

Monday, 14 July 2025

(10.30 am)

LADY HALLETT: Good morning, Ms Jung. Can you see and hear me?

MS JUNG: I can, my Lady.

The first witness is Dr Jane Townson.

DR JANE TOWNSON (affirmed)

Questions from COUNSEL TO THE INQUIRY

LADY HALLETT: Ms Jung.

MS JUNG: Thank you, my Lady.

Dr Townson, is it right that you are the chief executive of the Homecare Association, and you've been in that role since May 2009 -- sorry, 2019, and, therefore, you led the homecare sector through the pandemic? Is that right?

A. Yeah.

Q. Prior to that, you spent eight years as director and chief executive of a regional not-for-profit case provider. Your background is originally in science and industry. I think you qualified as a research scientist; is that right?

You spent 14 years in senior international leadership roles in research and development companies like AstraZeneca and Syngenta, where you served as Global Head of Bioscience Research, and you've also

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regulated homecare provider market?

A. They do.

Q. That includes small, medium, large organisations, start-ups and mature businesses, ones that are independently owned, part of corporate chains, not-for-profit charities and public sector organisations?

A. (Witness nodded)

Q. And do they provide both state funded and privately funded homecare services?

A. They do.

Q. You say in your statement that homecare providers can be generalist or specialist. The former meaning that they provide personal care services to individual -- with a broad range of needs, and specialist is where they provide -- or they support people with specific needs or conditions, for example if they've had a stroke or if they have dementia; is that right?

A. Yes, and there are some that will provide live-in care and also complex care with nursing.

Q. Thank you. I think the services that are provided by homecare services are broad, but for the purposes of this module we're interested in the domiciliary care, which I think are the regular visiting of someone in their home to provide support; is that right?

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chaired a number of technology start-ups in the care sector and have served nine years as a non-executive director on the board of an NHS foundation trust; is that correct?

I think for the purposes of the transcript, Doctor, you have to say "yes" rather than nod your head.

A. Yes.

Q. Thank you very much. Could I ask you to also keep your voice up, please.

A. Yes.

Q. Thank you.

Just dealing briefly with some of the background of the Homecare Association, you very kindly provided a very detailed witness statement, and that's at INQ000587670. But just dealing briefly with the association, is it right that it is the largest membership organisation specifically for homecare providers in the UK?

A. Correct.

Q. Also, referred to as domiciliary care providers?

A. (Witness nodded)

Q. And is it the case that you currently have over 2,000 members?

A. 2,200, yes.

Q. And do they represent the full diversity of the

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A. That's right, but live-in care was also significant in the pandemic.

Q. And just for context, although we are focusing on domiciliary care, your membership covers all of the other types of adult social care, homecare settings like supported living and --

A. Yes, our members will provide care into many different types of settings.

Q. Is it right that the majority of your membership operates in England? And so although you did provide some support to the devolved nations, your statement covers mainly the experience in England?

A. Yes. In normal circumstances, we cover all of the UK administrations, but the pandemic was difficult because we physically couldn't be in meetings everywhere, so we focused on England but worked in close partnership with similar organisations in the devolved admins.

Q. Thank you. And I think you ran a helpline which was funded by the government; is that right?

A. No, we run a helpline as a normal part of our operations.

Q. And was that not funded by -- or did the Department of Health and Social Care not contribute to that during the pandemic?

A. No, we have no funding from the government at all, apart

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1 from the Care Provider Alliance, which is a coalition of
2 the ten care associations, and that's for very specific
3 pieces of work.

4 **Q.** Thank you.

5 Can we deal with, please, the first topic, which is
6 the understanding of the homecare sector. Could I ask
7 for your statement, page 1, paragraph 2 to be displayed,
8 please. And it's the first bullet point. You say,
9 Dr Townson, there, that:

10 "... the pandemic exposed critical gaps in
11 understanding of homecare at senior government levels.
12 Nearly one million people in the UK received
13 professional homecare -- significantly more than in
14 residential care. Despite this, homecare was frequently
15 overlooked in the pandemic planning and response.
16 Policy decisions often failed to account for the unique
17 challenges of delivering care in people's homes."

18 Could you tell us, please, what were the unique
19 characteristics and operational challenges of delivering
20 homecare services during the pandemic, that you say were
21 not well understood, and at what levels of government,
22 the gaps in knowledge existed, please?

23 **A.** I think, first of all, in England, the knowledge of
24 social care as a whole was quite weak in the Department
25 of Health and Social Care. There weren't, when I first

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1 come from a background of understanding health, and as
2 a constituency MP had put considerable effort into
3 understanding care, as well. So prior to the pandemic
4 she had already been out on visits with homecare workers
5 in her constituency, and she worked very hard to get up
6 to speed.

7 As far as the regulators are concerned, in the Care
8 Quality Commission there are a lot of senior people with
9 significant experience of social care, many of them have
10 worked in councils as social workers, and including as
11 directors of adult social services.

12 **Q.** Thank you. And how important do you think the visits to
13 providers is assisting people in government to
14 understand how things operate on the ground?

15 **A.** I think nothing beats actually seeing with your own eyes
16 what it's like, and we also had journalists following
17 people around before the pandemic and after, and many of
18 them say how much respect they have for the work after
19 they've seen it with their own eyes.

20 **Q.** And could you just provide us with a little bit more
21 detail as to the, kind of, practical issues that you
22 think were not properly understood by government when it
23 made its initial policies and drafted its guidance?

24 **A.** Very frequently, social care was conflated with
25 residential care for older people, so the words

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1 started, all that many officials in the Department, and
2 the ones that did have experience of social care were,
3 unfortunately, moved elsewhere in government when the
4 pandemic started. So that corporate memory, if you
5 like, was missing. That was different in the devolved
6 administrations, where in general, the officials have
7 all worked with each other across all aspects of health
8 and social care for many years, so their level of
9 knowledge is higher.

10 **Q.** And I think you say in your statement that you and your
11 colleagues spent quite a bit of time educating people in
12 government about the basics of home care; is that right?

13 **A.** That's correct, and that was sort of exacerbated by the
14 fact that they recruited a lot more people into the
15 Department, which was necessary, but one of the
16 downsides of that is that there are a lot of new people
17 that didn't know anything.

18 **Q.** Thank you. If I could just ask you to slow down a tiny
19 bit, please.

20 And how widespread was that lack of knowledge? Did
21 it extend up to ministers and did it extend out of
22 government to arm's length bodies like regulators and
23 Public Health England?

24 **A.** Within the government, Minister Whately was new in
25 February 2020, just before the pandemic. But she had

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1 "care homes" were sort of used as shorthand, and I think
2 understanding that homecare workers are lone workers,
3 going out in the community to multiple people, they may
4 see ten different people on a round without any peer
5 support, understanding how personal protective equipment
6 was normally used, what the constraints might be with
7 the guidance that was suggested, and so on. So there
8 were many issues that were not understood.

9 And the nature of the work, as well, I think many
10 people still think that it's just making a cup of tea
11 for Mrs Smith, not realising that actually, people are
12 living much longer with complex, multiple health
13 conditions. Many people in normal circumstances will
14 die at home, as well, so the whole care sector is very
15 practised at supporting people with palliative and
16 end-of-life care. And I think perhaps people don't
17 realise the level of need is really high and that
18 requires a lot of training and skill to be able to
19 support people with those needs.

20 **Q.** Thank you. You also emphasised the role that the
21 homecare sector plays within the wider health and social
22 care system. Why do you say that's important for
23 decision makers to bear in mind when they are preparing
24 and planning for pandemics?

25 **A.** Well, homecare workers support people with complex needs

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at home, and if that support is done well, we can keep people out of hospital. And when people do have to go into hospital, they will be discharged back home. So if those connections and communications are effective, then we can reduce pressure on the NHS.

But more importantly it's improving lives for people in the community. We know that if people feel safe, they've got everything that they need, like food and drink, and they can wash and dress, they can -- and they will be helped to go out to visit their friends in normal circumstances, that enables them to have a sense of wellbeing, and that then also takes the pressure off their network of family and unpaid carers. And there's evidence that keeping people well at home reduces healthcare utilisation. So overall, it makes it more cost effective for the government.

Q. Thank you very much.

I think you say in your statement that the Care Quality Commission also lacked some understanding of how the homecare sector operated, whereas in Northern Ireland you say that the Regulation and Quality Improvement Authority "demonstrated better practical understanding of homecare operations and [they also] provided more hands-on support to providers", and that contrasted with the experience in England.

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Q. Thank you.

In your statement, sorry, if I could ask for page 90, paragraph 380 to be put up, please.

"Looking [forwards] ..."

You say that:

"... this experience demonstrates the critical importance of ensuring social care expertise is embedded in emergency planning and response mechanisms. Future preparedness requires a much deeper understanding of the homecare sector's unique characteristics, operational realities, and vital role in supporting independence and wellbeing in communities."

Do you have any suggestions as to how, practically, that expertise can be embedded at provider level. And also, how can we ensure that corporate memory and expertise is retained when ministers and government officials move on from the department?

A. In terms of what can be done going forward, the current government's strategy is "Home First", the three shifts from hospital to community, illness to prevention, analogue to digital. So home care should be at the centre of that vision, but they've managed to produce an NHS ten-year plan that doesn't talk about social care at all.

But to the practical way that we can interact with

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In what ways did they demonstrate better practical understanding, and is there any learning to be had from the experience in Northern Ireland that you'd like to highlight.

A. I think it goes back to what I said at the beginning: that there are more people who have been in their roles for longer. I would say that at local level there are many Care Quality Commission inspectors who are very expert and do know their subject. The problem was that the communication with them became difficult during the pandemic, and they effectively decided, as an organisation, to focus on residential care, and we felt that this was wrong. People in their own homes, there's no peer oversight or -- you know, there were no safeguards, especially if family couldn't go in there.

And we challenged them and said: if television crews -- the BBC worked with us early in the pandemic using smartphones to interview people drawing on services and care workers in people's own homes -- if the BBC can do that, why can't the Care Quality Commission? And they did say, well, fair point. And went off and did a pilot that there were about four times more volunteers for than they had slots for.

But having done that, they then didn't follow it up. And still to this day, we don't know why.

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the NHS is through these neighbourhood teams that they're talking about, but, so far, most providers on the ground, with a few notable exceptions, have been actually engaged at local level in conversations about how neighbourhood health could work.

There's one very good example at the moment in Sheffield, where they've got one homecare provider per geographic zone, and they're doing enough hours for it to be viable for them. And then every two weeks, the multi-disciplinary team, that includes general practitioners, district nurses, pharmacists and so on, brings in the homecare workers to their meetings.

And out of all of the professionals, the homecare workers are the ones that see people the most. They are in and out of people's homes four times a day. They are the eyes and ears of our healthcare system, and it makes no sense to ignore them.

And if they've got support of clinicians, that gives them much greater professional security as well, and they can ask if they've got issues on the ground.

Q. Thank you.

When considering the issue of why the homecare sector was overlooked, you talk about a hierarchy of invisibility. Who do you think fell within that hierarchy of invisibility and where do you think home

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1 care fell in relation to the others?

2 **A.** Well, in many ways, lots of parts of the health and care
3 system are affected by that, so acute hospitals are
4 perhaps the most visible, and historically, they have
5 had the most funding from the government. If you work
6 within the NHS and you're in community health services,
7 you can feel like a poor relation to the acute
8 hospitals, and similarly, mental health services might
9 feel like the poor relation to the physical health
10 services and then you've got care homes that are visible
11 in communities and home care is probably at the bottom
12 of that hierarchy.

13 **Q.** And where do you say unpaid carers fall in relation to
14 the domiciliary care sector?

15 **A.** Yes, well, they -- there are almost 6 million of them,
16 and they are absolutely vital. Often their care,
17 homecare teams will work in concert with them, and
18 having some professional home care when it's available
19 enables the unpaid carers who many times are doing
20 hundreds of hours a week, unpaid, to cope and for their
21 own health not to suffer unduly, but they were a very
22 forgotten part of the whole set-up, as well.

23 **Q.** Thank you. Do you think that anything more could have
24 been done during the pandemic to increase the visibility
25 of the sector?

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1 regulated providers.

2 One thing it is important to note in home care
3 that's different from the other parts of the care sector
4 is that 20% of the workforce is unregulated. So they
5 work as individual care workers with no oversight.
6 There's no requirement for training. They just work
7 one-on-one with people that choose to engage them.

8 **Q.** So just to clarify, are they care workers carrying out
9 the same type of caring work, but they are, effectively,
10 trading as sole traders, and they're not required to be
11 registered; is that right?

12 **A.** Correct.

13 **Q.** And what does that mean, in terms of whether they can be
14 identified?

15 **A.** Well, nobody knows who they are, and that therefore made
16 it difficult in the pandemic to get PPE, to check who
17 had been vaccinated, who had been -- who needed tests.
18 It -- the devolved administrations have register of care
19 workers. We don't in England, but with the exception of
20 Scotland, that has recently decided to add unregulated
21 personal assistants to their register -- I don't know if
22 they've actually done it, they've decided to do it --
23 the unregulated personal assistants are off everybody's
24 radar.

25 **Q.** Thank you.

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1 **A.** I think we all did what we could. We engaged heavily
2 with the media, which is a way of exposing issues.
3 I think the pandemic did public raise awareness of home
4 care, so we commissioned YouGov to do a survey for us in
5 2021 and asked the public if their decisions, their
6 preferences for care had changed as a consequence of the
7 pandemic. And many more -- 30% said that they were
8 likely -- more than 30% said they were more likely to
9 choose home care than care homes. But when we explored
10 that further, it wasn't fear of infection; it was fear
11 of being cut off from loved ones.

12 And we've heard many times from the very brave
13 bereaved families here the impact of that, and that's
14 what people feared.

15 **Q.** Thank you. Could I ask you this, please: in terms of
16 pandemic plans, do you think there should be any
17 legislative or regulatory changes to make oversight of
18 pandemic plans mandatory in the sector?

19 **A.** Well, there definitely need to be better pandemic plans
20 because it transpired that when the Covid pandemic
21 started that nobody had, for example, thought through
22 the logistics of how to get PPE to every registered
23 provider. People in government didn't even know that
24 there were lists. Some still appear not to. But the
25 Care Quality Commission keeps a register of all the

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1 Could I ask you about the movement of staff, please,
2 between settings. You describe that in your statement
3 as being complex, and that due to the nature of the
4 work, care workers are required to deliver care within
5 multiple homes, is that right, they will go between
6 homes delivering care? How many homes, for example,
7 would they have gone to pre-pandemic on an average day?
8 And to what extent did that change during the pandemic?

9 **A.** The number of people visited does vary very
10 substantially from place to place, and also whether the
11 care is private pay or state funded. So when people are
12 paying for their own care, quite often the visits are
13 longer, so they may last for an hour or two hours. In
14 the state-funded part of the market, the care calls are
15 often shorter. Northern Ireland is one of the most
16 extreme in having about 30% of calls of 15 minutes, and
17 I don't know about you, but I would struggle to get out
18 of bed and get ready in 15 minutes. That is a tall
19 order.

20 So the ones that are doing shorter visits will
21 obviously do more in the same amount of time. So
22 they'll all be up at 6.00 in the morning, they'll start
23 calls at 7.00, and probably work through until about
24 2 o'clock. Some of them will be doing, literally, you
25 know, just one after another, ten calls on a round.

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1 Others, it may only be two or three with gaps in
 2 between.
 3 **Q.** And to what extent were staff moving between care
 4 settings? So for example, between hospitals and home
 5 care, if they were nurses, providing nursing care, or
 6 between care homes in the homecare sector?
 7 **A.** In social care as a whole, there are at the last count,
 8 33,000 nurses. Only about 3,000 currently in home care.
 9 So we have fewer nurses. So that problem probably
 10 wouldn't have been significant. The bigger issue is
 11 homecare workers working for other agencies and also
 12 care homes and also working cash-in-hand in the
 13 unregulated part of the market.
 14 **Q.** So it's not possible to know to what extent those
 15 individuals were moving between settings?
 16 **A.** No.
 17 **Q.** Are you able to help us as to whether the movement
 18 between settings, so between home care and care homes,
 19 for example, whether that changed during the pandemic?
 20 **A.** I think in general, providers tried to minimise
 21 movement. Certainly in home care, quite a number of our
 22 members organised their care workers in cohorts so they
 23 would have a group of care workers that only supported
 24 people with Covid, and others that only supported people
 25 without Covid. And the ones that supported those with
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1 suggestion.
 2 One of the points that I feel is very important to
 3 make is that the real critical factor is the extent of
 4 community transmission of Covid-19. The greater the
 5 transmission, the harder it is to protect people. And
 6 if you look at international data collected by
 7 Adelina Comas-Herrera, there's a straight line
 8 correlation between high community transmission and high
 9 deaths, both in the care homes and in the community. So
 10 the real key to this is minimising community
 11 transmission right from the beginning. Once you lose
 12 control, then all other measures that you can suggest
 13 are going to have a limited impact.
 14 **Q.** In your view, is there any value or added value in
 15 restricting movement of staff between settings if you're
 16 not restricting the staff's contact with the community?
 17 **A.** It's almost impossible to -- unless you lock people up.
 18 And that's just not a practical option, is it? People
 19 have to go home to their families. Their children were
 20 at school. Schools were like petri dishes.
 21 Some people, as you've heard already, did move and
 22 live in care settings. In home care you can't easily do
 23 that, with the exception of live-in care, which is an
 24 established way of doing things. So, in that setting,
 25 the care worker lives 24/7 in the home of the person
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1 Covid had access to the best possible PPE that was
 2 available at the time. So ...
 3 **Q.** Thank you. We know that there was a discussion during
 4 the pandemic about introducing legislation to ban
 5 movement of staff between settings. It's right, isn't
 6 it, that you expressed some concerns about that policy?
 7 Could you briefly set out what those concerns were,
 8 please?
 9 **A.** In all of these decisions about the pandemic, we all had
 10 to consider balance of risk, and in our judgement, the
 11 risk of people going without care, which would have been
 12 a consequence of restricting movement, potentially, what
 13 we were worried about was care workers, if they were
 14 forced to choose between home care or care homes, might
 15 have opted for care homes, because the work is more
 16 stable, and then, if we had a shortage of people to
 17 support people at home, what would happen to them?
 18 **Q.** The Inquiry heard evidence from Mr Hancock that he
 19 thought it was possible to restrict movement. Do you
 20 have any views on whether that would be feasible and
 21 practical as far as the homecare sector is concerned?
 22 **A.** Well, home care by its nature involves visiting multiple
 23 households. So unless you had one care worker for every
 24 person that needed care, you wouldn't be able to
 25 maintain homecare services. So that isn't a practical
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1 that they are supporting. And that is very popular for
 2 people who have more advanced care needs and would
 3 rather not go into a care home.
 4 **Q.** Thank you.
 5 Can we move on to a different topic, please.
 6 If I could ask for page 91, paragraph 381, please,
 7 to be put up on screen. You say here that:
 8 "The government's engagement and consultation with
 9 the homecare sector during the pandemic was often
 10 inadequate, poorly timed, and demonstrated limited
 11 understanding of operational realities. While some
 12 improvement occurred as the crisis progressed, initial
 13 communication channels proved insufficient for the scale
 14 and urgency of the challenges faced."
 15 Is that correct?
 16 **A.** It is correct.
 17 **Q.** You say in your statement that you were involved in at
 18 least 12 groups which considered a various number of
 19 different topics. The Inquiry heard evidence from
 20 Professor Vic Rayner about those groups to some extent
 21 acting in silos. Is that an experience that you share,
 22 or is there anything else that you would like to tell us
 23 about, in terms of how those groups worked and whether
 24 you found them helpful forums?
 25 **A.** They were helpful. There is no question about that.
 20

1 And we are grateful to the Department of Health and
 2 Social Care and the director -- director who became the
 3 director general later, Ros Roughton, for trying to
 4 involve us all.
 5 We -- I mentioned the Care Provider Alliance, so
 6 this is a coalition of the ten care associations in
 7 England. Prior to the pandemic, we met about once
 8 a month, but when that lockdown first happened, we
 9 realised it was going to be bad, so we decided that we
 10 would meet every day. And we did that all the way
 11 through the pandemic, and are now meeting once a week.
 12 But there were just not enough of us to attend every --
 13 all of us to attend every single meeting, so we split up
 14 responsibilities and then regrouped every day to share
 15 intelligence. And then we tried, where possible, to
 16 present a united front to influence. Between us, the
 17 Care Provider Alliance, we cover 95% of care providers
 18 in all settings.
 19 **Q.** I think one of the forums that you and Professor Rayner
 20 both say was particularly helpful was the taskforce that
 21 was set up and led by, I think, Mr Pearson?
 22 **A.** Mm.
 23 **Q.** That taskforce had a number of subgroups; is that right?
 24 **A.** Yeah.
 25 **Q.** Looking at specific issues, and at the end of that

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1 **Q.** You say in your statement that some of the key decisions
 2 were made without meaningful input from the homecare
 3 sector, and an example you give is in relation to the
 4 February and March PPE guidance.
 5 Could you clarify, please, we looked at some
 6 correspondence with Professor Rayner where draft
 7 guidance was sent to her the day before for her
 8 comments. Were you copied into such correspondence?
 9 And so are you saying that you didn't have any
 10 meaningful input, or were you not included at all?
 11 **A.** No, we were included and if you look at that chain of
 12 correspondence you can see that we did comment on the
 13 draft but the comments that we made were not
 14 incorporated. So there were some inconsistencies and
 15 some confusion that were still there when they published
 16 the final version. But quite often, the guidance, the
 17 draft, would come out at quite a late stage of
 18 production with a very tight timeline, and
 19 unfortunately, they're still doing this. So a couple of
 20 weeks ago we received a 160-page document of pandemic
 21 preparedness guidance and were given about five or six
 22 working days with no notice to go through it. And that
 23 kind of thing is very difficult because even if you have
 24 comments, they won't get incorporated because there's
 25 some deadline.

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1 process reports were produced.
 2 Were those were the recommendations in those reports
 3 implemented, so far as you are aware?
 4 **A.** Certainly in the workforce subgroup that we were
 5 involved in, along with Vic Rayner. None of them --
 6 none of the recommendations made were implemented.
 7 **Q.** Are you able to help us as to why they weren't
 8 implemented? And what could be changed in future to
 9 ensure that that doesn't arise again?
 10 **A.** I think it probably reveals a general problem with
 11 social care, that the way the whole sector is structured
 12 and governed allows people to pass the buck.
 13 So ministers will say, "Oh, sorry, it's the
 14 statutory responsibility of local authorities to do X, Y
 15 or Z", so every time anything difficult comes up and we
 16 challenge ministers, local authorities get a letter
 17 telling them to do X, Y and Z.
 18 If you talk to local authorities, they'll say,
 19 "We're really sorry, we haven't got enough money because
 20 central government doesn't give us enough."
 21 That's also true.
 22 So there isn't anybody taking proper accountability
 23 and it's very easy for people to be ignored in that kind
 24 of environment, because it's always somebody else's
 25 fault.

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1 So what we want to see in future is much earlier
 2 engagement, and in -- with Public Health England later
 3 in the pandemic, a person appeared who was willing to
 4 engage with us one-to-one and really understood our
 5 sector, and things massively improved after that.
 6 **Q.** Thank you.
 7 On this topic I just want to ask two more questions.
 8 So firstly, you say that the government relied on the --
 9 on ADASS, is that right, the --
 10 **A.** ADASS, the Association of Directors of Adult Social
 11 Services.
 12 **Q.** -- to disseminate communications and guidance throughout
 13 the pandemic. You say that they only really had the
 14 contact details of those providers that they had
 15 contracts with, but you also say in your statement that
 16 the majority of homecare providers were receiving
 17 commissions from local authorities.
 18 So, first of all, do you know what the reach was,
 19 putting the personal assistants to one side, do you know
 20 what the reach was? And do you think that there's any
 21 better way of reaching out to a larger part of the
 22 sector in future?
 23 **A.** So independent industry analysts' data show that about
 24 80% of homecare services are purchased by either local
 25 authorities or the NHS, and about 21% are purchased

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privately. So it was very noticeable in some areas that councils didn't have a good idea of who -- which providers were there. But the Care Quality Commission has a register, and their data that's available on line is -- you can filter it by local authority area, by Parliamentary constituency, by lots of different means. So there wasn't really a reason for them not to know; it's just that they didn't have a working relationship.

And I think in future that -- it did improve during the pandemic, because later on, with the vaccination rollout, in home care, councils were told that they had to organise the vaccination programme for home care, and it was, honestly, very shambolic. We pushed and pushed to get the national booking service opened, which was resisted, but eventually they did agree and that made life very much easier.

Q. Thank you.

And can I ask you about data and research, please. We heard from Professor Shallcross about the difficulties in collating data from domiciliary care, and she identified it as being a research gap.

Could you help us as to what the current position is, with regard to digital transformation of the sector, and whether, from your perspective, there are certain types of data that you think are urgently needed to

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openly with the public, and not with the providers that are submitting it, and actually, access to that data would help everybody.

Other countries do it differently. So, for example, in New Zealand, the providers have to submit data using something called a "Minimum Data Set Resident Assessment Instrument". That data is useful to them in delivering their services, but when it moves up, it is aggregated and anonymised, and then government, whoever, regulators, can access it and see what's happening. That's where we ultimately need to move to, but we're quite a long way from that at the moment.

Q. Thank you.

You set out in quite a bit of detail in your statement the pre-existing challenges that the sector faced going into the pandemic. I won't go into all of those; they are set out in your statement. But can I just ask, in terms of the financial instability that you describe, is it fair to summarise it like this: that pre-pandemic, on average, councils were paying less than the minimum price for homecare services, and most of homecare services were paid for on a zero hours basis? And the way it was procured and commissioned meant that providers were effectively encouraged to race to the bottom on price to win packages of work? Payments for

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understand the sector better? And do you have any suggestions in how the data infrastructure can be improved?

A. So prior to the pandemic, about 40% of homecare providers had digital social care records. As we stand today, we're at about 80%. Most of the focus of digital support in the pandemic, though, was to care homes. Homecare providers were left to their own devices, and being an entrepreneurial and innovative bunch, did all sorts of changes to make remote working -- obviously you can't remote work and deliver domiciliary care, but in terms of office functions, training, support, some of our members created their own wellbeing apps and so on to try to find ways to support the remote-working workforce.

So I think the data collection in the pandemic did improve gradually. The problem we came up against was that suddenly everybody was asking for data. So central government wanted data, local authorities wanted data, and the poor providers were trying to keep the show on the road. So it created a huge administrative burden. So we spent a lot of time trying to encourage, to minimise that problem. Where we are now, there is much better data than we had before, but the big flaw, as far as I'm concerned, is that they are not sharing that

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care were also delivered in arrears.

How do you say that that combination of factors impacted on the ability of the sector to be able to respond to the pandemic?

A. It has a massive impact. And I think we're the only part of the entire health and care sector, and possibly the only part of the entire economy, where workers are paid by the minute. It's honestly a national disgrace.

And if the person that you're supporting has to go into hospital, the councils and the NHS stop paying the provider.

So this creates a working environment with insecure income, unpredictable, and insufficient, because the rules are that you have to be paid for all of your working time, so that is the visits to the people that you're supporting and also travel from one person to another --

Q. Okay --

A. -- and the amount that's paid isn't enough to cover all the costs, and the people that suffer are those drawing on services and the care workers.

Q. Thank you. I'm sorry, I didn't mean to interrupt. I think we have limited time so I'm trying to make sure we get through everything.

But is it right that one of the things that you were

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highlighting to government during the pandemic is that there were increased costs for providers associated with the pandemic? So, for example, the cost of PPE, the cost of having to pay for staff who were working extra hours or who were isolating. But also there was a reduction in the income of the providers.

And you say that that combined led to a 35-40% hit to most homecare businesses. How did that affect their ability to absorb unexpected costs during the pandemic?

A. Well, obviously it made it very difficult. We commissioned some work early on to come up with those numbers that were based on evidence, and we submitted a paper to the Department of Health and Social Care which went to the Treasury, and we were later told that that was instrumental in encouraging the Treasury to release money to local authorities. So they issued two tranches, 1.6 billion on 19 March, and another 1.6 billion in April.

And in the meantime, we worked closely with the Local Government Association and the Association of Directors of Adult Social Services, to make some suggestions, recommendations for how councils could help homecare providers, and one of the suggestions we made was that they switched from paying in arrears on actual delivery to paying in advance on planned. And many of

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So giving providers the flexibility is much the better way.

Q. Thank you.

Could I ask you about PPE, please. Could you just briefly give us some examples of the key issues that your members and the sector more widely had in accessing PPE, and in particular, with the portal, please?

A. So early -- prior to the pandemic, homecare workers typically used aprons and gloves; do not typically use masks except in very specific circumstances, if you've got a person who is generating aerosol, if there's a risk of aerosol exposure --

Q. Sorry, just pausing there. You highlight that in your statement.

A. Mm.

Q. Why is that significant?

A. Because nobody routinely ordered masks, and weren't familiar with the different types of mask and what they were used for. Providers normally have business-as-usual suppliers, so they will do a PPE order, have it, you know, routinely, pay for it, and then the suppliers deliver just in time. Many providers don't have much space. The homecare offices are usually pretty small rooms in industrial estates, and that's because there is no money in the sector. So the

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them did. And honestly that saved the sector, because it help to maintain some financial resilience.

Unfortunately, after the pandemic, they've all gone back to their ways of buying it by the minute at low rates.

Q. Thank you. And can I ask you specifically about the infection control fund, which you say was inconsistently distributed by local authorities during the pandemic. How do you think that process can be improved? And do you think it was right to give local authorities the power to decide how it should be distributed and to whom?

A. The first -- most -- the first tranche was 75% for care homes and the remaining 25% it was left to the discretion of local authorities about what to do with it. Some local authorities, I mentioned Hertfordshire, they basically just decided to get the money out to everybody ASAP. That was a better way of doing it because everybody had different ways and had different needs. So, for example, if you didn't -- if you were lucky enough not to have any infections you didn't need to use that money for isolation but you might have wanted to use it for other things. So for example, some of the care homes used it to create visiting pods in gardens and all kinds of things.

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suggestion that the Matt Hancock made about having five years of PPE supply, or something, simply isn't a practical proposition.

Q. I think it was a month.

A. A month, but even that --

Q. Is that practical?

A. -- even a week is a lot, but it works much better. The PPE Portal which we'd suggested they did is a really good idea because it allows you to procure in bulk, which enables good negotiation of prices. So, many of our members are very small providers, and the problem that they have is no negotiating power. Some of our larger providers did much better because they were able to buy it at prices that were more reasonable, but especially the small ones, the prices were really raised because it was so difficult.

So it was (a), accessing it, the business-as-usual orders that people had made were redirected to the NHS for whatever reason, it doesn't matter. The fact is they didn't have them. And it was difficult to know what PPE to use. The first set of guidance that came out, as you know, said that community transmission wasn't likely and they didn't need to use PPE. Nobody actually believed them so --

Q. Sorry to cut across you, but is it also right that there

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1 was some confusion about the specifications --
 2 **A.** Yes.
 3 **Q.** -- with regard to masks especially where the guidance
 4 appeared to be inconsistent, either in itself or with
 5 local guidance that was produced?
 6 **A.** Yes.
 7 **Q.** Could I just move you on, please, to deaths and end of
 8 life. Is it right that you did see a rapid rise in
 9 deaths in the sector, however those were consistent with
 10 levels in the community, but what you do say is that
 11 that was consistent with more people dying at home
 12 rather than in hospital? And did you see any evidence
 13 from your surveys and members that the quality of
 14 end-of-life care suffered as a result of that?
 15 **A.** In general, it was difficult for people to access
 16 healthcare services, and I would say that the people
 17 with professional homecare workers possibly did better
 18 because they had people advocating for them and fighting
 19 on their behalf. People that were being supported by
 20 unpaid family carers struggled much more and I think
 21 there was a lot of fear and anxiety not knowing the
 22 right thing to do and not being able to easily find
 23 people to talk to.
 24 **Q.** Thank you.
 25 And before I ask you finally about recommendations,

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1 **A.** So I think it would be useful to have some standing,
 2 high-level social care committee for the pandemic,
 3 because we need social care expertise at all levels, of
 4 operational, command, science and policy development.
 5 And guaranteeing equal access to PPE, testing, funding,
 6 you know, sick pay, vaccination. All of those things,
 7 home care was at the end of the queue, but the people
 8 that we were supporting had just as much risk, as
 9 I explained.
 10 **Q.** Thank you.
 11 **A.** Yeah.
 12 **MS JUNG:** Thank you, Dr Townson.
 13 My Lady, those are all my questions. I think there
 14 are some questions from the Core Participants.
 15 **LADY HALLETT:** Thank you.
 16 Ms Morris, I think you're going first.
 17 **Questions from MS MORRIS KC**
 18 **MS MORRIS:** Thank you, my Lady.
 19 Good morning, Dr Townson. I ask questions on behalf
 20 of the Covid Bereaved Families for Justice, and thank
 21 you for your kind words a moment ago.
 22 You also touched a moment ago on the issue of remote
 23 working, and I wanted to ask you some questions first of
 24 all on the topic of access to services.
 25 You said in your statement that access to certain

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1 can ask you this, please: you say in your statement that
 2 throughout the pandemic you witnessed the very best of
 3 human dedication in the sector. Could you provide some
 4 examples, please, of positive things that you saw, and
 5 good practice that you would like to share?
 6 **A.** I think, first of all, I just want to put on record our
 7 deepest sympathy to the bereaved families. I think
 8 they've been remarkable in their bravery coming here and
 9 engaging with the Inquiry. And I'd also want to thank
 10 care workers, because they were the only people, often,
 11 that were going out and about. The GPs were remote
 12 working, the district nurses were remote working, the
 13 housing managers were remote working, the CQC
 14 inspectors. So they were incredibly brave, and it was
 15 difficult, early on, to get them so-called key worker
 16 status. So, for example, they were being stopped by the
 17 police, they were being abused by members of the public
 18 who thought they were breaching lockdown rules, but they
 19 were just doing their jobs and they were the eyes and
 20 ears for everybody else in the system, because they were
 21 the only ones going in. So ...
 22 **Q.** Thank you.
 23 And finally, apart from the ones that we've covered,
 24 could you please give us your top recommendation that
 25 you would make?

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1 professionals during the pandemic became quite
 2 difficult, and that your members raised concerns about
 3 the quality of some of the remote assessments by social
 4 workers and GPs, are two examples that you give,
 5 particularly where those with care needs had problems
 6 with communication or, for example, those living with
 7 dementia.
 8 You gave examples of where packages of care were
 9 often inadequate because the carers had yet to meet the
 10 individuals, and providers were asked to start providing
 11 care and support without knowing, for example, whether
 12 the individual was able to move, mobilise, or
 13 communicate. And there are examples that you gave of
 14 care plans and time assessments being inaccurate.
 15 So was there a concern by your members that services
 16 had, if you like, stepped back from those receiving
 17 domiciliary care during the pandemic?
 18 **A.** Sorry, you -- could you --
 19 **Q.** Was there a concern that some services were sort of
 20 stepped back?
 21 **A.** Yes.
 22 **Q.** Particularly where people were receiving care in their
 23 home?
 24 **A.** Yes. We were very concerned about the social work
 25 assessments being done remotely, because you really need

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1 to see somebody's environment and sit down and talk with
 2 them. And we saw a big waiting list develop, of over
 3 half a million people, waiting for assessment. And
 4 until those assessments are done, care isn't available.
 5 So many people were struggling, when they needed support
 6 and weren't able to get it.

7 And then when the care workers went in, it wouldn't
 8 matter if the -- it wouldn't matter that the assessment
 9 was inaccurate if care workers were given more autonomy
 10 to make decisions about what did need to be done, which
 11 is more possible when you're supporting people buying
 12 their own care, because you're having a conversation
 13 with them. They are the commissioners. But in many
 14 cases, if it's a state-funded client, that care sector
 15 has to go up through, I don't know, could be eight
 16 different levels in a council, sometimes, to get
 17 permission to change the care package. So that isn't
 18 ideal.

19 And one of the changes we have -- we are pushing
 20 for, in general, is: the care workers know people better
 21 than anyone else, they're in and out of their houses
 22 multiple times a day, please trust them more.

23 **Q.** So what are some of the impacts that were being observed
 24 during the pandemic on those receiving care?

25 **A.** Well, many people became very isolated. Even the ones

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1 saying that they'd been approached by one of the local
 2 authorities saying that they needed to reduce the care
 3 packages in domiciliary care in order to free up
 4 capacity for hospital discharge. And they said in this
 5 email, "Oh, by the way, you know, they won't have
 6 Covid-19", which nobody -- you know -- nobody believed
 7 that. So that process to reduce the care available.

8 Some of that was also because families were at home,
 9 so people were remote working and were furloughed, so
 10 they might have taken risk factors like that into
 11 account.

12 But in general, we were concerned that people that
 13 needed support were having it taken away or reduced.

14 **Q.** Staying with easements, and moving beyond the pandemic,
 15 is there concern that that relaxation or easement set
 16 any precedent beyond the pandemic?

17 **A.** Well, all the time, because many local authorities are
 18 very short of money, they are constantly looking for
 19 ways of reducing the care available, and it is an
 20 ongoing issue of assessing, reassessing, cutting care,
 21 reducing care. And many people only qualify for
 22 state-funded home care in the first place because
 23 they've got quite high levels of need.

24 So we are very concerned.

25 And if that care reduces, then people just end up in

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1 who received professional care, who arguably were more
 2 fortunate than those who didn't, but it could be a long
 3 day, waiting by yourself without connection with family.
 4 As time went on, more providers were enabling the people
 5 that they supported to connect digitally with their
 6 loved ones, and that made a big difference.

7 **Q.** Thank you.

8 The next topic I'd like to ask you about, please, is
 9 about easements, and you discussed in your statement the
 10 impact of Care Act easements and noted that some local
 11 authorities seemed to relax Care Act duties even where
 12 the formal easements hadn't been triggered. And you
 13 expressed some concern about the impact on people
 14 receiving care, because members reported instances where
 15 some essential support was reduced or withdrawn.

16 So can you just expand on that a little bit? Kind
 17 of what were the concerns? What were the examples of
 18 support being withdrawn. And did they, in your view,
 19 sort of reduce the protections available to those with
 20 Care Act needs?

21 **A.** Yes. So we suspect that the Care Act easements, they
 22 didn't use the formal legal process in many cases.

23 The first inkling that we got that this was
 24 happening was in the middle of March. 11 March, we
 25 received a letter -- an email from one of our members

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1 hospital. That's what happens. Which puts pressure on
 2 the whole system, and we end up seeing ambulance queues,
 3 people not being able to be admitted because there
 4 aren't beds, the waiting lists for treatment reaching
 5 7.5 million. A lot of that is because the entire system
 6 is not being resourced in the most cost-effective
 7 manner.

8 **Q.** So are you concerned this is an ongoing issue?

9 **A.** Yes.

10 **Q.** Thank you.

11 My third and final topic is around data, and you've
 12 already touched on some of the concerns around
 13 unregulated care workers in your evidence this morning,
 14 because you've noted that the CQC holds the only
 15 comprehensive central register of regulated care
 16 providers.

17 You've said in your evidence this morning that you
 18 think about 20% of the workforce is unregulated
 19 within -- is that within domiciliary care?

20 **A.** It's over 120,000, according to Skills for Care data.

21 **Q.** Okay, thank you. And you said this morning, as well,
 22 that unregulated personal assistants, for example, are
 23 "off everyone's radar", so there is, in your evidence,
 24 there is a significant gap in understanding of this
 25 particular part and important part of the workforce.

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1 Okay. What is the impact, in your view, of not
2 being able to reach that full sector, both those
3 receiving care and those providing that care during the
4 pandemic? You've given two examples, I think, PPE and
5 its distribution out to those who need it, and
6 vaccination, but are there others?

7 **A.** Well, testing would have been another one. But just in
8 general, the support for those care workers, as well,
9 because often you will encounter quite challenging
10 situations, and at least in a regulated agency, the care
11 workers have got someone that they can ask for support,
12 or they can go to a Care Quality Commission person. But
13 the unregulated care workforce doesn't have anyone.

14 **Q.** You mentioned training, as well, this morning. Is that
15 an additional sort of gap for those in the
16 unregulated-- (overspeaking) --

17 **A.** There is no requirement for mandatory training. The
18 responsibility for that is left to the person drawing on
19 care, but the research that we've conducted suggests
20 that many members of the public don't understand that
21 there is a difference between a regulated, managed
22 service and unregulated care. Like anyone in this room
23 could walk out here this morning, put an advert up and
24 set up shop as an unregulated carer. No questions
25 asked.

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1 the introduction. So it's not that the care is
2 unnecessarily unsafe; it's just that if the regulation
3 is there to create a level playing field, that's what it
4 should do. There shouldn't be a group of people over
5 here allowed to get on and do whatever they want and
6 another lot of people over here having very stringent
7 regulatory requirements imposed.

8 **Q.** Understood. Thank you.

9 Just in my final questions, allowing you sort of
10 a chance to expand further. Can you explain the impact
11 of the limited understanding of the sector and that
12 number -- the lack of the number and identity of
13 providers had on central and local government
14 communication and coordination within the sector during
15 the pandemic?

16 **A.** Well, I think in terms of trying to find out how many
17 providers there are, what their needs are, what the
18 risks are to the people that they're supporting, was
19 hugely difficult. Obviously with the CQC-registered
20 organisations it's much more straightforward, and the
21 CQC has got rights to any information it requests. But
22 for everybody else, it's very difficult.

23 We think that -- in the devolved administrations
24 there are registers of professional care workers. We
25 think that everybody should do what's Scotland is doing,

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1 **Q.** Thank you.

2 Do you have any experience of whether the CQC
3 register tends to be accurate of the regulated providers
4 and whether it's regularly updated?

5 **A.** Yes, it is very accurate and it is a criminal offence to
6 operate a managed regulated service without registering
7 with the CQC. So if they find that that is going on,
8 they will investigate. We feel that they don't
9 investigate enough, but when they do, they have brought
10 some prosecutions in some cases.

11 **Q.** That's going to my next question. Do you have any
12 knowledge of whether, and to what extent, there are
13 providers that should be registered with the CQC, but
14 are still operating despite not having registration?

15 **A.** We think that there are more, there are quite a number.
16 You can report them when you come across them. It isn't
17 always that the -- there are organisations known as
18 introductory agencies. They're like employment
19 agencies, and they're a bit like an Uber platform. So
20 if a citizen wants care they register on that platform.
21 If an individual care worker wants work, they register
22 on the platform and then the platform connects them.

23 And some of the introductory agencies spend time
24 monitoring and managing the care, which technically
25 they're not supposed to do, they're only supposed to do

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1 and add the unregulated personal assistants to that
2 register.

3 Of the devolved administrations, we feel that
4 Northern Ireland has done it the best. They have
5 focused their register on competence and conduct, not
6 qualifications. And I think that is the most pragmatic
7 approach for our sector.

8 **MS MORRIS:** Thank you.

9 Those are my questions. Thank you, Dr Townson.

10 Thank you, my Lady.

11 **LADY HALLETT:** Thank you, Ms Morris.

12 And Mr Straw.

13 **Questions from MR STRAW KC**

14 **MR STRAW:** My Lady, my microphone doesn't seem to be
15 working -- it's on now. Thank you.

16 Dr Townson, I represent John's Campaign, The
17 Patients Association and Care Rights UK.

18 Firstly, you note that often the only professionals
19 who would visit homes were care workers, but there was
20 fear about infection being passed on if care workers
21 visited in multiple homes. Should more have been done
22 to ensure that a person's essential or family carer
23 could visit, given that they may not pose the same risk
24 in terms of multi-contact infection risk?

25 **A.** Yes. I think so and later, we had bubbles, didn't we,

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1 which made that process easier? That would have been
2 good to have had from the beginning.
3 **Q.** Thank you. At paragraph 144, you note that the majority
4 of excess deaths at home were not directly ascribed to
5 Covid but to other causes such as dementia. And
6 elsewhere you explain in detail the severe impact that
7 isolation had on those with dementia and others like
8 them. Are there changes that should have been made to
9 reduce isolation in the pandemic?

10 **A.** I think that we've learnt from many countries, not just
11 our own, that the risk to everybody's mental health
12 needs to go up the list of priorities. The focus was
13 very much on infection prevention and control, and the
14 wellbeing and ability for families to see their loved
15 ones was sacrificed. I think in future it would be much
16 better to have a more nuanced approach to that,
17 recognising the importance -- the vital importance for
18 health of human contact with people that you know and
19 love.

20 **Q.** Can you give any recommendations on how that might be
21 done? For example, would it be helpful if there was
22 government guidance which described those potential
23 adverse harms and encouraged risk assessments which
24 properly took into account those adverse harms?

25 **A.** I think government guidance is obviously helpful,
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1 in data collection and monitoring of deaths at home, and
2 you also explain that at the time of the pandemic,
3 homecare providers were not required to report a death
4 unless it may have been the result of regulated activity
5 or how it was provided.

6 Is it your understanding that this is likely to have
7 meant that the number of both Covid-19 deaths and also
8 non-Covid deaths would have been under-reported?

9 **A.** The reporting of deaths is governed by Regulation 16 of
10 the Health and Social Care Act 2008, which was revised
11 in 2014. So in a care home, everybody that dies has to
12 be notified to the Care Quality Commission. In home
13 care, it's only -- so for example, if Mr Jones has
14 a heart attack at 4 o'clock in the morning, his wife
15 calls an ambulance, he gets taken to hospital and dies
16 there, that does not have to be reported to the Care
17 Quality Commission by a homecare provider.

18 If, on the other hand, the homecare worker turns up,
19 Mr Jones is having a heart attack there and then, they
20 call an ambulance, do CPR, and he subsequently dies, you
21 would have to report that because you were physically
22 there as a homecare worker.

23 The other time when you have to report is if there
24 is any possibility that the person died as a result of
25 you carrying out the regulated activity. So an example
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1 because providers, especially the regulated providers,
2 they have to demonstrate that they are meeting
3 government guidelines and other regulatory requirements.
4 So it does help a lot to have some ground rules.
5 Everyone gets very nervous about making things up
6 themselves because the Care Quality Commission or
7 whoever might come along and say no. So I think that
8 would be a good idea.

9 And I think, if the visitors are consistent, what is
10 the risk? And if people have got mental capacity, they
11 should be allowed, I think, to judge that risk for
12 themselves.

13 Later on, when people had vaccination, triple
14 vaccination, the risks went right down.

15 **Q.** When you say if visitors are consistent, is an example
16 someone who has an essential carer who is their single
17 and only essential carer --

18 **A.** Yes.

19 **Q.** -- and that's the only person they're really visiting?

20 **A.** Yes. Like if, for example, it was a son or a daughter
21 that always went to visit mum, why would you not allow
22 them to carry on? Later it did -- those arrangements
23 were possible, but early on they weren't.

24 **Q.** And final area, please, is data.

25 You note in your witness statement significant gaps
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1 might be you accidentally drop someone out of a hoist or
2 something like that. It's vanishingly rare that that
3 kind of thing happens but that is the rule.

4 **MR STRAW:** Okay, I'll leave it there. Thank you very much.

5 **LADY HALLETT:** Thank you very much indeed, Mr Straw.

6 Thank you very much indeed, Dr Townson. You've been
7 very helpful, and a very powerful advocate for the
8 sector you represent. So thank you. I'm sure we shall
9 be seeing you again during the course of the Inquiry.

10 Thank you very much.

11 I shall adjourn now for a 15-minute break so I shall
12 return at 11.55. Just over 15-minute break. Thank you.

13 (11.38 am)

(A short break)

15 (11.55 am)

16 **MS CECIL:** My Lady, may I call Sir Savid Javid.

17 **LADY HALLETT:** Thank you, Ms Cecil.

SIR SAJID JAVID (affirmed)

Questions from COUNSEL TO THE INQUIRY

20 **LADY HALLETT:** Mr Javid, I think the last time you came
21 I was chairing the hearing remotely. It's nothing
22 personal, I assure you.

23 **THE WITNESS:** No, it's lovely to see you.

24 **MS CECIL:** Sir Sajid, thank you for attending and assisting
25 the Inquiry today. As my Lady has noted, you've
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1 provided evidence before now on a number of occasions,
 2 and that has touched upon some of the issues that we're
 3 dealing with today but what I do not want to do is go
 4 over old ground, effectively.
 5 So if I can just take you briefly, therefore,
 6 through your professional background, and specifically
 7 your role in the adult social care sector.
 8 On 26 June 2021 you were appointed as Secretary of
 9 State in the Department of Health and Social Care; is
 10 that right?
 11 **A.** Yes.
 12 **Q.** Immediately prior to that, you were a backbencher?
 13 **A.** Yes.
 14 **Q.** Following earlier appointments in government?
 15 **A.** Yes.
 16 **Q.** And the time period that we're dealing with or concerned
 17 with today is from the end of June of 2021 until the end
 18 of the following June, in 2022?
 19 **A.** Yes.
 20 **Q.** Similarly, we've discussed previously in your evidence
 21 the composition and structure of the Department of
 22 Health and Social Care, how it worked --
 23 **A.** Yes.
 24 **Q.** -- and the various interactions that took place, and
 25 you've helpfully set those out within your witness
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1 the Department for Communities and Local Government,
 2 because you'll know, from perhaps other evidence, the
 3 role that that department also plays in the social care
 4 setting.
 5 **Q.** Of course. We're going to turn to some of those aspects
 6 later --
 7 **A.** Right. And so that's where my, sort of, direct
 8 experience, sort of more direct, I guess, as
 9 a government minister really began. And it was clear to
 10 me from then on that, even before the pandemic, the
 11 social care sector as a whole is -- was under an
 12 enormous amount of pressure, enormous amount of
 13 challenge, especially around issues around funding.
 14 Because unlike the NHS, the social care sector is -- the
 15 funding is in different sources, central, local
 16 government, private providers -- is much more
 17 fragmented. It's locally run by the relevant, sort
 18 of -- local councils oversee it rather than central
 19 government. And so all of that, whilst there can be
 20 good reasons for the, sort of, fragmentation and things
 21 and -- when the system was, sort of, first set up, so to
 22 speak, it -- what I saw was a system that was already,
 23 before the pandemic, under, you know, severe stress,
 24 especially around funding, and especially around
 25 workforce as well.

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1 statement for this module, so I'm not proposing to go
 2 over those.
 3 **A.** Yes.
 4 **Q.** But I want to deal, if I may, instead, with your
 5 overarching thoughts on the adult social care system.
 6 In your statement, at paragraph 57, you describe
 7 that as being stretched financially and understaffed,
 8 and in need of significant reform on a national level to
 9 improve quality of care and increase in service need.
 10 I just want to ask you, please, if you can just
 11 expand upon that a little bit in relation to that
 12 pandemic period and specifically the pressures that were
 13 faced by the sector at that time.
 14 **A.** Yeah, thank you.
 15 And if I may, my Lady, may just given by thanking
 16 you and the Inquiry team for the vital work you're
 17 doing, and I deeply respect the importance of this
 18 process and all that you're doing, and I'm grateful for
 19 this opportunity to contribute, and hopefully contribute
 20 to lessons learned. So thank you for that.
 21 But turning to the first question, the -- in fact,
 22 when you referred to my experience a moment ago, I think
 23 what might also be relevant for social care, adult
 24 social care sector, is my time also as a local
 25 government secretary of state, in then what was called
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1 And then when I became Health Secretary, it was
 2 obviously in the, sort of, latter half of the pandemic,
 3 so to speak. There were obviously significant
 4 challenges, you've heard evidence on, in the first part,
 5 if I can call it that, of the pandemic. By the time
 6 I had become Secretary of State, I think some of the
 7 most immediate sort of challenges in the sector were in
 8 a better place because of the vaccines, for example,
 9 more PPE and better IPC and things, but there -- of
 10 course there were still challenges, particularly
 11 around -- you know, still issues around funding, around
 12 workforce and other challenges.
 13 **Q.** Thank you. And we're going to move through some of
 14 those, but if I may pick up on one of the things that
 15 you've just mentioned --
 16 **A.** Yes --
 17 **Q.** -- and it's the fragmentation of the sector, and the
 18 fact that obviously you have different government
 19 departments, you have local authority and then you have
 20 the sector itself, which is comprised of public,
 21 non-profit and private sector organisations.
 22 We've heard from your predecessor, Mr Hancock, that
 23 levers or the lack of policy levers was a specific issue
 24 of challenge within the pandemic --
 25 **A.** Yeah --

52

1 Q. -- from his perspective. Obviously that was earlier in
2 the pandemic.
3 A. Yeah.
4 Q. But is that something that you would agree with in terms
5 of that central departmental governmental role?
6 A. Yeah, the general point, I would agree with. But what
7 I would point out is that probably one of the key
8 reasons there's a lack of sort of central levers for
9 central government is because of the way the system is
10 set up in terms of local government control, private
11 providers, combination of funding, and all that. And if
12 central government were to have more levers -- none of
13 this is without trade-offs. There's always trade-offs,
14 I've found, in government, in making any decision and
15 often, I think they're not, sort of, fully appreciated
16 there's, if you move in one direction, you might lose
17 some valued aspects that you had before.
18 So for example, having local authorities in general,
19 certainly outside the pandemic, overseeing social care,
20 whether it's for working age adults or older people,
21 meant that you -- it would be closer to the community,
22 your local needs were met, in different parts of the
23 country there would be different ways to provide care in
24 different types of settings. There might be other sort
25 of local issues that would -- that could be more easily

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1 local authorities in their performance of doing their
2 statutory duty, in terms of social care, and also
3 allowing central government to make direct payments to
4 providers in the future, and also giving a general power
5 of direction to a Secretary of State in that sector,
6 whether it's in a crisis or a localised emergency.

7 Q. Thank you.

8 And you've provided that white paper to the
9 Inquiry --

10 A. Yeah.

11 Q. -- and the Inquiry has that.

12 If I can turn, then, to discuss another topic. It's
13 that of hospital discharge. Of course, the pressures
14 were not quite so acute at the point when you came into
15 the position, but just touching on the discharge to
16 assess model and delayed discharge. You've explained
17 that the issues are complex and you suggest there needs
18 to be some thinking about solutions in that respect, and
19 one solution you posit is the role of what was then
20 DLUHC, which has been now renamed --

21 A. Yes.

22 Q. -- and cross-local authority working via a central
23 system. Can you just expand on that very briefly?

24 A. Yes, sorry, can you just ask that latter part of the
25 question again?

55

1 addressed.

2 So I think, first of all, there is this trade-off.
3 But, that said, I think already it's clear from the
4 pandemic that it certainly, at the start of the pandemic
5 and throughout, it would have been helpful, had there
6 been, sort of, more levers and things done. And that is
7 actually one of the reasons when I -- social care was
8 a sector, I did spend a lot of time, I thought about it
9 a lot. Not just the immediate, sort of, pandemic needs,
10 but also more medium to longer term, how can we improve
11 this system that I had already had some contact with in
12 my previous government roles? And that was one of the
13 reasons I introduced the white paper on adult social
14 care reform in 2021 and I point to that because it did
15 include a number of what I would call levers that
16 I think would be very helpful to future governments, not
17 just in pandemic situations but just generally in
18 helping the sector.

19 So, for example, better access for central
20 government to data and information, including anonymised
21 data and also better -- having standard, sort of,
22 information standards, more digitisation of that data,
23 and also other measures again which were central, but
24 I think gave more levers, given the CQC, for example,
25 more levers to -- in terms of its ability to assess

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1 Q. Of course. Really, it is how would that work in
2 practice? So what I'm interested in is you suggest that
3 one potential solution is effectively cross-local
4 authority working --

5 A. Yes.

6 Q. -- via a centralised system in conjunction with what was
7 then, and staying with the pandemic, offices, as they
8 were, of the Department for Levelling Up Housing and
9 Communities?

10 A. Just to make sure I understand it, are you talking
11 particularly about the discharge to assess?

12 Q. I am, yes.

13 A. Okay. In fact, again, in my experience in that
14 department, you know, the local government department,
15 one thing I remember from that time, obviously
16 pre-pandemic, it was even at that time, delayed
17 discharge, the whole issue of delayed discharge, which
18 was one of the reasons for discharge to assess, was
19 a big issue then. The then Secretary of State for
20 Health was Jeremy Hunt, I remember a number of meetings
21 with him about what could my department or, more
22 accurately, I guess, local government do to help with
23 assessments of people that were medically able to leave
24 hospital, but the, sort of, assessment of any further
25 support or care had not been made.

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1 So it was something I would sort of -- the concept
2 of something I was quite, sort of, familiar with. Also,
3 when I came into the Health Department, you know, that
4 sort of policy in terms of more support, especially more
5 financing, direct financing to the NHS, had already
6 started and so I sort of came in and inherited this sort
7 of newer approach. And I continued with it, because
8 I saw it as an important part of, first of all,
9 certainly freeing up as many beds as possible in the NHS
10 for urgent medical needs.

11 Also, I thought it would reduce the, sort of, the
12 number of -- the transfer delays, because, you know, you
13 would also find people that were -- they knew they
14 didn't need to be in hospital, they were eager to get
15 out, and I think having this funding and support would
16 make that quicker.

17 And I think it was also a more, what I would call,
18 like, a person-centred approach, maybe it meant that you
19 want someone, sort of, out of the immediate environs of
20 a hospital and more in a community setting, maybe there
21 was some time to, sort of, assess more carefully, take a
22 little bit more time to work out what sort of
23 longer-term support they need.

24 I felt that in terms of -- more directly to your
25 particular question, I felt that it was an area where,

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1 say one way or the other on that because I wasn't there,
2 I didn't have the information at the time, and it wasn't
3 -- so I don't want to second-guess the decisions that
4 were made at the time because I don't have that
5 information.

6 **Q.** Putting it in a slightly different way then, but looking
7 to the future, is that something that would be
8 desirable? To have some form of step-down or designated
9 settings policy in place prior to discharge?

10 **A.** Yes.

11 **Q.** Now if I can turn to perhaps one of the levers that was
12 in place in the pandemic, or instituted, and that's
13 vaccination as a condition of deployment.

14 **A.** Yes.

15 **Q.** The regulations initially in relation to those working
16 or volunteering in a CQC-registered care home were laid
17 prior to your appointment as Secretary of State, as
18 I understand it?

19 **A.** Yes.

20 **Q.** And so the policy work that had already been undertaken.
21 But notwithstanding that, that policy was in place
22 effectively throughout your tenure?

23 **A.** Yes.

24 **Q.** Or certainly until it was revoked in March of 2022.

25 **A.** Yeah.

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1 you know, where the more cooperation there was between
2 local government and the NHS, in particular, because the
3 NHS obviously had the sort of purse strings, so to
4 speak, on the funding of discharge to assess, that the
5 more focused it could be on the needs of that particular
6 individual, and I felt that to do that, you know, going
7 forward it meant the more data the NHS had, the more
8 data and information there was on that individual, the
9 more data and information there was on the local setting
10 and what support was available, that would all help to
11 lead to a quicker assessment but a more appropriate
12 assessment.

13 **Q.** Thank you. And then just also picking up on the actual
14 discharges during the pandemic itself, at the time when
15 you were dealing with this, there were step-down
16 facilities or designated settings in place. In your
17 view, ought those to have been in place from the very
18 outset of the pandemic?

19 **A.** You mean before the pandemic started?

20 **Q.** No, no, in response to the pandemic, at the very outset
21 of the pandemic when the discharge policy was instituted
22 in March 2020?

23 **A.** I -- obviously, I wasn't there in the Department then,
24 I was a backbench Member of Parliament, so my access to
25 information was very limited. So I would hesitate to

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1 **Q.** Just dealing with that, you were quite heavily involved,
2 regardless, in relation to consultation and how that
3 would work in practice, because, of course, it was going
4 to come into force in November of 2021. So we're
5 talking directly prior to the Omicron period, if I can
6 put it in that way.

7 **A.** Yes, that's right.

8 **Q.** And in relation to that, the impact assessments in
9 relation to those produced an estimate of around 7% of
10 the adult social care workforce within care homes as
11 effectively being affected in terms of that they would
12 not undertake the vaccination. Do you recall that?

13 **A.** Yes.

14 **Q.** It's a fairly significant proportion, around
15 40,000 workers --

16 **A.** Yes.

17 **Q.** -- was the estimate in terms of the impact assessments
18 before you. And indeed, you record within your witness
19 statement, at paragraph 169, that making vaccination
20 a condition of deployment was likely to have
21 a significant impact on staffing in the short to medium
22 term.

23 **A.** Yeah.

24 **Q.** Notwithstanding that, the decision was taken to proceed
25 with the policy?

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1 A. Yes.

2 Q. And subsequently, quite separately to that,

3 a consultation was undertaken in relation to healthcare

4 professionals in the NHS, and then potentially for

5 further rollout across wider adult social care sector

6 settings?

7 A. Yes.

8 Q. So we had two -- so, effectively, two different

9 policies: one for adult social care staff within care

10 homes --

11 A. Yes.

12 Q. -- and a separate situation where consultation was being

13 undertaken?

14 But that policy was not in place for those

15 individuals; is that right?

16 A. Yeah, the -- what's called VCOD, that was -- I mean, the

17 policy began before I became Secretary of State,

18 certainly with respect to social care workers in care

19 homes, and so I believe I'm right in saying that the

20 referrals for that had already gone to Parliament.

21 I was aware of the policy, of course, as a Member of

22 Parliament, but was not a minister at that time. When

23 I became the Secretary of State for Health, I inherited

24 both the existing policy for, you know, VCOD for social

25 care workers in care homes. And then, as you say, the

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1 had for a significant period was staff members in care

2 homes subject to this policy --

3 A. Yeah.

4 Q. -- while other people working with similarly vulnerable

5 people were not?

6 A. Yeah, yeah.

7 Q. That's where the discontent arose --

8 A. Yeah.

9 Q. -- or the perception of unfairness. That's why I'm

10 asking to what extent do you consider

11 that -- (overspeaking) --

12 A. Well, I don't think I entirely follow your chain of

13 thought there, because -- or the reasoning, because, you

14 know, that is -- what you have had just said is only,

15 you know, true because it's after the events. That's

16 with hindsight. Obviously at the time VCOD 1, if I call

17 it -- if I separate, sort of, VCOD 1, being the initial

18 policy that was brought in, versus VCOD 2, which was the

19 policy I brought in, if you allow me to use that

20 distinction, VCOD 1 was brought in, and soon after the

21 government said its plans were to bring in VCOD 2.

22 So during -- certainly during all of 2021, the sort

23 of view, I guess, of a social care worker in a care home

24 would have been that: oh, I've been asked to -- this

25 policy has been applied to me early, but it is likely

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1 policy was eventually, under my leadership, you know,

2 extended to include not just NHS workers but also

3 care workers in all other settings, including

4 domiciliary care settings.

5 Q. Indeed. And just dealing with that separation for

6 a moment, or the -- in terms of the staff, you will no

7 doubt be aware there was significant discontent over the

8 fact that it was mandated for adult social care staff

9 within care homes but not for those with -- for example,

10 working with other vulnerable people within hospitals?

11 A. Yes.

12 Q. And certainly some individuals had the perception, at

13 the very least, of a lack of parity as between the adult

14 social care system and the NHS, with feelings of

15 stigmatisation. To what extent do you consider it was

16 acceptable to mandate it for one and not the other?

17 A. Well, it wasn't. It was mandated for both.

18 Q. Let me put it in different -- well, let me just take

19 a step back and unwind that a little bit.

20 In relation to those individuals working in care

21 homes it was mandated?

22 A. Mm.

23 Q. It was initially consulted on in relation to rolling it

24 out to the further, wider, broader NHS staff, but that

25 policy was effectively abandoned in 2022. So what we

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1 now to be applied to others.

2 The point you made about it was eventually withdrawn

3 and it was only ever applied was because of Omicron and

4 the facts changed. So I don't think it would have been

5 possible for someone in 2021 to know that it would have

6 been withdrawn later.

7 Q. But if I can take you back a step, for those individuals

8 working in care homes, they were mandated?

9 A. Yes.

10 Q. And a number effectively lost their jobs as

11 a consequence?

12 A. Well, they chose to leave.

13 Q. I suspect they would not call that, necessarily,

14 a choice. But taking that to one step back, if I may,

15 those individuals were subject to that policy --

16 A. Yes.

17 Q. -- when others in the NHS were not. That's what I'm

18 asking you about.

19 A. Yes.

20 Q. So there was this discrepancy or disparity in terms of

21 what they were required to do to undertake their roles.

22 I've explained about the perception. I'm asking you to

23 deal with that aspect, and perhaps if I can put it in

24 this way: do you consider that that failure to initially

25 apply VCOD 1, as you've termed it --

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1 A. Yes.

2 Q. -- across the board to include the NHS workforce or
3 other health and care settings would have damaged its
4 credibility as a policy because you would have had the
5 same types of people delivering the same types of care
6 to vulnerable people?

7 A. No, I don't think I do. Mainly because -- I wasn't
8 there for the decision making around VCOD 1. So I don't
9 know, for example, what practical considerations there
10 might have been at the time for having the, sort of,
11 let's say, if you call it VCOD 1 and 2 at the same time,
12 right, just having one approach for all workers in NHS
13 and all social care settings. So I just don't know what
14 were the issues that were considered at the time. There
15 could be some very good practical reasons, so I don't
16 want to second-guess that. I don't think it was an
17 issue of unfairness. And also --

18 Q. It's really a question of external perception,
19 Sir Sajid.

20 A. There may have been in some quarters, but if the -- and
21 obviously people will perceive what they choose to
22 perceive, but government, it will make, at any point in
23 time it makes a decision, often there's no perfection
24 here, so if it was more -- if the government had decided
25 VCOD is a good policy, which it clearly had, to protect
65

1 to 2022?

2 A. Yes.

3 Q. And they were acute?

4 A. Yes.

5 Q. And so in terms of the VCOD policy, that had the
6 potential to quite significantly exacerbate those
7 pressures, would you agree with that?

8 A. It would have contributed to workforce pressures, yes.

9 Q. And indeed, in your personal minute that you made to the
10 Prime Minister all the way back on 28 October, 2021, you
11 record that in terms of the stakeholder consultation,
12 63% of responses were against the VCOD policy being
13 rolled out further, and 26% were supportive. That
14 overall, all agreed that it was important to maximise
15 vaccination but that they did not agree with the
16 mandatory mechanism that was being proposed.

17 A. Yes.

18 Q. At that point, nonetheless, the decision was taken to
19 implement it, but as you've already explained, owing to
20 the evidence that you heard about transmissibility of
21 Omicron --

22 A. Yes.

23 Q. -- and developing understanding and knowledge --

24 A. Yes.

25 Q. -- ultimately it was not pursued?
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1 vulnerable people, being the objective, then there could
2 still be good practical reasons to have a, sort of,
3 VCOD 1 and VCOD 2.

4 Q. I'm just going to pick up, if I may, upon broader
5 concerns within the adult social care sector.

6 A. Yeah.

7 Q. Certainly there was -- there were consultations that
8 were rolled out. I just want to deal with, we've heard
9 this morning from Jane Townson. In her witness
10 statement she highlighted that, in terms of their
11 submissions, they said that 18% would be ineligible for
12 deployment were it to be implemented across the broader
13 sector. Using those statistics, they estimated around
14 75,000 to 100,000 care workers would be affected. And
15 this is at a point, of course, as I say, nearing
16 Omicron, where the sector is nonetheless under
17 significant pressure; is that right?

18 A. I don't know. I don't know when, from that, what period
19 you're exactly referring to, because Omicron really is
20 from, sort of, mid-November onwards so --

21 Q. The letter from Jane Townson, if it assists, is on
22 23 January 2022.

23 A. Yeah.

24 Q. Would you agree there were significant workforce
25 pressures during that period, that winter period of 2021
66

1 A. And also the less severity of Omicron, not just
2 transmissibility.

3 Q. Indeed, transmissibility and severity and vaccination
4 success, in short?

5 A. Yes. That's right.

6 Q. It did not evade immunity, vaccine-induced immunity to
7 the extent that it was perhaps thought that it might in
8 the initial instance?

9 A. Say that bit again, please.

10 Q. Omicron. Vaccines were effectively far more successful
11 against Omicron than was necessarily thought to be the
12 case in the initial instance?

13 A. Yes. And sorry, just to make sure it's clear there,
14 also because Omicron was so highly infectious so, for
15 example, something like in the last -- in the first
16 eight weeks of Omicron, that accounted for something
17 like a third of all Covid infections during the entire
18 pandemic, that -- and by -- within a matter of two
19 months, we'd switched from 99% of infections being Delta
20 variant to 99% of infections being Omicron, and also
21 people that had been infected by Omicron would have
22 built up some natural immunity, which clearly wasn't the
23 case when VCOD was introduced.

24 So all those factors were taken into account.

25 Q. Indeed. My question, then, is if the scientific
68

1 underpinning for the VCOD policy had changed, why was it
 2 decided that a further consultation would be embarked
 3 upon? The reason I ask that is because, of course, in
 4 terms of VCOD 1, care home staff were still having to
 5 comply with it.

6 **A.** Yes.

7 **Q.** So do you understand the question that I'm ask --

8 **A.** Well, for VCOD 1 the deadline had passed, had it not?

9 **Q.** No, for -- so VCOD 1 was already in place --

10 **A.** Yes, and the deadline for getting vaccinated for those
 11 affected had passed.

12 **Q.** Yes.

13 **A.** Yeah.

14 **Q.** Yes, it had.

15 **A.** Yeah.

16 **Q.** For VCOD 1.

17 **A.** Yeah. So what I mean is, because it had passed, you
 18 couldn't, sort of, really withdraw VCOD 1.

19 **Q.** Well, it would have had an impact upon --

20 **A.** Yes.

21 **Q.** -- individuals coming -- new individuals, new staff,
 22 coming into the care home sector?

23 **A.** Yes, but VCOD 2, the deadline had not passed. And
 24 that's why -- so the consultation -- as I remember it,
 25 the consultation on withdrawing VCOD was really focused

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1 **Q.** -- from people that really did feel that they
 2 effectively had no choice in that situation.

3 I just want to continue, if I may, to look Amara's
 4 story, from the Every Story Matters, because what you do
 5 say in your statement is that it was understood that
 6 there would be an impact on those individuals with
 7 protected characteristics?

8 **A.** Yes.

9 **Q.** Because the majority of the adult social workforce were
 10 female, may have disabled people's themselves, often
 11 have caring responsibilities at home, and often
 12 disproportionately from minority ethnic communities with
 13 large numbers of migrant workers.

14 Amara, gave her account to the Inquiry. She's
 15 a black Caribbean British woman living in the south-west
 16 of England. She'd worked as a healthcare assistant at
 17 a nursing care home for five years prior to the
 18 pandemic. She had exemplary attendance and performance
 19 record during her time there. But she was sacked for
 20 refusing to having the vaccine due to her personal
 21 reservations. She explained she believes in bodily
 22 autonomy and she felt bullied into having something that
 23 she didn't want.

24 She further explains that it was a waste of
 25 thousands of experienced care staff in a sector that was

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1 on VCOD 2, because the deadline had not passed.

2 **Q.** What I would like to do, just very briefly, is just pull
 3 up, if I may, some of the experiences from the Inquiry's
 4 Every Story Matters.

5 That's at 0129. And these are experiences that have
 6 been reported to the Inquiry.

7 **A.** Okay.

8 **Q.** Some care workers were refusing to have the vaccine
 9 because of the side effects that were being talked
 10 about.

11 **A.** Yes.

12 **Q.** And then given the ultimatum: if you don't have the
 13 vaccine, you can't work.

14 **A.** Yes.

15 **Q.** A registered manager of a care home explained that she
 16 resigned from her post because she did not agree with
 17 forced vaccinations herself, even though she had also
 18 had the vaccine in any event herself.

19 **A.** Yes.

20 **Q.** Another reported that:

21 [As read] "When the government said all care workers
 22 must be vaccinated, half our dedicated workers who had
 23 been here for years left."

24 So there are similar themes that are emerging --

25 **A.** Yes.

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1 already chronically understaffed, that most of those
 2 staff will never go back into the care work for fear of
 3 it happening again in the future, and she certainly did
 4 not go back into care work.

5 So, here, what you see a loss of experienced,
 6 excellent staff, never to return. Is there anything to
 7 learn from these experiences, Sir Sajid?

8 **A.** I mean, yes, there will be lessons to be learned, of
 9 course, because, you know, this pandemic, nothing like
 10 this had happened in living memory, and so therefore,
 11 for everyone involved, those affected, those making
 12 policy, this was sort of new policy, new ground, and
 13 I think there were always lessons to be learned.

14 But I think that, in learning those lessons, we
 15 mustn't losing away from what was a central objective of
 16 VCOD, is that, you know, thanks to medical science and
 17 all those that worked on the vaccine, that there was
 18 a -- quite quickly an effective vaccine for Covid-19
 19 that was deemed safe by the medical authorities, the
 20 independent regulators in the UK, and most of the
 21 respective regulators around the world, by scientists
 22 and many others.

23 So the facts of the vaccine were that worked and it
 24 was safe. And therefore, we knew it was safe not just
 25 to, sort of, prevent you catching -- an individual

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1 catching the infection, but also spreading the
2 infection.

3 I think with the Delta variant, it -- the studies --
4 certainly the information I'd been given, that it was
5 somewhere between 65-80% effective, depending on which
6 vaccine you took, on spreading infection.

7 And the purpose, therefore, of VCOD was to protect
8 vulnerable people. That includes not just those in the
9 NHS settings but in cases -- since we're talking about
10 social care, let's talk about people in either
11 domiciliary care or in care homes, elderly people were
12 more vulnerable to the virus. And although they had
13 vaccinated to a large extent themselves, you know, very
14 high uptake, which was great, the workers were -- there
15 was exposure, risk from exposure from the workers. And
16 that was the purpose: to protect vulnerable people.

17 And a balance had to be found between the sort of --
18 thinking about the workforce and what was -- what were
19 the concerns of some members of the workforce versus
20 protecting the vulnerable people.

21 And ultimately the balance was, with the -- prior to
22 Omicron -- was that the -- that this is the right
23 measure, albeit it will lead to some people leaving, and
24 so it will exacerbate some workforce pressures, as
25 you've mentioned and as I've said earlier, but it was

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1 after vulnerable people and it is deemed that the best
2 way to look after those vulnerable people is to take the
3 vaccine, then they have a choice: they either take the
4 vaccine or they don't take the vaccine. Their bodily
5 autonomy is totally protected. It might cost them their
6 job but it was the right balance in protecting those
7 vulnerable people.

8 So, ultimately, I think the lesson learned is,
9 whilst it can probably be improved by focusing on some
10 of the detail more, I think it was the right policy for
11 the right time. And should the country face a similar
12 situation again, I would certainly recommend the
13 then government to consider it strongly all over again.

14 **Q.** Thank you.

15 I now want to move on, if I may, to the winter
16 planning from 2021 to 2022.

17 **A.** Yes.

18 **Q.** If I can just call up INQ000346672.

19 It's a copy of messages between you and
20 Helen Whately, the former Minister for Social Care.

21 **A.** Yes.

22 **Q.** And in relation to those, what she sets out, and it's on
23 page 0002, if I can just go to the next page. Thank
24 you.

25 On 9 December 2021, looking at 19:27:21, so 7.30 in

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1 still the right balance to be found.

2 Now, turning to -- you mentioned an individual,
3 Amara, and there will be others like her, I am sure, and
4 I'm sure they were very valued and important members of
5 the social care workforce, and it's sad to see people
6 like that leaving, but I hope that individuals like
7 that, maybe even now, might reflect that, at the end of
8 the day, the government's job, you know, is -- it's a --
9 as I said, there's no perfection here -- had to strike
10 the right balance between protecting vulnerable people
11 and the demands of some parts of the workforce, and
12 I think the right balance was struck in that case.

13 And there were some people, and you mentioned people
14 from ethnic minority communities, for example, having,
15 in general, a lower uptake of the vaccine than other
16 members of the population, and that was a fact. I mean,
17 that was the case. And there's -- a huge amount of work
18 was done in terms of education, reach-out and stuff.

19 There was a fund to support social care, sort of
20 employers and local councils, to try to get more
21 information and detail out. But ultimately, if people
22 after not convinced the vaccine is safe -- I mean,
23 I believe in bodily autonomy as well. I think most
24 people would. No one should be forced to take anything.
25 But if they choose to work in a setting that is looking

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1 the evening, she provides you with some reflections
2 based on her experiences with dealing with Delta, so the
3 wave 2 we've already touched upon.

4 **A.** Yes.

5 **Q.** And what she says is:

6 "... if you can keep on allowing visiting but with
7 testing, that would be much better for mental health of
8 residents & relatives; frequent staff testing ...
9 [being] vital ... regular minister-led calls with the
10 stakeholders to hear from the coal face ..."

11 She explains that staffing would be her biggest
12 worry, and her experience with Delta showed it was very
13 hard to keep the infections out of care homes.

14 In terms of those reflections, are those ones that
15 resonate with you?

16 **A.** Yes.

17 **Q.** Moving on to Omicron, then, if I may.

18 **A.** Yes.

19 **Q.** The Cabinet Office commissioned a departmental paper as
20 part of its work with the Covid-19 taskforce, for DHSC
21 contingency planning for risks from Omicron, Omicron
22 being seen to pose a significant threat at that time.

23 **A.** Yes.

24 **Q.** I want to just pick up on one aspect and that relates to
25 testing, if I may.

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1 If I could call up INQ000067759, again page 2,
2 paragraph 7.
3 And that identified, approximately halfway down the
4 page, that they carried out a number of red team
5 exercises, and they identified that testing in
6 domiciliary care was an area for attention, and
7 following discussions at the adult social care subgroup
8 of SAGE on 17 December, they were urgently considering
9 the merits of aligning the testing regime for
10 domiciliary care staff with that of care home staff, and
11 then also looking at testing capacity.

12 So as we can see here, the testing regimes were
13 different. Why was aligning those not considered
14 earlier? Do you know?

15 **A.** I don't know.

16 **Q.** You don't know. Thank you.

17 Moving, then, to workforce challenges in relation to
18 Omicron. As we've touched upon, during that period the
19 challenges became acute. But we see, effectively, at
20 that period, a reflection -- a move to a more local
21 management of risk, and you've touched upon that already
22 and why that would be, in relation to local authorities.
23 And contingency plans that were in place, the
24 responsibility on those was for local authorities; is
25 that right?

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1 That's the first reason given.

2 Secondly:

3 "... it is unlikely to add much value [because of
4 the distance between from centre to local government]
5 ..."

6 But also, and I'd just like you to concentrate on
7 this one:

8 "and would transfer risk to the centre (if we are
9 seen to have provided endorsement.)"

10 Is that a legitimate concern, bearing in mind the
11 issues that were in place at the outset of the pandemic?

12 **A.** Reflecting on this, as you raise it, I can see the issue
13 and why it's raised. Your question is, is it
14 a legitimate concern? I think it's weak. I think it's
15 a weak concern. I think the other points that were
16 mentioned, that are mentioned here about it's
17 particularly about timing, as in being -- this was at
18 the time of Omicron. It was a -- obviously the whole
19 pandemic was a crisis but I remember at this time,
20 I think, this was what, mid-December or something, it
21 was a particularly high point in the crisis because the
22 focus was very much on boosters and testing and other
23 protections, so I could see that point being much more
24 important about would there practically be time to
25 quality assure.

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1 **A.** Yes, I think that's correct.

2 **Q.** Just touching on those contingency plans, one of the
3 most significant issues in the first wave at the outset
4 of the pandemic all the way back in early 2020 were the
5 adequacy of local authority contingency plans. You may
6 recall Helen Whately's evidence in relation to that --

7 **A.** Yes.

8 **Q.** -- about seeing the plans, and those being inadequate.

9 Can I ask you, please, to look at INQ000576530.
10 It's page 5.

11 And this concerns the contingency planning that is
12 in place. It's a paper that's being effectively sent to
13 you for sign-off. And these are the discussions that
14 are taking place between your private secretary and
15 others within the Department.

16 **A.** Yes.

17 **Q.** And it deals with a request about halfway down: "Can we
18 quality assure, QA, all contingency plans?"

19 If we go further down the page, I think it's 0005,
20 we see here a response that states:

21 "The one point ... that I've not reflected is the
22 suggestion that central Government should look to
23 quality assure the contingency plans of all ... [local
24 authorities] as, having discussed with colleagues, we
25 think this will take too long ..."

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1 **Q.** Of course, but that's not what I'm asking about.

2 **A.** Yes, but I think the point about -- the point you asked
3 about which is transferring risk to the centre, I think
4 that's weak.

5 **Q.** Well, I'm asking: is it acceptable? Is that an
6 acceptable and valid concern of the centre --

7 **A.** I think based on --

8 **Q.** -- that it would assume the risk --

9 **A.** I think based on what I've seen here, the documents
10 I looked at again recently, and my memory, I do not
11 think it's a valid concern.

12 **Q.** Now, a number of actions were taken throughout that
13 period to try to alleviate the pressures that were, as
14 we've already discussed, acute within the sector. There
15 was an ADASS survey that was undertaken between
16 24 December 2021 and 5 January 2022.

17 **A.** Yes.

18 **Q.** And out of those local authorities, 94 of them reported
19 managing -- that they were managing their contingency
20 actions but they were forced to implement actions that
21 they found unacceptable. And 49 of those councils were
22 taking at least one measure to prioritise care that the
23 directors regarded as least acceptable, for example,
24 prioritising life sustaining care over support to get
25 out of be. They were -- being unable to take reviews of

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1 risk, or leaving those with dementia, learning
 2 disabilities or poor mental health isolated or alone for
 3 longer periods of time. A number of issues were to be
 4 escalated to the government about the fact they were
 5 short-term fixes, they weren't translating to the
 6 ground, you had a tired and stressful workforce,
 7 bringing home the reality of riding out Omicron, and it
 8 was having a serious impact on their health.
 9 Were those concerns escalated to you?
 10 **A.** I don't particularly remember the ADASS survey, but
 11 I think those types of issues and about prioritising
 12 care, for example, about what, you know, local
 13 authorities might think is sort of unacceptable
 14 decisions from their point of view to take, those kind
 15 of concerns were often articulated to me but also,
 16 obviously, the Social Care Minister who I should
 17 mention -- obviously you know this, but for the record,
 18 I was the Secretary of State overseeing the entire
 19 Department. There was a dedicated Social Care Minister
 20 throughout my time --
 21 **Q.** Indeed.
 22 **A.** -- and she --
 23 **Q.** We have a statement from her -- (overspeaking) --
 24 **A.** Yeah, and she would be dealing with, naturally, a lot
 25 more issues pertaining to social care than I would be

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1 for a long time, have done a -- do a super important,
 2 hugely, you know, vital job, mostly they'll be looking
 3 after their loved ones. And were they considered? Yes,
 4 in general, in decision making, absolutely. I think
 5 in -- specifically I think you're referring to a set of
 6 decisions in the living with Covid, and testing, and
 7 what was available. I would, at the time I recall --
 8 I would have liked to see more tests, free tests, being
 9 made available for unpaid carers including asymptomatic
 10 testing, of course. And it's something I had requested
 11 and wanted funding for, but I was unable to secure.
 12 **Q.** But it was refused.
 13 Can I just now turn to a topic that runs throughout
 14 this period and that's in relation to efforts to
 15 restrict staff movement.
 16 **A.** Yes.
 17 **Q.** We've heard evidence in relation to that being an
 18 important infection prevention and control measure?
 19 **A.** Yes.
 20 **Q.** But that it was challenging and that it came clear that
 21 mandating such a policy would not work owing to concerns
 22 about the insufficient numbers within the workforce, and
 23 the practical issue of loss of income --
 24 **A.** Yes.
 25 **Q.** -- for those workers, in a precarious sector with

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1 dealing with directly.
 2 **Q.** I now want to move, if I may, to the end period that
 3 we're concerned with and the strategy for living with
 4 Covid.
 5 **A.** Yes.
 6 **Q.** So we're talking about, effectively, March of 2022
 7 onwards, and there was some to-and-froing between your
 8 department and Treasury in terms of what was going to
 9 remain in place and what provisions were not, in
 10 relation to adult social care and the like.
 11 **A.** Yes.
 12 **Q.** More broadly, free asymptomatic testing for the public
 13 was brought to an end albeit, importantly, symptom-free
 14 testing remained for social care staff. In making those
 15 decisions, the impact assessment set out that those with
 16 protected characteristics or over-represented would face
 17 higher clinical risks and would be the most
 18 significantly impacted by the policy. Can I ask you
 19 about this: the position of unpaid carers, were unpaid
 20 carers considered when the decisions were taken to cease
 21 the provision of asymptomatic testing?
 22 **A.** Yes. I mean, so first, unpaid carers -- over 5 million
 23 unpaid carers who, I think, as I alluded to earlier,
 24 I was -- had ministerial responsibilities broadly for
 25 the sector even before the Health Secretary. I've known

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1 insufficient staff and fragility. There's further been
 2 evidence that those funds that were designed to enable
 3 staff members to isolate without losing pay or restrict
 4 movement did not always reach those recipients. Do you
 5 agree, or do you have a view on, effectively,
 6 recommendations in regard to the future and future
 7 learning that these are areas that pandemic planning
 8 must explicitly address?
 9 **A.** Yeah, I think this is an area of future learning.
 10 I think -- I completely understand, from the -- in terms
 11 of protecting vulnerable people, the need to look at
 12 staff movement, but I think it's fair to say, especially
 13 at the start of the pandemic, that because these kinds
 14 of issues had not been sort of thought about in advance
 15 of the pandemic, there was no sort of pre-planning, so
 16 to speak, I think there will be lessons to learn from
 17 that.
 18 **Q.** And were mandatory restrictions to be considered, do you
 19 agree that they should not be introduced until effective
 20 mechanisms for full sick pay, for example, for
 21 self-isolation, or financial compensation for staff who
 22 are unable to work between
 23 locations -- (overspeaking) --
 24 **A.** I think those things should be considered. I just
 25 hesitate to say they must not be introduced before,

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1 because it's just that I -- we
 2 don't -- (overspeaking) -- of a future crisis, I think
 3 they should be considered.
 4 **Q.** Indeed. Now, throughout this period there was, and
 5 still is, a widely-held belief that the NHS was
 6 prioritised over adult social care with adult social
 7 care being the Cinderella service. What are your views
 8 on that from your time in post? Just briefly, if you --
 9 **A.** I think that was absolutely not the case. I mean,
 10 obviously I can't speak for activity before I was
 11 Secretary of State, but certainly in my time as
 12 Secretary of State, the -- in terms of adult social care
 13 there's all the things that we talked about that were
 14 specific to the pandemic, and that was my most immediate
 15 focus, naturally. But I also published the, as referred
 16 to earlier, the adult social care reform white paper, it
 17 was a very detailed set of reforms for the future
 18 thinking in much detail about the sector, how to improve
 19 it, particularly around issues around workforce and
 20 payment and long-term funding.
 21 I also published the adult social care integration
 22 white paper, I think early in 2022. I made amendments
 23 to the Health and Social Care Act that were -- many
 24 around adult social care because they were amendments,
 25 they were not originally envisaged when that Act was

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1 **A.** It's not.
 2 **Q.** If I can then turn to more general considerations with
 3 regard to the sector.
 4 **A.** Yes.
 5 **Q.** It's been posited that a register of adult social care
 6 workers in England would assist in a pandemic, both
 7 those working in care homes, domiciliary care, and also,
 8 on the converse, those individuals who live in care
 9 homes and receive domiciliary care.
 10 Do you consider that that would be a useful tool to
 11 have?
 12 **A.** In general, yes, I do. I do. Because I -- actually
 13 I think I might be right in saying that the England is
 14 the only part of the UK nations that don't have one, but
 15 I think that, in terms of professionalism, more
 16 confidence in the system, I think it sounds like
 17 a sensible thing to look at.
 18 **Q.** Finally, if I may, just turning to your recommendations,
 19 you've very helpfully set out your lessons learned and
 20 recommendations at the end of your witness statement.
 21 **A.** Yes.
 22 **Q.** You explain that you consider the adult social care
 23 model to be broken?
 24 **A.** Yes.
 25 **Q.** And you explain that, in your mind, this -- part of the

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1 introduced to Parliament, and also there were other
 2 things that I did that, for me, I was thinking a lot
 3 about adult social care and improving it even though
 4 there were maybe -- there were health components
 5 as well.
 6 **Q.** Thank you.
 7 **A.** So the work that I did on the 10-year dementia plan, for
 8 example, because I felt that if we could deal with
 9 dementia better, then we would -- it would help older
 10 residents, whether in care homes or domiciliary care,
 11 because we have a better approach so it was a sector
 12 I spent a lot of time thinking about and doing something
 13 about.
 14 **Q.** Thank you.
 15 Can I now ask you about domiciliary care. You've
 16 mentioned it there and there are only, really, passing
 17 references in your statement to it.
 18 Is that indicative of a lack of consideration in
 19 relation to domiciliary care, compared to both the NHS
 20 and --
 21 **A.** No.
 22 **Q.** -- care homes with the understandable focus as it was in
 23 the immediate --
 24 **A.** No.
 25 **Q.** -- start of the pandemic?

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1 solution is assisting more people to look after their
 2 own relatives where possible?
 3 **A.** Yeah.
 4 **Q.** What do you mean by assisting people to look after their
 5 relatives and how would it work in practice?
 6 **A.** I think this is again, if I may just draw the attention
 7 back to the adult social care reform white paper, and
 8 some of the comments and speeches I made around that at
 9 the time, is that, notwithstanding the huge amount of
 10 work done by unpaid carers already in recognising all
 11 that they do, I think that, you know, more should be --
 12 we should -- that the state should be looking at more
 13 ways to try to support that.
 14 And I wasn't -- at the time I suggested that in
 15 their adult -- in the reform white paper, I wasn't
 16 entirely sure what those mechanisms are. I think there
 17 are other countries we can learn from. I think I'm
 18 right in saying that I allocated something like
 19 £25 million of funding to help try to support that and
 20 suggested there should be workshops and other
 21 discussions with representative groups to look at what
 22 can be done.
 23 So I -- it was something that I think is long
 24 overdue in terms of focus, but I had not got round, in
 25 my tenure in that seat, to look at more specific

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1 examples.

2 **LADY HALLETT:** Sorry to interrupt, I think we'll have to
3 leave that there, Ms Cecil, please. Thank you.

4 **MS CECIL:** Indeed.

5 Those are all the questions I have, my Lady.

6 Sir Sajid, if you remain there, there will be some
7 more for you.

8 **THE WITNESS:** Thank you.

9 **LADY HALLETT:** Ms Morris.

10 **Questions from MS MORRIS KC**

11 **MS MORRIS:** Thank you, my Lady.

12 Sir Sajid, I ask questions on behalf of the Covid
13 Bereaved Families for Justice UK, and just one topic for
14 further exploration, please, and that's regarding
15 hospital discharge. You said to Ms Cecil this morning,
16 in respect of delayed discharge, that it was
17 a significant issue for the DHSC both before and during
18 the pandemic.

19 **A.** Yes.

20 **Q.** In your statement you mention a number of initiatives
21 around that, a discharge task force, a red team meeting,
22 winter planning meeting in October 2021, a deep dive
23 after that, and then a step-down plan that you've also
24 touched upon.

25 **A.** Yes.

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1 occasions, with some of the leaders of the sector,
2 different -- various organisations that represent
3 different aspects of adult social care.

4 **Q.** Around this topic specifically, can I ask?

5 **A.** I would have had discussions around this topic
6 specifically, yes, as well. I think my -- generally
7 when I'd have a meeting with a representative of the
8 a sector, they'd cover more than one topic, so it
9 wouldn't just be on this topic, I doubt. Whether it
10 would -- I think this topic would definitely have come
11 up because it was such an important part of the work
12 that they were looking at.

13 **Q.** That's why I pose the question, because I want to ask
14 you whether you consider it was sufficient engagement
15 with the sector itself, particularly having regard to
16 the grave concerns that had been raised around the
17 discharge policy from March 2020, so before your time,
18 but looking at the engagement you had, do you think it
19 addressed some of the persons that had
20 previous -- (overspeaking) --

21 **A.** I think -- I mean, my feeling is, is that -- if you're
22 talking about my engagement, I think it was sufficient,
23 keeping in mind that my responsibilities were --
24 included adult social care and this -- this issue, of
25 course, and it was a very important issue, but there

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1 **Q.** You also said that the NHSE were working with local
2 authorities and integrated care boards.

3 **A.** Yes.

4 **Q.** And this morning you were keen to highlight the work
5 that the NHS was doing with the local authorities, but
6 you haven't mentioned, either this morning or in your
7 statement, what arrangements were in place to engage
8 with the adult social care sector itself, whether that's
9 in the care homes or the carers.

10 So I wanted to ask you, what was that engagement
11 when you were Secretary of State, with the actual sector
12 itself? So beneath the local authority level.

13 **A.** Yeah, thank you.

14 And so, as you highlight, delayed discharge has been
15 an ongoing issue or challenge, obviously made much worse
16 and acute during the pandemic. The -- in terms of my --
17 if you're talking about my personal engagement with the
18 sector, it was at various levels. It was -- so at one
19 level it was actually visiting care homes, providers of
20 domiciliary care, meeting local authority leaders and
21 others working in the sector to sort of hear from them
22 direct, to see for myself some of the issues, things
23 that were working, things that were not working well.
24 It was still -- I think I must have met with, on -- on
25 probably more than one occasion, but a number of

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1 were a very wide range of responsibilities. I was also
2 trying to deal with the emergency of Omicron as well, in
3 particular, for a significant part of my period. But
4 also, as I alluded to earlier, one way to make sure that
5 there's a government -- that there's enough -- there's,
6 you know, more engagement than just the Secretary of
7 State, is why specifically there is a Social Care
8 Minister that would be the person, as it was in this
9 case, that would be having a lot, lot more engagement
10 than I would. As well as other ministers in government
11 generally but especially a Social Care Minister.

12 **Q.** Thank you very much, those are my questions.

13 **A.** And officials, of course, who I have engaged with.

14 **MS MORRIS:** Thank you.

15 **LADY HALLETT:** Thank you, Ms Morris.

16 Ms Weston.

17 **Questions from MS WESTON KC**

18 **MS WESTON:** Thank you, my Lady.

19 I'm asking questions on behalf of the Frontline
20 [Migrant] Healthcare Workers Group. Our questions
21 concern the impact of the pandemic on migrant care
22 workers.

23 **A.** Yes.

24 **Q.** In your statement for this module, with reference to the
25 impact on those with protected characteristics or

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1 vulnerabilities, you state -- for everyone's reference
 2 it's paragraph 44 of the statement -- firstly, that you
 3 were aware of the PHE June 2021 study, disparities in
 4 risks and outcomes -- my Lady, that report is
 5 INQ000399820, there's no need to turn it up -- which
 6 demonstrated the disproportionate impact of the pandemic
 7 as a result of health inequalities.

8 A. Yeah.

9 Q. Secondly, you note that you had an interest in the
 10 subject and were looking to take practical action.

11 Now, that study concludes -- page 4, my Lady -- that
 12 two of the most at-risk categories were specifically
 13 migrants and also social care workers.

14 A. Yes.

15 Q. Do you agree that it follows that it would have been
 16 obvious, therefore, that migrant care workers were at
 17 particular risk?

18 A. Sorry, just to clarify, do you mean particular risk of
 19 contracting Covid? Of what?

20 Q. Well, they were at the particular risk of the poorer
 21 outcomes identified in the study. That's because they
 22 fell into two categories which would attract a degree of
 23 risk, not that they would necessarily have worse
 24 outcomes, but that they were --

25 A. Well, I think -- I would agree that, you know, migrant
 93

1 Especially when you've mentioned health inequalities,
 2 during my time in this job, the health inequalities --
 3 I won't -- we've talked about it in previous evidence
 4 sessions, is something that I did a considerable amount
 5 of work on. Whether it was health inequalities for
 6 migrant workers or people in lower socioeconomic
 7 backgrounds or ethnic minorities, that was something
 8 I did a considerable amount of work on, which I think
 9 shows perhaps the extent to which I took issues like
 10 that into account.

11 Q. Yes, so can you tell -- help the Inquiry with what
 12 focused consideration you gave to reducing that risk?

13 A. To producing?

14 Q. Reducing that risk to that cohort of migrant care
 15 workers.

16 A. So I think the -- so one example I would give is that,
 17 in terms of vaccination, and the -- and especially
 18 referring to the VCOD policy we talked about earlier, is
 19 making sure that there was enough reach-out to members
 20 of that community, there was enough engagement, there
 21 was support for both local authorities and employers in
 22 terms of funding, support, and things to reach out, and
 23 to, for example, educate on the vaccine, why we have the
 24 VCOD policy, why it would make sense in terms of
 25 protecting vulnerable people. That kind of engagement
 95

1 workers working in social care, that there were, you
 2 know, certainly considerations particular to that group,
 3 that there should and I think would have been taken into
 4 account. So, for example, I think I'm right in saying
 5 that migrant workers were probably less likely -- we
 6 thought they were less likely to take the vaccine and
 7 less likely to be vaccinated, and so we would take that
 8 into account. And obviously, then, the fact that if
 9 they were migrant workers working in social care, other
 10 factors around social care.

11 So we would take all that into account, it's just
 12 that I wasn't entirely sure what you mean by that
 13 they're at more risk. I think I would say that we
 14 were -- that that would certainly be taken -- those
 15 facts that you mentioned, those issues that you
 16 mentioned, would certainly be taken into account.

17 Q. Well, there were risk factors that affected that group
 18 of people. There were risk factors by reason of them
 19 being migrants, due to health inequalities that were
 20 referred to in the study.

21 A. Yes.

22 Q. And there were risk factors in relation to their work as
 23 social care workers.

24 A. That's right. And if your question is would I -- would
 25 the department as a whole take them into account, yes.
 94

1 was something that was done specifically to try to
 2 reduce those risks.

3 Q. Thank you.

4 Could you help the Inquiry with what was the
 5 financial support that you gave that sector?

6 A. I don't remember exactly.

7 Q. Thank you.

8 I'm going to move on, if I may, to domiciliary care.

9 A. Yeah.

10 Q. So it's already been pointed out that you make little
 11 reference to domiciliary care in your statement, by the
 12 Counsel to the Inquiry. Had you fully appreciated that
 13 workers in domiciliary care are frequently on zero-hours
 14 contracts, that they're migrant workers on tied visas,
 15 and they're also undocumented workers who may have come
 16 to the UK legally but whose visas have expired and
 17 therefore those groups are less able to challenge
 18 conditions, their ability to challenge conditions is
 19 severely limited by that. Was that appreciated by you
 20 and your department?

21 A. Well, if you -- if by appreciation, if you mean was --
 22 was I aware of that and do I think the Department was
 23 aware of those, the points you've just made, yes.

24 Q. So Dr Townson in her witness statement on behalf of the
 25 Homecare Association explained the connection between
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1 those immigration policies and insecurities in this way
 2 in paragraph 303 of her statement. She said:
 3 "The prevalence of insecure zero-hours contracts and
 4 limited sick pay" --
 5 **LADY HALLETT:** Sorry, Ms Weston. I can't see where I've
 6 given permission for this question or this reference.
 7 **MS WESTON:** Sorry, yes, it's right. It's just the lead-in
 8 to question 7 for which we --
 9 **LADY HALLETT:** I'm sorry, you've got to be really careful,
 10 I'm sorry, to stick to what you're allowed, and I'm not
 11 going into overall policies like zero-hours contracts.
 12 There's a limit to what I can do in this Inquiry, so
 13 could you please stick to your question 7, please.
 14 **MS WESTON:** Point taken, my Lady.
 15 **LADY HALLETT:** Thank you.
 16 **MS WESTON:** Do you agree that the cohort of care workers to
 17 which -- which I just described, the three cohort of
 18 care workers, were simply ignored by the government with
 19 wholly foreseeable adverse consequences for
 20 transmission?
 21 **A.** No.
 22 **MS WESTON:** My Lady, those are my questions.
 23 **LADY HALLETT:** Thank you, Ms Weston.
 24 Next it's Ms Beattie, who I think is going to be
 25 across the room, if she's sitting where she usually

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1 **A.** Yeah, was that second report the Pearson review?
 2 **Q.** No, it's by the Social Care Institute for Excellence
 3 commissioned by the Department.
 4 **A.** Okay. Yes, but I would caveat it just by the -- as you
 5 alluded to, the policy was already in place when
 6 I became Secretary of State. And these reports came,
 7 although they may have been commissioned before I became
 8 Secretary of State, they weren't available until, as
 9 you've said, I think October, then September.
 10 **Q.** Well, I think the -- yes, so the CQC annual report came
 11 out in October '21.
 12 **A.** Yes.
 13 **Q.** And the Social Care Institute for Excellence report
 14 I think had been first exhibited in draft to the
 15 Department back in March '21 --
 16 **A.** Yes.
 17 **Q.** -- with a final report in April, but then it was finally
 18 published by the Department in December.
 19 **A.** Yes.
 20 **Q.** So they're being published during your time as
 21 Health Secretary.
 22 **A.** Yes, that's right and they -- and what typically
 23 would -- those reports, even before they're published,
 24 it might be that the officials had some interaction with
 25 the people working on the reports and things, just to

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1 does, Sir Sajid.
 2 **THE WITNESS:** Okay, yeah.
 3 **Questions from MS BEATTIE**
 4 **MS BEATTIE:** Thank you. I ask questions on behalf of
 5 Disabled People's Organisations.
 6 **A.** Yes.
 7 **Q.** You've told us that you continued with the discharge to
 8 assess policy which had been put in place before you
 9 came in, and you saw it as a more person-centred
 10 approach, in your evidence. During your time as
 11 Health Secretary, I think there were two reports which
 12 raised specific concerns about discharge to assess. In
 13 October 2021, the CQC State of Healthcare and Adult
 14 Social Care in England report noted concerning evidence
 15 that support needs were not being met of people
 16 following their discharge; and in December 2021, the
 17 Department of Health, your department, published
 18 a review by the Social Care Institute for Excellence,
 19 which had been commissioned by the department, which
 20 again reported that there were unmet needs and concerns
 21 about follow-up, particularly for people with complex
 22 social care needs?
 23 Did you take those reports into consideration in
 24 looking at discharge to assess when you were
 25 Health Secretary?

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1 sort of, if there's anything acute especially that needs
 2 immediate attention, and it would have been brought to
 3 my attention, sort of, at the time and indirectly,
 4 rather than me waiting for the report and, actually, it
 5 landing on my desk and going through it. So it would,
 6 if your question is would the findings of these reports
 7 have been taken into account --
 8 **Q.** Not "would" they --
 9 **A.** -- they would have.
 10 **Q.** -- Sir Javid, "did" they? Did you take them into
 11 account -- (overspeaking) --
 12 **A.** Yes, but my only caveat is that it wouldn't have been
 13 I would have actually received the report on my desk and
 14 I would have read every word in the actual report, it
 15 would have gone through my officials and they would have
 16 picked out the most important bits and this would have
 17 been an important area.
 18 As I remember, I think, for example, the CQC report
 19 which obviously is -- the first one you mentioned, a
 20 very important report -- I think they generally
 21 supported the discharge to assess policy as the right
 22 policy in general, but what they picked up on and you've
 23 touched on, is there are certain aspects of it that
 24 could be improved.
 25 **Q.** Are you aware of any auditing of discharge to assess

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1 cases in light of what these reports were telling you?
 2 **A.** I'm not aware, no.
 3 **MS BEATTIE:** Thank you, my Lady.
 4 **THE WITNESS:** Thank you.
 5 **LADY HALLETT:** And next -- is it Mr Straw? Who also will be
 6 across the room.

7 **Questions from MR STRAW KC**

8 **MR STRAW:** I'm just waiting for the microphone to come on.
 9 Thank you.
 10 Sir Sajid, I represent John's Campaign, Patients
 11 Association and Care Rights UK. So there's just one
 12 area. You recognise at paragraph 42 of your statement
 13 that the people the adult social care sector exists to
 14 serve should be at the core of all decision making, but
 15 many of those who represent people drawing on care
 16 consider that their views were not adequately listened
 17 to by the government. Do you accept that more should
 18 have been done by government to ensure the views of
 19 these people were taken into account in decision making?
 20 **A.** Look, I am very much in favour of those that are
 21 affected by government policy, that their views are
 22 taken into account in whatever -- and there are a number
 23 of ways to try and do that, whether it's consultations,
 24 direct meetings, obviously numerous ways to do that, and
 25 I've always been in favour throughout my time in

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1 them, I would probably have to spend, you know, less
 2 time somewhere else. And if I did that, I would
 3 probably have someone standing in front of me saying,
 4 "Why didn't you spend more time with us, and why did you
 5 spend even more time with adult social care people?"

6 So it was a very difficult balance and I think I got
 7 the right balance.

8 **Q.** How about helping in terms of recommendations for the
 9 future? Is there anything specific, any specific
 10 mechanism which you think might help to ensure that
 11 those views are filtered up in an easy way for you to
 12 quickly understand in a situation and crisis like this?
 13 **A.** No, I think that's a very good question, and I think
 14 there probably are, in the -- I alluded to earlier that
 15 the sector, adult social care sector, is very
 16 fragmented, for the reasons that I've said, and that
 17 fragmentation does, I think, just make it that much
 18 harder to sort of -- for the centre to, sort of, get
 19 views and those views to be sort of, you know, put
 20 together and see if there's, for example, themes
 21 emerging from those views. So I think probably there is
 22 something that can be done, and maybe -- I wouldn't want
 23 to, sort of, just, sort of, come up with ideas on the
 24 spot now, but some kind of structure where people
 25 receiving care or their families, their loved ones,

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1 government. Your question was, could -- was more
 2 specific, I think, was could more have been done?
 3 Well, firstly, I can't speak to the first part of
 4 the pandemic because I wasn't there and I'm not going to
 5 second-guess the decisions that were made then. So
 6 could I have done more during my time to engage more?
 7 It would be hard to see how, in the -- you know, and
 8 what I mean by that is that, as I alluded to, my
 9 responsibilities were quite, you know, were broader
 10 than -- adult social care was a very important part of
 11 it, of course, but they were much broader. I was
 12 dealing with a national emergency, and -- especially
 13 during the Omicron period, and I was pretty much working
 14 every hour that there was available to work.

15 So, you know, I mentioned earlier about, you know,
 16 going -- meeting people in, you know, domiciliary care
 17 settings, in care home settings, meeting stakeholders in
 18 terms of both employers and local councils and people
 19 actually receiving care, and also I had the support of
 20 other ministers. So -- but I want to be very accurate
 21 in my answer to you. You asked me, could we have done
 22 more, even more? It's hard to see because something
 23 would have to give. If I spent more time with the adult
 24 social care sector listening to people's views and
 25 concerns, which are very legitimate and I want to hear

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1 could input in a structured way, and then themes could
 2 be identified, and then the ministers are -- have some
 3 kind of responsibility to maybe, on a regular period,
 4 annually or something, to respond to that.

5 **MR STRAW:** Thank you very much.

6 **LADY HALLETT:** Thank you, Mr Straw.

7 Finally -- oh no, not finally. Mr Boyle. I'm not
 8 sure where Mr Boyle is sitting, Sir Sajid.

9 **THE WITNESS:** I can see him. Thank you.

10 **Questions from MR BOYLE KC**

11 **MR BOYLE:** Thank you, my Lady.

12 Good afternoon, Mr Sajid, I ask questions on behalf
 13 of the Royal College of Nursing.

14 **A.** Yeah.

15 **Q.** In your witness statement you helpfully describe how you
 16 met with the Chief Medical Officer roughly three or four
 17 times per week.

18 **A.** Yeah.

19 **Q.** Whereas you met with the Chief Nursing Officer two or
 20 three times in total, by which we understand across the
 21 piece that we are looking at --

22 **A.** Yes.

23 **Q.** -- of your reign, June 2021 to June 2022.

24 **A.** Yeah.

25 **Q.** Given the importance of nursing staff to healthcare

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1 response, do you feel it would have been helpful to meet
 2 the Chief Nursing Officer more often to discuss critical
 3 safety issues?
 4 **A.** I think in one respect it might have been more helpful,
 5 but as I-- the previous question, I talked about the
 6 trade-off in my time. I think something else would have
 7 to give. So someone else I would be meeting a lot less,
 8 and maybe -- so I had to -- you -- think about my time
 9 a holistic way. And that's -- and so because of that,
 10 and knowing that the views and the work done by the
 11 Chief Nursing Officer is so important, the way I tried
 12 to deal with it is -- as well as my own meetings, is to
 13 make sure that the views, the concerns, of the Chief
 14 Nursing Officer are taken into account, not just through
 15 meeting me -- because often sometimes that could be too
 16 late, you know, because it could be something is in the
 17 diary but it's two or three weeks away, because that's
 18 just the way the diary is, and so there had to be -- and
 19 there was -- direct contact between the officer and her
 20 office and my office and other parts of the department.
 21 And also other ministers would meet with the Chief
 22 Nursing Officer, not just the Social Care Minister but
 23 maybe other ministers. And I think taken together, the
 24 interaction with my department, officials, with junior
 25 ministers and with myself, I think that was the right
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1 a centralised body. Do you consider that that was
 2 a feature in the difficulties of the information you've
 3 described today reaching care workers, there wasn't
 4 a centralised oversight body?
 5 **A.** I'm not sure. Because -- and I say that because the
 6 NHS, for example, is a centralised body, and I know that
 7 some of the concerns you articulated on behalf of social
 8 care workers have also come from the health sector, so
 9 I'm not sure if that was an important factor. But
 10 I think it's worth looking at.
 11 **Q.** If I may just clarify, I think you said in Module 4 that
 12 it was easier to address hesitancy because of that
 13 structure in the NHS being an -- a centralised state
 14 body, you said. So is it fair to say that a mechanism
 15 that can give some centralised deployment of information
 16 and support to care workers in relation to vaccines or
 17 therapeutics, as it may be in a future
 18 pandemic -- (overspeaking) --
 19 **A.** I think if you're referring to, you know, maybe a more
 20 sort of central-led way to distribute information and
 21 make sure that it reaches the right people for them to
 22 consider it and stuff, I think that is -- that is worth
 23 considering in terms of disseminating information.
 24 I think it's worth considering.
 25 **MS PEACOCK:** Thank you, my Lady.
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1 balance.
 2 **MR BOYLE:** Thank you very much.
 3 **LADY HALLETT:** Thank you, Mr Boyle.
 4 Now, finally, Ms Peacock.
 5 **Questions from MS PEACOCK**
 6 **MS PEACOCK:** Good afternoon. I appear on behalf of the
 7 Trades Union Congress. My question pertains to vaccine
 8 confidence in social care workers.
 9 The Inquiry has received some individual accounts
 10 from social care workers which recall receiving little
 11 information or support regard vaccination against
 12 Covid-19. And similarly, in a recent survey of over
 13 1,600 social care workers, 58% of respondents said that
 14 they did not feel they were given enough information and
 15 support by their employers regarding the vaccines.
 16 Do you agree that some information -- some work can
 17 be done, rather, in advance of any future pandemic to
 18 improve lines of communication with the workforce and to
 19 ensure that all workers can, if necessary, be provided
 20 with the information and support required to build
 21 vaccine confidence?
 22 **A.** Yes.
 23 **Q.** You've mentioned, I think, in your evidence before that
 24 one feature of the social care workforce that was
 25 a challenge in comparison to the NHS is that it wasn't
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1 **LADY HALLETT:** Thank you very much, Ms Peacock.
 2 Sir Sajid, that completes the questions we have for
 3 you, I think I can say for the Inquiry ...
 4 **THE WITNESS:** Oh really? What if I want to come back?
 5 **LADY HALLETT:** No, you can't come back unless I call you.
 6 **THE WITNESS:** Right, thank you very much.
 7 **LADY HALLETT:** So thank you very much for your help.
 8 **THE WITNESS:** Thank you, my Lady. Thank you.
 9 **LADY HALLETT:** Right, I shall return at 2.05 pm.
 10 (1.08 pm)
 11 (The Short Adjournment)
 12 (2.05 pm)
 13 **MS SHOTUNDE:** Good afternoon, my Lady.
 14 **LADY HALLETT:** Good afternoon.
 15 **MS SHOTUNDE:** May I please call Heléna Herklots.
 16 **MS HELÉNA HERKLOTS (affirmed)**
 17 **Questions from COUNSEL TO THE INQUIRY**
 18 **LADY HALLETT:** Welcome back.
 19 **MS SHOTUNDE:** Thank you, Ms Herklots, for coming back to
 20 give evidence at the Covid Inquiry.
 21 You were the former Older People's Commissioner for
 22 Wales, appointed on 20 August 2018, and your term of
 23 office ended on 19 August 2024; is that correct?
 24 **A.** That's correct.
 25 **Q.** The role of the Older People's Commissioner for Wales is
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an independent statutory role with the remit to protect and promote the rights of older people; is that right? And you undertook a lot of work during the pandemic in order to promote the rights of older people within care homes and also in their own homes.

However, I'm going to mainly focus on the liaison that you had with the Welsh Government.

You had weekly meetings with the Deputy Minister for Health and Social Services, Julie Morgan, and also the deputy director for Health and Social Services during the pandemic; is that correct?

A. That's correct.

Q. And in Module 2B you spoke about a letter that you wrote to Julie Morgan dated 14 April following a meeting with her on 9 April in which you set out concerns about the impact of the pandemic on older people in care homes. You'd mentioned a number of matters that you wanted addressed in that, and that also included there being a care home actions plan.

You received a response from Julie Morgan on 21 April, and in your statement you have stated that you were not happy with the response that you'd received. In particular, she declined your suggestion of a care homes action plan, stating that she was not convinced that an additional plan would add value.

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And then I was extremely disappointed to get a letter saying no, it won't add value. There was reference to a number of different groups that were set up, and there was going to be another workstream, but it didn't, in my view, show the urgency that was needed. And it didn't address the issue of people needing to hear from Welsh Government that it understood what was happening and it was going to do all it could to protect older people living in care homes and people working in care homes.

Q. In the letter Julie Morgan also invited you to join the social care subgroup. Just to clarify, was that the Welsh Government social care planning and response sub-group?

A. Yes, I think it was called that, and there was going to be a workstream as part of that, that they said would look at care homes.

Q. And was this the first time you were invited to join a working group specifically for the adult social care sector during the pandemic?

A. I'm trying to recollect now, because there are a lot of different working groups, and there was a lot of engagement, actually, with Welsh Government at that time. So it might have been the first time, in terms of a formal group, but I can't quite recollect that.

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In your view, what do you think the care homes action plan could have brought about to the benefit of older people, if she'd agreed with your suggestion in April?

A. So at that time, in April, people were in a really desperate situation in care homes. People were being discharged from hospital without testing. We were seeing increasing numbers of people losing their lives in care homes. And I felt there needed to be coordinated action, led by Welsh Government and led by the Deputy Minister, to bring together the different strands of action that were needed. So that included things like access to PPE, testing, looking at issues around visiting.

I also felt that older people living in care homes, their family and friends and the care sector, needed to know that the Welsh Government was being focused on doing all it could to protect older people in care homes, and to offer that reassurance by public plan. That would have, in my view, as a plan, some time scales and some way in which, therefore, the public and myself, as the Older People's Commissioner, could constructively scrutinise the action. And in my discussions with Julie Morgan, Deputy Minister, I felt that she was sympathetic to the issues that I was raising.

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Q. That's fine. I can see from your statement that you had been invited to the Covid-19 Moral and Ethical Advisory Group on 3 April 2020, but I presume that wouldn't have just been in relation to the adult social care sector, would it?

A. So the Covid-19 Moral and Ethical Advisory Group, part of the reason I think I was invited to that, and part of the reason it was set up, was because of the issue of do not attempt CPR notices. So that obviously covered a lot of issues across health and care in terms of ethical decision making.

Q. Thank you.

I'm going to briefly ask you some questions in respect of the work that you undertook with the Equality and Human Rights Commission.

You and the head of the Equality and Human Rights Commission for Wales, on 20 July 2020, wrote to the Minister for Health and Social Services expressing concerns about the rights of older people in care homes, and requesting information.

If I could just pull up on screen INQ000514106, page 18, paragraph 93. This is the specific information that you requested from the Welsh Government: equality impact assessments and scientific evidence for all decision making linked to care homes; evidence of how

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due regard was given to the three needs of the Public Sector Equality Duty in the decision-making process around protecting care homes by the Welsh Government; and details of the arrangements in place to review and revise policies to ensure that they complied with the Public Sector Equality Duty and specific duties.

There were a number of meetings and letters after that, at which it was clarified that the Welsh Government's response would focus on care homes, specifically decisions on testing, including decisions made to discharge people into care homes from hospital without testing, the provision of PPE, and visits to care homes. You also, and the head of the Equality and Human Rights Commission in Wales stated you wanted evidence on how the rights of older people living in care homes were considered from the beginning of the delay phase --

A. Yes.

Q. -- from 13 March 2020 until 18 June 2020.

You received a response from the Deputy Director General for Health and Social Services on 2 November, and in it he was responding to what you had requested. However, on 27 November 2020, you and the head of the Equality and Human Rights Commission wrote back in response stating that the evidence provided was not

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and unless you have mechanisms in place to make sure that people's assumptions, stereotypes that they might hold, aren't present in decision making, in policy making, there is a risk that they are. So we felt we'd asked the questions, they hadn't been answered sufficiently or comprehensively. So that's why we went back asking for further meetings and further work to be done.

Q. And for completeness, what was the outcome of this investigation?

A. So the work took us through to December time, that initial phase of work, and we had a more productive meeting, I would say, towards the end of December with the Minister for Health and Social Services, the Deputy Minister, and other officials, where the Welsh Government at that point then said they could see there had been some gaps in what they were doing, they hadn't necessarily recorded equality impact assessments. The Equality and Human Rights Commission was following up in terms of training, there was going to be work done internally within Welsh Government to look at its processes, and we felt at that point that they'd really started to address the issues we'd raised specifically in relation to their decision making and use of equality impact assessments.

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sufficient to address the concerns highlighted.

What was it about the evidence that made it insufficient, in your view?

A. One of the key things we asked for was evidence of the undertaking of equality impact assessments. This was crucial because we wanted to see if and how the Welsh Government had examined the possible impact of its policy and decision making on older people and older people's rights, and to also ensure from the Equality and Human Rights Commission perspective that they were following their obligations under the Equality Act.

The information that was sent to us did not give us the assurance that that had been done. It did set out ways in which decisions had been made to some extent, and some evidence, but in relation to the key element which was about equality impact assessments, instead of really saying this is what we had undertaken, it wasn't able to demonstrate it had undertaken equality impact assessments. Instead, it really set out a rationale for why they say they hadn't done it, and this included something that I found very worrying at the time, and still do, which is that they set out that they didn't need to do that at all times because they intuitively knew the action that was needed.

Now, we all have blindspots and unconscious bias,

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Q. Thank you.

I'm going to move on to discuss the discharge of people from hospitals both into care homes and also into their own homes. You've stated that the discharge of people from hospitals to care homes without the testing needed was a key concern of yours during the early months of the pandemic. Were you consulted on the decision to discharge without testing?

A. Not to my recollection.

Q. On 11 December 2020, you were consulted regarding the proposed low-positive cases and also the admission into care homes and the duration of outbreaks.

If I could just bring up INQ000185024.

And if we look at the part that's in -- that is italicised, that explains what the revised discharge criteria would have been. In essence, before that, it was negative tests in order for them to be discharged into hospitals. But the Welsh Government was considering that they could allow either the test being negative or there being a low positive with a CT value of 35.

In your statement you stated that you had some concerns about the testing criteria only being applied to older people living in care homes or those who had moved down to a step-down facility, that the admission

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of low positive cases involved increased risk in comparison to the current policy, which would have been a negative, test and there was uncertainty about how the change would work in practice.

You'd mentioned those concerns to the Welsh Government and you received a response on 14 December from the Welsh Government. But you still had concerns.

And if I could pull up INQ000185049, page 1, please.

Thank you.

If we just look at paragraph 2 of your email that was sent on 16 December 2020. The first paragraph, you give thanks for the response to the questions you had raised, but the second paragraph you state:

"I note the TAG paper's 'high confidence' that individuals can be judged to be non-infectious 'if there has been symptomatic improvement, if 20 days have elapsed from symptomatic onset or, RT-PCR testing for SARS-CoV-2 is negative for has a high CT value ...' However, it also states that there remains uncertainty around the period of infectivity for individuals infected with SARS-CoV-2. During Monday's press conference, the Minister for Health and Social Services stated that in these circumstances, individuals would be 'very unlikely to be infectious in the vast majority of cases'. This indicates that some risk would still

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implemented and monitored.

And at that stage it felt that that was all I could do, because it felt like the decision was being made.

Q. I'm going to ask some questions about visiting restrictions, which I understand was a key concern of yours during the pandemic.

Now, I understand there was a Care Home Visiting Stakeholder Group which was set up by Care Inspectorate Wales, and you first attended the group in June 2020. Is this around the time that the group was first set up?

A. Yes.

Q. What benefits did the group bring?

A. It was -- I was really pleased that the group was set up, because there were a lot of different organisations and agencies involved in making decisions and having perspectives about visiting, and it felt like quite a muddled situation about where did accountability lie, who was responsible for making decisions.

So bringing everybody into the same group to work through felt like the only possible way forward, really. And it meant that everybody could hear the different perspectives that could be brought to it.

I attended the first few meetings and then members of my team attended on my behalf, and we were able to raise issues about the rights of older people, about the

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remain that individuals could still be infectious in this situation or could pose a risk of an infection spreading in a care home or other setting".

You then mentioned that:

"At [the] meeting last week it was confirmed that the Welsh Government [was] the only administration in the UK making this change ..."

You asked if that remains the case, and you asked if there was able to provide any evidence from other countries that had implemented a policy of discharging people from hospital whilst they were still returning a low positive result.

Did you receive a response to this?

A. No.

Q. What, if anything, did you do to try to obtain a response?

A. So this was just in the run-up to Christmas, and the nature of this meeting, it was one of my regular meetings with the Deputy Minister for Social Services, so I didn't know that this discussion was going to take place.

It felt to me that I was being asked for my views at a very late stage and I felt that the decision had really already been made. And I did what I could to raise questions and also questions about how would it be

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impact of people being isolated from family and friends, about the need to work harder to enable safe visiting.

So it felt like the best mechanism at that point, really, to try to make progress in terms of producing guidance that would then be implementable as well, so that it could be operationalised.

Q. Do you think it succeeded in that aim?

A. I think it definitely made progress. It definitely led to guidance being produced, and it kept the spotlight on visiting.

I think the nature of it meant there were a number of different iterations as time went on, and I think that was difficult for people working in care homes. There was also an issue at all times, really, between guidance at the national level and then what would happen at the local level. And, again, issues about where did accountability lie, therefore, for making decisions about visiting.

So I felt it was the best possible mechanism at the time, and it definitely had a positive impact, in terms of easing visiting restrictions. And also because, I think, Welsh Government were very plugged into it as well, it meant that, you know, the ultimate decision makers on things were part of it.

Q. Do you think, in a future pandemic, such a group should

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1 exist from the start?

2 **A.** I think in a future pandemic there needs to be, at the

3 outset, greater clarity about who is responsible for

4 making those decisions, and clear accountability for

5 that.

6 I found it incredibly frustrating in the early

7 stages, having conversations where, you know, somebody

8 might be sympathetic but saying, "It's not my area of

9 responsibility or accountability to make that decision."

10 So there needs to be much clear clarity about,

11 particularly, where the role of Public Health Wales is

12 and where the role of local teams are as well.

13 And that should have a much greater focus on the

14 rights of older people and the importance of weighing up

15 the risk of Covid infection against, and giving due

16 weight to, the risk of being isolated from their

17 families and isolated from their loved ones.

18 **Q.** And you had mentioned in Module 2B that issue with not

19 knowing who the decision maker was in respect of care

20 home visiting. How did this issue affect care homes

21 visiting in practice?

22 **A.** It took longer to work through who could make the

23 decisions to get visiting happening, and it meant that

24 there was a lack of clarity about that.

25 I -- it took some time for me to find the right

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1 If I could pull that up on screen, it's

2 INQ000184951, page 1.

3 So this is a letter that you sent to Public Health

4 Wales, and it was in respect of the suspension of

5 outdoor visits, which is what you mentioned before.

6 And as you said, you weren't happy with that and you

7 asked a number of questions, which you can see in the

8 bullet points. The first one being:

9 "• What evidence is there of transmission from

10 outdoor visits by family and friends?"

11 "• What level of risk is there from outdoor visits,

12 assuming these are carried out more than two metres

13 apart and with visitors wearing masks?"

14 "• In taking decisions to suspended outdoor visiting

15 was the impact of not receiving visits on older people's

16 healthcare professional also considered?"

17 "• How is the decision on suspension of visits being

18 kept under review and what evidence is [being] used to

19 inform that review?"

20 Presumably you were asking those questions because

21 essentially there was just blanket suspensions without

22 there being, in your mind, any sort of evidence as to

23 why that was necessary.

24 **A.** I was asking the questions because I couldn't --

25 I didn't see any evidence, and it seemed a completely

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1 people, actually, and then to liaise with the key person

2 in Public Health Wales who had the responsibility for

3 that. And then it took some time to get across the

4 importance of visiting, because they hadn't really --

5 I don't think they'd factored that into their decision

6 making.

7 And I think it may -- things took longer. Sometimes

8 one was starting from the perspective of having to sort

9 of almost educate people about what care homes are and

10 how care homes -- how people live in care homes, and

11 they're not medical institutions.

12 So all of that took time and people's energy, and

13 I think, you know, it was a frustration at the time.

14 That said, once we'd got through that phase, people

15 worked hard together to try to make those -- you know,

16 make the right things happen. And then it was more of

17 an issue, I think, of particular local areas taking

18 different views. So I remember, for example, around

19 outdoor visiting, where, in two local authorities,

20 they'd kind of moved back from that and I wasn't clear

21 at all the rationale for that. So I then had to go to

22 Public Health Wales to kind of raise that issue directly

23 with them again.

24 **Q.** And just speaking on that, I have seen a letter from you

25 to the Welsh Government dated 21 September 2020.

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1 disproportionate response at a time when, you know, just

2 getting to outdoor visiting had taken a huge amount of

3 steps to get there, and the idea that that could then be

4 suspended so quickly just felt entirely wrong, and it

5 comes up back to, you know, in a sense to a bit of

6 a recurring theme, really, which was how are these

7 decisions being made? What is the evidence? How are

8 they going to be monitored? How are they going to be

9 communicated?

10 So that was the questions I was raising at this time

11 as well, and then discussed in my meetings.

12 **Q.** Did you get an answer to those questions?

13 **A.** So I didn't get a formal letter in response. We

14 discussed these questions during my meeting. I can't

15 recollect the detail of that now, but my sense of it was

16 that I didn't get answers to all of that. Partly my

17 role was about encouraging those sorts of agencies to

18 ask these sorts of questions and to take this sort of

19 action.

20 **Q.** And I just wanted to point to you a position from Care

21 Inspectorate Wales when it comes to visiting.

22 If we could bring up their statement. It's

23 INQ000569773, page 86, paragraph 258.

24 In it, Care Inspectorate Wales say that they were:

25 "... aware of the profound impact on [the] wellbeing

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that could result from restrictions on visitors. I was keen to ensure proportionate and balanced decisions were made in relation to restricting visits, in particular outdoor visits. Our position at this time was what happened in care homes should mirror what was happening and permissible in the local communities. In particular, our view was while the public could meet outside, people in care homes should also have that right, and we shared that with the Welsh Government ..."

Do you agree with that view?

A. I certainly agree that the very minimum should be that people in care homes should have the same rights as people elsewhere. In addition, I would add that if you are living in a care home, there are reasons for that. It might be because of your care and support means. It might be because you have other vulnerabilities, so actually, there should be additional work to see if actually people living in care homes can actually have more contact and support than perhaps those of us who were able to, you know -- didn't need to have that kind of level of care and support.

So I would have said that was the very minimum that we should be working towards.

Q. Thank you. And I just wanted to go back because I forgot to ask you a question about the difficulty in

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professionals that there are increased opportunities for abuse. The commissioner also warned that with people caring for one another there can be increased pressures on the carer which can also lead to abuse."

And you said that:

"... the issue of abuse doesn't get the profile it deserves and that more needs to be done to safeguard older people."

So you've mentioned in that paragraph, the risk coming from the lack of visits from loved ones and healthcare professionals. I was wondering what your views were on the suspension of routine inspections by Care Inspectorate Wales and whether or not that might have added to this risk of abuse.

A. Yes, the prevention of abuse and the recognition of abuse of older people is one of the major areas of work I undertook during the pandemic. And actually my main focus was about people living in their own homes, where I felt the risks were particularly high.

In relation to people in care homes, what is very valuable when you are living in a care home, and indeed working in a care home, is to have people coming in and out, to have relatives there, to have family and friends, to have professionals visiting.

Sometimes that's just because small things can be

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not knowing who the decision maker was. Is there a particular organisation that you think should hold the responsibility when it comes to visiting restrictions within the Welsh Government?

A. I think ultimately it needs to be a clear decision by Welsh Government, because it is the body that can coordinate what is happening.

It felt to me that they were waiting on advice from Public Health Wales, and therefore it felt like, maybe almost by default, it was a sort of Public Health Wales decision. So I think in -- in any pandemic in the future, I think, you know, governments need to own those decisions, and they need to be clear about where they're taking advice and then the decisions that they're making as a government on that basis.

Q. I want to turn to your concerns about the increase in abuse towards older people during the pandemic.

And if I could pull up a document, it's

INQ000584937, page 2, please.

These are minutes of a meeting of the Cross Party Group on Older People and Ageing, which was held on 23 June 2020. And if we look at the paragraph with the heading "Abuse of older people" it states that you said:

"The commissioner told the group that many older people no longer getting visits from families and health

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raised before they can become big things. If an older people, maybe, who is living a care home, is a bit worried about making a complaint or something, if they have a family member there, they can help them to do that. And if you have professionals and family and friends coming in, there's a lot of eyes on that care.

And so my concern was that that was being removed, so it was about partly Care Inspectorate Wales not visiting and doing inspections, but it was a much broader issue. That was one part of it. But it was about the entirety of, you know, no visits from GPs in most cases, for example, relatives and families not being able to go in. And therefore that there could be an increased risk in terms of abuse of older people.

Or -- and not necessarily, you know, talking about extreme cases, but those issues where people feel they are not being listened to or maybe there are elements of their care which is not as it should be.

Q. And do you think that the profile of this issue, this risk of abuse, was raised during the pandemic or do you think it was still not really taken or seen as important?

A. I work with a number of organisations. I set up an action group on the prevention of the abuse of older people, and one of the things I called for, actually,

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1 was an action plan, which I'm pleased to say was
2 subsequently worked on and published by the Welsh
3 Government.

4 So the issue of the risks of older people
5 experiencing abuse wherever they live, and hugely
6 different types of abuse from domestic violence to
7 neglect, for example, I think that the awareness of that
8 has increased. There is still good work going under
9 way. There is a long way to go yet for it to be
10 recognised, and for it to be prevented and for people to
11 get the support that they need. But I do feel that's an
12 area that improvements have been made, and I think some
13 of those improvements certainly are sustainable and will
14 sustain.

15 **Q.** I'm going to ask you some questions about DNACPRs, and
16 blanket use. You've referred to a letter sent by a GP
17 surgery to some of their patients. I'm not going to ask
18 you any questions about that because some of the CPs
19 will and you also answered some questions in Module 2B.
20 However, I understand you were made aware of other
21 practices where GPs were contacting older people or
22 their family members over the phone to get them to agree
23 to DNACPRs and the fact that that was causing a lot of
24 distress for the person concerned and also their family
25 members, especially considering the fact that sometimes

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1 there mustn't be -- any link between a decision on
2 DNACPR, which is specific to do not attempt CPR, and
3 access to other treatment.

4 And one of the most chilling things, I think, about
5 what we were seeing during the pandemic was where DNACPR
6 was also linked to saying, "And you won't get other
7 treatment, you won't get an ambulance", for example, and
8 that was frightening, and really frightening for older
9 people, and that cast a very, very long shadow
10 throughout the pandemic and possibly beyond where older
11 people rather than trusting the NHS, some feared going
12 to it because they feared that their lives might not be
13 protected in the way that they should be, and that --
14 I remember the conversations that older people had with
15 me about that.

16 **Q.** So do you think, for example, the example that you'd
17 mentioned in your witness statement about the
18 97-year-old mother being contacted on the phone and she
19 was living alone, for example, and was asked to agree to
20 a DNACPR, do you think that sort of scenario with GPs
21 just calling older individual people on their own in
22 a pandemic is the right way to do it, or do you think it
23 should be dealt with the differently?

24 **A.** It's not the right way to do it at all. It's a very
25 frightening call to get out of the blue, isn't it? What

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1 they were separated from them.

2 I've seen at least two of those instances in your
3 witness statement. Was it -- how common was this? How
4 common was it?

5 **A.** When the issue came to the fore from that initial letter
6 and became public, we then got contacted by a member of
7 the Senedd, some family members and others, and
8 throughout, actually, throughout the pandemic at
9 different times, those issues were raised and sometimes
10 it might be I was having meetings with older people and
11 they raised it informally. So I was aware that it was
12 certainly much more than, you know, a few isolated
13 incidents.

14 **Q.** How do you think we can prevent this from happening
15 again?

16 **A.** Well, there needs to be a number of actions taken
17 forward and I'm pleased to say that some of this has
18 been happening in Wales where there's been work to
19 review the NHS guidance on this and particularly in
20 relation to communications. So there needs to be much
21 better and clearer communications about what DNACPR is,
22 and particularly the area that needs to be strengthened
23 is to make sure there have been proper discussions with
24 the individual and/or their family or advocate as
25 appropriate. And also that there shouldn't be -- and

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1 we need to see more broadly is an approach to advanced
2 care planning where these things, as far as possible,
3 are done in advance, so that you can have a conversation
4 outwith a crisis where you can make your wishes known.
5 That's obviously the ideal approach. When it is much
6 more of an emergency, I think those sorts of calls just
7 are -- you know, and it was expressed to me how
8 terrifying those calls could be.

9 So it is an area where I believe there are actions
10 that can be taken to improve processes into the future
11 and those need to be taken.

12 **Q.** I want to bring up some concerns that were raised by the
13 Covid Bereaved Families for Justice Cymru in their
14 witness statement. And if I could pull that up.

15 It's INQ000474759, page 26. Paragraph 77. Thank
16 you.

17 They state that they met with you to lobby for
18 change concerning DNACPRs, care homes, and complaint
19 procedures on various dates from October 2021 onwards.

20 They state that they were pleased to see the steps
21 taken by you and voicing these issues. However, it was
22 their view that these steps should have been the norm in
23 the first place. The fact that they needed addressing
24 shows a shocking lack of care and respect for older
25 people's problems in Wales in the first place.

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1 And if you can look at paragraph 78, they state it's
2 their view that:
3 "... these meetings felt unproductive. The group
4 acknowledges that [you] appeared to actively engage with
5 the discussion and showed genuine sympathy to what was
6 conveyed throughout these meetings. However, this
7 discussion felt wholly unproductive."

8 It's their position:

9 "... that the Welsh Government and the First
10 Minister failed to heed any recommendation made to [you]
11 by [them]."

12 What do you have to say in response to that?

- 13 **A.** Well, I'm surprised by that. It wasn't something that
14 was reflected to me at the time at all. We had a number
15 of meetings which I felt were very useful. I can
16 understand their frustration that their recommendations
17 weren't necessarily being taken forward by Welsh
18 Government, however.
19 **Q.** And I'm just going to come to your lessons learned and
20 recommendations which you've helpfully set out in your
21 witness statement. Your assessment was essentially that
22 older people were not adequately considered by the Welsh
23 Government when making decisions during the pandemic.
24 And that's, for your reference, it's from page 48,
25 paragraph 226 onwards.

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1 still going on in terms of improving the way in which
2 GPs can support older people more generally.

3 I'm not aware of the detail of what's happening now,
4 though.

- 5 **Q.** And you mention also changes to government structures
6 and processes to ensure that there is social care
7 experience and expertise in policy and decision making
8 at an appropriate level. And you recommend this because
9 you say there was a lack of knowledge and understanding
10 of the care sector amongst policy and decision makers in
11 the Welsh Government.

12 Do you think that this has been rectified, in your
13 view? Obviously before you left your position.

- 14 **A.** Yeah, I think there's two elements to this. One is the
15 ministerial element and one is the official levels. And
16 in the Welsh Government, and indeed other governments,
17 the Social Care Minister is often or almost always
18 junior to the Health Minister, and I think that's the
19 first part of the problem, which should be addressed at
20 that level. You should have, in my view, a Care
21 Minister that -- at cabinet level, so that at cabinet
22 level, there is that feed-in in terms of the social care
23 sector, which is a hugely important sector in terms of
24 the people it supports but also in terms of the economy
25 and wider society.

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1 And you list number of decisions to illustrate your
2 point, namely the Coronavirus Act, removing people's
3 legal right to have their eligible needs for care and
4 support met. Presumably you're referring to what we
5 colloquially call easements?

6 **A.** Yes.

7 **Q.** The discharge of older people from hospitals without
8 testing --

9 **A.** Yes.

10 **Q.** -- for Covid-19; and visiting restrictions and
11 restrictions on residents being able to go out of the
12 care home, which you say caused great distress and harm.

13 You've made a number of recommendations but I'm only
14 going to focus on three. The first one being
15 improvements in the support that the NHS provides to the
16 social care sector, particularly to care homes, and
17 monitoring residents' access to medical treatment to
18 ensure that they are not being disadvantaged.

19 As far as you're aware, has any work been undertaken
20 on this point in preparation for a future pandemic?

- 21 **A.** I caveat my response to say I'm the former commissioner
22 and haven't been in post since the middle of last
23 August. There has been some work undertaken,
24 particularly in relation to GPs and in fact some of the
25 work that I was doing around access to primary care is

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1 So, first of all, I think there's needs to be
2 ministerial weight, if you like, given to social care.

3 And then in relation to the structures within
4 government, the importance of having a role similar to
5 a Chief Social Care Officer. I think, importantly, that
6 person has a clear specialist advisory role to
7 government, across government, and expertise in terms of
8 being a professional social care practitioner.

9 And that that is supported by ensuring that those
10 charged with making decisions around social care have
11 enough understanding of social care, including
12 operational realities.

- 13 **Q.** And the final one I wanted to ask you on was your
14 recommendation of improvements in social care data
15 collection, analysis, insight, and reporting, both to
16 inform policy and decision making and to understand the
17 consequences of policy and decisions taken.

18 Before you'd left your post, do you think there'd
19 been any improvements in respect of data collection and
20 analysis?

- 21 **A.** Some slow improvements gathering data from local
22 authorities, and beginning to -- Welsh Government
23 gathering that data and beginning to look at what that
24 data was saying.

25 There is a long way to go, I think, to make sure not

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just that the data is collected but, importantly, that it's made public, that there's opportunities to analyse it and gather the insight from that. And also that it specifically draws out the different groups.

Social care helps an enormous number of different groups, from children to disabled people to older people, and it's very important that those -- that data is disaggregated, so you can actually see what the issues are for differing groups of people. And that's where you can see if there are any persistent inequalities, for example, or particular groups experiencing disadvantage in their access to social care.

Q. Thank you.

And is there anything else that you would wish to tell the Inquiry?

A. I think just two final things, if I may. The first one is that I think the pandemic demonstrated the insidious ageism that is embedded in our society, the way in which, as we get older, too often our lives are not valued in the same way. The way in which the stereotypes and assumptions that people make about older age can then feed into policy and decision making.

I think there's a need to treat ageism, in combatting ageism, much more seriously and that needs to

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The first question relates to the letter that was mentioned earlier by Ms Shotunde from a GP surgery in Wales in March that you refer to at paragraphs 166 and 167 of your statement.

An INQ reference to the letter, just for the Inquiry record, is INQ000400633, but there's no need, I think, to bring the letter up. I think you're well aware of it. And it's been mentioned already on a number of occasions in the Inquiry hearings.

But that letter advised vulnerable and elderly patients that it was unlikely that they would be offered hospital admission, that they certainly wouldn't be offered a ventilated bed, and it requested that they complete a DNACPR form so that family and friends would not call 999. And you've referred already to your concerns in this area.

In response to the letter, you issued public statements on the 1 and 6 April -- and they're at INQ000181737 and INQ000181738 -- describing such pressure as shameful and unacceptable, and you called for the protection of people's fundamental human rights.

Please could I ask, following these interventions, what changes were made in Wales to the indiscriminate application of DNACPR notices?

A. The first actions that happened, and one which I'd

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be done throughout organisations in terms of training and awareness, and, within that, much more serious adherence to the issue of the rights of older people.

The second thing I'd like to say is that my work during the pandemic, and the extent to which we were able to effect changes, was only possible because of the way in which older people worked with me and because of the help and support of my team, and particularly the deputy commissioner.

So I'd just like to place on record my thanks to them and also my condolences for all of those who lost loved ones and who are still dealing with that grief today.

MS SHOTUNDE: My Lady, those are my questions, but I believe there are some questions from Core Participants.

LADY HALLETT: There are. Thank you very much, Ms Shotunde.

I think it's Mr Stanton, probably directly across from you, I should think.

Questions from MR STANTON

MR STANTON: Thank you, my Lady.

Good afternoon, Ms Herklots. I ask questions on behalf of the Covid-19 Bereaved Families for Justice Cymru. I have three questions for you, all of which are focused on the responses of Welsh Government and public bodies in Wales to your interventions.

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proposed, was a letter from the Chief Medical Officer and Chief Nursing Officer stating that age alone should not be used in any way to make decisions, and being clear about what the guidance was in relation to DNACPR. That was followed also by a joint letter, I think, from Care Inspectorate Wales and Health Inspectorate Wales on the same basis.

So the first -- you know, the first thing that I felt needed to happen was very clear statements from both the health side and the care side that stated that was unacceptable. So that's the first thing that happened.

It then was about how can we make improvements into those processes? So I started working on issues about communications on DNACPR and about information, and one of the issues that came up was just people didn't always understand what DNACPR meant, or what the process should be. So I undertook work as commissioner to carry out some work on that myself. So we subsequently later produced information about DNACPR and guidance for people which we put on our website.

We then -- and I think this is probably more like '22, '23 time -- were involved in work that was being undertaken in Wales to review the DNACPR guidance.

And our role there was about the importance of

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making sure it attended to older people's rights and to improvements in communication and also to get a better picture of what was happening because we didn't know, for example, how many DNACPR notices were being issued by each health board. So I also raised these issues with Health Inspectorate Wales and they subsequently undertook a review looking at what was happening in health boards in relation to the issuing of DNACPR notices, because if there were particular areas where there seemed to be a disproportionate number being issued then that would potentially be a cause for concern.

Q. Thank you very much.

Moving forward a couple of months, in May 2020 you became so concerned at the failure to protect older people that you took the extraordinary step of referring the Welsh Government for investigation to the Equality and Human Rights Commission. And that's at INQ000181746.

Then on 21 June 2020, you produced a report titled A snapshot of life in care homes in Wales during Covid, at INQ000171725 (sic).

One of your conclusions at page 22 of that report is that more action was needed to tackle the significant disconnect between what was promised at policy level and

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referral and found that there may have been a failure in Wales to adequately protect life. That's at INQ000253853.

At this time, numbers of infections in care homes were building, and numbers of deaths were also, sadly, increasing, and there was very significant further loss of life through November, December, culminating in January 2021.

The Cymru group's position in this regard is that the huge loss of life in the second wave was entirely predictable, and its severity could have been avoided, but that there was a collective failure by public bodies in Wales to look after older people throughout the pandemic, not just at the beginning, and you touched on earlier in your evidence one of those decisions to continue in December -- or, sorry, to reverse the decision to only release into a care home with a negative test to allowing that to happen with a low positive, and your concerns in that regard.

Do you agree with the concerns of the Cymru Group that there has been a collective failure throughout the pandemic to protect older people?

A. I found that there were failures at times to protect older people, and so particularly early in the pandemic, issues around people not being tested, not enough

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what was being delivered on the ground.

Can I ask, was this conclusion and recommendation because public bodies in Wales were not acting on the concerns of you and others?

A. No, I don't think it was that. I think it was more that there needed to be a greater focus on implementation. So -- and this is a more general issue that can happen. Governments issue guidance and sometimes expect it to be implemented immediately, and actually there needs to be a lot of focus on how can that be implemented. And that means engaging as far as possible, which was more difficult, of course, during a pandemic, but engaging as far as possible with people who -- whose job it will be to implement that guidance, to make sure that it is practical, that it can be taken forward. That's, for example, why the visiting stakeholder group was useful, because it had that ability to do that.

So it was the disconnect, really, between, you know, a policy and then maybe an assumption that that's being taken forward, when actually you need time, you need support, you need help to make sure that that is implemented.

Q. Thank you. And finally, moving forward again a few months, in October 2020, the Equality and Human Rights Commission produced their report in response to your

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support, healthcare support, for older people living in care homes. So a risk to their lives not from just from Covid but from other illnesses and conditions that they may be having.

I also saw extraordinary work by public servants across Wales, and indeed people in the voluntary and community sectors, who were doing all they could to protect and support older people. So it was a mixed picture, I would say, in that regard.

MR STANTON: Thank you very much.

Thank you, my Lady.

LADY HALLETT: Thank you, Mr Stanton.

Mr Straw, who is probably over the other side of the room but slightly further down the hearing room.

Questions from MR STRAW KC

MR STRAW: Ms Herklots, I represent John's Campaign, The Patients Association and Care Rights UK.

You mentioned earlier a recommendation for the future to have a Care Minister and a supporting civil servant. In your view, were the views of older people in care and their supporters properly taken into account, and also properly implemented by the government during the pandemic?

A. In terms of the Deputy Minister for Social Services, who is the person that I had the main contact with, I found

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the Deputy Minister to be very attuned to the issues and to want to take action on those.

That didn't always translate into action by the government, however. And I think there needed to be a stronger voice, probably, at cabinet level, to make sure that issues affecting older people, and indeed disabled people, were better taken account of and a greater focus placed on the need to protect older people living in care homes.

Q. Thank you.

In your statement you raise concerns that blanket decisions were made about people in care homes, for example blanket bans on access to visits or to healthcare. You say that decisions should have been made on an individual basis, considering the person's risks, needs and wishes.

In your view, did care service users receive person-centred care based on individual assessments during the pandemic?

A. Well, from many thousands of older people living in care homes, and from what I know about the care homes I had contact with and worked with, then many of them would have been getting really good care, provided by compassionate and skilled people who were doing their utmost under unbelievably difficult circumstances.

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statutory duties are implemented, I think you mentioned earlier training is one, and then you've also just touched upon accountability and resources. Are those the, well, three things that can be put in place to ensure that those statutory duties are better effected?

A. Yes. Yes, I believe so.

Q. Thank you.

At paragraph 139, you state:

"In my opinion, the initial decision making on visiting, under public health guidance, was based on the risks of Covid-19 infection, but did not take into account the harm to health and wellbeing for older people being isolated ... I also felt it did not take adequate account of the human rights of older people ..."

In what way should the balance between indirect harms resulting from visiting restrictions and Covid infection control, on the other hand, have been better struck?

A. My sense was that at the beginning of the pandemic, there was hardly any consideration of the harms of people in care homes being isolated from their loved ones, that the entire focus, particularly from Public Health Wales, was about the infection risk rather than the risk caused by isolation or, as some people felt,

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It's impossible to say that everybody had that level of care. Indeed, that's not the case. I know that not everybody would have had that level of care. But it would be wrong, I think, to say that no one had that level of care.

Q. Can you make any recommendations as to how, in future, these sorts of blanket decisions can be avoided and better individualised assessments implemented in a pandemic?

A. Well, we have quite a lot of the legislation in place for that. In Wales, the Social Services and Well-being Act, for example, is very person-centred. It's all about implementation. And being -- having legislation is not enough on its own, and it's not enough if there is no accountability to it if it's not followed. So I think there needs to be a much greater focus, as I've said, on ensuring that the legal rights that older people have, wherever they live, are recognised and followed.

And along with that, ensuring that there's sufficient resourcing so that people working in social care can follow the legislation and can work in the way that they want to work and have been trained to work, which is in a person-centred way.

Q. So in terms of practical steps to ensure that those

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feelings of abandonment from their family.

So I think it's a case of due weight being given to those different aspects, and a better understanding of the impact of isolation of not being able to see loved ones, of people not being able to visit into care homes, and there's probably some more work that needs to be done to demonstrate that evidence about those harms so that should there be a future pandemic, it's much -- the evidence is already there to make those decisions more quickly and more robustly.

Q. So in answering the question why was so much weight given to Covid and so little weight given to indirect harms, is one answer that the data wasn't available, but are there other answers to that question?

A. I think it's about people not being aware of the impact. So data is one way to demonstrate that; qualitative evidence is also, I think, very important in this context. And also, you know, it was the case that some of the people making decisions about care homes had little understanding about care homes and how they operate, and how people live in care homes. And that is definitely an area that needs to improve. It shouldn't be the case that people are making decisions about an area where they don't really understand it.

Q. Thank you.

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1 The last area is about dementia. Can you outline
 2 the particular problems that people with dementia, and
 3 also their carers, had during the pandemic?
 4 **A.** For many people living with the dementia and their
 5 carers, the pandemic was unbelievably difficult. If
 6 I think about people living in the -- living in their
 7 own homes, with the closure of respite facilities,
 8 daycare facilities, people not always wanting
 9 domiciliary care workers to come into their homes,
 10 because they are frightened of the risk, it meant that
 11 many unpaid carers of people with dementia had to do
 12 a lot, lot more. So the demands on them became more
 13 challenging during the pandemic because their network of
 14 support had been taken away. So there's stress on
 15 unpaid carers of people living with dementia in the
 16 community. And the difficulty for people living with
 17 dementia as well, if they weren't getting the support
 18 they were getting before.

19 In relation to people living with dementia in care
 20 homes, I think particularly sometimes it meant that it
 21 was more difficult for them to understand why they
 22 couldn't see their loved ones. And in my Care Home
 23 Voices report, you know, and from the discussions I had
 24 with older people and families at the time, people
 25 expressed that to me. They said that their loved one,
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1 example, that, you know, support services were shut,
 2 people who normally would access help, particularly
 3 people living with dementia from organisations and
 4 charities, they couldn't carry out their work in
 5 a normal way. So that complete picture meant that it
 6 would be very difficult for people to maintain the level
 7 of care and support that they needed.

8 **MR STRAW:** Thank you very much.

9 **LADY HALLETT:** Thank you, Mr Straw.

10 That completes the questions we have for you,
 11 Ms Herklots.

12 I think it's probably the last time we're going to
 13 have to ask you to come along and give evidence. I'm
 14 very sorry to have to make you relive obviously what
 15 were difficult times for everybody. So thank you very
 16 much for all the help you've given to the Inquiry.

17 **THE WITNESS:** Thank you.

18 **LADY HALLETT:** Very well. I shall return at 3.25.

19 (3.08 pm)

(A short break)

21 (3.25 pm)

22 **LADY HALLETT:** Ms Paisley.

23 **MS PAISLEY:** My Lady, the next witness is Melanie Minty.

24 **MS MELANIE MINTY (affirmed)**

25 **Questions from COUNSEL TO THE INQUIRY**

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1 you know, didn't understand why they couldn't see their
 2 family, felt abandoned by their family. And therefore,
 3 I think, for people with dementia during the pandemic,
 4 it was a particularly difficult time. And we know also
 5 that some of what happened in the pandemic would have
 6 meant that their dementia may have advanced more as
 7 well, because they weren't getting the support and the
 8 stimulation that they needed.

9 **Q.** Do you consider that the government understood those
 10 difficulties that people with dementia faced?

11 **A.** I don't know. Again, I think the Welsh Government is,
 12 you know, it's not one entity in that sense. There are
 13 certainly people that I work with at official level who
 14 understood and were passionate about helping people with
 15 dementia. So, again, I think it's about whether those
 16 people with expertise were in the right positions in
 17 order to influence decisions and whether those decisions
 18 were ultimately taken by Welsh Government.

19 **Q.** And similar question: do you consider that the Welsh
 20 Government made appropriate provision for people with
 21 dementia during the pandemic?

22 **A.** Again, it's difficult for me to assess that overall.
 23 What I would say is that the lack of support that people
 24 experienced because of a number of things, actually, so
 25 not just in terms of government action, but issues, for
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1 **LADY HALLETT:** Ms Minty, I'm sorry you're the last witness
 2 of the day and we've kept you waiting.

3 **THE WITNESS:** Thank you, my Lady.

4 **MS PAISLEY:** Good afternoon and thank you for attending the
 5 Inquiry today and for providing your statement to this
 6 module, dated 13 November 2024. By way of background,
 7 you have worked for Care Forum Wales since 2012,
 8 currently as a senior policy adviser, and prior to that,
 9 as policy adviser supporting the former chief executive;
 10 is that right?

11 **A.** That's right.

12 **Q.** Care Forum Wales is the main representative organisation
 13 for care providers in Wales. It has 418 members across
 14 all regions of Wales. Approximately 85% of those are
 15 residential settings and the remainder are domiciliary
 16 care providers.

17 You explain that your members include a variety of
 18 organisations, ranging from small family-run enterprises
 19 to larger corporate organisations and local government
 20 providers, and your members provide both private and
 21 publicly funded care for a wide range of individuals,
 22 including younger and older adults, those with physical
 23 and mental health needs, and those that require complex
 24 nursing. Is that all correct?

25 **A.** Yes, absolutely.

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1 Q. Can I move, please, to the role of Care Forum Wales
 2 during the pandemic. At paragraph 88 of your statement
 3 you provide an overview of key groups attended by Care
 4 Forum Wales which were led by the Welsh Government, and
 5 some of those meetings were also attended by the
 6 regulator, commissioners, and Public Health Wales.
 7 Generally speaking, what was the role played by Care
 8 Forum Wales in those meetings?
 9 A. Generally speaking, it was to feed back intelligence
 10 from the ground, as it were. So, in particular, we had
 11 a WhatsApp group for our members that we'd set up in
 12 early March, and they used that to share concerns and
 13 good practice and ideas for resolving things. So we
 14 were able to keep it a sort of -- really sort of quite
 15 live eye on things that were going on and then use that
 16 to feed back to policymakers to influence what was being
 17 done to support the sector.
 18 Q. And in your experience, do you think, firstly, that
 19 there was enough engagement with stakeholders such as
 20 Care Forum Wales by those different entities and groups
 21 that we've just discussed?
 22 A. I think we were disappointed that it got off to a bit of
 23 a slow start. I think, you know, we were in the
 24 position in the early days of probably having to chase
 25 people up and say, "Don't forget about the sector. Have
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1 home cleaning guidance.
 2 A. Yes.
 3 Q. And it developed strong links with Public Health Wales
 4 that have continued beyond the pandemic. Are there any
 5 other particular instances of good practice?
 6 A. We have been working with the former Older People's
 7 Commissioner on, sort of, visiting -- sorry, not
 8 visiting, but, sort of, rights of tenure of older people
 9 in care homes, and that's involved the families groups,
 10 as well, just to sort of try to work out some of those
 11 rights and that we don't lose sight of them moving
 12 forward.
 13 Q. Another specific group I just have a question about,
 14 please, is the Social Care Fair Work Forum, and at
 15 paragraph 101 you say:
 16 "The recognition of the value of the social care
 17 workers led to the creation of the Social Care Fair Work
 18 Forum by Welsh Government and the commitment to
 19 improving terms and conditions."
 20 Does that forum still meet?
 21 A. Yes, it does. It's evolved into a social care fair work
 22 partnership, and it's actually doing quite a lot of the
 23 work that the UK Government is now doing in terms of
 24 looking at the voice of unions in the sector, pay and
 25 progression, fair working conditions.
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1 you got anything, a policy, that's specific to the
 2 sector that we need to know about?"
 3 After -- probably after late March, early April,
 4 things were much better, and once everybody was pulling
 5 together, that engagement was excellent from that point
 6 onwards.
 7 Q. So, from your perspective, in the event of a future
 8 pandemic of a similar nature, including those
 9 stakeholders at the earliest opportunity, is something
 10 you would endorse?
 11 A. Absolutely.
 12 Q. And you've just briefly touched upon it, but can you
 13 give an overview of how open and effective the
 14 engagement was?
 15 A. It was very open. You know, our chair was meeting
 16 weekly with the minister, and Mary Wimbury, our chief
 17 executive, and myself, were involved in a number of
 18 national meetings. There were a lot of strategic
 19 meetings held weekly with all the stakeholders involved,
 20 and then there were a number of task and finish groups,
 21 working groups, looking at things like do not
 22 resuscitate decisions.
 23 Q. And reflecting then on some aspects of good practice,
 24 one example you raise is that Care Forum Wales was
 25 engaged in working groups looking, for example, at care
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1 Q. So that's a positive that that's
 2 still -- (overspeaking) --
 3 A. Oh, absolutely. Absolutely.
 4 Q. Can I then, please, move to some questions about
 5 guidance provided to the sector and ask for your
 6 comments.
 7 If we can have on screen INQ000183761, please.
 8 And Mary Wimbury sent an email to Sir Frank Atherton
 9 on 2 March, stating:
 10 "Following my email last week asking if advice was
 11 specifically being provided to the care sector, I note
 12 that Public Health England has issued some advice."
 13 And she went on to say:
 14 "In the absence of other information, we assume
 15 Public Health Wales advice ... [would be] as per ...
 16 Public Health England advice ..."
 17 And then Sir Frank's office responded on 10 March to
 18 say:
 19 "There is specific Welsh guidance similar to that
 20 issued by Public Health England ..."
 21 Now, guidance had been issued on 9 March. Do you
 22 think that the initial guidance produced by both Public
 23 Health Wales and the Welsh Government was done in
 24 a timely manner?
 25 A. It could have been done earlier, I believe. It's
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1 something that, you know, maybe it's the benefit of
 2 hindsight but I think providers were very risk averse
 3 right from the beginning, had started to worry about it
 4 quite some time before messages began to come out
 5 through the governments about the potential scale of the
 6 pandemic. You know, before this advice had come out,
 7 we'd already got a lot of providers who felt they were
 8 forced into the position of refusing to take admissions
 9 from hospital because they weren't satisfied with the
 10 guidance and the potential risks to their residents,
 11 because of the very nature of an elderly population with
 12 existing comorbidities.

13 **Q.** And we'll come on to touch upon the specific guidance
 14 but, generally speaking, would your view be that the
 15 earlier guidance can be produced for the sector, the
 16 better?

17 **A.** Absolutely, absolutely. Especially in -- and it needs
 18 to be tailor-made because so often, as in this instance,
 19 a lot of the initial guidance that came out was more
 20 geared towards health and it's really important that
 21 people understand, in social care, that you've got
 22 a different workforce and you're talking about people's
 23 homes, not institutions.

24 **Q.** And likewise, it should also be tailor-made for the
 25 domiciliary care sector as opposed to residential?

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1 And at paragraph 35 of your statement you say:
 2 "At the end of March 2020, we issued a press release
 3 about care homes being treated as collateral damage, as
 4 a result of the discharge policy. During this time,
 5 many members were resisting pressure to take new
 6 admissions directly from hospital unless they had been
 7 tested -- often insisting on two tests to allow for
 8 false results."

9 So bearing in mind, then, the email that was sent by
 10 Mary Wimbury and the comments in your statement, was it
 11 the view of Care Forum Wales that in principle, there
 12 was nothing wrong with this decision, it was just poorly
 13 executed?

14 **A.** Sorry, the decision to --

15 **Q.** To discharge.

16 **A.** No, no, I think we thought it was faulty without knowing
 17 more and understanding more about Covid itself. But we
 18 were -- our members were broadly concerned about the
 19 behaviour, sometimes, of visiting families, but also the
 20 lack of PPE, the lack of testing for anybody other than
 21 symptomatic residents. So we could have got all that
 22 straight, I think it would have assisted in those
 23 decisions.

24 **Q.** Yes, returning back to what Mary Wimbury had said, that
 25 Care Forum Wales would be happy, it seems as though it's

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1 **A.** Yes, absolutely, yes, because, you know, we did find
 2 discrepancies in things like PPE guidance which is very
 3 different for someone who's within a care home and
 4 someone who's accompanying someone outside.

5 **Q.** Staying with this document, please, on page 2,
 6 Mary Wimbury had said on 2 March:

7 "... we would be happy to facilitate faster
 8 discharge from hospital and the use of care home beds to
 9 free up space in our hospitals, should that become
 10 necessary."

11 Can you help us with what role Care Forum Wales
 12 would have to play generally?

13 **A.** I think probably it would be encouraging members to take
 14 people from hospitals, subject to us all being satisfied
 15 that the procedures for that were safe.

16 **Q.** Thank you. That document can come down.

17 Staying with the topic of discharge, please. At
 18 paragraph 24 of your statement you say:

19 "Before COVID-19, the sector didn't have enough beds
 20 to help free up hospital beds (especially suitable
 21 dementia care places). The situation got dramatically
 22 worse in the first few months of COVID-19, with
 23 hospitals trying to free up beds and social care workers
 24 trying to find suitable placements for people who were
 25 going to be stuck shielding in their own homes."

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1 not against it in principle, it's just how it was
 2 operating that was the problem?

3 **A.** Yes. I think that's probably a fair description.

4 **Q.** You explain generally that there were difficulties when
 5 guidance was issued on a Friday. What sorts of
 6 difficulties arose, if it was issued on a Friday?

7 **A.** The guidance would appear, or the statement would be
 8 made on a Friday, but it wouldn't necessarily get
 9 through to everybody at once. Very often care homes are
 10 operating on fairly low levels of staffing over the
 11 weekend but of course people at Public Health Wales,
 12 local authorities, all those people who were also
 13 decision makers may not be working at all at weekends.
 14 So people would come in and not know that things had
 15 changed, and they'd be telling care homes that they were
 16 working on the wrong guidance. So it did cause a lot of
 17 toing-and-froing.

18 **Q.** And practically speaking, given in such a fast-moving
 19 scenario, where there is need to get guidance out as
 20 urgently as possible, where does the balance lie
 21 between, for example, issuing on a Friday and getting it
 22 out as quickly as possible, if you have any views?

23 **A.** It's not an easy solution, I would admit. I think it
 24 would have been difficult for people to coordinate. But
 25 there must be something we can learn, I think, about

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1 communicating throughout the piece, as it were, so that
 2 everybody has the same understanding of the information.
 3 **Q.** In fact, one of the things you raise in your statement
 4 is that there were difficulties with version control?
 5 **A.** Mm.
 6 **Q.** So sometimes it was not clear what had been updated.
 7 Would that perhaps be one way of rectifying the
 8 difficulties?
 9 **A.** Absolutely, because unless you had the two versions side
 10 by side you wouldn't know what had changed. And when
 11 people were working in such difficult circumstances, the
 12 last thing they needed was to be spending a long time
 13 trying to work out what they should be doing.
 14 And I did raise it a few times with Welsh
 15 Government, but the impression I had was that it was
 16 actually a problem with the Welsh Government central
 17 communications team, who didn't like to have, sort of,
 18 scrappy track changes documents online.
 19 But I think things have improved. I noticed the
 20 other day that Public Health Wales had put something on
 21 their website, with -- and CIW had tracked changes,
 22 so ...
 23 **Q.** I think the Inquiry has seen some examples of updates
 24 being given on page 1, for example, so it can be quite
 25 quickly seen.

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1 Does that give a general overview of
 2 the -- (overspeaking) --
 3 **A.** Yes, yes.
 4 **Q.** Can we have then, please, page 5. And one of the issues
 5 identified was that:
 6 "Some local authorities were too keen to get on top
 7 of it quickly. Some wrote their own guidance, and this
 8 rapidly was out of date, particularly around PPE. There
 9 needed to be a balance across local authorities in how
 10 quickly they responded. At the same time some local
 11 authorities waited for instruction and specific policy
 12 guidance, and expected 'the system' to take care of
 13 supporting providers, rather than taking action
 14 themselves."
 15 And so it's whether you have any views on where the
 16 balance may lie in respect of local authority action.
 17 **A.** I think it's probably a situation that's worse in Wales,
 18 because it's a population the size of Manchester but
 19 we've got 22 local authorities. So very quickly you'll
 20 find that a provider has got residents who are
 21 commissioned by -- from about three different local
 22 authorities. So that need for a sort of consistent and
 23 early approach is, I think, particularly relevant for
 24 our members.
 25 **Q.** Do you think perhaps greater stakeholder engagement or

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1 **A.** Mm.
 2 **Q.** So there is an importance in being able to rapidly
 3 identify --
 4 **A.** Yes.
 5 **Q.** Again, dealing with the rapidly changing guidance, are
 6 you aware if there was, somewhere, a forum that Care
 7 Forum Wales could go to identify all relevant guidance
 8 in place at any given time?
 9 **A.** Eventually it came to be held on Public Health Wales's
 10 website.
 11 **Q.** And do you think that was something that was helpful, so
 12 if somebody could go in and go to one place?
 13 **A.** Yes, definitely.
 14 **Q.** Now, a SWOT analysis was undertaken in July 2020.
 15 And if we can, please, have on screen INQ000183763.
 16 Firstly at page 1, and this gives an overview of
 17 this analysis, and it says:
 18 "In June 2020 a group of social care and support
 19 providers were brought together by Care Forum Wales [and
 20 to others] to discuss and reflect on the shared response
 21 to the initial outbreak of Covid-19 in the first half
 22 of 2020. The purpose of this exercise was to provide
 23 a space for shared reflection, to identify what worked
 24 well and less well during this initial period to inform
 25 future action."

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1 early stakeholder engagement with, for example, Care
 2 Forum Wales, might be a way to -- (overspeaking) --
 3 those?
 4 **A.** Yes, I think so, and I think it's probably a little bit
 5 like the engagement that we were talking about earlier.
 6 And it is one of the issues, as well, with relying too
 7 much on local authorities to do things, sometimes.
 8 **Q.** And that document can come down, please.
 9 In fact we're going to be staying with the topic of
 10 local authorities, but in respect of funding provisions
 11 over the pandemic. And at paragraph 56 you say:
 12 "Members welcomed the extent of the hardship funding
 13 provided by the Welsh Government during Covid to support
 14 providers with the additional costs of Covid, without
 15 which many would not have been able ... to operate."
 16 But in a similar vein, you explain:
 17 "Significant problems were experienced with regard
 18 to the distribution of the funding through the local
 19 authorities, which resulted in 22 different ways of
 20 working."
 21 Do you have any ideas or thoughts as to how that
 22 could be avoided?
 23 **A.** I think a greater degree of direction from government
 24 about how local authorities should distribute the
 25 funding, because they all came up with their own

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1 methodologies, be it fixed payments, percentages. They
 2 all had different interpretations of whether it was to
 3 include private funders or self-funders that they were
 4 covering. So I mean, the funding itself was fabulous --
 5 I don't think there was anything similar in England, and
 6 undoubtedly it saved many closures. But I think there's
 7 a lingering issue in Wales in that we have these 22
 8 local authorities and Welsh Government is under great
 9 pressure from them not to erode any local democracy by
 10 taking any central decisions.

11 **Q.** So finding the balance, then, in the clarity --

12 **A.** Yes.

13 **Q.** -- and perhaps if those decisions had been explained to
 14 providers, might that have assisted?

15 **A.** It might have done, but I think really, it was -- there
 16 didn't need to be as many different ways of doing it.
 17 There really didn't.

18 **Q.** We don't need it back on screen, but this was something
 19 else that was discussed in the SWOT analysis and it was
 20 noted that "funding had been slow to reach the front
 21 line". Was that also in relationship (sic) to the
 22 hardship funding or was that in respect of something
 23 else?

24 **A.** I think that was in respect of the hardship funding.

25 **Q.** And do you have any view on how it could get to the
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1 examples of what you were hearing about the situation in
 2 care homes?

3 **A.** We had a lot of nervousness about the fact that care
 4 homes were being told that they only needed PPE when
 5 people were symptomatic, whereas it was -- people in
 6 hospitals were being treated with it routinely, people
 7 were being tested routinely, whether they were
 8 symptomatic or not. And I think what probably pushed
 9 people over the edge slightly is the number of
 10 professionals who visited care homes who were wearing
 11 full PPE. It felt as if they were protecting themselves
 12 and not the care homes.

13 **Q.** You actually touch upon this in your statement and you
 14 say there was a general perception that stocks were
 15 being ring-fenced for hospitals.

16 **A.** Mm.

17 **Q.** What steps would have helped to make care sector staff
 18 feel as though they were on a parity with health care?

19 **A.** What -- well, I think they established a really good
 20 method of administering and circulating PPE further on,
 21 which, you know, would have solved the problem if it had
 22 been there at the start. But we didn't have the volumes
 23 that we needed and I think, you know, it partly goes
 24 back to social care always being the, sort of, junior
 25 member of the partnership, shall we say, and, you know,
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1 front line quicker beyond what we've just discussed?

2 **A.** It was really about what we just discussed, about having
 3 different ways which meant some people were very -- some
 4 local authorities were very bureaucratic about it and
 5 were asking for receipts and so on.

6 **Q.** Finally on funding, please, in respect of the financial
 7 support given to individuals and specifically sick pay
 8 issues, do you feel that support was given quickly
 9 enough to individuals in Wales?

10 **A.** I think Welsh Government sorted it out fairly quickly.
 11 I mean, there were a few lingering concerns about some
 12 of the employment law aspects, but by and large, I think
 13 it came fairly quickly.

14 **Q.** The Inquiry has heard evidence that in fact it was much
 15 later in Wales with regards to sick pay than it was in
 16 the rest of the UK.

17 **A.** Yes, I think it probably was, actually.

18 **Q.** And what sorts of difficulties would that cause on the
 19 ground?

20 **A.** Well, I suppose the main one is if someone is not going
 21 to be paid sick leave, they're going to carry on working
 22 and potentially bring the infection into the care home.

23 **Q.** I'm going to move topic again, please, to concerns about
 24 PPE, and you've explained that staff were frightened to
 25 work because of the lack of PPE. Do you have any direct
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1 protecting health.

2 **Q.** In your statement you talk about the NHS Wales Shared
 3 Services Partnership which was established, and so in
 4 your evidence, it would have been helpful if that had
 5 been established at the outset?

6 **A.** Yes, because at the beginning it was providing PPE for
 7 health, but they had the expertise to do it more widely.

8 **Q.** And similarly to previous points that we've discussed,
 9 you say that it was distributed to local authorities in
 10 proportion to the size of the local authority rather
 11 than the size of the care home within the authority,
 12 which led to delays in providing adequate stock -- and
 13 you give an example -- to one of the largest care homes
 14 in Wales because that was in fact situated in the
 15 smallest local authority.

16 And the Inquiry hearing evidence yesterday (sic)
 17 from Dr Llewelyn who said he thinks that this may have
 18 been as a result of issues with communication. So
 19 again, does that just reiterate the importance of
 20 discussions with the sector as early as possible?

21 **A.** Yes, and I think as time went on, they got better at
 22 actually working out the volumes that people would need,
 23 and how to do it on a better sort of formula.

24 **Q.** Mr Hancock said in his evidence to the Inquiry that:
 25 "Everybody's got a cupboard, and so it's totally
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1 reasonable to require a degree of PPE, say a month's
2 supply, you know, you can pull any time period out of
3 a hat but a month would seem reasonable."

4 Is that something you endorse and is that something
5 practical for care homes?

6 **A.** It isn't, really. I think somewhere in the statement
7 I said that we had members who would keep two to
8 three weeks as standard. A lot of care homes in Wales
9 in particular are sort of quite old structures, they're
10 probably converted residential homes and so on. So
11 storage space is at an absolute premium, and it wouldn't
12 be possible for people to keep large amounts.

13 **Q.** And so would your evidence then be, given the nature of
14 the care sector in Wales, having essential distribution
15 system that works effectively, it's
16 better-- (overspeaking) --

17 **A.** It certainly did, yes -- yes, well, once it was up and
18 running.

19 **Q.** Can I now ask you a couple of short questions about
20 staff shortages, please. And at paragraph 30 you
21 explain that:

22 "Care homes were trying to avoid use of agency staff
23 due to the risk of infection [however] some reached the
24 point of desperation where they were forced to ask staff
25 with covid to look after residents with covid."

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1 INQ000183763, at page 7.

2 And just to remind ourselves, this was around
3 July 2020 that this was undertaken. And it says, under
4 "Testing policy and implementation":

5 "'Testing is generally still a mess and took a long
6 time to get even where we are now!'

7 "Initially getting testing for those who were
8 asymptomatic or even those who were symptomatic in
9 a care home which already had an outbreak was
10 challenging."

11 It then goes on to say:

12 "Now there is regular testing but results are still
13 slow to turnaround and there is no routine testing of
14 frontline care and health [care] workers outside care
15 homes."

16 And two questions arise from this, please. Firstly,
17 can you assist, in the summer of 2020, so this is July,
18 how slow were the tests being taken to turn around for
19 providers at this point, and what issues did that cause?

20 **A.** It's quite a long time to remember but I think it was
21 probably about a week. A week to get the results back
22 in most cases. And we did have incidents where, for
23 instance, someone had been at work before they were even
24 sent a notice that they needed a re-test, and they'd
25 been working almost the week before they were told that

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1 How wide-scale an issue was that?

2 **A.** I don't think the use of staff with Covid was a regular
3 occurrence. I think it only happened in a sort of
4 handful of homes where they were so desperate that they
5 would have to close the doors if they didn't do
6 something about it. But certainly the shortages were
7 widespread.

8 **Q.** And to your knowledge, in an example where somebody with
9 Covid was asked to work through, of course, desperation,
10 how did that operate in the homes? So, for example,
11 were the residents or the families of the residents told
12 about it?

13 **A.** To be honest, I can't answer that one. I don't know.

14 **Q.** Do you have any views on how reaching that point of
15 desperation could be avoided in the future?

16 **A.** I think if we'd had proper protection for care workers
17 from the beginning, in terms of PPE, and the regular
18 testing, if it hadn't just been symptomatic, I think
19 that would have resolved a lot of issues from the
20 beginning. But a lot of it is also down to the sort of
21 financial vulnerable situation that we were in before
22 Covid, even.

23 **Q.** And in fact, if we can move on to discuss testing in
24 more detail, please.

25 Can we have the SWOT analysis back on the screen,
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1 they shouldn't be there. So, yeah, that sort of thing
2 was very regular.

3 **Q.** And the second question, please, talking about there is
4 no regular testing or routine testing of frontline care
5 and health workers outside care homes, is that in
6 respect of domiciliary care?

7 **A.** Yes.

8 **Q.** And the Inquiry understands regular testing of
9 domiciliary care in Wales was not rolled out until
10 14 December 2020. Do you consider that was too late?

11 **A.** I think so. I mean, domiciliary care workers are, by
12 nature, well, going round the community, they're going
13 into different people's homes, and these people are very
14 vulnerable. So it makes no sense to have left it to
15 that position.

16 **Q.** To the best of your knowledge, do you know if Care Forum
17 Wales, having seen this analysis, raised this directly
18 with the Welsh Government at this time?

19 **A.** I'm fairly sure that we would have done, on a -- at the
20 meetings, along with, you know, all the other things
21 that we've been raising, we would have been raising it
22 for domiciliary care workers too.

23 **Q.** And just the final line of this:

24 "The holy grail would be a point of care test with
25 a fast result readily available."

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1 Now, the Inquiry understands lateral flow devices
2 were a point-of-care test. Did that resolve any of the
3 problems or did problems still persist?
4 **A.** Lateral flow certainly speeded things up dramatically.
5 **Q.** Staying with testing, please, and can we have your
6 statement on screen, INQ000517219, paragraph 68, which
7 is on page 24. You explain:

8 "In October 2020, we carried out an informal survey
9 with our members about the various issues being reported
10 over the previous fortnight. 75 providers across Wales
11 responded, with 45.7% saying they had experienced
12 problems entering data on the Lighthouse lab system;
13 22.5% reporting a collection meaning the tests had gone
14 to waste; 28.2% were still waiting at least one further
15 result after seven days, while 16 had waited
16 6-7 days ..."

17 And perhaps I don't need to read the rest of it out
18 but we see a general picture that there were problems
19 with testing.

20 Now, point-of-care testing with quick results may
21 not be something that's immediately ready in the event
22 of a new disease. Are there any practical things that
23 you could help us with that may resolve these issues,
24 for example whether administrative tasks associated with
25 testing that caused a delay, or do you have any ideas on

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1 **A.** Yes.
2 **Q.** Mr Hancock said in his evidence to the Inquiry his big
3 recommendation now was that every care home needs to
4 have isolation facilities.

5 Is that something in fact in Wales that is realistic
6 and achievable?

7 **A.** I would suspect it wouldn't be achievable; I suspect it
8 would be very difficult without an immense amount of
9 investment, even if it was structurally possible because
10 some of these buildings are very old indeed.

11 **Q.** The Inquiry, again, has heard evidence about the use of
12 designated settings and step up and step down. Would
13 that be a solution for those care homes that are perhaps
14 too small to have designated isolation facilities?

15 **A.** Yes, potentially, potentially.

16 **Q.** At paragraph 82 you discuss further approaches that care
17 homes took themselves, and another example you give is
18 that:

19 "... many care homes stopped using agency workers,
20 and introduced new rotas to reduce the frequency in
21 which staff had to change over. In many cases, staff
22 moved into the care home itself to reduce the risk of
23 transmission between work and family."

24 Do you think these types of measures had a place in
25 centrally issued guidance or the public health body

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1 how issues like this could be avoided?

2 **A.** I think a lot of it was about the system. Sometimes
3 providers ended up having to put things in manually. So
4 I think it would be good to have that sort of database
5 kept up to date in the background so that it could be
6 rolled out again if necessary.

7 **Q.** And so looking at the databases and the processes, in
8 non-pandemic times to ensure that they're ready --

9 **A.** Yes.

10 **Q.** -- to -- (overspeaking) --

11 **A.** -- and fit for purpose, yes.

12 **Q.** Thank you. That document can come down.

13 I have two substantive topics before I ask about
14 your final reflections, please. The first of those is
15 infection prevention and control.

16 The Inquiry has heard evidence, and you've mentioned
17 in your statement at paragraph 81, that some providers
18 took innovative approaches to try to isolate residents.
19 You give an example of a care home dividing itself into
20 wings or sections to isolate people with symptoms or
21 those that had had positive tests. However, as you
22 acknowledge, this was not always possible, depending on
23 the size and layout of the building, and the Inquiry has
24 heard evidence about Wales, in particular, having
25 a number of smaller care homes.

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1 advice so, perhaps, as options that care homes could
2 consider?

3 **A.** Yes, definitely, it did feel as if providers were coming
4 up with best practice off their own bat, and we were
5 sharing it through our networks but there would be
6 people who wouldn't have access to that.

7 **Q.** And I understand there was a WhatsApp group
8 facilitated --

9 **A.** Yes.

10 **Q.** -- for example? Was there a way that these innovative
11 approaches were fed back into central government that
12 you were aware of?

13 **A.** We would have used the weekly meetings, with the Covid
14 strategy groups, and any other sort of *ad hoc* groups.
15 We were in almost constant contact with different
16 organisations, so we would have passed them on where
17 they were relevant.

18 **Q.** And so your view would be that it could perhaps provide
19 a list of things that a care home that was struggling --

20 **A.** Yes.

21 **Q.** -- as innovative examples of ways to help them?

22 **A.** Yes.

23 **Q.** If I could then move, please, to visiting.

24 At paragraph 51 of your statement you explain:

25 "We were involved in detailed discussions on the

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1 guidance to opening up care home visiting. This was
2 undertaken with the best of intentions, but often with
3 little recognition that our members were dealing with
4 visitors who may refuse to abide by infection prevention
5 and control measures and did not always react
6 predictably."

7 Now, of course, the lack of visiting was very
8 difficult for residents and their families but were your
9 members perhaps raising the other side of the coin,
10 which is the risks which come with visiting in
11 a pandemic scenario?

12 **A.** At the start, definitely. A lot of them actually closed
13 down deliberately because of the pressure to take people
14 from hospital when they weren't being tested, and so on.
15 And we did have some very early conversations. I think
16 it was back in February, one of our members had had
17 a visitor who came from the area in China where it
18 all started. He'd just come back and he refused to wash
19 his hands or wear a mask to visit the residents. So
20 that caused immediate concerns, obviously.

21 **Q.** And I think you made an important caveat there, which
22 was that this was at the start?

23 **A.** At the very start, yes.

24 **Q.** And so, for example, if there had been better PPE,
25 better testing, for example, that might not have been

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1 difficult sometimes, because you've got some families
2 who obviously desperately wanted to see the resident,
3 but you'd have other families who would say, "Don't let
4 anybody in, you know, I don't want it spreading to my
5 family."

6 So it's a very difficult thing to balance.

7 **Q.** One thing you mentioned was that because this went on
8 for so long it was a problem, so, in your view, was
9 there a point at which the blanket banning simply became
10 disproportionate?

11 **A.** I think so. I think there was a stage where providers
12 were saying, "We need to let people back in now", and
13 then, I suppose, that's when the risk assessment could
14 take place, when the pandemic was easing somewhat.

15 **Q.** And a similar point is made in your statement about
16 advice -- sorry, visits from medical professionals and
17 the difficulties that were caused. Again, this is on
18 both sides of the coin.

19 **A.** Mm.

20 **Q.** You say, for example, one care home worker in Wales told
21 the Inquiry that they often felt unsupported in their
22 attempts to keep people safe.

23 "One member contacted us saying, 'In this specific
24 home we have a client with COPD and Asthma and another
25 with Stage 2 Respiratory Failure and as such we've

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1 the view of providers?

2 **A.** No, I think if we'd had guidance as well, because it was
3 left very much to care homes to make their own
4 decisions, which of course put them in the middle
5 between health and the need for people to be able to see
6 their families, and so on.

7 **Q.** So where does the balance lie between keeping people
8 safe and facilitating those visits? Is it the
9 initiatives that were set up? So greater use of
10 essential caregiver status, outdoor visiting, and
11 ensuring that there is guidance, as you've discussed?

12 **A.** I think so, but I think also that the pandemic went on
13 for so long that those measures weren't enough of
14 themselves, because people were beginning to deteriorate
15 when they weren't able to access their families. So
16 they could only be short-term measures. But I think the
17 Welsh Government came up with a raft of some good
18 visiting policies, but also support for things like the
19 visiting pods were really helpful.

20 **Q.** And do you think that there is an importance to risk
21 assess each individual visit or each individual resident
22 regarding what they might need?

23 **A.** I think it would be really difficult to do it on an
24 individual basis because it's the footfall into the home
25 that is the problem, and, you know, it was very

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1 contacted the NHS Mental Health team and asked to
2 postpone the planned meetings or to do these via
3 Facetime and instead of an understanding approach my ...
4 Manager was told that it was going ahead and they were
5 coming to the home regardless in no uncertain terms.
6 This means that there will be 4 social workers/mental
7 health coordinators from different offices in Wales
8 coming into an environment which we consider high risk.
9 My staff feel they can manage the Coronavirus situation
10 and protect the high risk people we care for but
11 I cannot express now unhelpful this approach from the
12 local authority and NHS is."

13 Then, on the other side, the Inquiry has heard
14 evidence from Every Story Matters and an example of
15 a care home worker who told the Inquiry he would have
16 doctors completely refusing to come in or, if they did,
17 you would have to wait absolute hours for them to come
18 in and certify the deaths.

19 So a similar question: where does the balance lie?
20 Because, of course, both are attempts to keep people
21 safe.

22 **A.** Yes, I think the balance is that people who are visiting
23 for genuine health needs, clinical needs, should be able
24 to visit, and certainly should make the option --
25 I suppose that's the issue, is that in many cases care

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1 homes and residents weren't given the option. They were
2 just told the district nurse isn't coming or the GP
3 isn't coming.

4 And I think some of the issues expressed about the
5 number of local authority people coming in was probably
6 more where -- it was to do with a planning or assessment
7 of needs type thing, which is quite a sort of
8 bureaucratic thing rather than actually something that
9 would help someone with their actual health needs.

10 **Q.** Final question, please, on visiting medical
11 professionals. Particularly in regards to lack of
12 access to clinical support at the end of life, now of
13 course that would be distressing for staff, it may cause
14 residents to experience a lack of dignity, and of course
15 the impact on families that couldn't be there. In
16 respect of end-of-life care, do you have any thoughts on
17 how it could be ensured that these traumatic events
18 don't happen in the future?

19 **A.** I think it improved. I think probably the most
20 horrendous examples were from early on in Covid, and
21 it's about that lack of messaging.

22 We had -- I think I used an example of a care home
23 in North Wales where they couldn't get the GP to come
24 out, the staff were having to take observations that
25 they weren't trained, because there was no one else

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1 have assisted those working in the sector?

2 **A.** Possibly some level of palliative care training because
3 I know a lot of people who died were in residential
4 homes where you wouldn't expect someone necessarily to
5 die in the care home unless they were supported and had
6 that wrap around service. And I think the counselling
7 for care workers themselves probably came later than it
8 should have done.

9 **Q.** Just two final short reflections if I can, please. Do
10 you have any thoughts on the impact of staff movement
11 within the sector and any views on if that can be
12 addressed, and if so, how?

13 **A.** Do you mean around the sector or --

14 **Q.** Yes, so the Inquiry has heard evidence about the risk of
15 staff movement in terms of transmission.

16 **A.** Yeah.

17 **Q.** Is that something that practically could be dealt with,
18 or is that just the nature of the sector?

19 **A.** I think most -- one of the issues is the heavy reliance
20 on agency staff and I think most people cut down on
21 agency staff by using -- by staff volunteering to move
22 into the home by changing the way the rosters worked.
23 So there was that element of it but I'm -- I don't think
24 we are at all prepared for anything similar to happen in
25 the future when we've got such a reliance on the

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1 there to do it. The person was in horrendous pain, and
2 they had to --

3 **Q.** Sorry to interject. Would training, for example, in
4 those circumstances have been something that may have
5 helped?

6 **A.** I think, yes, it would help if we prepared social care
7 workers to step up further, and I suppose there are
8 elements of that happening. But I think, you know, it
9 was that nobody knew what was going on so nobody would
10 go in and offer help.

11 **Q.** So advanced planning?

12 **A.** Advanced planning, again.

13 **Q.** In terms of training, who would deliver training in
14 those scenarios? Or who should deliver training?

15 **A.** I think there are some good modules probably from health
16 that could quite easily be rolled out. I mean,
17 certainly, we're doing more and more with medicines,
18 administration and so on, for care workers and
19 domiciliary care workers so ...

20 **Q.** So Care Forum Wales itself delivers --

21 **A.** We don't deliver training, no, but we do work closely
22 with PHW and Social Care Wales who, sort of, sign off on
23 most of the training.

24 **Q.** Other than, for example, clinical support at the end of
25 life, what other areas of training do you think would

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1 overseas workforce and that's an issue in itself.

2 **Q.** So perhaps when we explored earlier about central
3 guidance and having options and ideas, might that be one
4 anyway to help?

5 **A.** Yes, yes.

6 **Q.** And just finally, please, beyond any matters we have
7 already covered, are there any specific recommendations
8 you would urge the Inquiry to consider in particular?

9 **A.** I don't think there are. I think we have probably
10 covered them all, thank you.

11 **MS PAISLEY:** I'm very grateful.

12 My Lady, I have no further questions. I believe
13 there are some Core Participant questions.

14 **LADY HALLETT:** There are, and I think Mr Stanton, who should
15 be directly across the hearing room.

Questions from MR STANTON

17 **MR STANTON:** Thank you, my Lady.

18 Good afternoon, Ms Minty.

19 **A.** Good afternoon.

20 **Q.** I ask questions on behalf of the Covid-19 Bereaved
21 Families for Justice Cymru. I have a question in
22 relation to paragraph 66 of your statement, which I'd be
23 grateful if it could be brought up on screen, please,
24 and that's at INQ000517219_0023.

25 Hopefully you see that on your screen, Ms Minty?

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1 A. Yes.

2 Q. Halfway through the paragraph, there is a sentence that

3 begins "The early focus of care home testing." Do you

4 have that?

5 A. Yes.

6 Q. And it continues:

7 "... was on larger homes with symptomatic residents

8 on the basis of 'evidence' that Covid spread more

9 readily in larger environments."

10 The use of inverted commas applied to the word

11 "evidence" would tend to suggest that you have doubts

12 about the focus on larger care homes and I wonder if

13 that is correct. Please could you explain them?

14 A. Yes. I think the view of most providers would be that

15 there was very little evidence of anything during Covid,

16 because advice and medical opinion changed constantly,

17 and we were aware of outbreaks in small homes, as well.

18 So I think -- I suppose there's a likelihood of it

19 spreading more in a contained situation just because it

20 was bigger, but then again, some of the bigger homes

21 would also have had more facilities to isolate people

22 and keep the residents safe, and smaller homes would

23 have found that more difficult. So I don't think we

24 ever believed that there was a strong enough basis to

25 deny that sort of same level of testing and so on in

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1 dealt with fairly shortly at paragraph 58 and you

2 indicate that:

3 "This does not appear to have been a particular

4 issue in Wales."

5 You may have heard the evidence given earlier today

6 by Heléna Herklots, and which indicated a slightly

7 different position. She obviously considered it to be

8 an issue, and it is a very big issue for my clients.

9 I wondered whether there's any explanation for the

10 statement you make to the effect that you didn't think

11 it was a big issue?

12 A. I think it's not something that was brought up

13 particularly by members on our WhatsApp group. I didn't

14 mean it to sound dismissive, because obviously it's

15 a massive situation when it does occur. The only one

16 I was aware of was a GP surgery in Bridgend. But it

17 wasn't flagged up by most of our other members and Welsh

18 Government fairly quickly set up a task and finish group

19 looking at them, which I was involved in, and I think it

20 was clear that we needed to do much better about that in

21 future. That's one way that we can definitely plan.

22 And I think one of the problems that we found was

23 that it should be a function of a doctor, primarily, to

24 discuss this with someone before it becomes necessary,

25 but a lot of the training hasn't been done, so it was --

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1 smaller homes. It felt as if we were sort of leaving

2 them to it.

3 Q. Thank you.

4 My next question relates to a Care Forum Wales

5 submission to the Health, Social Care & Sport Committee

6 on 7 May. This is at INQ000183754 but we don't need to

7 bring it up on screen.

8 Within that submission, it is stated on behalf of

9 Care Forum Wales that anecdotally, most outbreaks in

10 care homes can be traced back to asymptomatic residents

11 and staff.

12 And my question is, are you able to indicate when

13 Care Forum Wales was first aware of the risk of

14 asymptomatic transmission on such a significant level?

15 A. I can't honestly say how early it was. It was very much

16 anecdotal information, but it was something that people

17 on our WhatsApp group were saying that, you know, they

18 hadn't had any signs of anything. So how else was it

19 getting in if people weren't already carrying it when

20 they were asymptomatic?

21 Q. Thank you.

22 And final question, back to your statement, please.

23 If we could have up on screen, please, paragraph 58 of

24 your statement, which is at INQ000517219_0021.

25 Here you address the issue of DNACPRs. And it's

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1 so we were aware that -- in pockets, that people were

2 being asked to carry out the conversations, but we

3 weren't -- I wasn't aware of it being a blanket "You

4 need to get all your residents to sign these."

5 Certainly, as I said in my evidence, our members

6 would have been horrified by that.

7 MR STANTON: Yes. Well, thank you, Ms Minty.

8 Thank you, my Lady.

9 LADY HALLETT: Thank you, Mr Stanton.

10 Mr Straw, who will be the other side of the room

11 again, but slightly further down, towards the back.

12 Questions from MR STRAW KC

13 MR STRAW: Good afternoon.

14 A. Good afternoon.

15 Q. I represent John's Campaign, The Patients Association

16 and Care Rights UK.

17 In your witness statement, in paragraph 103, you say

18 the lack of protection given to people in care was

19 "symptomatic of prejudice, in particular towards older

20 people"?

21 Do you know where that prejudice towards older

22 people in care came from?

23 A. I think it's a societal thing. I think it's just the

24 way, as a society, we treat older people, as if they

25 don't seem to matter once they hit a certain age and

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1 they're not considered to add particular value.
 2 I think in Wales we're very lucky that we've got the
 3 Older People's Commissioner, and a very sort of firm
 4 rights base. But even then, I think it's easy to
 5 overlook the older generation. And my perception
 6 sometimes is that if you're in a care home, it's
 7 considered that that's what you need, and nothing more.
 8 And there's little investment in all the things that
 9 make it fulfilling.
 10 **Q.** Thank you. A different issue. In your statement and
 11 earlier on today as well you noted that there was
 12 guidance which wasn't appropriate to domiciliary care,
 13 to put it broadly.
 14 Can you explain what adverse consequences this had,
 15 so the inappropriate guidance, for people in domiciliary
 16 care?
 17 **A.** I think a lot of it was sort of practical, around the
 18 donning and doffing of uniform. If you're doing that in
 19 someone's house, you know, where do you go to do it? Or
 20 are you supposed to do it in the car when you get there?
 21 So it was confusion, which probably ate into the
 22 time that someone was actually supposed to be there
 23 giving support direct to the individual.
 24 But also, when PPE was needed to be worn out in the
 25 community, and when it wouldn't necessarily be required
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1 weren't equipped to deal with that sort of end-of-life
 2 situation.
 3 We know that some GPs refused to visit. It was
 4 difficult to access GP surgeries. There should probably
 5 have been attempts to set up direct lines to make it
 6 easier for people to get through. Generally speaking,
 7 I think there was support in a lot of areas, but in
 8 other areas it was things like the district nurses not
 9 being allowed to visit, so they couldn't help
 10 residential homes, where there's no nurse on duty, with
 11 things like insulin. So the routine medication that
 12 a care home isn't allowed to do, they were suddenly
 13 having to work out how to do it. So it comes back to
 14 that training thing that we were talking about earlier.
 15 **Q.** Yes. My next question was going to be, can you help
 16 what caused the difficulties? You've mentioned training
 17 there. Are there other factors that caused those
 18 difficulties?
 19 **A.** A lot of it's down to the regulations. There are
 20 certain things in a residential home that care workers
 21 can't do because there's not a nurse to supervise or to
 22 delegate duties. In a residential home, things like
 23 medications administration is delegated by a GP, so, of
 24 course, when the GP isn't visiting, that's an added
 25 complication.
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1 by other people, it just made the whole experience for
 2 the individual more unpleasant than it needed to be.
 3 **Q.** And that's on PPE. Were there other areas of guidance
 4 which was inappropriate, unclear, and that caused
 5 problems for people in care?
 6 **A.** I don't -- I think perhaps there wasn't a great deal of
 7 specific guidance for domiciliary care, generally.
 8 I think probably the worst issue was the lack of
 9 testing, and the general -- generally forgetting that
 10 when you're a domiciliary care worker you're in someone
 11 else's home, and it's therefore very difficult to
 12 enforce certain things that you would in a care home,
 13 and quite rightly so, because, you know, it's the
 14 individual's right to have the care provided the way
 15 they need it.
 16 **Q.** Thank you.
 17 At paragraphs 47 and 49 you explain that care homes
 18 had certain difficulties in accessing medical services
 19 and the necessary clinical support. Again, this is an
 20 issue you touched upon earlier.
 21 Firstly, what were the consequences for people
 22 needing care of this?
 23 **A.** Well, I think we've already touched on probably the
 24 worst elements, which was the lack of a sort of -- of
 25 professional palliative care in care homes, which
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1 **Q.** And just taking -- going back a little bit further, so
 2 that's what -- the immediate cause of the difficulties
 3 within the care homes, but do you know what was the
 4 cause of the difficulties of medical care coming into
 5 the care homes?
 6 **A.** I think there was -- it was perceived, rightly or
 7 wrongly, I think as a fear of actually catching it from
 8 the care home, possibly also a concern about spreading
 9 it. And it wasn't all bad, because, I mean, it did come
 10 up with some fairly good ways of doing virtual
 11 examinations where that was appropriate. But some of
 12 those were probably also where it wasn't appropriate,
 13 and where a physical presence would have been a better
 14 solution for the person.
 15 **MR STRAW:** Okay. Thank you very much.
 16 **LADY HALLETT:** Thank you, Mr Straw.
 17 Thank you very much indeed, Ms Minty. That
 18 completes all the questions that we have for you. Thank
 19 you very much for your help to the Inquiry and for being
 20 with us today.
 21 **THE WITNESS:** Thank you, my Lady.
 22 **LADY HALLETT:** I don't know if you're going back to Wales.
 23 Are you still living in Wales?
 24 **THE WITNESS:** Yes.
 25 **LADY HALLETT:** Safe journey back whenever you go back.
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1 **THE WITNESS:** Thank you.
 2 **LADY HALLETT:** Very well, that completes the evidence
 3 I shall hear today. I shall return at 10.00 tomorrow.
 4 **(4.22 pm)**
 5 **(The hearing adjourned until 10.00 am the following day)**
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