah, it's essentially non-pharmaceutical.
I mean, what you have to realise is this was a lit review of all influenza outbreaks over the last hundred years or so, so it -- it went right the way back to the 1890 pandemic, 1918, some seasonal flu, I think

there were a few care homes in the '90s -- 1990s, that reported outbreaks, and '68 and '57. So it would have taken a -- yeah, a sort of -- a broad range, where different intervention technologies would have existed.
Q. Thank you.
Professor, that study was communicated back to the -- the findings of the study were communicated back to the government; is that right?
A. Yes.
Q. And from your involvement in SPI-M, did you see any evidence that the advice or findings from that study had been implemented in terms of pandemic plans or preparedness?
A. Not that I could point to categorically, perhaps. I mean, I think that feedback loop is perhaps something that we need to get better at as a community, in the sense that we wouldn't necessarily have asked them if they had inter -- come up with a plan yet, because it was a commissioning process for SPI-M, not necessarily an asking back question.
Q. But is it right that SPI-M was involved in the modelling in Exercise Cygnus?
A. Well, I was by virtue of it being the team that ran the modelling for Exercise Cygnus. So my team in PHE was responsible for developing the modelling for Cygnus.

Q. I see, thank you.
And in that role, do you think care homes or the care sector more widely played a big enough role in that exercise in pandemic planning?
A. I do not remember explicitly modelling care homes in the Cygnus scenario, but the Cygnus scenario was designed to be a look at the national wave, sort of the community wave, and then there would have been modules within that that the policy teams playing the exercise could have had their own bespoke injects for that wouldn't have required my modelling or my team's modelling explicitly.
I think the only thing I can point to in the public domain around Cygnus and care homes is the Cygnus report that has an annex that explicitly says the lessons learnt from Cygnus related to adult social care, which I think -- I haven't quite got it in my head chapter and verse but I think it made --
Q. Don't worry about the detail.
A. -- it -- yeah, it's definitely in the public domain, and the lessons were identified, hopefully learnt, from that.
Q. Is it your case that, based on the work that you had done pre-pandemic, and the conversations you had through SPI-M, the government was well aware, before the pandemic started, that care homes were particularly

vulnerable to infectious disease outbreaks?
A. Um, "well aware" is possibly -- it's difficult to quantify, sort of, "well aware", but they certainly had the information. I can't comment further than that.
Q. In the May 2020 consensus paper, you refer to pre-pandemic papers, and one of those is a 2018 paper by Cassell and others on --
A. Yes.
Q. It's on scabies outbreaks in care homes, but, at the end of that paper, the authors mention the fact that care homes are a vulnerable group in need of advocacy. Do you agree that that was the case --
A. Yes.
Q. -- pre-pandemic? Had you seen that paper?
A. I was aware of that paper. We are quite a small community out there. That paper is one of the leading -- well, it is a very important study of modelling applied to care homes. One of my colleagues -- modelling colleagues in Manchester is a co-author, and Jackie Cassell was the lead author.
Because of my awareness of that paper, that was why I invited her to the Social Care Working Group membership, participantship, participants, and then she has subsequently, not for anything -- under her own accord become the head -- national lead for adult social

care within UKHSA --
Q. Thank you.
A. -- so she's now in a position of -- yeah.
Q. And Professor, given what was known about vulnerability of the care sector or care homes, why do you think that the research gap that you identify in your statement existed pre-pandemic?
A. Which research gap are you alluding --
Q. You say in your statement that care homes were the focus of scientific research --
A. Yeah.
Q. -- prior to the Covid pandemic, however the specifics of respiratory disease transmission and its control represented a gap and needed further research.

Are you able to help us as to why that research gap existed?
A. I think it is -- I think, with hindsight, I think the gap is that we -- we needed a more integrated community -- research community response, and so -- so we needed modellers but epidemiologists working with experts in social care, experts in frailty, to understand the implementation barriers. Also -- I mean, experts in social care, so yeah. And then practitioners, as well. So I think it's -- we probably didn't invest enough as a country, as a sort of -- yeah,

as a group -- yeah -- working on that particular area.
Q. And just before I move on to the next topic, do you have any recommendations for how we can ensure that the care sector is the focus of academic research going forwards?
A. Yeah, and I think Professor Shallcross alluded to this as well. I think the -- well, I think the -- or I've definitely heard it in some of the previous witnesses, that we need to have a research-engaged social care sector. So we need to work, we need to engage and involve the social care sector more in infectious disease research. So it needs to be a two-way dialogue.

Also, I think when we started Social Care Working Group, I'm going to call it Social Care Working Group even though it had a few different names beforehand, just for everyone's simplicity. When we started this, we had to set this up from scratch and so we brought people in at pace. And you need, in some of these groups where people haven't known each other, you need to develop trust and academic trust, sort of, to, sort of, exchange ideas, and so we need some sort of forum in peace time to talk about infectious disease risks in these settings.

Care homes aren't necessarily the only setting of this type. I think we found in the pandemic that a lot of translation of the advice we were giving to care

homes was -- sorry, a lot of the advice we were giving to care homes was translated to prison settings. That is not -- and I don't want this to go down as we are equating care homes with prisons, it's just an artefact that they are both enclosed societies, and I appreciate that's outwith the remit of Module 6, I just want to -- (overspeaking) --
Q. Sorry, if we can try and keep on topic, I'm sorry, we've got quite a lot to cover and I just want to make sure we get through it all.
A. Yeah, sorry.
Q. Thank you.

Can we move on to early knowledge during the pandemic, and the initial response of the government, please?
A. Yeah.
Q. So you carried out your work pre-pandemic on modelling, on enclosed societies. Is it right that in February 2020, you were involved in some rapid work in relation to the Diamond Princess outbreak, and that was the cruise ship from Japan?
A. Yeah. Cruise ship, yeah.
Q. And what were the key findings from that?
A. The key finding was that the attack rate was large, very high. And the immediate take-home message that -- so

this is -- this is really important, that we were struggling until February to get good international -- data on the international perspective. And that was the first dataset that I saw that was clearly saying that an enclosed society -- a cruise ship is slightly different, but an enclosed society could have a high attack rate.

So that really triggered -- I then immediately reached out to colleagues in PHE, in the Health, and Justice teams to check what the plans were for prisons and we started having discussions on the Joint Modelling Team about the need for, sort of, care home work, and build from that.
Q. And is it right that on 13 February you sent your work on the Diamond Princess outbreak, along with your previous work on enclosed societies, to the government through SPI-M?
A. Yes, yeah.
Q. Did you receive any response to that?
A. Not -- I mean, not that I can recollect, except -- and this is where timing -- I'd need to go back to my emails to find out precise timings, but we did start soon after that to have -- to talk to the economists in the -- the analysts within the Department of Health adult social care team, and so we were making reasonable worst case projections for them through February, March, but the

exact timings, I get a little bit hazy.
Q. I think you may be referring to this: in February/March you were commissioned through SPI-M to carry out some modelling work and you did that on cocooning; is that right?
A. Yeah, I was a co-author on that, the lead -- yeah, another colleague actually led the modelling, but yeah.
Q. Thank you. And if I could ask for that document to be brought up, please. It's INQ000575255.
Is this the paper that you sent?
A. Yes, this is the SPI-M paper that Professor Pellis wrote, yeah.
Q. Thank you, and what was your rationale in sending this paper?
A. My understanding is that the chair of SPI-M-O had phoned Lorenzo Pellis and asked him to develop -- to look at the impact, the potential role that cocooning may have. "Cocooning" was the term at that time. It morphed into being called "shielding" later. So these terms change.
Q. Thank you. And did that paper ultimately advise that shielding could substantially reduce the number of cases and hospitalisations and deaths in care homes?
A. I mean, the table there shows that it could have a role. I think the caveat that I would put on this is that that proportion of probability of introduction, which was our

sort of scaling for the role of cocooning and how much of a fortress you can make these settings, that is just a number in the simulations. There is no correlation there to the effort required to achieve that number.
Q. But just in terms of the numbers that you were advising on, what does that table show us? Does that show that if you can reduce the likelihood of the virus entering a care home to, say, 70%, was it saying that it estimates that that would reduce -- would that avoid 21,000 deaths?
A. No, it would -- you would get 21,000 deaths but you --
Q. You would get 21,000 --
A. -- you would save 5,000 deaths.
Q. And as you go down the table, you can see that as you reduce the likelihood, you reduce the number of deaths?
A. Yeah, yeah, yeah. But I would read that -- so that was delivered in March, and as I say, that probability of reduction was not linked to an effort required. I think the companion paper that most -- that is most key is then the -- the Social Care Working Group chair's briefing on shielding that we wrote in December 2021 as Omicron was coming through about the challenges of implementing shielding.
Q. Yes, and we've got your evidence on that in your statement.

A. Yeah.
Q. But just in terms of, sticking to the advice that was given and the timeline, if I may.
A. Yeah.
Q. So you do this cocooning work in February, March, and do you get any response to that?
A. Well, because it was another colleague that was the lead author, the -- any responses may have gone to him. I didn't personally get any responses, but then, why would I? The thing that was -- yeah. We then, having written that paper, the next two weeks we were incredibly busy, as a group, looking at the doubling time of the community cases, and advising on lockdown.
Q. So this is your work through SPI-M --
A. SPI-M.
Q. -- on doubling time -- (overspeaking) --
A. Doubling time of the pandemic.
Q. But sticking to the timeline for -- that's relevant to the care sector --
A. Yes.
Q. -- is it right that your next involvement or the key involvement that I want to focus on is in April 2020, you then sent some papers to the government on analysing, a preliminary analysis of some of the data that was available on -- (overspeaking) --

A. Yes, the emerging data that was coming through, yeah.
Q. And that was the Public Health England's outbreak data; is that right?
A. Yeah.
Q. And what did that preliminary analysis show?
A. It showed that if the trend continued, you'd have a very large outbreaks in care homes. A very large number of outbreaks in care homes, I can't remember the exact proportion --
Q. I think it was 90 --
A. 90% -- yeah.
Q. 90% of --
A. -- (overspeaking) --
Q. -- care homes would have an outbreak if the -- (overspeaking) -- is that right?
A. -- (overspeaking) -- unmitigated, yeah.
Q. Is it also right that on 17 April, CQC shared data with you and Public Health England?
A. Yes.
Q. And did that show that whilst hospital deaths were plateauing, there was a rapid increase in care homes?
A. I -- I think we have to be careful here in interpreting the data. And I've seen in -- that there were some emails that I wasn't copied into between someone in UKHSA and the chair of SPI-M.

Q. It may help -- sorry to interrupt, but it may help if we actually bring that up on screen. So it's INQ000229026.
A. 603, yeah.
Q. And as you say, you're not copied into these emails?
A. No.
Q. But Graham Medley was the chair of --
A. SPI-M-O, yes.
Q. And this is an email chain between him and Patrick Vallance?
A. Yes.
Q. And if we start on page 2, we can see --
A. I think the -- the thing that I would want to -- I'd have to go back to and check with the data -- because there is a difference between place of death and residence at time of death. So some of the signals -- and so the graphs that are shown on page 3, that could be, and I don't know, but it could be that that is place of death. And so some of the increasing in -- so there's an increase in care home deaths, but actually, the people who were in care homes are dying in hospital, because they've been so sick they've been put into hospital, and then -- but actually the reconciliation brings them back. And that's why the CQC data is important, because this -- I don't recognise this as CQC data.

-- (overspeaking) --
A. I think, yeah --
Q. -- and the realisation that care home deaths were on the rise?
A. Yeah, it would have been around this time that I'd have been called by Graham and asked to set up a subgroup. I think you kind of -- sometimes, the dates of the papers is a little bit misleading, but it takes a couple of weeks for us to do the analysis, so we'd have been getting the modelling -- I mean, certainly I think CQC turned on their mortality specific to Covid about 11 April, so probably around this time we were already getting, sort of, CQC data. So I was looking at CQC data. This metric looks like it's NHS data. Yeah.
Q. I see.
A. So --
Q. Sorry, Professor, if I could just try to keep you on track a little bit.
A. Sure.
Q. So we know that on 17 April this information comes through by email from Mr Medley about the number of care home deaths being on the rise. The Care Home Working Group is set up towards the end of April; is that right?
A. Yeah.
Q. I think you met informally when it was a subgroup of

Q. Forgive me, Professor. I don't want to get into the detail of what the analysis actually shows. I'm interested in what the government knew and were thinking at the time.
A. Right.
Q. And if we look at this email, it's between the chief government scientific adviser and Graham Medley. And can we see in the highlighted section that Mr Medley at that point was quite concerned about the widespread ongoing transmission in health and social care systems, and he says:

"Hospital and community-health and social care appear to be driving transmission, and potentially at an increasing rate, in effect, this is the opposite of shielding -- vulnerable are being preferentially infected."

Do you see that?
A. Yes, I can see that, yes.
Q. And Mr Vallance responds to that, as does Mr Whitty, indicating that the government was already aware of this issue.

It was after that, on 27 April 2020, that the Care Home Working [sub] Group was formally established.
A. Yes.
Q. Do you know if that was as a result of this data or

SPI-M-O?
A. Yeah.
Q. About a week before that?
A. Yeah.
Q. But by 24 April there had been at that point approximately -- the death rate in care homes had increased from approximately 2,500 deaths per week to 7,400 deaths per week. And in a meeting note by Charlotte Watts, who went on to become the chair, didn't she, of the Care Home Working Group --
A. Yeah.
Q. -- she also notes that there were discussions about being -- there being serious gaps in the data --
A. Yeah.
Q. Serious gaps in understanding what the drivers were of transmission, it being recognised that there were differences between different types of care settings, and the kinds of issues that the Care Home Working Group went on to formally consider after it was established; is that right?
A. Yeah, yeah. But we were probably having some of those conversations sequentially -- yeah. Yeah, at the same time as -- yeah, at the same time as those emails were being sent.
Q. So can I ask you, in terms of the conversations that

started, then, in mid-April, and the formal group that was set up at the end of April, do you have any reflections on the timing of those conversations? Do you think that that thinking about the care sector should have happened earlier on in the pandemic?

A. With hindsight, you can always say we should have done things earlier and faster. So, yes, we could have had some of those conversations, but we were responding, then, to a signal in the data. And so -- so, yeah, it was a responsive decision. If we'd -- yeah, if we'd had a group looking at this with a responsibility and a mandate to look at that, then you could have been a bit more agile maybe, but I think there -- yeah, we weren't -- we weren't looking at that. And when I say "we", I mean it's a collective, very much a collective, and I mean across government as well.

Q. Thank you.

A. I mean, I think -- so, yeah, things could have always been done faster.

Q. And what, if any, impact do you think that the delay in establishing the formal group might have had on the quality or timeliness of advice provided to the government in respect of the care homes and the care sector more widely?

A. I think that's a very difficult question to answer

quickly.

Q. If you could try to answer it shortly, please.

A. I think we would have been -- I think the studies that were being considered to improve the data quality, probably -- you'd have to ask the PIs of those studies, but I would say that that wouldn't have changed the outcome from those studies.

Yes, so I think -- I think we may have been in a similar situation if we'd only been set up a week or two earlier. That does sound a little bit nihilistic when I sort of say it out loud but --

Q. But if you'd been set up at the beginning of the pandemic?

A. If we'd been set up in January we could have started to have conversations about studies and what models exist -- or, well, what we would need to model that situation. So yeah, we -- yeah, if we'd -- yeah.

Q. Thank you.

LADY HALLETT: Or by February, when you knew about the Diamond Princess and that this virus might target older people?

A. Yeah, yeah. I mean --

LADY HALLETT: This is a "you" collectively, it's -- (overspeaking) --

A. Yeah, yeah. I mean, it's difficult not to feel kind

of -- yeah, sort of a personal responsibility there. But I think it -- yeah, I mean, I think we could always have acted earlier. I mean, I don't know -- I don't -- yeah, I mean, that's just sort of a truism of this -- with hindsight.

And the swirling mix of things we were doing at that time, we just don't -- we didn't know where it was going to end up. Now it looks obvious, but, um, yeah, we were still trying to understand some of the fundamentals of the disease epidemiology.

MS JUNG: Thank you, Professor.

Can I move on, please, to the hospital discharge consensus statement.

A. Yeah.

Q. It's right, isn't it, that that was published in 2022, although is it right that that was actually discussed and authored in 2021?

A. Yeah, yeah, it was --

Q. Could you help us as to why there was a delay in the publication of that statement.

A. Yes. There were a number of reasons. We had a meeting in 2021 after a commission from the Department of Health to look at the discharge question. We had a meeting with PHE, NHS England, Scottish and Welsh analysts, and everyone agreed to go away and do the analysis that they

then did. Some of that was already being done. I mean it's not just because we said they should do it; they had their own proactive academic freedom.

And then we that another meeting to sort of reflect on that. The -- my memory is that the NHS England struggled because there was -- to get sufficient data from the England signal, they needed to wait for the -- a certain period of time to elapse. They needed two or three months for their data to work through the system. And then we -- so PHE then delivered their work, as did the Scottish group and the Welsh group.

And then when we came back to this, and this is one of my --

Q. When did this all happen? Because --

A. This was happening through 2021. I can't remember the dates, so I'd have to go away and sort of find the dates of some of these meetings. It would have been talked about during Social Care Working Group -- routine Social Care Working Group meetings as well, so it would have been an ongoing dialogue.

Q. So are you saying that the data was being collected and the statement was being authored -- (overspeaking) --

A. Yeah, yeah, so it evolved over time. We had various drafts of this. Nothing --

Q. So it's not as if the statement had been written and

then there was a pause in the -- (overspeaking) --
A. No, no, I don't think -- there was a pause for two reasons, before it was eventually published. One was the Gardner legal case because some of the members on Social Care Working Group felt conflicted by the legal process and I'm not a lawyer so I don't want to go into that.
Q. We don't need to go -- (overspeaking) -- thank you.
A. But I think that caused a delay. The other delay was NHS England then not doing the analysis that they had committed to, for reasons that -- yeah. Again, I'm not -- we asked them to do it and then the analysts were quite happy to do it but someone in the process stopped that work being done.
Q. What was the analysis meant to -- (overspeaking) --
A. The analysis was supposed to be a repeat of the Welsh and Scottish work, on a bigger population, and that was then the --
Q. So just --
A. -- so because it wasn't done, we wrote the paper, we decided we had to sort of -- we were getting pressure to actually deliver this, so we wrote it and we put that in as a recommendation that it should be done in the future.
Q. Thank you. In terms of the analysis that the NHS

England were meant to be doing, was that, to put it simply, linking the hospital discharge data with the epidemiological data from PHE?
A. No, they were own --
Q. Their own data?
A. -- (overspeaking) -- yeah.
Q. But carrying out that linking of the data.
A. Yeah, the linking to the social care side of things.
Q. And is it right that that -- the NHS's hospital discharge data was not ever made available to you?
A. It wouldn't -- why would it be to me? Because they have their own analysts to do the analysis.
Q. Sorry, I mean for the purpose of your analysis as part of the Social Care Working Group?
A. Yeah, they share -- so the analysts -- I -- they shared a subset of the data, but it was insufficient to run at that time that they shared the data because the numbers were too small. So they needed to wait two or three months to -- on a bigger sample to run the numbers.
Q. Right. But it's right, isn't it, that you were asked to look at the impact of hospital discharges on outbreaks in care homes?
A. Yeah.
Q. That initially, you were asked to do that by looking at the Public Health England data as well as the NHS

discharge data, and then when it became known that the NHS data would not be available, you were then asked to look at analysis that were done in other countries, so the analysis done by Public Health Wales, Public Health Scotland, the Public Health Agency, and the UKHSA?
A. No, I think that's a slight conflation of the process. I think Scotland and Wales had done their analysis first, through their -- through commissions through their own governments. And so the -- I'm not exactly sure on their commissioning process but that work had been done and it had been published and we cite those publications. PHE and NHS England were supposed to do the equivalent analysis on the English data.
Yeah, I remember a meeting where the -- when --
Q. It's -- forgive me, Professor. It might help.
Can we have the consensus statement up, please? It's INQ000343826.
A. Mm-hm.
Q. And if we look at page 3 --
A. Yeah.
Q. -- we can see the order of commissions there. Sorry, if we can go up to the "Motivation" section. So you can see that:
"The Public Accounts Committee recommended in summer 2020", that the review be carried out.

The DHSC then commissioned a consensus statement, and you can see there, "to take into account work already undertaken by NHS England --
A. Yeah.
Q. -- and Public Health England and any relevant analysis from the devolved administrations".
A. Sure.
Q. Then in July 2021, when it became apparent that NHS England and the improvement data and analysis would not be available, DHSC revised the ask to cover Public Health England, Public Health Wales, Public Health Scotland, and the Department of Health Northern Ireland; is that right?
A. Yes. Yeah, yeah, that's helpful, yeah.
Q. So the data that you did eventually end up using for your analysis was not what would have ideally have been used if the NHS data had been available; is that fair?
A. Yeah, yeah. I think the analysis that was done was sufficiently -- it's just a statistical -- it's just a bigger sample. You've got ten times the population, it would have given more power to the study if NHS England had done their analysis.
Q. But the review you were being asked to carry out was in relation to hospital discharges impacting care homes in England, is that right, rather than the UK overall?

A. Yeah, I mean, so the precise wording from the Department of Health -- the precise wording of the commission I would have to double-check, but --
Q. I don't need to know the precise wording --
A. -- we took a four-nations approach on Social Care Working Group, so we had --
Q. Sorry. I don't mean to overspeak.
A. No, no.
Q. But could you just clarify whether the work was looking at whether there was a link between hospital discharges and care homes in England or whether you were giving a consensus statement on the impact --
A. We took a four-nations approach --
Q. -- across the UK?
A. -- so we were looking at the whole of the UK, all four nations.
Q. Thank you. The conclusion that you reached in that consensus statement, Professor, was that hospital discharges did not appear to be the dominant way in which Covid-19 entered care homes, and were highly unlikely to have been the dominant driver of all care home outbreaks in wave 1; is that right?
A. Yes.
Q. The statement further concluded that care home staff and visiting professionals were likely to dominate routine

connectivity; is that right?
A. Yes.
Q. In the consensus statement, if we can look at page 3, please. At the bottom of the page, can we see there it says:

"Any person going into a care home could introduce COVID-19 to the care home. The main groups of people crossing the threshold of care homes, shown in figure 1, are listed below in terms of frequency of contact with residents ..."

Am I right in understanding that the list below of the categories of people that potentially might bring in Covid, are they listed in descending order of frequency of contact?
A. Yes. So staff would have the most contact because they're there every day, all day, for care provision. Visiting professionals and friends and family, maybe they're similar in terms of frequency of contact.

And then, from there.
Q. And what was the data that you relied on and the methodology to be able to work out who had the most frequent contact?
A. I think it was -- we did not have good data because of the very reasons we've been talking about. We don't have the social contact mixing. So that can and should

be improved. We do need to look at that as a priority.

This was based on a sort of risk assessment kind of approach, where we took the care home size, the typical workforce in those care homes, and typical -- steer from -- on how many friends and family would come in and that sort of thing. So it was -- wasn't based on accurate specific data; it was based on expert opinion from colleagues in Social Care Working Group who were experienced in the care sector.
Q. And can I just ask you about some of these categories.

So we can see in the top category you have grouped together care home staff and non-care staff, such as cleaners and cooks.
A. Yeah.
Q. What was the rationale for grouping them together? Because presumably non-caring staff, such as cooks and cleaners, may have less contact than the caring staff?
A. Sure, yeah.
Q. So what was the rationale in grouping those together?
A. I think it was probably a presentational one of having fewer bullet points. I don't think it was -- I think -- I think, yeah, we obviously did see of the difference. I think one of the comments we had -- I do remember a discussion, and again I wouldn't be able to be clear on dates, but we had a discussion at one of the Social

Care Working Group meetings about the nature of staff, because we were talking about staff in the generality, as it appears in this list, and then I think others were interpreting it just as the care staff.

And in terms of general connectivity, the receptionists, the cleaners and the cooks are still part of the setting, and they are still mixing with the staff. And so, as part of a dynamic in the disease transmission, even if they're not having regular contact with the residents, there may still be staff-to-staff transmission before they get to the resident transmission, so they still need to be counted as part of -- and considered.
Q. The Inquiry has heard that many caring staff were themselves vulnerable.
A. Sure.
Q. So, to what extent did this analysis take into consideration, for example, staff who may have been shielding for significant periods of time, or indeed staff who may have been cohorting, or had moved into care homes so as to reduce transmission?
A. Yeah, I mean -- this paper was on hospital discharges. So it would -- that wouldn't have been a consideration in detail in this piece of work. That sort of discussion would have come in some of the other outputs

we would have had, where we were sort of, yeah, looking at that sort of role of staffing.

Q. Forgive me, Professor, but I thought this list was looking at frequency of contact --

A. Yeah --

Q. -- generally.

A. -- it was --

Q. What time period did that cover?

A. Sorry, what time --

Q. What time period did that cover?

A. The -- it would have been a sort of ...

So the frequency of contact -- by what we mean there, we would have meant daily contact. So per day, these are the, sort of, bulk contact rates.

If you think about it for a resident, they get care provision from a member of staff on a daily basis, hopefully more than a daily basis, but they will have a GP visit them once a week or whatever it might be, a visitor come in once a week. That sort of thing.

Q. Perhaps I should assist by referring back to Professor Shallcross's evidence.

A. Yes, sure.

Q. She told the Inquiry earlier on that it was important to note that the route, the potential routes into a care home changed dynamically over time, and that's because

various policies came in at different times.

A. Yeah, yeah.

Q. Is it right that there were also regional differences in --

A. Yeah.

Q. -- in implementation of policies, different care homes had different policies? So to what extent were all of those variations taken into consideration in your analysis?

A. Well, yeah, that's true. You've got to balance the full complexity with being able to write something that people can take away. So this is sort of a deliberate simplification down to that schematic, just down the page.

Yes, we would have been aware, fully, of the fact that these different -- yeah, there would have been a churn or flux through the pandemic of different things, factors, and -- and sort of with shielding or not in place, or various interventions in place.

So, yeah, and that -- but that's where you need to have good-quality data on contact patterns, so you can start to consider the different magnitudes of this sort of thing.

Q. Thank you. And Professor Shallcross also said in relation to this diagram that her view was that you

wouldn't be able to say which of these potential routes was the main source of transmission without carrying out comprehensive testing of all of them. Do you agree with that?

A. I do to some extent. I think the one thing I would say, we tried to look at this as a dynamic risk assessment tool with the Scottish Government at one point, because they were wanting to have a sort of -- some sort of local delegation of management and when we looked at that and we started putting in realistic numbers to these ingress rates based on the Scottish healthcare -- social care system, the staff, core staff came out as a larger number than these other -- as at these other angles. So it would require quite a lot of mitigation on the staff to make that not be the dominant ingress mode.

But I do entirely agree with Professor Shallcross that it's complex and nuanced and it would change over time.

Q. Thank you. And if we look at the data that was and wasn't available, if we can look at page 4, please. The last paragraph of that page. Can we see there, it says:

"Evaluating all these routes contemporaneous to the period of discharge is not possible due to testing capacity at the time and variation in policy around

visiting and staff. Data on the number of visitors could be extracted from log books but this is likely to be a huge effort to digitise and there is no routine system for systematically collecting electronic visitor data (family or professionals)."

A. Yeah.

Q. So is it right that it's saying it's not possible to test all of those routes because there isn't enough -- there wasn't enough testing capacity?

A. Yeah, yeah, always read ahead. Yeah, no, I think, yeah -- no, exactly, I stand by that --

Q. And there was no routine system for collecting visitor data; is that right?

A. Yeah, yeah, and this is similar, if you're thinking around -- I mean, Vivaldi notwithstanding or the Easter 6 study notwithstanding, which were the two, sort of, best outbreak investigations during the pandemic in England -- other countries may have other options. When we were looking at routine surveillance data, you can link the case -- the resident data to care homes by UPRN or various technical solutions to that but it is -- you just couldn't link the staff or the visitors to those settings because there was no question in the survey, when someone took a swab, to say, "Where do you work?", to sort of get the linkage so when the linkages of

Pillar 1 and Pillar 2 were set up, that wasn't a feature, and it would have been even harder for visitors to link that data, because you'd have to have a question of: where have you been every day for the last week or so? And it's -- it just gets quite complex.

So staff data is hard, visitor is even harder.

Q. And is it right, also, that there was no system in place in any of the UK countries to routinely identify who was permanently or temporarily resident in care homes?

A. I'm probably not best placed to answer that question. You probably would want someone from the Department of Health or something to -- (overspeaking) --

Q. I'll ask you about a number of data sources and you can let me know if you know the answer or if you agree or disagree. Was there a system in the UK, or in any UK country, to routinely monitor Covid-19 hospital admissions in individual care homes?

A. So we were -- in individual care homes, we were eventually -- so once testing capacity scaled up through September time, we were able to -- or colleagues were able to sort of match that based on UPRN to settings generally.

Q. But is it the case that comprehensively, none of the analyses that you were looking at were able to gather

all of the data required and a big part of the reason for that was that testing was very limited especially early on in the pandemic --

A. Testing, yeah -- the limited capacity in testing. I think you have to be careful with what you mean by testing though, because testing means two different things.

Q. Yes, it --

A. So early on it would be PCR testing. LFD testing was the game changer later on.

Q. Yes. So, just to be clear, we're talking about earlier on in the pandemic --

A. Early on, PCR testing, you've got a physical constraint on lab capacity, which is very difficult to get around.

Q. And the Inquiry understand that there was very limited or no testing of hospital discharges into care homes --

A. Yeah.

Q. -- before the policy was changed in mid-April; is that right?

A. Yeah.

Q. Residents who went into hospital were mostly tested only if they were symptomatic?

A. Yeah.

Q. Residents, if they were asymptomatic, may not have gone into hospital at all?

A. Yeah.

Q. And so these are just examples of the way in which the testing --

A. Yeah --

Q. -- data was limited.

And can I ask you this, do you think that those limitations were clearly and strongly set out in the consensus statement?

A. Yes, because we talk about two different analyses, one looking at case data -- sorry, the test positive data. So -- sorry, we -- in the summary of evidence on page 11 we talk about care home outbreaks epidemiologically associated with a positive test, and we talk about that -- so that's the PHE analysis, then Scotland, Wales, Northern Ireland -- or Northern Ireland, not Wales. And then we talk about the analyses attached to all discharges. And so that's, again, a -- so we looked -- we did another -- colleagues did another analyses looking at all discharges, not just Covid testing.

So we look at both scenarios. There's probably not much more -- yeah, evidence that we could have extracted.

Q. Can I just ask you lastly on this topic, do you think that the limitations of the data consider, in each of

those individual analyses that you looked at, was set out strongly and clearly enough in the consensus statement?

A. In my opinion, yes. But I'm reading these as a statistician rather than -- yeah. So others may have their own interpretation.

Q. Thank you.

Professor, can I move on, please, to the topic of visiting restrictions.

A. Yes.

Q. In your statement you describe visiting restrictions in adult social care settings as a complex and difficult issue, and you set out all of the various efforts that you made, all of the studies that tried to quantify wellbeing and the impact of visiting restrictions.

A. Yeah.

Q. Do you think that modelling can be devised in such a way to take account of both the benefits and risks of visiting restrictions. And put another way, what I'm really asking is: do you think that the psychological impacts and the quality of life outcomes, such as the effects of isolation, can ever meaningfully be quantified?

A. I hope so. I mean, I think that's an area of future research. I mean, I've got a -- it's difficult. As

academics, we don't often talk about grants we've got under review, but I've got a grant under review to look at exactly that topic, integrating the ASCOT tool with the role of -- with staff, with -- within care homes.

So, yeah, I mean, hopefully, if that's funded, we would have a number of years study to look at the proof of principle of whether that is feasible. And that's the nature of research.

Q. Could I ask for page 20, paragraph 75 of the professor's witness statement to be brought up, please.

And here, in relation to visiting restrictions, you say that:

"We sought to finely balance the recognised benefits to residents of visitors, whilst also managing the risk of disease introduction and transmission. At that point in time, our understanding had evolved such that there was then strong evidence of the significant negative impact caused by loneliness and isolation on care home residents."

Then you say:

"It was advised that 'Policy decisions therefore need to take into consideration not only the scientific evidence about the two sorts of harm, risk of harm from COVID-19 and risk of harm from isolation -- but also the views of, and impact on, all of those affected,

residents, their loved ones, staff and community'."

Those negative impacts of isolation were well known to decision makers. What do you think the added value would have been in trying to quantify those impacts? Was it not something that was just common sense and known to policymakers, and do you think that all of the effort and time that went into this risked, in fact, overcomplicating the decision making?

A. That's a view. I think unless you look, you can't answer that question. I mean, you can't just assume things. I mean, obviously that's the joke about modelling, that we do just assume things, but you need -- you only assume things to test them later. So it's incredibly dangerous just to assume that, oh, it's obvious, it's common sense. You need to look -- there might be an area of where it is actually advantageous to do something else. So I think there is a -- it's often more complex than we would like it to be.

Q. And do you think that it risked adding unnecessary delay to the decision making because the decision making came down to a matter of balancing -- of judgements, didn't it?

A. Actually, I see where you're going. So I think, yeah, okay, so in peace time, we certainly should look at that complex balance. Here, I do not think it caused

unnecessary delay by us pausing and looking at this, and that's an artefact -- I say that because this was an organic process. So it's easy to see that we have SAGE's Social Care Working Group consensus statements punctuated with key dates, and this was delivered in November 2020 or whenever it landed.

But we were having that conversation about this -- about isolation and vulnerability through from probably July 2020 every week at Social Care Working Group. So we were having that dialogue, there were policy observers on the line. They could hear the direction of travel that we were heading, and that feedback -- so yeah, that -- yeah. The fact that this evolved over time was important for them to hear. And just hear where the nuance potentially came in. Yeah.

Q. Thank you. And finally, can I just deal with data gaps, please. You've identified a number of areas in which you believe further research is required.

A. Mm-hm.

Q. And those include, for example, the role of the environment and ventilation on transmission, as well as research on domiciliary care and people with learning disabilities. Is there anything that you would like to add to that, and are there any recommendations that you would like to make?

A. Yeah, so I think -- I mean, I think one of -- I was quite shocked at the quality of data around people with learning disabilities, when there were questions about the potential impact of Covid on people with learning disabilities. As I say in my witness statement, my sister has learning disabilities, so I had sort of -- and I could see the impact on her, sort of, from the, sort of, isolation of stopping day centres and things like that.

So because of that, I was thinking, okay, there will be some sort of database that we would be able to look at, and look at the impact of Covid on people in that risk group, and it just didn't exist. I mean, there was a PHE report that did the best it could with the data they had.

So I think there needs to be some sort of concerted effort to improve the quality of data in that sector, in that risk group. That's not just -- there's not necessarily a modelling aspect to that, so it's not necessarily for me to lead, but yeah, there should be more effort on -- (overspeaking) --

Q. And do you have any practical recommendations in terms of improving the data infrastructure?

A. Well, I think you need to have an ongoing dialogue. So this comes back to the fact that you need some sort of

social care forum, whether you call it a working group -- whatever you call it -- that looks at the risks of infectious diseases to two settings, social care settings, that is multi-disciplinary, and can enable interdisciplinary work, and look at research questions. I think, by the end of the pandemic, we had quite a good system going up to look at that. A lot of the traditional Department of Health, sort of, advisory groups are focused on explain, so SPI-M, NERVTAG, SPI-B, not necessarily looking interdisciplinary, and I think you need some sort of grouping.

And then once you've got that forum you can start to look at what data needs you have, and so SPI-M, we do look at data needs, we have a data document that comes out of -- regularly from SPI-M. You could start to look at that and look at concrete ways of developing protocols to collect that data, or, and it's incredibly expensive in terms of the setting, sometimes, to collect that data, because they've got a job to do, these aren't settings that are just waiting around for us to turn up; they've got a mandate to deliver care. So you need to work with -- yeah, so you need to just, sort of, make sure that it's as light touch as you can. So you need sort of a low technology readiness level research and then you need to think about operationalisation of that

sort of --

Q. Thank you, Professor.

A. -- in a group way.

MS JUNG: Thank you.

My Lady, those are all my questions.

LADY HALLETT: Thank you very much, Ms Jung.

Who is next? Oh, it's Ms Stone. Ms Stone is just there.

Questions from MS STONE

MS STONE: Thank you, my Lady.

Good afternoon, Professor. Can you hear me okay?

A. Yeah, yeah, I can.

Q. I ask questions on behalf of Covid Bereaved Families for Justice UK, and it's just one topic that I have, please, which relates to data generally, and particularly in respect of the data available to inform the hospital discharge consensus statement. And specifically it relates to data from the CQC.

A. Okay.

Q. Now, we know from an internal report provided by the CQC to the Inquiry that in April 2020, the CQC -- some regional groups heard increasing concerns from providers about accepting new users from hospital without being tested, and that there were lots of examples where this had led directly to the death of many other residents.

So that was being reported to the CQC.

We also know from a statement provided by Mary Cridge of the CQC that between March 2020 and March 2022, CQC had a significant number of queries from providers about admission and discharge, some of which were recorded in their adult social care response panel log.

So the question, Professor, if I may, is were you offered access to that data from the CQC?

A. I do not know. We had -- the CQC were very quick in April 2020 to open out their data -- their mortality data. They obviously switched Covid as an explicit factor on 11 April, if memory serves, and within a week we had full access to that. And that was the dataset I was using primarily to look at trends myself.

So if that dataset is the same, then we had that. But it wasn't linked -- from memory, it was just looking at mortality in those settings. So it wasn't explicitly linked to any discharge. So I'm not sure how that would have helped us answer the discharge question.

Q. Yes, sort of more generally, did you know -- so, understand that you were provided with the mortality data, I think you say that in your statement, but did you know that this adult social care response panel log existed at the CQC, for example?

A. That's not a series of words that -- so no, I don't think so --

Q. It wasn't something you recognise --

A. Sometimes these things have slightly different names in emails and things, so it's difficult to know definitively, but it doesn't -- that precise wording I don't recognise.

Q. And would that sort of information have been useful to inform the work carried out by the group, including modelling?

A. I would have to -- to be definitive in that, I would have to see the data and form a view. It sounds like it could have been useful. And it would -- just -- I mean, the different triangulations would have been useful. I think one of the points of discussion -- I thought the CQC data was excellent in terms of its pace, its -- the fact that it was useful to understand trends, but it was by date of report of death rather than date of actual death, so the epidemiological signal gets a little bit lost, so we may have had interpretation challenges in terms of comparing mortality across the different settings.

But yeah, I haven't -- as far as I know, I haven't seen that data, if that answers your question.

Q. And generally speaking I think you say that more

information always improves certainly modelling?
A. Yeah.
Q. So, in principle, additional data would have been --
A. Yes.
Q. -- of use to inform your work; would you agree with that?
A. I would. More data is always good. There is an old joke often used where modellers always want more data than we've got.

So yeah, more data is always better, but we use the data we have as best we can.

LADY HALLETT: Thank you, Ms Stone.

Ms Jones.

Ms Jones is over there.

Questions from MS JONES

MS JONES: Thank you, Professor Hall. I ask questions on behalf of John's Campaign, The Patients Association, and Care Rights UK.

I want to ask you about the findings your care home analysis paper from May 2020. At paragraph 57 of your witness statement you describe that one of your findings was that a possible approach to reducing risk in care homes was cohorting residents with a small number of carers, which may have had a positive impact on reducing transmission.

When your paper refers to carers in this context, did you include family members who provide essential care in your understanding of who might be included in the cohort?
A. I do not believe we got to that level of detail in the assumption -- in the modelling done. I think cohorting, and again, this comes down to precision of wording, and nuance in the wording, I think cohorting was potentially, after we wrote that paper, a challenge, because moving -- it depends how you're implementing cohorting. So if you're moving the resident, so that there's, sort of, half the care home over here and half the care home over there so you can focus your staff, moving the residents because they're frail and elderly has a potential negative outcome in and of itself.

So again, this comes down to balancing the harms. So I think cohorting was a challenge but it comes down precisely to what the definition of cohorting was, but yeah -- (overspeaking) --
Q. But in terms of the data that you were modelling to identify risk factors --
A. Yeah.
Q. -- was there any basis for considering that the inclusion of essential family carers in a cohort would have affected the risk of that?

A. I do not believe -- I do not believe we got to that level of fidelity in working out the scenario, there is a later paper from 2021 where we looked at the different interventions and we carefully tried to characterise the interventions and the benefits and the harms of those interventions, which may have gone into a little bit more detail and probably -- I don't have it to my fingertips or my memory at the moment -- it probably is here somewhere, but I don't know what -- whether that went into that detail either.

So we didn't look at it in that detail, to answer your question. I suspect if it had become a viable policy lever, then that's -- but I think it comes back to allowing visitors in (unclear).

MS JONES: Thank you, my Lady.

LADY HALLETT: Thank you, Ms Jones. Very grateful.

That completes the questions we have for you, Professor Hall. Thank you very much indeed for your help. Very grateful.

THE WITNESS: Thank you.

LADY HALLETT: Thank you. I shall return at 1.50.

(12.53 pm)

(The Short Adjournment)

(1.50 pm)

LADY HALLETT: Ms Paisley.

MS PAISLEY: My Lady, the next witness is Heather Reid.

MS HEATHER REID (affirmed)

Questions from COUNSEL TO THE INQUIRY

LADY HALLETT: I don't know how long you've been waiting but I'm sorry if we've kept you waiting. Thank you for your patience.

THE WITNESS: Not at all. Thank you, my Lady.

MS PAISLEY: Good afternoon, Ms Reid. Thank you for attending the Inquiry today and for providing your statement to this module dated 2 June 2025.

By way of your background, please, you qualified as a nurse in 1989 and then, after a number of roles, in 1994 you completed a masters in health services management. In 2012 you were appointed as a public health consultant within the Public Health Agency on a range of areas, and you remained in post until 2023, when you became interim Director of Nursing, Midwifery and Allied Health Professionals within the Public Health Agency, Northern Ireland; is that correct?
A. That's correct.
Q. The agency was established in 2009, and its functions can be summarised under three broad hearings: improvement in health and social wellbeing; health protection, including a lead role in the public health response to major incidents and other emergencies; and

service development, which includes working with the Department of Health to play an important role in providing professional leadership to the collective system of health and social care in Northern Ireland.

Is that all correct?

A. That's all correct.

Q. At paragraph 19 of your statement you say:

"In 'normal' times, the PHA is responsible for a range of issues in respect of the adult care sector ..."

Can you provide a brief overview of its responsibility towards the sector in normal times.

A. Sorry, could you just repeat that question, please?

Q. Yes, you say:

"In 'normal' times, the PHA is responsible for a range of issues in respect of the adult care sector ..."

Can you give a broad overview of those responsibilities?

A. In normal stages, so the adult social care sector would -- is commissioned through the Health and Social Care [services] Board -- also known, currently, as the Strategic Planning and Performance Group.

The PHA would support the commissioning of services for adult social care and provide input through, for

example, nursing -- professional input from nursing, from allied health professions as well, and also supporting on any issues around communicable disease and for outbreak management and things like that.

But the main, I suppose, role prior to Covid would have been around that support for the commissioning of health and social care services.

Q. At paragraph 49 of your statement you say that as the pandemic progressed and it became clear that a longer-term response was required, some of the work of PHA changed at the direction of the DoH. Were any of those additional responsibilities specifically related to the management of the pandemic in the adult social care sector?

A. They would have been. Whenever the surge planning was -- during the initial response, actually, obviously, the PHA would have been involved right the way through from December into January and then through February, as well. Whenever silver response was set up, I think it was around the end of January, whenever that was set up, a number of cells were created, a number of subgroups were created, one of them being social care and community care and the care home sector would have been included in that wider remit, and there would have been a lot of specific information and activities around, I

suppose, preparing for what was potentially to come. Obviously, there wasn't a huge amount known about the virus at that stage.

So a lot of the staff were involved from that early stage looking at things like infection prevention and control, mitigating -- potentially mitigating risks around making sure that adequate training, PPE, was involved.

Q. And just focusing on whether there were any additional responsibilities, was there anything new that the Public Health Agency was asked to do?

A. Not new. Not new at that stage.

Q. On 23 January 2020, the PHA stood up the Emergency Operations Centre, the purpose of which was to manage the information coming to the PHA, and to ensure that this information was shared with the right people.

A. Mm-hm.

Q. And you explain that the EOC did not deal with calls from the care sector --

A. That's correct.

Q. -- which, instead, were redirected to the duty room within the PHA?

A. Yes.

Q. And the duty room's day-to-day work is in relation to the public health management of infectious diseases of

public health significance?

A. That's right.

Q. And you say it supports care homes, for example through regular check-ins when an outbreak has been declared?

A. Mm-hm.

Q. Is that background all correct?

A. That's correct, yes.

Q. In your statement you explain that the PHA health protection team who staffs the duty room had well-established relationships with care homes as part of their role in supporting them with outbreaks of other infectious diseases like that of influenza?

A. Mm-hm.

Q. Was the operation of the duty room an effective way to manage calls from the sector during Covid-19?

A. Certainly at that outset the decision was made purely because of the existing relationships and understanding that the duty room would have had with the care home sector. There would have been regular contact and the health protection and duty room would have been very much the initial point of contact for any concerns that a care home might have been. So that was one of the reasons why the decision was made at that stage to keep all of the communication coming through the duty room.

The vast number of questions did relate to: what are

the concerns around infection? What does this virus potentially mean for me? So we felt that actually at that stage that the staff who were staffing the duty room were best placed to support care homes in doing that, because they knew the context in terms of where they were coming from.

Q. Was there a mechanism by which the concerns that you've just touched upon could be raised from the duty room and escalated to the Department of Health, for example, or other relevant decision makers to inform their response at this time?

A. Yeah, absolutely. There would have been very, very regular contact with members of the duty room, and there is always -- there has always been a consultant with oversight for duty room, so any particular complex health protection questions, there would always have been medical oversight so that they could escalate those issues.

Again, there would always have been very, very regular contact, and the Public Health Agency is a relatively small organisation, and also co-located, as well, so individuals would have very close working relationships generally so escalation would have been a matter of course in day-to-day, and regular meetings, as well, so that would be absolutely supported, yes.

Q. And in the event of a future pandemic, is this the structure that the agency would encourage to be used in the future?

A. I think -- and that's a difficult one to say for sure, because obviously we don't know what a future pandemic might look like, and I think that decision was made with the best of intentions at the time.

I think looking back, what we might do is consider how we might better bring all of the information together and, with respect to care homes, into one individual cell. But, again, by the nature of -- the different teams did actually work extremely well together and -- because, as I said, co-located, the information flowed well. People knew each other, you know, existing relationships were already in place there, so -- formal structures we might adapt slightly moving forward.

Q. Now, at paragraphs 44-45 of your statement, you explain that, prior to the pandemic, the agency's public health directorate had a number of staff vacancies as well as a number of key posts that were filled on a temporary basis, and this related particularly to HP consultants, who were involved in work on care home testing, visiting, and rollout of guidance. And you also explain there was a shortfall in specialist epidemiological

resourcing, and this was a known risk to the PHA in 2019.

A. Mm.

Q. You go on to say at paragraph 47:

"Despite the level of vacancies within the Agency, I do not believe that this significantly impacted the PHA's ability to support the care sector during the pandemic."

A. Mm-hm.

Q. Would you say there was any impact? And if so, can you give an overview, please.

A. Yeah, I think it's fair to say that, even prior to the pandemic, the PHA was sort of staffed for business as usual, in terms of the response to communicable diseases in doing that, and there was an understanding that there were some gaps, even before the pandemic, particularly in the areas you mention. But part of the business continuity process, whenever we became aware that the pandemic was gathering pace and complexity, the organisation quite quickly flexed additional staff. So the staff that you've mentioned earlier on, in terms of working in the service development, they were all moved, and the work that would prior -- have been done in different areas prior to pandemic, they were focused into the pandemic.

On reflection, there obviously were some changes in leadership as well, but there was a cohort of very senior staff -- it's a regional organisation, there is a cohort of very senior staff -- providing stability throughout that process.

I'm not sure they were hugely different to any organisation across the UK in terms of trying to manage at the outset of what was a very, very difficult scenario.

Q. If we could perhaps have on screen, please, table 2 of your statement, which is INQ000587734, at page 12. And this shows the number of calls received by the duty room for care homes in 2019 and 2020. And these escalated significantly, we can see, in March 2020.

And over the page, at table 3, there was also a sharp increase in the number of respiratory illness outbreaks and incidents managed by the acute response team.

A. Mm.

Q. Again, we can see that in this table.

That document can come down, please.

Was there then difficulty in the duty room in those early months managing those levels of calls, and was staffing in the duty room increased as a result?

A. Staffing was certainly -- and the staff were stretched,

absolutely they were stretched, but, as I mentioned before, other staff in the agency were redirected. So for example, the staff in the Nursing and Allied Health Directorate, a vast majority of them would have registrant backgrounds, so would have had skills and competencies that could easily work in the duty room under supervision as well. All of the registrars in training as well, and I believe there were about 13 in place at that stage, again, all reorientated to support the duty room.

So everything was done to try to support and make sure the duty room was fully functioning in that regard.

Q. Can I ask, please about the Hussey review.

A. Mm-hm.

Q. So there was a review that was delivered to the Department of Health in December 2020 and Professor McBride notes in his statement that the view of the PHA was that there was insufficient capacity to manage NHS and care home outbreaks. Were proactive steps taken prior to December to address those issues?

A. Yes, indeed, and there were some additional staff. I mean, we also brought in staff from agencies where we could, and from other organisations where we could, as well. And so staff were drafted in where possible. Since the Hussey report, as well, there have been

significant changes with, I suppose, enhancements made both in terms of numbers of staff but also in terms of the governance and reporting arrangements as well. That has all happened since the pandemic.

Q. Now, you explain at paragraph 37 that staff within the duty room had to review and understand new guidance as it emerged, you say cross-referencing it with previous versions to identify where changes had been made and what the implications for care homes would be. Can you help us, please, what specific pieces of guidance are you discussing there?

A. Thinking, you know, as the pandemic progressed, guidance on isolation, guidance on testing, guidance on PPE. So obviously the detail of the guidance, just the sheer scale and speed that guidance was being changed, PHA really worked off Public Health England guidance as well and we adapted it locally, usually just through changes to logistics but the essence of the guidance was from Public Health Agency, England, and it really just reflected the changes in terms of what was known about the virus and as that came through, our understanding came through and guidance had to be amended accordingly, as well.

So making sure that everybody was over that was quite a feat at timetables.

Q. Practically speaking, is there any way that it could have been easier for those that worked in the duty room to see the difference in guidance?

A. As far as possible, that was undertaken, and where new guidance was issued, there was a process at the outset, actually, to compare them side by side to see what are the differences, and that would have been made clear at daily briefings, as well, so that everybody could understand exactly where the changes were and change their protocols and advice accordingly.

Q. Just one final question, please, on this topic, which is HP Zone, which was used by the PHA for the management of outbreaks of infectious disease. You explain it was not designed to support the management of large-scale outbreaks. And you say that whilst it continues to be used, work is ongoing to identify and implement a replacement system that would be better placed to use in the future?

A. Yeah.

Q. What difficulties did it cause and what work is currently ongoing to identify a different system?

A. Okay. As you mentioned, it's not really fit for purpose, it's again a business as usual and, again, I'm not an expert in this area per se, but the data collected was at care home level and it didn't allow us

to collect surveillance information at individual level throughout the pandemic. And obviously that's really important if you're trying to understand what the impact has been, particularly in a care home setting, so that you can understand how many people have been vaccinated, how many people have been tested, for example. HP Zone doesn't facilitate that, and it also doesn't facilitate, in terms of my understanding, about data linkage, as well. So making sure that we could look at outcomes --

Q. So something that would have been able to do that would have been helpful?

A. Exactly, and processes are under way to try and sort that out, moving forward.

Q. I understand that Public Health Agency Northern Ireland in non-pandemic times physically attends care homes where there's a particularly complex outbreak, and that this had to be stopped over the pandemic. Did that have an impact upon PHA's ability to manage complex outbreaks of Covid-19 in particular?

A. Yeah. No, there would still have been day-to-day conversations with the care homes and the teams involved in managing the outbreaks would still have had a lot of in-depth conversations. Now, at roughly the same time, as well, at the request of the Department, trusts were also asked to support care homes. So there was a lot of

additional experience and expertise going in. The trust teams, as well, that were supporting care homes were again infection prevention and control leads in the trust, as well.

So they weren't left without that hands-on guidance, if that was required, and also had support from RQIA, as well, at that stage.

Q. Moving on then, please, to infection prevention and control. And the PHANI was a member of the UK IPC cell. To what extent was the IPC guidance issued to care homes in Northern Ireland specifically adapted for Northern Ireland?

A. Again, it would mostly have been around logistics in terms of where you go to access tests and what the various arrangements would be within Northern Ireland. The actual technical and the scientific aspects of that would not have changed.

Q. You explain at paragraph 151 that the physical environment in some care homes was not conducive to isolation measures, and the PHA worked with care home managers to find solutions to these issues on a case-by-case basis. What sorts of solutions were found?

A. Well, in some cases it just would have been whether or not there would have been single rooms or double rooms,

so sometimes it would just be about looking at it like that. One of the particularly challenging ones was for individuals with limited capacity, as well. So it would have been working with, carefully with the care home managers, as well, in terms of what might be feasible or possible for them in those situations.

Q. It's right as well, that the PHA placed senior nurses and midwives from the agency into trusts?

A. That's right.

Q. Do you think that assisted the care homes?

A. Well, I hope so. I hope so, and again, it was just about trying to increase capacity and expertise and make that available to the care homes as much as possible.

Q. Can we then change topic, please, and talk about the surge plans.

A. Mm-hm.

Q. By way of background in your statement you say that it was acknowledged by April or May 2020 that it was broadly accepted that asymptomatic spread was possible. Now, the Inquiry has heard a lot of evidence about the evolution of understanding on asymptomatic transmission, but would you agree that in fact there was ample evidence it was possible much prior to April?

A. Yes. No, it -- certainly, looking at the evidence, that was possible. And I did go back and actually check with

the surveillance team, and you will see in the evidence bundle one of the surveillance reports that actually looks at respiratory outbreaks in care homes in Northern Ireland, and actually, from between the period of January to March, there weren't any. There were a couple of others in other sectors in Northern Ireland but there weren't any.

Now, that doesn't mean to say that there was no asymptomatic, but given the prevalence and the potential harm that Covid could do, particularly at the outset and particularly in that vulnerable population, there was a good indication that it wasn't hugely an issue.

That's not to say that it wasn't there but it wasn't causing respiratory outbreaks that the PHA was able to pick up on, or monitor, until past mid-March.

Q. But there was an acceptance it was a possibility?

A. Absolutely. Absolutely.

Q. With that context in mind, then, it's right that the PHA was involved in the preparation of surge planning in January and early February 2020.

If we can have on screen, please, INQ000381485.

This is a document exhibited by you, and if we go to the page 19, please, we can see the heading "Discharge Planning". It cuts off but then we can see that heading.

Then at page 20 we see some details, for example, patients may not be discharged to their first choice of home.

A. Mm-hm.

Q. And then at the bottom of page 20 it says:

"There is an expectation that hospital discharges of those medically fit for discharge will be expedited immediately."

If that document can come down.

Can we then, please, have INQ000120731, page 1.

This is the surge plan that's been exhibited by Professor Holland dated 13 March. Can you help with the difference between those two plans?

A. The -- now, again, my understanding of reviewing the -- both plans, the one that -- the one that's on the screen at the moment was the initial plan that was done at the request of the Chief Medical Officer, and had been led by colleagues in the Health and Social Care Board at that stage, but obviously PHA would have had input into that.

That particular surge plan was based on a -- it was a RAG rating based on staff availability, and there is a section on care homes and discharge towards the end, and it outlines a series of -- outlines a series of actions that would be taken to try to ameliorate that.

My understanding is that there were further conversations with the Department after that stage, and the blue document --

Q. The second one?

A. The second one, actually, I suppose, just gives further emphasis in some of the other areas in terms of the pandemic plan. And it's just really a further iteration of the original surge plan.

So it really demonstrates, I suppose, the ongoing development of surge planning in those first two or three months.

Q. If we can then go to page 72, briefly, of this document, and you've told us that this document also dealt with the hospital discharge?

A. Yes, that's correct.

Q. And you've said, "The Public Health Agency and I would have had some involvement within this."

A. Mm-mm.

Q. This document can come down, thank you.

In your statement you say at paragraph 99 that the PHA had no input into the original plans for discharge of patients from hospitals into care homes, and a letter was sent to the sector on 13 March about this.

But in light of the surge plans, did PHA in fact provide advice on this?

A. I think we would certainly have been in -- potentially in the room. It's difficult for me to say at this stage whether or not. I don't think that the PHA actually had any operational input into those decisions.

I mean, ultimately, a decision on discharge is a clinical decision made at trust level. The reference to discharges in the -- in both of the surge plans were really focusing on social services, because obviously discharge is -- into a care home is run by social services as well, and the risk assessment is done there.

So I suppose the emphasis on the discharge planning was really about augmenting the social services care teams that actually sit -- and that that team sits within the Health and Social Care Board, both in terms of commissioning and then at trust level, as well.

So it was really about trying to put places -- things in place to augment, support that process to happen a little bit quicker, if possible, but do it safely as well, bearing in mind all of the other aspects of it, working with the clinical teams to make sure it could be done safely, because obviously we don't want older people in hospitals. It's not a good environment for them to be in either.

Q. If I can perhaps put it this way then: would it be right to say that PHA wasn't involved in the decision itself

but was involved in operational planning if that decision was taken?

A. I think they would have been in the room, potentially, yes.

Q. To combat the risk of potentially asymptomatic patients being discharged into care homes, do you agree that as a minimum, there should have been guidance for the sector at this time in the middle of March that all new admissions be isolated?

A. I think that's -- again, I'm not an expert in that area so I preface it with that. At that stage, whenever this surge planning was being done, we didn't have the information in terms of asymptomatic transmission, it was, sort of, I think the end of the first week in April before that information became available. So at that stage we were working on guidance that was really about -- the extant guidance in terms of how we would manage any infectious respiratory disease.

Q. In the event of a future pandemic where there is the risk of asymptomatic transmission, would you agree that admission to care homes should be isolated?

A. I would be deferring that to experts in that area.

Q. Was the Public Health Agency NI involved in any discussions about whether there would have been enough tests available at this stage to test everyone on

discharge, or as far as you're aware, is that something that didn't come up?

A. I'm not sure whether or not, as I say, I can't tell at this stage whether or not it was discussed. It may have been, but certainly in terms of testing capacity, there was very, very limited testing capacity in March, and you can see that as well, as we go on through the testing questions. I'm sure that will come to light.

Q. At paragraph 39 you explain:

"In April 2020, as more intelligence on transmission became available through pre-existing communication channels and reporting process, the PHA became aware of concerns that the region could experience an exponential growth in the number of care homes affected by Covid-19."

We've touched on capacity within PHA, but did that lead to a step-up of resources at that point?

A. The resources at that stage were -- it wasn't, I think, I believe, that that's the paper, the exponential growth paper that you are referring to --

Q. -- (overspeaking) --

A. -- the modelling paper, and you'll see that there is some additional information provided by the Chief Medical Officer in his statement around that modelling paper because the paper didn't take into consideration

the wider lockdown and the community spread. But regardless of the scientific aspects of it, the steps in terms of managing the care home outbreaks would have been exactly the same. It would have been about trying to understand the level of outbreaks in the care homes, making sure that they were fully protected where they can, guidance on PPE, infection prevention and control, all of the steps that we would have been taking would not have changed.

Q. And were there extra resources placed in the teams to deal with --

A. In the duty room?

Q. Yes.

A. In the duty room, again, that was kept under constant supervision.

Q. Now, an operational group was set up to oversee the implementation and monitoring of the regional surge plan for the social care sector. Was that something that had been in place prior to the pandemic and then tailored for Covid-19 or was that a new plan?

A. That was a new, that was a new group.

Q. And can you provide a brief overview of how that plan operated?

A. The -- is this the plan, sorry? If I can just get clarification on which plan it is that you're talking

about?

Q. Yes, the original surge plan, I think it rated different care homes red, amber and green.

A. That's correct, so that sort of plan on a page became -- and it was really a distillation of the previous surge plans that could be used specifically to support the care homes. On one side it had, sort of, the principles in terms of mitigation and risk, and on the other side it had the red, amber green. And that surge plan was really developed on the back of information that was collated jointly between PHA and RQIA on care home status, and it was delivered every single day around that.

That group was initially set up informally, again, going back to my earlier statement about the staff working together and being co-located, and that group wasn't formally put in place, I think, I believe, until May.

Q. Until May. When it was used, was it something that was beneficial to manage?

A. It was, it was very beneficial, actually, at that stage yes.

Q. On 27 February 2020, initial guidance for the care home sector was published in Northern Ireland. The Inquiry understands this was based closely on equivalent

guidance in England.

A. That's correct.

Q. And it was assessed by the PHA to make any changes required to then make it relevant for Northern Ireland. I think you have briefly touched upon this perhaps about contact details, for example.

A. Mm.

Q. But what other sorts of changes were necessary?

A. I think, I understand it was largely around those contacts, and that first couple of sets of guidance was really about making sure that the care homes had the same information as the PHA in terms of the emerging virus, bearing in mind that the actual clinical managing of outbreaks had not changed. That clinical management was still using the extant flu outbreak packs, as well. But the guidance that was sent out to the care homes was in an effort to try and make sure that care homes had as much information on the emerging virus as possible so that they could have conversations with their staff and bring them up to speed on that.

Q. The next guidance, I think it was the interim guidance --

A. Yeah.

Q. -- was published on 12 March 2020. That was the same day that contact tracing ceased in Northern Ireland; is

that right?

A. That's my understanding, yes.

Q. And the guidance that was issued on 12 March 2020 said:

[As read] "If, after assessment, the person has a positive test, then a contact tracing exercise will be undertaken by the PHA. You will be advised of any further actions, depending on your recent exposure to the patient."

So was that guidance out of date, effectively, as soon as it was published?

A. Contact tracing for care homes, everything for care homes went through the duty room, as well, so the contact tracing wouldn't have been done for care homes in the wider contact tracing centre.

Q. Did contact tracing in care homes continue beyond 12 March?

A. I'm afraid I would have to go back and find out the answer for that for you.

Q. Was the Public Health Agency NI consulted on the 12 March interim guidance?

A. Yes, they were.

Q. Moving in to the next guidance for care homes, which was published on 17 March, along with guidance for domiciliary care providers on the same date, both had been circulated to the Public Health Agency for comment.

Who was taking the lead on Care Home Guidance? So who would effectively have the final say on the version that was published?

A. In terms of the Public Health Agency?

Q. The care home guidance, was that the Department of Health, was -- (overspeaking) --

A. It was the Department of Health, the Department of Health.

Q. Now, that guidance said that nursing and residential homes are not expected to have dedicated isolation facilities for people living in the home but should implement isolation precautions when someone in the home displays symptoms of Covid-19 in the same way that they would operate if an individual had influenza. If isolation is needed, a resident's own room can be used. Ideally, the room should be a single bedroom with en suite facilities.

Professor Hopkins was before the Inquiry yesterday and it's understood that also appeared in the equivalent Public Health England guidance, and she was asked: do you think this was sufficiently clear guidance for care homes when it was drafted for dealing with people where they had symptoms of Covid-19? And her answer was, "I think looking at this now in isolation, I'm sure we could improve the clarity."

Is that something you would agree with that? Could that clarity have been improved?

A. Yeah, I would agree with that and I think that's true against a lot of guidance, but in the context that this was being developed at pace, at scale and in a very, very complex area, and I think that's probably reflective of a lot of guidance developed in that manner where we would normally take a much longer period to make sure that every word was correct.

Q. Can I now please turn to the Expert Advisory Group on Testing. You explained that this was convened by the Department of Health but it was chaired by a member of staff of the PHA; is that correct?

A. That is correct.

Q. Was PHA, prior to this, asked for any advice on the first interim protocol for testing? And that advice that staff working in care homes were not included in the definition of a healthcare worker?

A. I'm -- not to my knowledge, but I can go back and check for that, for you.

Q. Was the Public Health Agency asked to provide advice on version 2 of the interim protocol for testing? That was operational from 28 March, and that enabled testing of care home staff who were symptomatic or isolating if a member of their household was symptomatic?

A. Because the chair was involved and there were other people from the PHA involved in the Expert Advisory Group on Testing, I would assume that, yes, they were included in that.

Q. If they weren't consulted, so members of the PHA were not consulted on those pieces of guidance, should they have been?

A. I suppose my expectation is that there would have been informal conversations and again, I can't say for sure, but I would expect there to have been informal conversations between the health protection consultants and the Expert Advisory Group on Testing.

Q. Can you help with the date that a symptomatic care worker could first receive a test?

A. Oh gosh, um, care worker? I actually would have to check. I'm sorry, I don't know at this point in time.

Q. We've discussed that the first interim protocol for testing was -- the definition of a healthcare worker did not include care homes so it would have been beyond 20 March --

A. -- (overspeaking) --

Q. -- is that right?

A. Yeah, (unclear).

Q. What about symptomatic residents in a care home?

A. Symptomatic residents, outbreak testing would not have

changed throughout. So that would have been the same as pre-Covid. So there would be a requirement on care homes to notify the duty room if there was any symptomatic resident, and they would then do a risk assessment to see whether or not it merited an outbreak. And throughout the entire pandemic, that would trigger a request for testing and obviously when it became available, that testing would have included the Covid tests as well.

Q. So an early stage -- (overspeaking) --

A. -- (overspeaking) -- early stage that was the case, and, obviously, for symptomatic staff, again the same advice would have applied in terms of: don't come to work if you're symptomatic and, actually, that would have maintained, and I can come back to you with a date for that.

Q. You confirm in your statement at paragraph 102 that on 10 April the EAGT recorded its first discussion on care homes. The first probable outbreak of Covid in a care home in Northern Ireland was on 16 March, so would the PHA accept that that was a delay and that conversation should have happened earlier than 10 April?

A. Could you repeat that question, again, please?

Q. Yes. So the first probable outbreak of Covid in a care home was 16 March. The first meeting of the Expert

Advisory Group on Testing that discussed care homes was 10 April, so would you accept that that was a delay, and it should have been discussed earlier?
A. I suppose it's very difficult to tell at this stage, or surmise that other conversations hadn't happened in between. So whilst it may not have been minuted, there may have been conversations in the background. But again, I couldn't -- I can't confirm at that point.
Q. That first discussion within the group recommended all symptomatic care home residents be tested when there was a suspected outbreak. On 18 April, the Public Health Agency Northern Ireland, along with the other devolved health agencies, attended a meeting with Public Health England, and they discussed the Easter 6 study and that study concluded that symptoms are poorly predictive of infection, therefore a poor trigger for control measures. And, in fact, you mention in your statement that the PHANI itself conducted a surveillance study --
A. That's right.
Q. -- which highlighted that testing only symptomatic residents and staff would not identify all individuals with Covid-19.
A. Mm.
Q. Version 3 of the testing protocol, which was dated 19 April, did not extend testing for asymptomatic

residents. My question is whether that then was purely a decision based on capacity?
A. At that stage -- probably it was at that stage.
Q. On 17 April, the expert advisory group recommended all hospital patients must be tested 48 hours in advance of discharge to a hospital. That was incorporated into the 19 April protocol; is that your understanding?
A. That's correct, yes.
Q. Can we please have that on screen.
INQ000103724, page 3.
And we can see in bold:
"This new testing requirement must not hold up a timely discharge. The information from the test results, with any supporting care information, must be communicated and transferred to the relevant ... home. Some care providers will be able to accommodate individuals with a confirmed COVID-19 positive through effective isolation strategies or cohorting policies. If appropriate, isolation or cohorted care is not available with a local care provider, the local HSC Trust will provide alternative appropriate accommodation and care for the remainder of the required isolation period. This alternative accommodation should also be used in the exceptional cases of test results not being available at the point of discharge."

Is this referring to the use of step-down or designated setting facilities?
A. I believe so.
Q. Should arrangements for isolation in facilities where care homes cannot effectively isolate people have been put in place in March, in mid-March, when the decision was taken to expedite patients into care homes?
A. Quite possibly. But it's difficult to, I suppose -- it's really, I suppose, around the timing and the capacity and being able to identify such areas.
Q. Thank you. That document can come down.
On 24 April you confirm, at paragraph 108, that whole home testing was introduced for care homes with a new outbreak. So by 24 April it was no longer restricted to those with symptoms.
Would that have been because there was an increase in capacity or something else?
A. There would have been an increase in capacity.
Q. Do you know why at that date it was only for new outbreaks?
A. I'm afraid I don't.
Q. Updated guidance was issued to care homes on 26 April 2020. The Inquiry understands this is the first date that all discharges from hospital, whether negative or not, were to be isolated for 14 days upon

discharge; is that correct?
A. That's correct, yes.
Q. And I think your answer earlier was that you would have to defer to somebody with the expertise --
A. Yes.
Q. -- as to whether that was something that was beneficial.
The Care Home Guidance had not been updated again between 17 March 2020 and 26 April 2020.
A. Mm.
Q. Given the policy changes that impacted on care homes between those dates, would you agree that further iterations would have been helpful?
A. I think I would concur with that.
Q. Moving, then, to the impact of the discharge decision, and you explain at paragraph 111:
"The PHA would accept that some care home outbreaks of Covid-19 were as a result of the movement of people from hospital to care homes, although these were likely a small minority cared to the larger number of outbreaks that arose from the normal connections between care home residents, staff, visitors and the wider community."
Do you agree though, that given the limited testing that was undertaken in the early months of the pandemic, it's difficult to draw a firm conclusion?
A. Absolutely, it was impossible draw a firm conclusion.

Q. And alongside the discharges in a care homes, what, in the view of the Public Health Agency, were any other pathways?
A. Well, obviously care homes are busy institutions and there would have been staff moving in and out, and we do know that from the evidence that there were certain particular variables that caused an increase in risk associated. So, larger care homes, where obviously there was a higher degree of footfall, and where there was a significant change in staff, an increased use in bank staff that may not have been familiar with it. There would have been a whole potential range of ingress into care homes where ideally we would try to manage it. But there were possibilities. So it would have been very difficult to understand, if an outbreak had happened, the -- very difficult to pinpoint the exact method of ingress.
Q. I'm going to move on, please, to May 2020 and on 18 May, Robin Swann confirmed that testing was to be made available to all care home residents and staff across Northern Ireland.
A. That's correct.
Q. He said:
[As read] "Our intention is to complete testing of all care home residents during June."

Had there been greater capacity, should that have been brought in earlier if capacity had allowed?
A. Again, I wouldn't have the technical experience to make that determination.
Q. You explain that, on the advice of the expert advisory group, a revised testing policy was introduced in all Covid-19-free care homes, and from 3 August 2020, staff would be tested every 14 days, and residents every 28 days?
A. That's correct.
Q. Now, the Inquiry understands that this regular testing was later than both England and Wales by some weeks; can you help with why it was later?
A. I'm afraid I can't, but I can certainly find out for the Inquiry.
Q. At paragraph 121 you say:
"... the PHA's evaluation indicated that proactive asymptomatic testing reduced the length and severity of outbreaks seen in care home settings."
A. Mm-hm.
Q. Would it then be fair to conclude that if capacity had allowed, it would have been sensible to do that testing as soon as practical?
A. That would seem reasonable.
Q. Moving, then, on to a few general comments on guidance,

please. You explain in your statement that during the pandemic, the PHA did not have the capacity, expertise or access to the most up-to-date information to attempt to produce technical guidance from scratch.
A. That's correct.
Q. Generally, guidance from PHE, UKHSA and other devolved nations was amended to reflect NI structures.
Can you help us, please, if there had been more resources, do you think that they would have been significantly different, or was it -- the same outcome was still achieved?
A. I suspect the same outcome would have been achieved. Northern Ireland participated in a four-nations meeting in respect of all of the mitigating areas for Covid, as well, and there is also some real benefit in making sure that there is similar guidance against the four nations in terms of continuity of advice and support for the care home sector.
Q. I'm going to move now and ask a few questions about PPE, please.
A. Okay.
Q. On 26 March 2020, a meeting took place between the Department of Health and independent sector providers. Can we have on screen, please, INQ000508447. On page 1:
"Providers advised they felt the extant guidance

from PHA was insufficient and unhelpful and that the Department need to exercise control around media messaging."
Had the PHA issued any additional guidance beyond that of 17 March care home guidance, and does the PHA accept that criticism?
A. Obviously it's very different because the PHA wasn't represented at that particular meeting, so may have been able to provide some different advice or context, or address some of the concerns at the time. I am conscious, however, in preparation for giving evidence today, that the very initial guidance around PPE was particularly acute focused, and it did take a little bit of time to try and develop that and make it much more community focused at that point.
Q. When you say "acute focused", what does that mean?
A. As in hospitals.
Q. Hospitals?
A. Hospitals.
Q. So could more have been done, do you think, to provide guidance -- (overspeaking) --
A. I think potentially, yes. Yes. But again, the scale, you know, doing things at speed -- (overspeaking) --
Q. That document can come down, thank you.
A rapid review was undertaken of PPE and a final

report was submitted on 14 May, and Professor Holland outlines that one of the actions taken forward was assurance from the independent sector to PHA through the relevant HSE trust that systems were in place to manage supply, and that PPE was being used in line with the guidance. What assurances were necessary?

A. I think this was just a reflection of trying to make sure that, because trusts had been asked to support care homes with their PPE, and in terms of supply for PPE, as well. So it was just really, I think, an assurance to try and make sure that everybody was doing the same thing and adhering to guidance in terms of best practice, use, donning, doffing, disposal of PPE, as well, and just trying to make sure that everything was in order around the guidance.

Q. A few questions, please, then on visiting.

A. Okay.

Q. Now, the agency played a lead role in the development of the Care Partner Scheme. What was the intention behind the scheme?

A. The Care Partner Scheme was really intended on the back -- there was a rapid learning initiative done in the summer of 2020 triggered by the Chief Nursing Officer at that stage, and it was really on the back of that as an effort to try and support residents and,

indeed, families in care homes. This was over and above testing -- or sorry, over and above visiting, as well, and it wasn't suitable for all residents or, indeed, all care homes, but it was really an initiative whereby a pre-existing member of a family or a friend, where residents would have additional needs such as support for social isolation, eating, drinking and encouragement, that they could provide additional support working closely with the care home, as well, so they had additional training and could, I suppose, visit the care home regularly to provide that initial support.

It started in September and care homes were all asked by, I think it was the early November, to make sure that that was in place, and then RQIA also did some monitoring around visiting and the use of the care partners, but I believe it was widely, widely expected -- or accepted and widely used.

Q. The Inquiry understands that there were some difficulties in implementation of it. Was the PHANI involved in implementation?

A. They were involved in terms of encouraging it and there were regular conversations and contacts between the PHA and the independent sector and representatives, so it would have been very much the PHA would have been involved in encouraging and supporting, and if there

were any, sort of, questions around it, they would have had conversations with the care homes and with RQIA to try and, I suppose, put right any issues.

Q. What thought should be given to using this type of scheme in the future?

A. I think, certainly in terms of the feedback and reflection, it was well received, and it actually seemed to work extremely well, and in particular, you know, moving forward, care partners were also included in the testing, as well, and similarly, to staff, as well. So I think it actually worked very well, and certainly the feedback that we have received to date would indicate the same.

Q. It's right, as well, that the PHANI was asked to lead on the development of the normalised visiting forum?

A. That's correct.

Q. Can we have on screen, please, INQ000591869.

This was a briefing paper produced by the PHANI and on page 2, the first paragraph, it says:

"The approach agreed must continue to protect care homes from the introduction of COVID-19, but also enable family caregivers and visitors to provide much needed contact, support and care to residents to maintain and enhance their overall health and wellbeing."

Now, you say in your statement that this was done at

an appropriate juncture. However, do you think in the future thought could be given to something like this earlier?

A. I think it is, it's such an important -- visiting is perhaps one of the most challenging, complex and important areas, because it's really about managing risk and it's about balancing the risk of infection towards that vulnerable position -- or vulnerable population, along with the potential harm due to isolation.

So, actually, it's a really important issue, not just for the pandemic but actually moving forward in terms of care home management and support for care homes much more generally. So I think it's a really, really important area.

Q. So this is something you would encourage to be considered --

A. Absolutely.

Q. -- perhaps from the outset --

A. Absolutely.

Q. -- of a future pandemic?

A. Absolutely, as I said, not just for a pandemic, actually, much more visiting, you know, outbreaks do happen, unfortunately, in care homes, respiratory winter viruses, and I think it's really important throughout all of those scenarios.

Q. Thank you. That document can come down.
You explain that the forum included representation from families, trusts, and so on.
A. That's correct.
Q. Generally speaking, with respect to visiting in particular, what is the importance of that engagement with stakeholders?
A. I think the -- the importance with stakeholders in terms of visiting policy?
Q. Yes.
A. Yes, no, it's hugely important, absolutely hugely important and, in fact, I don't think you can do it without that full engagement. Indeed, there was a survey conducted by all of the stakeholders that you have mentioned and you can really see the disparity in terms of opinion, and it's really difficult and challenging to get one size fitting all, because we had, on one hand, some relatives who were wanting to visit more, and other relatives, at the other end of that spectrum, who were very keen for isolation and protecting their loved ones at all costs. And so it's really important to actually make sure that we have that breadth of view so that everybody can be around the table whenever you're trying to develop the frameworks.
Q. And again, would you agree that it's important to have

that from the outset?
A. Absolutely, where possible.
Q. Three more very brief topics, please.
The first is data collection. Did the Public Health Agency have access to definitive data regarding how many people were in receipt of care in the social care sector?
A. No, and that is a particular gap.
Q. And would it have been helpful?
A. Absolutely, absolutely.
Q. Did the agency have access to definitive data regarding how many people at any given time worked in the sector and what their roles were?
A. Again, no, we didn't have details on the numbers.
Q. Again, would it have been --
A. Absolutely.
Q. -- helpful? Were there any particular difficulties in reporting of deaths data within care homes and can you give a brief overview of those?
A. That's quite a complicated area and, I suppose, NISRA is the -- Northern Ireland Statistics Research Agency is the definitive guidance, but it takes -- there's a little bit of a delay.
Q. Perhaps if I can cut through it.
A. Yes, of course.

Q. Is it the case that NISRA has the responsibility, however the Public Health Agency were asked to report on some deaths rapidly?
A. They were, but those were largely in the acute sector, again, in hospitals, and medical practitioners were asked to report deaths on a daily basis. In the care home sector, deaths also have to be reported to RQIA, as well, but just the way that the information is collated on deaths data, it's quite difficult to understand why, the reason. Obviously, in that population, deaths would not be that uncommon. So it was quite difficult to tease out exactly which deaths may have been associated with Covid and which may not have been associated with Covid.
Q. In the view of the agency who should be the body that collects that data and provides, if it were a single source, that decisions can be made upon?
A. I think it would be NISRA.
Q. Training provided to care homes, please. You explain that number of Echo and Zoom sessions were facilitated by the PHA to support care homes and they covered topics such as the role of the regulator, environmental cleanliness, and balancing the risks and rights of visiting.
A. Mm-hm.

Q. Did the PHA receive feedback on those sessions?
A. We did a little bit, both at the sessions and also afterwards, and they were extremely well received.
Q. Can you help with what sorts of issues were covered particularly in the session on visiting?
A. Everything that you might imagine, as well, in terms of how it can be done safely, how it can be, you know, ramped up quickly, how it, you know, PPE, anything that you can imagine was discussed. The sessions were very well attended. There could have been upwards of 160, 200 care homes at any one of those sessions. So the questions were wide and varied across all of the aspects associated with visiting.
Q. Now, of course, we've talked about the limited resourcing of the PHANI, particularly at the beginning of the pandemic, but with adequate resourcing, would the PHANI put on more of that training in the future? Was it helpful?
A. That training had happened before the pandemic. It was just tailored. There was a specific resource identified by a previous director of nursing in the PHA to identify a very senior nurse, who actually used to be a director of nursing in RQIA as well, who had well established networks and had started to develop programmes for training for care homes, and that was on the back of

a report from COPNI previously.

So the actual process, and that's one of the reasons why I think the training bit helped, and we were able to hit the ground running, because the systems and processes had already been put in place, but they were incredibly valuable and a very good way of getting training and allowing feedback that ordinarily would have been much more difficult, in terms of, for example, we spoke about earlier about actually writing guidance. It -- and it allowed -- facilitated, because three or four people would be able to go on and have conversations there and then, and questions with care homes, and allow for clarity, questions, sharing information and sharing experiences. So it was incredibly valuable.

Q. And so I think you would agree if there was the resourcing, then even more training would be something helpful?

A. Absolutely. Absolutely. Very much so.

Q. Two short questions on domiciliary care workers before I move to final reflections, please.

At paragraph 116 you state:

"The PHA acute health protection response did provide support to domiciliary care agencies ..."

However:

"The Agency did not have access to accurate data in respect of those receiving care and those working in domiciliary care from which to assess impact."

As with other data that we've talked about, would it have been helpful to have more data? And who would collect that data?

A. I'm not sure on the exact answer that. On the background of the Hussey report, one of the areas that was identified as a gap was actually data, digital and intelligence, and there is a new directorate in the Public Health Agency going to be focusing on that, so I'd expect it to sit within that directorate moving forward.

Q. Can you give just a brief overview of what support the PHA did provide to domiciliary care providers, please?

A. Certainly in terms of information given to care homes it would also have been provided to those providing domiciliary care. A lot of information would also have filtered down through the trusts in terms of domiciliary care, and testing as well, in terms of asymptomatic testing would have been in line with the wider community setting as well, but symptomatic testing for domiciliary care would also have happened through the PHA.

So a lot of the guidance that would have been sent to care homes would also have been shared wider with

domiciliary care providers through RQIA.

Q. Is there scope for ensuring that guidance that is provided to the domiciliary care sector is specifically tailored to domiciliary care?

A. Ideally, yes.

Q. You just touched upon testing there briefly. The Inquiry understands that regular testing of asymptomatic domiciliary care workers was not available until August 2021?

A. That's correct.

Q. Would you agree that that was too late?

A. Again, I would have to take technical advice on that one.

Q. Can I then ask just for some final reflections, please. Can I ask if you can reflect on the wider experience of the pandemic, particularly with a focus on the impact on the adult social care sector, and you say at paragraph 88 of your statement:

"There is learning for the PHA and looking back, it was the case that the Agency's support to the care sector was being managed largely through two different Directorates in which a number of discrete workstreams were being progressed such as visiting, testing and the day to day support being provided by the Duty Room. An alternate model in which a senior member of staff had

oversight of the entire care home response may have provided for a better approach to the care sector within the Agency."

Can you please give a brief overview of what the problem was and how it could be resolved?

A. And again, I think it's just -- again, it's obviously easier to look back with the benefit of hindsight in terms of what might have been -- might have worked better, but I think that there would have been opportunities for us actually to bring all of the information related to care homes in -- under one single group, with a role of one or two people, actually, with having oversight of all of that information in one place.

We were probably over-reliant on having close networks and close working relationships. So it wasn't that the information wasn't shared, but the formal structures didn't always, I think, reflect that.

Q. Has there been any restructure to reflect that?

A. There has been a significant restructuring across the whole of the agency on the back of the Hussey review, which was very much welcomed and very much a catalyst for doing that.

Q. So in terms of structure and resourcing, both of which were acute problems --

A. Yes.
Q. -- is it your opinion that those matters have been resolved as best as they can or is there room for further improvement?
A. I think there's always room for improvement in any scenario, and it's always very difficult to get that balance between working effectively and -- in a business-as-usual, and also in preparing for what the next major incident might be. Obviously this was one of the biggest events that any of us will ever see, in terms of a public health emergency, so it's really quite difficult to balance that. But certainly, I think that the new structures that are in place very much support and address that.
Q. Just finally, other than any matters that we've already touched upon, are there any other significant recommendations or lessons that you think it's important that this Inquiry considers?
A. I think the matter of data that we've already done, and that ability to understand and have live access to information in the care home sector. And there are certainly ways that Northern Ireland has an encompassed system, which is a new electronic system that's live across all of the trusts now, but it's very much linking that information with the care home datasets, and using

things like honest broker services to make sure that there are no data breaches in that as well. I think areas like that, and the digital and data infrastructure obviously would be a major part of that.

I think there's also something about how we commission and plan for services for older people more generally. Care homes are obviously an important aspect of that as well, but I think the lessons from this are much, much wider. In society, the care home population, we think of that as a bubble, but these are people who have spent their lives working as members of society and really deserve that respect and that encouragement and that focus.

So I think that the learning around how we balance risk -- I mean, I've personal experience of that as well, and I can only imagine how difficult that is for individuals whenever you -- where you are separated from a loved one. I can only imagine how difficult that was during the pandemic. So -- but the learning and the reflection that we've had, both personally and within the agency, goes much more beyond that.

So the new structures in the agency, we look at a live course now, with one of the main areas about being -- living well into older age as well.

So the lessons are much wider than just for the

pandemic. I think it's really important that we focus on getting the lessons embedded into this in our day-to-day lives and our day-to-day worlds, not just for the pandemic.

MS PAISLEY: Thank you, my Lady, I've no further questions. I think there are some Core Participant questions.

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

Mr Wilcock?

Questions from MR WILCOCK KC

MR WILCOCK: Good afternoon, Ms Reid, I'm asking you questions on behalf of the Northern Ireland Covid Bereaved Families for Justice.
A. Thank you.
Q. And my questions are all based on evidence that the Inquiry has heard from the Office of the Commissioner for Older People.
A. Mm-hm.
Q. And the first question can be prefaced in this way: in your statement, you observe that during the pandemic, the Commissioner for Older People shared information with the PHA, which the PHA used in carrying out its functions.
A. Mm-hm.
Q. Now, both the then Commissioner, Eddie Lynch, and the

chief executive of the Older Persons Northern Ireland (sic), Evelyn Hoy, have stated that when, on 16 March 2020, the chief executive of the Commissioner for Older Persons Office Company (sic) highlighted the alarming number of elderly individuals contracting and dying from Covid in Italy, which we will all remember from the news, as at 16 March, the response from PHA, they have said, was characterised by what they describe as an air of unreality about the possibility of the reported high numbers of deaths of the elderly in Italy ever happening in Northern Ireland.

The question is this: are you able to comment on Mr Lynch's and Ms Hoy's evidence that the PHA expressed the view that, and I quote:

"That won't happen here. They have a completely different system over there", as Ms Hoy raised the possibility in the meeting.

A. I suppose there are two points to my answer to that, is, is one, and I've looked at both those sets of evidence, and in one statement it says that it was the PHA and in the other statement it said that it was a member of the Department of Health that actually made -- had made that statement. So again, I can't, not being present at the meeting, I can't verify the context.

But the more important aspect of it is PHA was

involved right from the very beginning in four-nation conversations with WHO, the rest of the four nations, and watching the evolution of this, as they would do with any new virus of note, with the evolution, those conversations were happening on a day and daily basis. There was a very, very real understanding of what -- the potential that this could happen in Northern Ireland, and that was one of the reasons why there was -- silver was set up very early in the PHA, as well.

Locally, we were extremely concerned about what the impact that Covid could potentially have for all of Northern Ireland.

Q. Thank you very much.

Second question, again based on their evidence, Mr Lynch has observed that the guidance issued by the Department of Health on 17 March, Covid guidance for nursing and residential care homes in Northern Ireland, contained little on testing for Covid-19, and in contrast with the position in England, predicated the involvement of the Public Health Agency dedicated team with a care home "in the event of one or more residents testing positive for Covid-19."

A. Yeah.

Q. And you will have read that in the statement?

A. Yeah.

Q. Do you agree with him that the weakness of that approach was that it pre-supposed that testing facilities had by then been made available in care homes in Northern Ireland?

A. Yeah. And again, I think there's maybe something lost a little bit in translation and it probably should have been made clearer in the guidance, but the testing that Mr Lynch referred to in England was outbreak testing, which was already actually available in Northern Ireland, as well. As I mentioned earlier on, that didn't change right from the outset. So whenever there is any symptomatic case of respiratory illness or disease, obviously we came to know that as Covid quite early on in March, but even before then, that didn't change at all in Northern Ireland, and that would have been part of the extant guidance. Care homes would have been in touch with the Public Health Agency. They would have done a risk assessment. And depending on that risk assessment, up to five symptomatic residents would have been tested, and obviously whenever the Covid test became available in Northern Ireland, that would have been included in that suite of tests.

So that absolutely was available in Northern Ireland at the time.

Now, I think it may just have been a gap in terms of

the information that was provided in the guidance, but at that stage, the extant, I suppose, guidance for managing respiratory illness remained in the Public Health Agency duty room. So there wasn't any difference between Northern Ireland and England in that regard.

Q. So you spoke earlier on about the clarity of some of the guidance. Did Mr Lynch's confusion as to this guidance underline, perhaps, that it wasn't as clear as it could be?

A. Absolutely. I would absolutely take that on board without a doubt.

Q. Final question. According to Mr Lynch, the Public Health Agency's website at this time stated that, and I quote:

[As read] "Testing is currently limited to patients who are being admitted to hospital ..."

And I can't read my own writing ...

"... and some healthcare workers."

Is Mr Lynch justified in telling the Inquiry that this approach confirmed his concern -- and again, I'm quoting:

[As read] "... older people in care homes would only be tested if their symptoms progressed to the extent that they were admitted to hospital, that there was no effective means for having them tested prior to that,

and that at this stage, there was resistance from officials, from the Department of Health, to the testing of staff and residents in care homes, consistent with the minister having been briefed that this was not necessary."

A. Well, as I've outlined earlier on, there would have been, for -- symptomatic testing in a potential outbreak scenario, would have been available. But the other thing to bear in mind in terms of the testing capacity and availability at that stage, at the outset there was about 40 tests a day available moving to about 200 and that was for the whole of Northern Ireland as well.

So testing at the beginning was very much limited to those in -- critically ill, to support clinical decision making around that, and largely would have been done in hospitals, but some of that would have been done to support symptomatic testing in care homes as well.

Q. And you will appreciate I'm asking you about Mr Lynch's understanding?

A. Absolutely.

Q. Does it come to this: he has misunderstood again?

A. Well, it's not necessarily his misunderstanding. It may have been just in terms of the guidance not have been --

Q. -- (overspeaking) --

A. -- not have been clear.

MR WILCOCK: Thank you very much. I was going to ask you one more question, my Lady, but Ms Paisley has already covered it more than adequately, so I'm not going to ask any more questions.

LADY HALLETT: Thank you very much, Mr Wilcock.

Ms Beattie, I think.

Questions from MS BEATTIE

MS BEATTIE: Hello. I ask questions on behalf of Disabled People's Organisations. You've been asked already by Counsel to the Inquiry about testing of asymptomatic domiciliary care workers, which you told us wasn't brought in until August 2021; yes?

A. That's correct.

Q. I understand that's about nine months after it was brought in, in England, Scotland and Wales, that made that testing available towards the end of November 2020 and early December 2020.

Did the PHA take account of that development in the other nations to consider bringing that testing in sooner?

A. Do you know, I'm afraid I don't have the answer to that, but I'll certainly find out for you and come back to you on that.

Q. Right.

A. I wouldn't want to give you -- misrepresent decisions or

conversations that already happened, so apologies that I can't answer that question at this point in time, but we certainly will find out and come back to you, if that's okay?

MS BEATTIE: Yes, thank you, my Lady.

LADY HALLETT: Thank you, Ms Beattie.

That completes the questions we have for you, Ms Reid. I think there are a number of questions where you said you could get back to us. I don't know, have you got somebody who can help you going through a transcript of the evidence?

THE WITNESS: I have indeed.

LADY HALLETT: I will be really grateful if you could do that, because I know a number of questions were -- that Ms Beattie asked and others asked and Ms Paisley asked that we'd quite like the answers to, so --

THE WITNESS: Super, thank you.

LADY HALLETT: Thank you very much for your help and safe journey back to Northern Ireland.

THE WITNESS: Thank you.

LADY HALLETT: Very well, we'll take a ten-minute break. I shall be back at 3.15.

(3.03 pm)

(A short break)

(3.15 pm)

LADY HALLETT: Ms Lyons, you're our last witness of the week, so thank you very much for waiting.

THE WITNESS: Thank you.

LADY HALLETT: And I'm sure that, from our point of view, it would have been worth your wait.

THE WITNESS: I hope so.

MS SUSAN LYONS (sworn)

Questions from COUNSEL TO THE INQUIRY

LADY HALLETT: Just so you know, Ms Lyons, as Ms Paisley knows, I've read your written statement, so, you know, we don't -- and it's an extremely moving and extremely powerful statement. So Ms Paisley doesn't have to go through every detail, so -- I understand -- she'll go through the most important parts, all right?

THE WITNESS: Thank you.

MS PAISLEY: Thank you, my Lady.

Good afternoon Mrs Lyons and thank you very much for attending the Inquiry today and providing your statement.

I'm going to ask you some questions about your daughter, Sarah, and your collective experience as a family over the pandemic.

Sarah is in her early thirties; is that right?

A. Yes.

Q. You outline this in your statement, but can you please

give an overview of Sarah's needs?

A. Sarah was always -- diagnosed from the age of 2 with her significant language disorder, then she was diagnosed with dyslexia, dyspraxia, profound memory problems. So she was always in special provision at school. She couldn't cope in mainstream. And we fought hard for her to get the education that she was legally entitled to, and needed, rather than being left in mainstream to fail.

At the age of 12 the epilepsy started, and at first it was just a few absences. It's like a ten-second seizure. And we didn't actually see them, only the school saw them, until I saw the consultant paediatrician and he elicited a seizure by getting her to blow on a paper windmill.

After that the epilepsy accelerated, she went from absences to 50 focal seizures a day, so probably 350 a week and by January, she had her first tonic-clonic. I'd never seen a seizure before Sarah, and I had never seen a tonic-clonic. I didn't know what to do and we took her to A&E where she was diagnosed eventually with epilepsy. They gave her a drug which for two years worked. There were no more seizures and we thought her epilepsy is not a big problem.

Then the seizures came back, again accelerating from

10 to 50 seizures a day. She was put on two drugs, three drugs, four drugs, in an effort to control it. And nothing did.

She was referred first to our local hospital and then our regional centre, to see the head of paediatric neurology there for the region. And they tried various things, like ketogenic diet, different drugs, none of which really worked.

We didn't appreciate how severe her epilepsy was. Nobody told us that this is way more severe than normal, and eventually the schools couldn't cope with her epilepsy and we had to look at specialist epilepsy schools. And it was only there that we were told she's got the most severe epilepsy here, and we realised that she was amongst the most severe in the country. She was under Great Ormond Street.

Q. Thank you for providing that background for us. And against that background, you explain in your statement that Sarah needs one-to-one care as a result. Why is it so important that she receives one-to-one care?

A. If you saw Sarah in a restaurant, you wouldn't realise there was anything wrong with her. She looks normal, she's lively behind the eyes, she can walk and talk and eat the same as everybody else, but the question is the seizures. She can have a seizure at any time, fall

down, hit her head on that desk, and need to go to hospital for assessment, or she could break a bone.

There is also the risk that a seizure doesn't stop. If they go on for more than five minutes, they must be stopped, with emergency medication, and if that doesn't work, you have to call 999, because hospitals can use intravenous drugs that we can't.

So it's really about the seizures and the risks that come from them, that she needs one-to-one.

Q. And you explain in your statement, though, that Sarah loves life, and her life is just as important to her as it is to everybody else?

A. Yes, it is. She's always been sunny, warm, happy. She enjoys all of the things that people her age do, like eating out, cinema, restaurants, theatre, and generally, she was very happy until the epilepsy went out of control.

Q. You explain in your statement that you have previously been told by a consultant neurologist just how important it is that you are involved in Sarah's care and decisions about her care and you were told that you were the best people in the world to get her the help that she needs. Why is it so important that you are so closely involved in Sarah's care?

A. She's so complex, her epilepsy is going to be more

complex than the average doctor in a hospital will see again in their lifetime, and it's not just the epilepsy; it's the added complication of the language disorder. So you need to speak to her in clear, simple language. You can't just use slang, puns, et cetera, because she doesn't understand. And also, there is really, often, a tacit attitude in the NHS that the NHS resources are wasted on people with learning disabilities, and she wouldn't get as good treatment, possibly, as if we're there pushing it.

Q. Can I move, then, please, to the first lockdown in March 2020, and Sarah had been in a care home setting, but I understand she was back at home for her birthday, going into the lockdown.

A. Yeah.

Q. How long was it intended that Sarah would be back at home?

A. It was intended that she'd be back at home for a week, but because her aunt had died the day before she came home, and we were told the funeral was going to be on the Monday, we intended to keep her home for ten days so she could at the attend her aunt's funeral and get closure.

Q. I understand that, of course, events then moved on. You received a letter complaining that residents including

Sarah, who were on home leave, could not return to the care home premises.

A. Yes.

Q. What was your initial reaction?

A. Shock. I was shellshocked. I -- we had seen Wuhan on the news in January and we said to ourselves: that is coming here. And we were astonished that the government didn't do anything, like ban international travel, that sort of thing. But I didn't know what a lockdown was until the day Boris Johnson announced it, and I never thought that the care home would refuse to have her back when everything until that day had been normal.

Q. Can I deal then, please, with the impact on Sarah's care as a result of her staying within the home.

I understand that there was an impact upon the supply of medication that Sarah needed. Can you explain that, please?

A. Yes. I mean, Sarah had always come home weekends and school holidays throughout her education, and in the school holidays occasions had happened where she'd broken a bone or she was ill and she couldn't take her back, so we needed an extra supply of drugs for a week in case of those eventualities.

I had asked them, before she came home, for an extra week's supply of drugs, and they didn't give me enough,

and I knew we were going to run out, given the circumstances of the lockdown, and it's very difficult to get her registered with a GP and get them to prescribe drugs they've never heard of, which are very expensive, and you've got to get documentation to prove that this what she's on. They don't take my word for it.

Then the pharmacy has got to get hold of drugs which they don't keep in stock -- they're too expensive.

Q. So how easy or, indeed, how difficult was it for you to have to spring into action and try to organise all of this in a lockdown?

A. It was difficult. Registering her as a temporary patient, getting the drugs from my GP, and even when I did manage to get the prescription, my pharmacist couldn't get hold of one of the drugs for about ten days, and we had no choice but for her to come off it, which I had always been told could only be done safely in a hospital. Normally the drugs are weaned off very slowly, there are rebound seizures and -- which are obviously stressful and dangerous. To take her off abruptly could have killed her.

Q. You explain that Sarah was not counted as clinically extremely vulnerable.

A. Yes.

Q. Did that cause any difficulties in terms of supermarket deliveries or how you were able to manage with having her at home?

A. Yes, food for me, was the biggest problem. The -- I'd always had online deliveries ever since they started, and suddenly they were all stopped, and people who were shielding got priority, which was absolutely right, but I found it very difficult to get deliveries, and I would have to log on to the website at half 11 at night, the slots opened at midnight. I would sit in a queue on the website until about quarter to 1, when I would get the choice of a slot in about three weeks' time.

And considering Sarah was waking us up at 4 am every morning, I was extremely tired.

Q. And you explain in your statement the impact that this lack of sleep, for example, and having to manage Sarah's care one-to-one yourself, the impact that had on you and your husband. Can you tell us a bit about that?

A. Yes, two care agencies had said it was too stressful for one of their care workers to look after Sarah by themselves. They insisted it was either one care worker with me, and if I wasn't there, say I had a hospital appointment, there had to be two. And while she lived in a care home with one-to-one care, they had to take on three care workers to provide that seven days a week in

the waking hours.

Well, there was just me. Plus, on -- in her care home there were about 900 staff. It's not the average care home for the elderly. There are all the medical centre, the speech therapists, OTs, physios, social workers, plus maintenance, IT, finance. So if the staff had a problem with their computer, they just had to ring up IT. If I had a problem, I had to fix it myself. And the same with everything. I was trying to do all of that work while looking after Sarah, who needs full-time supervision.

Q. Can I please ask you about DNACPR decisions, please. You received a letter from Sarah's GP surgery asking to confirm your preferences. This is the first letter you received. How did you feel when you received that letter?

A. Well, I was incandescent. As I said, I'd come across in the NHS before this tacit attitude that resources were wasted on her. For instance, they wouldn't pin her collarbone when she broke it. And I just thought this is yet another example of the NHS seeing her as a second-class citizen. And although she has human rights under the Human Rights Act, this had been disregarded, really.

And, you know, she was a healthy young woman in her

twenties, apart from the epilepsy. And at that time she was in better health than the rest of us. So I had suspicions that, for her, it would be no more than flu, and I didn't see why I should agree to a DNACPR for a healthy young woman in her twenties.

Q. You explain that you wrote back and explained you didn't agree with the decision until Sarah -- if or until Sarah had a terminal diagnosis. However, you in fact received another letter the year later.

A. Yes.

Q. Can we have that on screen, please, INQ000612650.

There's no particular piece of text I wish to ask you about, but in general the language. How did you feel that that was communicated, such a significant subject, in this letter?

A. I felt it was being dropped on us, it was as if we were going to agree with it. It wasn't a discussion; it was: here is a form for you to sign. And I felt it should have been brought up with us and Sarah, to get her views, and I just -- I just could not understand why somebody in their twenties could not go through CPR.

She's a large -- well, a large -- she is a well-built young woman, and if CPR is not appropriate for her, then maybe it should be banned altogether. Who is it appropriate for?

Q. And you've just touched on it briefly, but was there any other contact at all, over the phone, to reach out to you to try to discuss a sensitive topic, or it was just the letter?

A. Yes. I mean they did offer a telephone call, but I didn't want to discuss it. As I said, if she was diagnosed with a terminal illness, then yes, we would have been happy to discuss it.

Q. I think, in fact, you took some action following this --

A. Yes.

Q. -- that you wanted to draw to our attention. If you could just explain what that was.

A. Yes, I was so upset about it, I wrote to MENCAP, they've got a helpline, and I sought their advice. Because what worried me was that it was in the news that doctors were applying DNACPRs on care home residents with or without their relatives' permission, and I was concerned that the doctors would do that, and it would be a proxy for no treatment for anything.

So I asked MENCAP's advice, and they asked to see the forms, and I think they were as shocked as I was.

And originally they took it up with NHS England, who spoke to the care home and eventually brought it to the attention of the Parliamentary Human Rights Committee, and then NHS England wrote the letter saying this

shouldn't be applied to people with learning disabilities and autism. And I was really grateful for that.

Q. Thank you.

It's right that Sarah did eventually return to the home that she had been in prior. When was that? What month?

A. November 2020.

Q. Generally speaking, did the restrictions, in your view, balance the needs of someone like Sarah, with Sarah's needs, with the risks that Covid-19 presented to her as an individual?

A. No. I felt -- as I said, none of us knew very much then about Covid, but I had the suspicion that for a healthy young person in their twenties, it might be no more than flu, and in that case I felt the risk to her from her epilepsy far outweighed the risk to her from Covid.

We'd been told by Great Ormond Street consultant that when she was at the residential school, and we spoke to her on the phone in the evenings, we were not to bring up anything stressful. She was worried that Sarah would die in the night from sudden death in epilepsy.

So we've always got that in the back of our minds every day: today she could fall down the stairs and

break her neck during seizure, tonight she could suffer sudden death in epilepsy. And we've been told she's in the highest risk group. And it seemed to me no attention was paid to the risks from her epilepsy which, for us, far outweighed what we thought about Covid.

Q. When were you first able to visit Sarah in the care home?

A. I think it was in January. We took her back in November, we got a letter in December talking about visitors could book slots in the visitors centre. Lateral flow tests had just come out then. And we said -- they said we could test on arrival. If it was negative, then we could see her for an hour in the visitors centre.

So I think we probably applied fairly quickly, but obviously everybody else did, and there were over 100 residents so I think the first slot we got was January.

Q. I think, in fact, you wrote to the home and you were able to at one point take the lateral flow test before you left because you lived so far away from the home; is that right?

A. Well, I took it up with John's Campaign. I thought it was ludicrous that we had to drive three and a half, five hours on the motorways to the care home to take

a lateral flow test which, if it was positive, we'd then have to drive home, possibly feeling ill, and morally we couldn't stop at the service stations and infect hundreds of people. And I just thought: this is nonsensical. And I wrote to John's Campaign talking about the difficulty, because I had the impression they saw all care home residents as elderly people five minutes away from their family, and I don't -- didn't think they were taking into account people in specialist care homes.

And John's Campaign told me to write to the Minister for Social Care, because she said she didn't think it had occurred to them, and that's what I did, wrote a piece about it for the Minister for Social Care and guidance was changed to allow people to test before they left home.

Q. In your view, how appropriate were other measures put in place when you couldn't see Sarah for her, so virtual visiting? Was that suitable for Sarah?

A. It was, we'd never used Skype, Teams, Zoom, whatever, before. We had to learn pretty quickly. We realised that talking on the phone just didn't cut it when she couldn't see us. But we felt -- she was often in tears on the phone to me. Sarah likes the care staff but she often doesn't talk to them about what she really thinks,

like, for instance, how awful her life is, how awful the epilepsy is, why has this happened to her and not us?

So she saves it all up for when she sees me and then she starts crying. And that is what often happened on Skype. She'd be saying, "When can I see you again?" And we couldn't answer that question. I couldn't give her comfort. Although she's a young woman, legally, and I recognise that, what she needs is a cuddle when she's upset and I could not give that to her for over six months and I felt dreadful that she couldn't have the physical comfort that she needed.

Q. Did you feel, in those conversations, I think you explained that you felt staff may have been able to hear those conversations?

A. Yes.

Q. Do you feel confident that if Sarah did have any concerns about the care or the staff, that she would be able to tell you?

A. No. Sarah is -- I think her underlying intelligence is still there, but it is held back by the profound language problems and memory problems. She cannot remember -- she's virtually got no short-term memory, like many people with dementia. So she often can't talk about what she's done today, how she feels -- how she felt this morning, whatever. But she did know that if

she talked to me about a member of staff she didn't like, and the person in the room with her was friends with them it could get back to the person she was complaining about and they could take it out on her. So that was always a concern of hers, all the way through school and college.

And so no, I don't think she would have reported abuse to us in the presence of a member of staff.

Q. At various points there were rules to do with isolation within the home, and I'm not asking about any particular rule, but generally speaking, what was the impact of isolation upon Sarah?

A. Well, obviously she missed the close physical relationship with us, she missed coming home, seeing her brother and sister, our cats. She missed having that outlet for her emotions that she normally had when she comes home and she cries to me every night at bedtime. And often they're questions I can't answer. I can't say why she's got epilepsy. I can't say why it happened to her and not us. But I just try and comfort her and say, "Look, try and get some pleasure every day from your life. That's what we all have to do. We all have to work. It's boring."

So I think she would have been very isolated. As I said, it's like taking a toddler away from their

parents, putting them in an orphanage and saying, "You can only see your parents once in a blue moon." I think it's the same impact.

Q. And did you notice a difference with her mental or her physical health? Did that deteriorate in any way?

A. I would say her mental health did. She lost social skills. Like, for instance, going to the supermarket, you walk around together, in order, around the whole shop. Now, since Covid, she's lost all that (unclear) and she just rushes in and rushes round the shop looking for the things she wants. Same with eating, she will now steal food off our plates, whereas at one time that would have been anathema to her. She took rules very seriously.

And also I think -- she has one-to-one care, people telling her all day, "You're an adult, Sarah, you can do what you want", and so it's a bit like a spoiled 2-year old, she wants what she wants straight away, and there is no awareness that you're living in a society, a family, possibly, where you cannot do what you want all the time. We have to go out shopping even if you don't feel like it, and take her. We can't just say, "We'll go without food because you don't feel like going today." So I feel that loss of social skills.

Q. And I think it's right that there was a limitation upon

the recreational activities that Sarah could undertake, and do you think that contributed to that as well?

A. Yes. The care home has a fleet of minibuses. Normally the house would go out together, and they were trips every day to theme parks, football matches, to theatres, cinema. It was up to her if she went or not, but she could go. There was work experience she could do. She could go to the shop, the gym, play football. All of that stopped during Covid. And really she was kept shut up within the house for two years, and it was, you know, like watching television, colouring, that sort of thing.

I think the lack of exercise was bad for her and I think she became more isolated in her mentality, not sociable, and her behaviour deteriorated. She was more verbally abusive to the staff and us.

Q. Do you think there has been any lasting impact of the Covid pandemic upon both Sarah and perhaps upon both you and your family as well?

A. Yes, before the pandemic, she would go out anywhere. If I had said we've got to go out to such-and-such a place, she'd go. Now she doesn't want to go out basically, we have to drag her out and say, "You need to go out, you need to get out of the house, you need to walk so you'll sleep tonight." Otherwise she can be up all night, until late in the morning, at the care home.

We don't do that. We try to do something with her. She gets up at a regular time, has three meals at regular times and she goes to bed when we do. Her life there is chaotic.

As I said, she was up until 8 one morning this week, so she woke up at, like, six in the evening, had breakfast, and then talked to us. And I think she got used to being in a room indoors, and now she doesn't really want to go out.

Q. Thank you, Ms Lyons.

I don't have any further questions for you, but is there anything significant you feel you haven't mentioned that you would wish my Lady to hear?

A. I feel quite often, on the news -- and the care home would write to us and say, "We've sought advice from the Director of Public Health, we're waiting for their answer", they never seemed to say, "We have also sought advice from consultant neurologists to see how we can balance the needs of the Covid with the needs from her epilepsy."

And it seemed like the Covid was the only concern, and her epilepsy, which actually was far more life threatening, never came into consideration. There was no individual risk assessments. There was no awareness. This wasn't a care home for the elderly,

with people living in one big building. People lived in bungalows of about six people. And so it was completely a different set-up to the average care home. Staffing ratios were much higher; Sarah had one-to-one, but other people could have two-, three-, four-to-one. And no allowance was made for that in the public guidance, or for people of working age with disabilities who were much healthier than the elderly.

There was very little in the media about it. I only saw one news report in the two years on a care home that was short of staff and was really struggling. We'd looked at them for Sarah, so we knew them.

But in general, there was no consideration. I looked at MENCAP, Epilepsy Action's websites. They never really talked about their client groups in care homes until I raised it. I'd write to them and say, "Your client group is suffering this in a care home", and then they would write a letter for me, which I really appreciate, it's very good of them, but I just felt that they were totally left out of government thinking, and no specialist advice was sought.

And there was no thinking that we were in our sixties, working from home. My husband is a great birdwatcher, so in the afternoons, to relieve our stress, we'd go for a walk in the country. We didn't

mix with other people two weeks before we saw Sarah. The chance of us giving her Covid must have been remote. And yet the staff could go out to pubs and restaurants, they had school-age children coming home with all the risks of that exposure that we didn't have, and yet they could spend eight hours a day with her in her bedroom and we could see her for about an hour a month from behind a Perspex screen in full PPE.

And to us, it was illogical. We were not the biggest risk to Sarah, we felt.

MS PAISLEY: Thank you very much, my Lady, no further questions.

LADY HALLETT: Ms Lyons, thank you so much. Did you ever expect you would become a campaigner?

THE WITNESS: No. As my husband said to Leigh Day before this, until we had Sarah, we were shy people. We never even complained in a restaurant about bad service or poor food, but we were so incensed at the way the public sector treats the disabled and lies, cheats and bullies families who generally are not aware of the law and their rights, that I spent 20 years studying the law myself. So I knew what Sarah's rights were in certain fields, and I was not going to stand by and see my daughter's life wrecked because other people's major concern was saving money, and I knew all I ever did was

use the law to try to get what she was entitled to.

LADY HALLETT: Good for you.

THE WITNESS: Thank you.

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

Sarah is very lucky to have you, but you're very lucky to have her, too.

THE WITNESS: Yes, we are. Thank you very much.

LADY HALLETT: Thank you. I shall sit again on Monday, 14 July at 10.30, and next week I shall be chairing the hearings remotely.

(3.48 pm)

(The hearing adjourned until Monday, 14 July 2025 at 10.30 am)

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