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

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

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?

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

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

Q. Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Well, homecare workers support people with complex needs

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.

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.

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

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

care fell in relation to the others?
A. Well, in many ways, lots of parts of the health and care system are affected by that, so acute hospitals are perhaps the most visible, and historically, they have had the most funding from the government. If you work within the NHS and you're in community health services, you can feel like a poor relation to the acute hospitals, and similarly, mental health services might feel like the poor relation to the physical health services and then you've got care homes that are visible in communities and home care is probably at the bottom of that hierarchy.
Q. And where do you say unpaid carers fall in relation to the domiciliary care sector?
A. Yes, well, they -- there are almost 6 million of them, and they are absolutely vital. Often their care, homecare teams will work in concert with them, and having some professional home care when it's available enables the unpaid carers who many times are doing hundreds of hours a week, unpaid, to cope and for their own health not to suffer unduly, but they were a very forgotten part of the whole set-up, as well.
Q. Thank you. Do you think that anything more could have been done during the pandemic to increase the visibility of the sector?

A. I think we all did what we could. We engaged heavily with the media, which is a way of exposing issues.
I think the pandemic did public raise awareness of home care, so we commissioned YouGov to do a survey for us in 2021 and asked the public if their decisions, their preferences for care had changed as a consequence of the pandemic. And many more -- 30% said that they were likely -- more than 30% said they were more likely to choose home care than care homes. But when we explored that further, it wasn't fear of infection; it was fear of being cut off from loved ones.
And we've heard many times from the very brave bereaved families here the impact of that, and that's what people feared.
Q. Thank you. Could I ask you this, please: in terms of pandemic plans, do you think there should be any legislative or regulatory changes to make oversight of pandemic plans mandatory in the sector?
A. Well, there definitely need to be better pandemic plans because it transpired that when the Covid pandemic started that nobody had, for example, thought through the logistics of how to get PPE to every registered provider. People in government didn't even know that there were lists. Some still appear not to. But the Care Quality Commission keeps a register of all the

regulated providers.
One thing it is important to note in home care that's different from the other parts of the care sector is that 20% of the workforce is unregulated. So they work as individual care workers with no oversight. There's no requirement for training. They just work one-on-one with people that choose to engage them.
Q. So just to clarify, are they care workers carrying out the same type of caring work, but they are, effectively, trading as sole traders, and they're not required to be registered; is that right?
A. Correct.
Q. And what does that mean, in terms of whether they can be identified?
A. Well, nobody knows who they are, and that therefore made it difficult in the pandemic to get PPE, to check who had been vaccinated, who had been -- who needed tests. It -- the devolved administrations have register of care workers. We don't in England, but with the exception of Scotland, that has recently decided to add unregulated personal assistants to their register -- I don't know if they've actually done it, they've decided to do it -- the unregulated personal assistants are off everybody's radar.
Q. Thank you.

Could I ask you about the movement of staff, please, between settings. You describe that in your statement as being complex, and that due to the nature of the work, care workers are required to deliver care within multiple homes, is that right, they will go between homes delivering care? How many homes, for example, would they have gone to pre-pandemic on an average day? And to what extent did that change during the pandemic?
A. The number of people visited does vary very substantially from place to place, and also whether the care is private pay or state funded. So when people are paying for their own care, quite often the visits are longer, so they may last for an hour or two hours. In the state-funded part of the market, the care calls are often shorter. Northern Ireland is one of the most extreme in having about 30% of calls of 15 minutes, and I don't know about you, but I would struggle to get out of bed and get ready in 15 minutes. That is a tall order.
So the ones that are doing shorter visits will obviously do more in the same amount of time. So they'll all be up at 6.00 in the morning, they'll start calls at 7.00, and probably work through until about 2 o'clock. Some of them will be doing, literally, you know, just one after another, ten calls on a round.

Others, it may only be two or three with gaps in between.

Q. And to what extent were staff moving between care settings? So for example, between hospitals and home care, if they were nurses, providing nursing care, or between care homes in the homecare sector?

A. In social care as a whole, there are at the last count, 33,000 nurses. Only about 3,000 currently in home care. So we have fewer nurses. So that problem probably wouldn't have been significant. The bigger issue is homecare workers working for other agencies and also care homes and also working cash-in-hand in the unregulated part of the market.

Q. So it's not possible to know to what extent those individuals were moving between settings?

A. No.

Q. Are you able to help us as to whether the movement between settings, so between home care and care homes, for example, whether that changed during the pandemic?

A. I think in general, providers tried to minimise movement. Certainly in home care, quite a number of our members organised their care workers in cohorts so they would have a group of care workers that only supported people with Covid, and others that only supported people without Covid. And the ones that supported those with

Covid had access to the best possible PPE that was available at the time. So ...

Q. Thank you. We know that there was a discussion during the pandemic about introducing legislation to ban movement of staff between settings. It's right, isn't it, that you expressed some concerns about that policy? Could you briefly set out what those concerns were, please?

A. In all of these decisions about the pandemic, we all had to consider balance of risk, and in our judgement, the risk of people going without care, which would have been a consequence of restricting movement, potentially, what we were worried about was care workers, if they were forced to choose between home care or care homes, might have opted for care homes, because the work is more stable, and then, if we had a shortage of people to support people at home, what would happen to them?

Q. The Inquiry heard evidence from Mr Hancock that he thought it was possible to restrict movement. Do you have any views on whether that would be feasible and practical as far as the homecare sector is concerned?

A. Well, home care by its nature involves visiting multiple households. So unless you had one care worker for every person that needed care, you wouldn't be able to maintain homecare services. So that isn't a practical

suggestion.

One of the points that I feel is very important to make is that the real critical factor is the extent of community transmission of Covid-19. The greater the transmission, the harder it is to protect people. And if you look at international data collected by Adelina Comas-Herrera, there's a straight line correlation between high community transmission and high deaths, both in the care homes and in the community. So the real key to this is minimising community transmission right from the beginning. Once you lose control, then all other measures that you can suggest are going to have a limited impact.

Q. In your view, is there any value or added value in restricting movement of staff between settings if you're not restricting the staff's contact with the community?

A. It's almost impossible to -- unless you lock people up. And that's just not a practical option, is it? People have to go home to their families. Their children were at school. Schools were like petri dishes.

Some people, as you've heard already, did move and live in care settings. In home care you can't easily do that, with the exception of live-in care, which is an established way of doing things. So, in that setting, the care worker lives 24/7 in the home of the person

that they are supporting. And that is very popular for people who have more advanced care needs and would rather not go into a care home.

Q. Thank you.

Can we move on to a different topic, please.

If I could ask for page 91, paragraph 381, please, to be put up on screen. You say here that:

"The government's engagement and consultation with the homecare sector during the pandemic was often inadequate, poorly timed, and demonstrated limited understanding of operational realities. While some improvement occurred as the crisis progressed, initial communication channels proved insufficient for the scale and urgency of the challenges faced."

Is that correct?

A. It is correct.

Q. You say in your statement that you were involved in at least 12 groups which considered a various number of different topics. The Inquiry heard evidence from Professor Vic Rayner about those groups to some extent acting in silos. Is that an experience that you share, or is there anything else that you would like to tell us about, in terms of how those groups worked and whether you found them helpful forums?

A. They were helpful. There is no question about that.

And we are grateful to the Department of Health and Social Care and the director -- director who became the director general later, Ros Roughton, for trying to involve us all.

We -- I mentioned the Care Provider Alliance, so this is a coalition of the ten care associations in England. Prior to the pandemic, we met about once a month, but when that lockdown first happened, we realised it was going to be bad, so we decided that we would meet every day. And we did that all the way through the pandemic, and are now meeting once a week. But there were just not enough of us to attend every -- all of us to attend every single meeting, so we split up responsibilities and then regrouped every day to share intelligence. And then we tried, where possible, to present a united front to influence. Between us, the Care Provider Alliance, we cover 95% of care providers in all settings.

Q. I think one of the forums that you and Professor Rayner both say was particularly helpful was the taskforce that was set up and led by, I think, Mr Pearson?

A. Mm.

Q. That taskforce had a number of subgroups; is that right?

A. Yeah.

Q. Looking at specific issues, and at the end of that

process reports were produced.

Were those were the recommendations in those reports implemented, so far as you are aware?

A. Certainly in the workforce subgroup that we were involved in, along with Vic Rayner. None of them -- none of the recommendations made were implemented.

Q. Are you able to help us as to why they weren't implemented? And what could be changed in future to ensure that that doesn't arise again?

A. I think it probably reveals a general problem with social care, that the way the whole sector is structured and governed allows people to pass the buck.

So ministers will say, "Oh, sorry, it's the statutory responsibility of local authorities to do X, Y or Z", so every time anything difficult comes up and we challenge ministers, local authorities get a letter telling them to do X, Y and Z.

If you talk to local authorities, they'll say, "We're really sorry, we haven't got enough money because central government doesn't give us enough."

That's also true.

So there isn't anybody taking proper accountability and it's very easy for people to be ignored in that kind of environment, because it's always somebody else's fault.

Q. You say in your statement that some of the key decisions were made without meaningful input from the homecare sector, and an example you give is in relation to the February and March PPE guidance.

Could you clarify, please, we looked at some correspondence with Professor Rayner where draft guidance was sent to her the day before for her comments. Were you copied into such correspondence? And so are you saying that you didn't have any meaningful input, or were you not included at all?

A. No, we were included and if you look at that chain of correspondence you can see that we did comment on the draft but the comments that we made were not incorporated. So there were some inconsistencies and some confusion that were still there when they published the final version. But quite often, the guidance, the draft, would come out at quite a late stage of production with a very tight timeline, and unfortunately, they're still doing this. So a couple of weeks ago we received a 160-page document of pandemic preparedness guidance and were given about five or six working days with no notice to go through it. And that kind of thing is very difficult because even if you have comments, they won't get incorporated because there's some deadline.

So what we want to see in future is much earlier engagement, and in -- with Public Health England later in the pandemic, a person appeared who was willing to engage with us one-to-one and really understood our sector, and things massively improved after that.

Q. Thank you.

On this topic I just want to ask two more questions. So firstly, you say that the government relied on the -- on ADASS, is that right, the --

A. ADASS, the Association of Directors of Adult Social Services.

Q. -- to disseminate communications and guidance throughout the pandemic. You say that they only really had the contact details of those providers that they had contracts with, but you also say in your statement that the majority of homecare providers were receiving commissions from local authorities.

So, first of all, do you know what the reach was, putting the personal assistants to one side, do you know what the reach was? And do you think that there's any better way of reaching out to a larger part of the sector in future?

A. So independent industry analysts' data show that about 80% of homecare services are purchased by either local authorities or the NHS, and about 21% are purchased

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

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

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

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

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

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.

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

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

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

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

A. So I think it would be useful to have some standing, high-level social care committee for the pandemic, because we need social care expertise at all levels, of operational, command, science and policy development. And guaranteeing equal access to PPE, testing, funding, you know, sick pay, vaccination. All of those things, home care was at the end of the queue, but the people that we were supporting had just as much risk, as I explained.
Q. Thank you.
A. Yeah.
MS JUNG: Thank you, Dr Townson.
My Lady, those are all my questions. I think there are some questions from the Core Participants.
LADY HALLETT: Thank you.
Ms Morris, I think you're going first.

Questions from MS MORRIS KC

MS MORRIS: Thank you, my Lady.
Good morning, Dr Townson. I ask questions on behalf of the Covid Bereaved Families for Justice, and thank you for your kind words a moment ago.
You also touched a moment ago on the issue of remote working, and I wanted to ask you some questions first of all on the topic of access to services.
You said in your statement that access to certain

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

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

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

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

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

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

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

Q. Thank you.

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

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

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

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

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

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

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

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

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

So we are very concerned.

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

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

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

A. Yes.

Q. Thank you.

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

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

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

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

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

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

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

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

Q. Thank you.

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

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

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

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

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

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

Q. Understood. Thank you.

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

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

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

and add the unregulated personal assistants to that register.

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

MS MORRIS: Thank you.

Those are my questions. Thank you, Dr Townson.

Thank you, my Lady.

LADY HALLETT: Thank you, Ms Morris.

And Mr Straw.

Questions from MR STRAW KC

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

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

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

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

which made that process easier? That would have been good to have had from the beginning.

Q. Thank you. At paragraph 144, you note that the majority of excess deaths at home were not directly ascribed to Covid but to other causes such as dementia. And elsewhere you explain in detail the severe impact that isolation had on those with dementia and others like them. Are there changes that should have been made to reduce isolation in the pandemic?

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

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

A. I think government guidance is obviously helpful,

because providers, especially the regulated providers, they have to demonstrate that they are meeting government guidelines and other regulatory requirements. So it does help a lot to have some ground rules. Everyone gets very nervous about making things up themselves because the Care Quality Commission or whoever might come along and say no. So I think that would be a good idea.

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

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

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

A. Yes.

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

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

Q. And final area, please, is data.

You note in your witness statement significant gaps

in data collection and monitoring of deaths at home, and you also explain that at the time of the pandemic, homecare providers were not required to report a death unless it may have been the result of regulated activity or how it was provided.

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

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

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

The other time when you have to report is if there is any possibility that the person died as a result of you carrying out the regulated activity. So an example

might be you accidentally drop someone out of a hoist or something like that. It's vanishingly rare that that kind of thing happens but that is the rule.

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

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

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

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

(11.38 am)

(A short break)

(11.55 am)

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

LADY HALLETT: Thank you, Ms Cecil.

SIR SAJID JAVID (affirmed)

Questions from COUNSEL TO THE INQUIRY

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

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

MS CECIL: Sir Sajid, thank you for attending and assisting the Inquiry today. As my Lady has noted, you've

provided evidence before now on a number of occasions, and that has touched upon some of the issues that we're dealing with today but what I do not want to do is go over old ground, effectively.

So if I can just take you briefly, therefore, through your professional background, and specifically your role in the adult social care sector.

On 26 June 2021 you were appointed as Secretary of State in the Department of Health and Social Care; is that right?

A. Yes.

Q. Immediately prior to that, you were a backbencher?

A. Yes.

Q. Following earlier appointments in government?

A. Yes.

Q. And the time period that we're dealing with or concerned with today is from the end of June of 2021 until the end of the following June, in 2022?

A. Yes.

Q. Similarly, we've discussed previously in your evidence the composition and structure of the Department of Health and Social Care, how it worked --

A. Yes.

Q. -- and the various interactions that took place, and you've helpfully set those out within your witness

statement for this module, so I'm not proposing to go over those.

A. Yes.

Q. But I want to deal, if I may, instead, with your overarching thoughts on the adult social care system.

In your statement, at paragraph 57, you describe that as being stretched financially and understaffed, and in need of significant reform on a national level to improve quality of care and increase in service need.

I just want to ask you, please, if you can just expand upon that a little bit in relation to that pandemic period and specifically the pressures that were faced by the sector at that time.

A. Yeah, thank you.

And if I may, my Lady, may just given by thanking you and the Inquiry team for the vital work you're doing, and I deeply respect the importance of this process and all that you're doing, and I'm grateful for this opportunity to contribute, and hopefully contribute to lessons learned. So thank you for that.

But turning to the first question, the -- in fact, when you referred to my experience a moment ago, I think what might also be relevant for social care, adult social care sector, is my time also as a local government secretary of state, in then what was called

the Department for Communities and Local Government, because you'll know, from perhaps other evidence, the role that that department also plays in the social care setting.

Q. Of course. We're going to turn to some of those aspects later --

A. Right. And so that's where my, sort of, direct experience, sort of more direct, I guess, as a government minister really began. And it was clear to me from then on that, even before the pandemic, the social care sector as a whole is -- was under an enormous amount of pressure, enormous amount of challenge, especially around issues around funding. Because unlike the NHS, the social care sector is -- the funding is in different sources, central, local government, private providers -- is much more fragmented. It's locally run by the relevant, sort of -- local councils oversee it rather than central government. And so all of that, whilst there can be good reasons for the, sort of, fragmentation and things and -- when the system was, sort of, first set up, so to speak, it -- what I saw was a system that was already, before the pandemic, under, you know, severe stress, especially around funding, and especially around workforce as well.

And then when I became Health Secretary, it was obviously in the, sort of, latter half of the pandemic, so to speak. There were obviously significant challenges, you've heard evidence on, in the first part, if I can call it that, of the pandemic. By the time I had become Secretary of State, I think some of the most immediate sort of challenges in the sector were in a better place because of the vaccines, for example, more PPE and better IPC and things, but there -- of course there were still challenges, particularly around -- you know, still issues around funding, around workforce and other challenges.

Q. Thank you. And we're going to move through some of those, but if I may pick up on one of the things that you've just mentioned --

A. Yes --

Q. -- and it's the fragmentation of the sector, and the fact that obviously you have different government departments, you have local authority and then you have the sector itself, which is comprised of public, non-profit and private sector organisations.

We've heard from your predecessor, Mr Hancock, that levers or the lack of policy levers was a specific issue of challenge within the pandemic --

A. Yeah --

Q. -- from his perspective. Obviously that was earlier in the pandemic.
A. Yeah.
Q. But is that something that you would agree with in terms of that central departmental governmental role?
A. Yeah, the general point, I would agree with. But what I would point out is that probably one of the key reasons there's a lack of sort of central levers for central government is because of the way the system is set up in terms of local government control, private providers, combination of funding, and all that. And if central government were to have more levers -- none of this is without trade-offs. There's always trade-offs, I've found, in government, in making any decision and often, I think they're not, sort of, fully appreciated there's, if you move in one direction, you might lose some valued aspects that you had before.

So for example, having local authorities in general, certainly outside the pandemic, overseeing social care, whether it's for working age adults or older people, meant that you -- it would be closer to the community, your local needs were met, in different parts of the country there would be different ways to provide care in different types of settings. There might be other sort of local issues that would -- that could be more easily

addressed.

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

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

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

And you've provided that white paper to the Inquiry --
A. Yeah.
Q. -- and the Inquiry has that.

If I can turn, then, to discuss another topic. It's that of hospital discharge. Of course, the pressures were not quite so acute at the point when you came into the position, but just touching on the discharge to assess model and delayed discharge. You've explained that the issues are complex and you suggest there needs to be some thinking about solutions in that respect, and one solution you posit is the role of what was then DLUHC, which has been now renamed --
A. Yes.
Q. -- and cross-local authority working via a central system. Can you just expand on that very briefly?
A. Yes, sorry, can you just ask that latter part of the question again?

Q. Of course. Really, it is how would that work in practice? So what I'm interested in is you suggest that one potential solution is effectively cross-local authority working --
A. Yes.
Q. -- via a centralised system in conjunction with what was then, and staying with the pandemic, offices, as they were, of the Department for Levelling Up Housing and Communities?
A. Just to make sure I understand it, are you talking particularly about the discharge to assess?
Q. I am, yes.
A. Okay. In fact, again, in my experience in that department, you know, the local government department, one thing I remember from that time, obviously pre-pandemic, it was even at that time, delayed discharge, the whole issue of delayed discharge, which was one of the reasons for discharge to assess, was a big issue then. The then Secretary of State for Health was Jeremy Hunt, I remember a number of meetings with him about what could my department or, more accurately, I guess, local government do to help with assessments of people that were medically able to leave hospital, but the, sort of, assessment of any further support or care had not been made.

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

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

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

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

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

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

A. You mean before the pandemic started?

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

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

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

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

A. Yeah.

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

A. Yes, that's right.

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

A. Yes.

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

A. Yes.

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

A. Yeah.

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

A. Yes.
Q. And subsequently, quite separately to that, a consultation was undertaken in relation to healthcare professionals in the NHS, and then potentially for further rollout across wider adult social care sector settings?
A. Yes.
Q. So we had two -- so, effectively, two different policies: one for adult social care staff within care homes --
A. Yes.
Q. -- and a separate situation where consultation was being undertaken?
But that policy was not in place for those individuals; is that right?
A. Yeah, the -- what's called VCOD, that was -- I mean, the policy began before I became Secretary of State, certainly with respect to social care workers in care homes, and so I believe I'm right in saying that the referrals for that had already gone to Parliament.
I was aware of the policy, of course, as a Member of Parliament, but was not a minister at that time. When I became the Secretary of State for Health, I inherited both the existing policy for, you know, VCOD for social care workers in care homes. And then, as you say, the

policy was eventually, under my leadership, you know, extended to include not just NHS workers but also care workers in all other settings, including domiciliary care settings.
Q. Indeed. And just dealing with that separation for a moment, or the -- in terms of the staff, you will no doubt be aware there was significant discontent over the fact that it was mandated for adult social care staff within care homes but not for those with -- for example, working with other vulnerable people within hospitals?
A. Yes.
Q. And certainly some individuals had the perception, at the very least, of a lack of parity as between the adult social care system and the NHS, with feelings of stigmatisation. To what extent do you consider it was acceptable to mandate it for one and not the other?
A. Well, it wasn't. It was mandated for both.
Q. Let me put it in different -- well, let me just take a step back and unwind that a little bit.
In relation to those individuals working in care homes it was mandated?
A. Mm.
Q. It was initially consulted on in relation to rolling it out to the further, wider, broader NHS staff, but that policy was effectively abandoned in 2022. So what we

had for a significant period was staff members in care homes subject to this policy --
A. Yeah.
Q. -- while other people working with similarly vulnerable people were not?
A. Yeah, yeah.
Q. That's where the discontent arose --
A. Yeah.
Q. -- or the perception of unfairness. That's why I'm asking to what extent do you consider that -- (overspeaking) --
A. Well, I don't think I entirely follow your chain of thought there, because -- or the reasoning, because, you know, that is -- what you have had just said is only, you know, true because it's after the events. That's with hindsight. Obviously at the time VCOD 1, if I call it -- if I separate, sort of, VCOD 1, being the initial policy that was brought in, versus VCOD 2, which was the policy I brought in, if you allow me to use that distinction, VCOD 1 was brought in, and soon after the government said its plans were to bring in VCOD 2.
So during -- certainly during all of 2021, the sort of view, I guess, of a social care worker in a care home would have been that: oh, I've been asked to -- this policy has been applied to me early, but it is likely

now to be applied to others.
The point you made about it was eventually withdrawn and it was only ever applied was because of Omicron and the facts changed. So I don't think it would have been possible for someone in 2021 to know that it would have been withdrawn later.
Q. But if I can take you back a step, for those individuals working in care homes, they were mandated?
A. Yes.
Q. And a number effectively lost their jobs as a consequence?
A. Well, they chose to leave.
Q. I suspect they would not call that, necessarily, a choice. But taking that to one step back, if I may, those individuals were subject to that policy --
A. Yes.
Q. -- when others in the NHS were not. That's what I'm asking you about.
A. Yes.
Q. So there was this discrepancy or disparity in terms of what they were required to do to undertake their roles. I've explained about the perception. I'm asking you to deal with that aspect, and perhaps if I can put it in this way: do you consider that that failure to initially apply VCOD 1, as you've termed it --

A. Yes.
Q. -- across the board to include the NHS workforce or other health and care settings would have damaged its credibility as a policy because you would have had the same types of people delivering the same types of care to vulnerable people?
A. No, I don't think I do. Mainly because -- I wasn't there for the decision making around VCOD 1. So I don't know, for example, what practical considerations there might have been at the time for having the, sort of, let's say, if you call it VCOD 1 and 2 at the same time, right, just having one approach for all workers in NHS and all social care settings. So I just don't know what were the issues that were considered at the time. There could be some very good practical reasons, so I don't want to second-guess that. I don't think it was an issue of unfairness. And also --
Q. It's really a question of external perception, Sir Sajid.
A. There may have been in some quarters, but if the -- and obviously people will perceive what they choose to perceive, but government, it will make, at any point in time it makes a decision, often there's no perfection here, so if it was more -- if the government had decided VCOD is a good policy, which it clearly had, to protect

vulnerable people, being the objective, then there could still be good practical reasons to have a, sort of, VCOD 1 and VCOD 2.
Q. I'm just going to pick up, if I may, upon broader concerns within the adult social care sector.
A. Yeah.
Q. Certainly there was -- there were consultations that were rolled out. I just want to deal with, we've heard this morning from Jane Townson. In her witness statement she highlighted that, in terms of their submissions, they said that 18% would be ineligible for deployment were it to be implemented across the broader sector. Using those statistics, they estimated around 75,000 to 100,000 care workers would be affected. And this is at a point, of course, as I say, nearing Omicron, where the sector is nonetheless under significant pressure; is that right?
A. I don't know. I don't know when, from that, what period you're exactly referring to, because Omicron really is from, sort of, mid-November onwards so --
Q. The letter from Jane Townson, if it assists, is on 23 January 2022.
A. Yeah.
Q. Would you agree there were significant workforce pressures during that period, that winter period of 2021

to 2022?
A. Yes.
Q. And they were acute?
A. Yes.
Q. And so in terms of the VCOD policy, that had the potential to quite significantly exacerbate those pressures, would you agree with that?
A. It would have contributed to workforce pressures, yes.
Q. And indeed, in your personal minute that you made to the Prime Minister all the way back on 28 October, 2021, you record that in terms of the stakeholder consultation, 63% of responses were against the VCOD policy being rolled out further, and 26% were supportive. That overall, all agreed that it was important to maximise vaccination but that they did not agree with the mandatory mechanism that was being proposed.
A. Yes.
Q. At that point, nonetheless, the decision was taken to implement it, but as you've already explained, owing to the evidence that you heard about transmissibility of Omicron --
A. Yes.
Q. -- and developing understanding and knowledge --
A. Yes.
Q. -- ultimately it was not pursued?

A. And also the less severity of Omicron, not just transmissibility.
Q. Indeed, transmissibility and severity and vaccination success, in short?
A. Yes. That's right.
Q. It did not evade immunity, vaccine-induced immunity to the extent that it was perhaps thought that it might in the initial instance?
A. Say that bit again, please.
Q. Omicron. Vaccines were effectively far more successful against Omicron than was necessarily thought to be the case in the initial instance?
A. Yes. And sorry, just to make sure it's clear there, also because Omicron was so highly infectious so, for example, something like in the last -- in the first eight weeks of Omicron, that accounted for something like a third of all Covid infections during the entire pandemic, that -- and by -- within a matter of two months, we'd switched from 99% of infections being Delta variant to 99% of infections being Omicron, and also people that had been infected by Omicron would have built up some natural immunity, which clearly wasn't the case when VCOD was introduced.
So all those factors were taken into account.
Q. Indeed. My question, then, is if the scientific

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

A. Yes.

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

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

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

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

Q. Yes.

A. Yeah.

Q. Yes, it had.

A. Yeah.

Q. For VCOD 1.

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

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

A. Yes.

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

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

on VCOD 2, because the deadline had not passed.

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

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

A. Okay.

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

A. Yes.

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

A. Yes.

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

A. Yes.

Q. Another reported that:

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

So there are similar themes that are emerging --

A. Yes.

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

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

A. Yes.

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

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

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

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

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

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

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

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

catching the infection, but also spreading the infection.

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

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

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

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

still the right balance to be found.

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

And there were some people, and you mentioned people from ethnic minority communities, for example, having, in general, a lower uptake of the vaccine than other members of the population, and that was a fact. I mean, that was the case. And there's -- a huge amount of work was done in terms of education, reach-out and stuff. There was a fund to support social care, sort of employers and local councils, to try to get more information and detail out. But ultimately, if people after not convinced the vaccine is safe -- I mean, I believe in bodily autonomy as well. I think most people would. No one should be forced to take anything. But if they choose to work in a setting that is looking

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

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

Q. Thank you.

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

A. Yes.

Q. If I can just call up INQ000346672.

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

A. Yes.

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

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

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

A. Yes.

Q. And what she says is:

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

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

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

If I could call up INQ000067759, again page 2, paragraph 7.

And that identified, approximately halfway down the page, that they carried out a number of red team exercises, and they identified that testing in domiciliary care was an area for attention, and following discussions at the adult social care subgroup of SAGE on 17 December, they were urgently considering the merits of aligning the testing regime for domiciliary care staff with that of care home staff, and then also looking at testing capacity.

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

A. I don't know.

Q. You don't know. Thank you.

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

A. Yes, I think that's correct.

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

A. Yes.

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

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

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

A. Yes.

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

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

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

That's the first reason given.

Secondly:

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

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

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

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

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

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

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

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

A. I think based on --

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

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

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

A. Yes.

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

risk, or leaving those with dementia, learning disabilities or poor mental health isolated or alone for longer periods of time. A number of issues were to be escalated to the government about the fact they were short-term fixes, they weren't translating to the ground, you had a tired and stressful workforce, bringing home the reality of riding out Omicron, and it was having a serious impact on their health.

Were those concerns escalated to you?

A. I don't particularly remember the ADASS survey, but I think those types of issues and about prioritising care, for example, about what, you know, local authorities might think is sort of unacceptable decisions from their point of view to take, those kind of concerns were often articulated to me but also, obviously, the Social Care Minister who I should mention -- obviously you know this, but for the record, I was the Secretary of State overseeing the entire Department. There was a dedicated Social Care Minister throughout my time --

Q. Indeed.

A. -- and she --

Q. We have a statement from her -- (overspeaking) --

A. Yeah, and she would be dealing with, naturally, a lot more issues pertaining to social care than I would be

dealing with directly.

Q. I now want to move, if I may, to the end period that we're concerned with and the strategy for living with Covid.

A. Yes.

Q. So we're talking about, effectively, March of 2022 onwards, and there was some to-and-froing between your department and Treasury in terms of what was going to remain in place and what provisions were not, in relation to adult social care and the like.

A. Yes.

Q. More broadly, free asymptomatic testing for the public was brought to an end albeit, importantly, symptom-free testing remained for social care staff. In making those decisions, the impact assessment set out that those with protected characteristics or over-represented would face higher clinical risks and would be the most significantly impacted by the policy. Can I ask you about this: the position of unpaid carers, were unpaid carers considered when the decisions were taken to cease the provision of asymptomatic testing?

A. Yes. I mean, so first, unpaid carers -- over 5 million unpaid carers who, I think, as I alluded to earlier, I was -- had ministerial responsibilities broadly for the sector even before the Health Secretary. I've known

for a long time, have done a -- do a super important, hugely, you know, vital job, mostly they'll be looking after their loved ones. And were they considered? Yes, in general, in decision making, absolutely. I think in -- specifically I think you're referring to a set of decisions in the living with Covid, and testing, and what was available. I would, at the time I recall -- I would have liked to see more tests, free tests, being made available for unpaid carers including asymptomatic testing, of course. And it's something I had requested and wanted funding for, but I was unable to secure.

Q. But it was refused.

Can I just now turn to a topic that runs throughout this period and that's in relation to efforts to restrict staff movement.

A. Yes.

Q. We've heard evidence in relation to that being an important infection prevention and control measure?

A. Yes.

Q. But that it was challenging and that it came clear that mandating such a policy would not work owing to concerns about the insufficient numbers within the workforce, and the practical issue of loss of income --

A. Yes.

Q. -- for those workers, in a precarious sector with

insufficient staff and fragility. There's further been evidence that those funds that were designed to enable staff members to isolate without losing pay or restrict movement did not always reach those recipients. Do you agree, or do you have a view on, effectively, recommendations in regard to the future and future learning that these are areas that pandemic planning must explicitly address?

A. Yeah, I think this is an area of future learning. I think -- I completely understand, from the -- in terms of protecting vulnerable people, the need to look at staff movement, but I think it's fair to say, especially at the start of the pandemic, that because these kinds of issues had not been sort of thought about in advance of the pandemic, there was no sort of pre-planning, so to speak, I think there will be lessons to learn from that.

Q. And were mandatory restrictions to be considered, do you agree that they should not be introduced until effective mechanisms for full sick pay, for example, for self-isolation, or financial compensation for staff who are unable to work between locations -- (overspeaking) --

A. I think those things should be considered. I just hesitate to say they must not be introduced before,

because it's just that I -- we don't -- (overspeaking) -- of a future crisis, I think they should be considered.

Q. Indeed. Now, throughout this period there was, and still is, a widely-held belief that the NHS was prioritised over adult social care with adult social care being the Cinderella service. What are your views on that from your time in post? Just briefly, if you --

A. I think that was absolutely not the case. I mean, obviously I can't speak for activity before I was Secretary of State, but certainly in my time as Secretary of State, the -- in terms of adult social care there's all the things that we talked about that were specific to the pandemic, and that was my most immediate focus, naturally. But I also published the, as referred to earlier, the adult social care reform white paper, it was a very detailed set of reforms for the future thinking in much detail about the sector, how to improve it, particularly around issues around workforce and payment and long-term funding.

I also published the adult social care integration white paper, I think early in 2022. I made amendments to the Health and Social Care Act that were -- many around adult social care because they were amendments, they were not originally envisaged when that Act was

introduced to Parliament, and also there were other things that I did that, for me, I was thinking a lot about adult social care and improving it even though there were maybe -- there were health components as well.

Q. Thank you.

A. So the work that I did on the 10-year dementia plan, for example, because I felt that if we could deal with dementia better, then we would -- it would help older residents, whether in care homes or domiciliary care, because we have a better approach so it was a sector I spent a lot of time thinking about and doing something about.

Q. Thank you.

Can I now ask you about domiciliary care. You've mentioned it there and there are only, really, passing references in your statement to it.

Is that indicative of a lack of consideration in relation to domiciliary care, compared to both the NHS and --

A. No.

Q. -- care homes with the understandable focus as it was in the immediate --

A. No.

Q. -- start of the pandemic?

A. It's not.

Q. If I can then turn to more general considerations with regard to the sector.

A. Yes.

Q. It's been posited that a register of adult social care workers in England would assist in a pandemic, both those working in care homes, domiciliary care, and also, on the converse, those individuals who live in care homes and receive domiciliary care.

Do you consider that that would be a useful tool to have?

A. In general, yes, I do. I do. Because I -- actually I think I might be right in saying that the England is the only part of the UK nations that don't have one, but I think that, in terms of professionalism, more confidence in the system, I think it sounds like a sensible thing to look at.

Q. Finally, if I may, just turning to your recommendations, you've very helpfully set out your lessons learned and recommendations at the end of your witness statement.

A. Yes.

Q. You explain that you consider the adult social care model to be broken?

A. Yes.

Q. And you explain that, in your mind, this -- part of the

solution is assisting more people to look after their own relatives where possible?

A. Yeah.

Q. What do you mean by assisting people to look after their relatives and how would it work in practice?

A. I think this is again, if I may just draw the attention back to the adult social care reform white paper, and some of the comments and speeches I made around that at the time, is that, notwithstanding the huge amount of work done by unpaid carers already in recognising all that they do, I think that, you know, more should be -- we should -- that the state should be looking at more ways to try to support that.

And I wasn't -- at the time I suggested that in their adult -- in the reform white paper, I wasn't entirely sure what those mechanisms are. I think there are other countries we can learn from. I think I'm right in saying that I allocated something like £25 million of funding to help try to support that and suggested there should be workshops and other discussions with representative groups to look at what can be done.

So I -- it was something that I think is long overdue in terms of focus, but I had not got round, in my tenure in that seat, to look at more specific

examples.
LADY HALLETT: Sorry to interrupt, I think we'll have to leave that there, Ms Cecil, please. Thank you.
MS CECIL: Indeed.
Those are all the questions I have, my Lady.
Sir Sajid, if you remain there, there will be some more for you.
THE WITNESS: Thank you.
LADY HALLETT: Ms Morris.

Questions from MS MORRIS KC

MS MORRIS: Thank you, my Lady.
Sir Sajid, I ask questions on behalf of the Covid Bereaved Families for Justice UK, and just one topic for further exploration, please, and that's regarding hospital discharge. You said to Ms Cecil this morning, in respect of delayed discharge, that it was a significant issue for the DHSC both before and during the pandemic.
A. Yes.
Q. In your statement you mention a number of initiatives around that, a discharge task force, a red team meeting, winter planning meeting in October 2021, a deep dive after that, and then a step-down plan that you've also touched upon.
A. Yes.

occasions, with some of the leaders of the sector, different -- various organisations that represent different aspects of adult social care.
Q. Around this topic specifically, can I ask?
A. I would have had discussions around this topic specifically, yes, as well. I think my -- generally when I'd have a meeting with a representative of the a sector, they'd cover more than one topic, so it wouldn't just be on this topic, I doubt. Whether it would -- I think this topic would definitely have come up because it was such an important part of the work that they were looking at.
Q. That's why I pose the question, because I want to ask you whether you consider it was sufficient engagement with the sector itself, particularly having regard to the grave concerns that had been raised around the discharge policy from March 2020, so before your time, but looking at the engagement you had, do you think it addressed some of the persons that had previous -- (overspeaking) --
A. I think -- I mean, my feeling is, is that -- if you're talking about my engagement, I think it was sufficient, keeping in mind that my responsibilities were -- included adult social care and this -- this issue, of course, and it was a very important issue, but there

Q. You also said that the NHSE were working with local authorities and integrated care boards.
A. Yes.
Q. And this morning you were keen to highlight the work that the NHS was doing with the local authorities, but you haven't mentioned, either this morning or in your statement, what arrangements were in place to engage with the adult social care sector itself, whether that's in the care homes or the carers.
So I wanted to ask you, what was that engagement when you were Secretary of State, with the actual sector itself? So beneath the local authority level.
A. Yeah, thank you.
And so, as you highlight, delayed discharge has been an ongoing issue or challenge, obviously made much worse and acute during the pandemic. The -- in terms of my -- if you're talking about my personal engagement with the sector, it was at various levels. It was -- so at one level it was actually visiting care homes, providers of domiciliary care, meeting local authority leaders and others working in the sector to sort of hear from them direct, to see for myself some of the issues, things that were working, things that were not working well. It was still -- I think I must have met with, on -- on probably more than one occasion, but a number of

were a very wide range of responsibilities. I was also trying to deal with the emergency of Omicron as well, in particular, for a significant part of my period. But also, as I alluded to earlier, one way to make sure that there's a government -- that there's enough -- there's, you know, more engagement than just the Secretary of State, is why specifically there is a Social Care Minister that would be the person, as it was in this case, that would be having a lot, lot more engagement than I would. As well as other ministers in government generally but especially a Social Care Minister.
Q. Thank you very much, those are my questions.
A. And officials, of course, who I have engaged with.
MS MORRIS: Thank you.
LADY HALLETT: Thank you, Ms Morris.
Ms Weston.

Questions from MS WESTON KC

MS WESTON: Thank you, my Lady.
I'm asking questions on behalf of the Frontline [Migrant] Healthcare Workers Group. Our questions concern the impact of the pandemic on migrant care workers.
A. Yes.
Q. In your statement for this module, with reference to the impact on those with protected characteristics or

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

A. Yeah.

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

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

A. Yes.

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

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

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

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

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

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

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

A. Yes.

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

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

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

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

A. To producing?

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

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

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

Q. Thank you.

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

A. I don't remember exactly.

Q. Thank you.

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

A. Yeah.

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

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

Q. So Dr Townson in her witness statement on behalf of the Homecare Association explained the connection between

those immigration policies and insecurities in this way in paragraph 303 of her statement. She said:

"The prevalence of insecure zero-hours contracts and limited sick pay" --

LADY HALLETT: Sorry, Ms Weston. I can't see where I've given permission for this question or this reference.

MS WESTON: Sorry, yes, it's right. It's just the lead-in to question 7 for which we --

LADY HALLETT: I'm sorry, you've got to be really careful, I'm sorry, to stick to what you're allowed, and I'm not going into overall policies like zero-hours contracts. There's a limit to what I can do in this Inquiry, so could you please stick to your question 7, please.

MS WESTON: Point taken, my Lady.

LADY HALLETT: Thank you.

MS WESTON: Do you agree that the cohort of care workers to which -- which I just described, the three cohort of care workers, were simply ignored by the government with wholly foreseeable adverse consequences for transmission?

A. No.

MS WESTON: My Lady, those are my questions.

LADY HALLETT: Thank you, Ms Weston.

Next it's Ms Beattie, who I think is going to be across the room, if she's sitting where she usually

does, Sir Sajid.

THE WITNESS: Okay, yeah.

Questions from MS BEATTIE

MS BEATTIE: Thank you. I ask questions on behalf of Disabled People's Organisations.

A. Yes.

Q. You've told us that you continued with the discharge to assess policy which had been put in place before you came in, and you saw it as a more person-centred approach, in your evidence. During your time as Health Secretary, I think there were two reports which raised specific concerns about discharge to assess. In October 2021, the CQC State of Healthcare and Adult Social Care in England report noted concerning evidence that support needs were not being met of people following their discharge; and in December 2021, the Department of Health, your department, published a review by the Social Care Institute for Excellence, which had been commissioned by the department, which again reported that there were unmet needs and concerns about follow-up, particularly for people with complex social care needs?

Did you take those reports into consideration in looking at discharge to assess when you were Health Secretary?

A. Yeah, was that second report the Pearson review?

Q. No, it's by the Social Care Institute for Excellence commissioned by the Department.

A. Okay. Yes, but I would caveat it just by the -- as you alluded to, the policy was already in place when I became Secretary of State. And these reports came, although they may have been commissioned before I became Secretary of State, they weren't available until, as you've said, I think October, then September.

Q. Well, I think the -- yes, so the CQC annual report came out in October '21.

A. Yes.

Q. And the Social Care Institute for Excellence report I think had been first exhibited in draft to the Department back in March '21 --

A. Yes.

Q. -- with a final report in April, but then it was finally published by the Department in December.

A. Yes.

Q. So they're being published during your time as Health Secretary.

A. Yes, that's right and they -- and what typically would -- those reports, even before they're published, it might be that the officials had some interaction with the people working on the reports and things, just to

sort of, if there's anything acute especially that needs immediate attention, and it would have been brought to my attention, sort of, at the time and indirectly, rather than me waiting for the report and, actually, it landing on my desk and going through it. So it would, if your question is would the findings of these reports have been taken into account --

Q. Not "would" they --

A. -- they would have.

Q. -- Sir Javid, "did" they? Did you take them into account -- (overspeaking) --

A. Yes, but my only caveat is that it wouldn't have been I would have actually received the report on my desk and I would have read every word in the actual report, it would have gone through my officials and they would have picked out the most important bits and this would have been an important area.

As I remember, I think, for example, the CQC report which obviously is -- the first one you mentioned, a very important report -- I think they generally supported the discharge to assess policy as the right policy in general, but what they picked up on and you've touched on, is there are certain aspects of it that could be improved.

Q. Are you aware of any auditing of discharge to assess

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

Questions from MR STRAW KC

MR STRAW: I'm just waiting for the microphone to come on. Thank you.

Sir Sajid, I represent John's Campaign, Patients Association and Care Rights UK. So there's just one area. You recognise at paragraph 42 of your statement that the people the adult social care sector exists to serve should be at the core of all decision making, but many of those who represent people drawing on care consider that their views were not adequately listened to by the government. Do you accept that more should have been done by government to ensure the views of these people were taken into account in decision making?
A. Look, I am very much in favour of those that are affected by government policy, that their views are taken into account in whatever -- and there are a number of ways to try and do that, whether it's consultations, direct meetings, obviously numerous ways to do that, and I've always been in favour throughout my time in

government. Your question was, could -- was more specific, I think, was could more have been done?

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

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

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

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

could input in a structured way, and then themes could be identified, and then the ministers are -- have some kind of responsibility to maybe, on a regular period, annually or something, to respond to that.
MR STRAW: Thank you very much.
LADY HALLETT: Thank you, Mr Straw.

Finally -- oh no, not finally. Mr Boyle. I'm not sure where Mr Boyle is sitting, Sir Sajid.
THE WITNESS: I can see him. Thank you.

Questions from MR BOYLE KC

MR BOYLE: Thank you, my Lady.

Good afternoon, Mr Sajid, I ask questions on behalf of the Royal College of Nursing.
A. Yeah.
Q. In your witness statement you helpfully describe how you met with the Chief Medical Officer roughly three or four times per week.
A. Yeah.
Q. Whereas you met with the Chief Nursing Officer two or three times in total, by which we understand across the piece that we are looking at --
A. Yes.
Q. -- of your reign, June 2021 to June 2022.
A. Yeah.
Q. Given the importance of nursing staff to healthcare

response, do you feel it would have been helpful to meet the Chief Nursing Officer more often to discuss critical safety issues?

A. I think in one respect it might have been more helpful, but as I-- the previous question, I talked about the trade-off in my time. I think something else would have to give. So someone else I would be meeting a lot less, and maybe -- so I had to -- you -- think about my time a holistic way. And that's -- and so because of that, and knowing that the views and the work done by the Chief Nursing Officer is so important, the way I tried to deal with it is -- as well as my own meetings, is to make sure that the views, the concerns, of the Chief Nursing Officer are taken into account, not just through meeting me -- because often sometimes that could be too late, you know, because it could be something is in the diary but it's two or three weeks away, because that's just the way the diary is, and so there had to be -- and there was -- direct contact between the officer and her office and my office and other parts of the department. And also other ministers would meet with the Chief Nursing Officer, not just the Social Care Minister but maybe other ministers. And I think taken together, the interaction with my department, officials, with junior ministers and with myself, I think that was the right

balance.

MR BOYLE: Thank you very much.

LADY HALLETT: Thank you, Mr Boyle.

Now, finally, Ms Peacock.

Questions from MS PEACOCK

MS PEACOCK: Good afternoon. I appear on behalf of the Trades Union Congress. My question pertains to vaccine confidence in social care workers.

The Inquiry has received some individual accounts from social care workers which recall receiving little information or support regard vaccination against Covid-19. And similarly, in a recent survey of over 1,600 social care workers, 58% of respondents said that they did not feel they were given enough information and support by their employers regarding the vaccines.

Do you agree that some information -- some work can be done, rather, in advance of any future pandemic to improve lines of communication with the workforce and to ensure that all workers can, if necessary, be provided with the information and support required to build vaccine confidence?

A. Yes.

Q. You've mentioned, I think, in your evidence before that one feature of the social care workforce that was a challenge in comparison to the NHS is that it wasn't

a centralised body. Do you consider that that was a feature in the difficulties of the information you've described today reaching care workers, there wasn't a centralised oversight body?

A. I'm not sure. Because -- and I say that because the NHS, for example, is a centralised body, and I know that some of the concerns you articulated on behalf of social care workers have also come from the health sector, so I'm not sure if that was an important factor. But I think it's worth looking at.

Q. If I may just clarify, I think you said in Module 4 that it was easier to address hesitancy because of that structure in the NHS being an -- a centralised state body, you said. So is it fair to say that a mechanism that can give some centralised deployment of information and support to care workers in relation to vaccines or therapeutics, as it may be in a future pandemic -- (overspeaking) --

A. I think if you're referring to, you know, maybe a more sort of central-led way to distribute information and make sure that it reaches the right people for them to consider it and stuff, I think that is -- that is worth considering in terms of disseminating information. I think it's worth considering.

MS PEACOCK: Thank you, my Lady.

LADY HALLETT: Thank you very much, Ms Peacock.

Sir Sajid, that completes the questions we have for you, I think I can say for the Inquiry ...

THE WITNESS: Oh really? What if I want to come back?

LADY HALLETT: No, you can't come back unless I call you.

THE WITNESS: Right, thank you very much.

LADY HALLETT: So thank you very much for your help.

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

LADY HALLETT: Right, I shall return at 2.05 pm.

(1.08 pm)

(The Short Adjournment)

(2.05 pm)

MS SHOTUNDE: Good afternoon, my Lady.

LADY HALLETT: Good afternoon.

MS SHOTUNDE: May I please call Heléna Herklots.

MS HELÉNA HERKLOTS (affirmed)

Questions from COUNSEL TO THE INQUIRY

LADY HALLETT: Welcome back.

MS SHOTUNDE: Thank you, Ms Herklots, for coming back to give evidence at the Covid Inquiry.

You were the former Older People's Commissioner for Wales, appointed on 20 August 2018, and your term of office ended on 19 August 2024; is that correct?

A. That's correct.

Q. The role of the Older People's Commissioner for Wales is

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.

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.

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.

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

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

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,

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.

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

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

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

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

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

exist from the start?
A. I think in a future pandemic there needs to be, at the outset, greater clarity about who is responsible for making those decisions, and clear accountability for that.
I found it incredibly frustrating in the early stages, having conversations where, you know, somebody might be sympathetic but saying, "It's not my area of responsibility or accountability to make that decision."
So there needs to be much clear clarity about, particularly, where the role of Public Health Wales is and where the role of local teams are as well.
And that should have a much greater focus on the rights of older people and the importance of weighing up the risk of Covid infection against, and giving due weight to, the risk of being isolated from their families and isolated from their loved ones.
Q. And you had mentioned in Module 2B that issue with not knowing who the decision maker was in respect of care home visiting. How did this issue affect care homes visiting in practice?
A. It took longer to work through who could make the decisions to get visiting happening, and it meant that there was a lack of clarity about that.
I -- it took some time for me to find the right

people, actually, and then to liaise with the key person in Public Health Wales who had the responsibility for that. And then it took some time to get across the importance of visiting, because they hadn't really -- I don't think they'd factored that into their decision making.
And I think it may -- things took longer. Sometimes one was starting from the perspective of having to sort of almost educate people about what care homes are and how care homes -- how people live in care homes, and they're not medical institutions.
So all of that took time and people's energy, and I think, you know, it was a frustration at the time.
That said, once we'd got through that phase, people worked hard together to try to make those -- you know, make the right things happen. And then it was more of an issue, I think, of particular local areas taking different views. So I remember, for example, around outdoor visiting, where, in two local authorities, they'd kind of moved back from that and I wasn't clear at all the rationale for that. So I then had to go to Public Health Wales to kind of raise that issue directly with them again.
Q. And just speaking on that, I have seen a letter from you to the Welsh Government dated 21 September 2020.

If I could pull that up on screen, it's INQ000184951, page 1.
So this is a letter that you sent to Public Health Wales, and it was in respect of the suspension of outdoor visits, which is what you mentioned before.
And as you said, you weren't happy with that and you asked a number of questions, which you can see in the bullet points. The first one being:
"• What evidence is there of transmission from outdoor visits by family and friends?"
"• What level of risk is there from outdoor visits, assuming these are carried out more than two metres apart and with visitors wearing masks?
"• In taking decisions to suspended outdoor visiting was the impact of not receiving visits on older people's healthcare professional also considered?
"• How is the decision on suspension of visits being kept under review and what evidence is [being] used to inform that review?"
Presumably you were asking those questions because essentially there was just blanket suspensions without there being, in your mind, any sort of evidence as to why that was necessary.
A. I was asking the questions because I couldn't -- I didn't see any evidence, and it seemed a completely

disproportionate response at a time when, you know, just getting to outdoor visiting had taken a huge amount of steps to get there, and the idea that that could then be suspended so quickly just felt entirely wrong, and it comes up back to, you know, in a sense to a bit of a recurring theme, really, which was how are these decisions being made? What is the evidence? How are they going to be monitored? How are they going to be communicated?
So that was the questions I was raising at this time as well, and then discussed in my meetings.
Q. Did you get an answer to those questions?
A. So I didn't get a formal letter in response. We discussed these questions during my meeting. I can't recollect the detail of that now, but my sense of it was that I didn't get answers to all of that. Partly my role was about encouraging those sorts of agencies to ask these sorts of questions and to take this sort of action.
Q. And I just wanted to point to you a position from Care Inspectorate Wales when it comes to visiting.
If we could bring up their statement. It's INQ000569773, page 86, paragraph 258.
In it, Care Inspectorate Wales say that they were:
"... aware of the profound impact on [the] wellbeing

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 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

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

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

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,

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

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

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

they were separated from them.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And if you can look at paragraph 78, they state it's their view that:

"... these meetings felt unproductive. The group acknowledges that [you] appeared to actively engage with the discussion and showed genuine sympathy to what was conveyed throughout these meetings. However, this discussion felt wholly unproductive."

It's their position:

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

What do you have to say in response to that?

A. Well, I'm surprised by that. It wasn't something that was reflected to me at the time at all. We had a number of meetings which I felt were very useful. I can understand their frustration that their recommendations weren't necessarily being taken forward by Welsh Government, however.

Q. And I'm just going to come to your lessons learned and recommendations which you've helpfully set out in your witness statement. Your assessment was essentially that older people were not adequately considered by the Welsh Government when making decisions during the pandemic. And that's, for your reference, it's from page 48, paragraph 226 onwards.

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

A. Yes.

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

A. Yes.

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

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

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

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

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

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

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

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

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

So, first of all, I think there's needs to be ministerial weight, if you like, given to social care. And then in relation to the structures within government, the importance of having a role similar to a Chief Social Care Officer. I think, importantly, that person has a clear specialist advisory role to government, across government, and expertise in terms of being a professional social care practitioner.

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

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

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

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

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

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

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.

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

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

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

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

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

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

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.

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

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,

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.

The last area is about dementia. Can you outline the particular problems that people with dementia, and also their carers, had during the pandemic?

A. For many people living win the dementia and their carers, the pandemic was unbelievably difficult. If I think about people living in the -- living in their own homes, with the closure of respite facilities, daycare facilities, people not always wanting domiciliary care workers to come into their homes, because they are frightened of the risk, it meant that many unpaid carers of people with dementia had to do a lot, lot more. So the demands on them became more challenging during the pandemic because their network of support had been taken away. So there's stress on unpaid carers of people living with dementia in the community. And the difficulty for people living with dementia as well, if they weren't getting the support they were getting before.

In relation to people living with dementia in care homes, I think particularly sometimes it meant that it was more difficult for them to understand why they couldn't see their loved ones. And in my Care Home Voices report, you know, and from the discussions I had with older people and families at the time, people expressed that to me. They said that their loved one,

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

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

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

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

A. Again, it's difficult for me to assess that overall. What I would say is that the lack of support that people experienced because of a number of things, actually, so not just in terms of government action, but issues, for

example, that, you know, support services were shut, people who normally would access help, particularly people living with dementia from organisations and charities, they couldn't carry out their work in a normal way. So that complete picture meant that it would be very difficult for people to maintain the level of care and support that they needed.

MR STRAW: Thank you very much.

LADY HALLETT: Thank you, Mr Straw.

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

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

THE WITNESS: Thank you.

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

(3.08 pm)

(A short break)

(3.25 pm)

LADY HALLETT: Ms Paisley.

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

MS MELANIE MINTY (affirmed)

Questions from COUNSEL TO THE INQUIRY

LADY HALLETT: Ms Minty, I'm sorry you're the last witness of the day and we've kept you waiting.

THE WITNESS: Thank you, my Lady.

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

A. That's right.

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

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

A. Yes, absolutely.

Q. Can I move, please, to the role of Care Forum Wales during the pandemic. At paragraph 88 of your statement you provide an overview of key groups attended by Care Forum Wales which were led by the Welsh Government, and some of those meetings were also attended by the regulator, commissioners, and Public Health Wales. Generally speaking, what was the role played by Care Forum Wales in those meetings?

A. Generally speaking, it was to feed back intelligence from the ground, as it were. So, in particular, we had a WhatsApp group for our members that we'd set up in early March, and they used that to share concerns and good practice and ideas for resolving things. So we were able to keep it a sort of -- really sort of quite live eye on things that were going on and then use that to feed back to policymakers to influence what was being done to support the sector.

Q. And in your experience, do you think, firstly, that there was enough engagement with stakeholders such as Care Forum Wales by those different entities and groups that we've just discussed?

A. I think we were disappointed that it got off to a bit of a slow start. I think, you know, we were in the position in the early days of probably having to chase people up and say, "Don't forget about the sector. Have

you got anything, a policy, that's specific to the sector that we need to know about?"

After -- probably after late March, early April, things were much better, and once everybody was pulling together, that engagement was excellent from that point onwards.

Q. So, from your perspective, in the event of a future pandemic of a similar nature, including those stakeholders at the earliest opportunity, is something you would endorse?

A. Absolutely.

Q. And you've just briefly touched upon it, but can you give an overview of how open and effective the engagement was?

A. It was very open. You know, our chair was meeting weekly with the minister, and Mary Wimbury, our chief executive, and myself, were involved in a number of national meetings. There were a lot of strategic meetings held weekly with all the stakeholders involved, and then there were a number of task and finish groups, working groups, looking at things like do not resuscitate decisions.

Q. And reflecting then on some aspects of good practice, one example you raise is that Care Forum Wales was engaged in working groups looking, for example, at care

home cleaning guidance.

A. Yes.

Q. And it developed strong links with Public Health Wales that have continued beyond the pandemic. Are there any other particular instances of good practice?

A. We have been working with the former Older People's Commissioner on, sort of, visiting -- sorry, not visiting, but, sort of, rights of tenure of older people in care homes, and that's involved the families groups, as well, just to sort of try to work out some of those rights and that we don't lose sight of them moving forward.

Q. Another specific group I just have a question about, please, is the Social Care Fair Work Forum, and at paragraph 101 you say:

"The recognition of the value of the social care workers led to the creation of the Social Care Fair Work Forum by Welsh Government and the commitment to improving terms and conditions."

Does that forum still meet?

A. Yes, it does. It's evolved into a social care fair work partnership, and it's actually doing quite a lot of the work that the UK Government is now doing in terms of looking at the voice of unions in the sector, pay and progression, fair working conditions.

Q. So that's a positive that that's still -- (overspeaking) --

A. Oh, absolutely. Absolutely.

Q. Can I then, please, move to some questions about guidance provided to the sector and ask for your comments.

If we can have on screen INQ000183761, please.

And Mary Wimbury sent an email to Sir Frank Atherton on 2 March, stating:

"Following my email last week asking if advice was specifically being provided to the care sector, I note that Public Health England has issued some advice."

And she went on to say:

"In the absence of other information, we assume Public Health Wales advice ... [would be] as per ... Public Health England advice ..."

And then Sir Frank's office responded on 10 March to say:

"There is specific Welsh guidance similar to that issued by Public Health England ..."

Now, guidance had been issued on 9 March. Do you think that the initial guidance produced by both Public Health Wales and the Welsh Government was done in a timely manner?

A. It could have been done earlier, I believe. It's

something that, you know, maybe it's the benefit of hindsight but I think providers were very risk averse right from the beginning, had started to worry about it quite some time before messages began to come out through the governments about the potential scale of the pandemic. You know, before this advice had come out, we'd already got a lot of providers who felt they were forced into the position of refusing to take admissions from hospital because they weren't satisfied with the guidance and the potential risks to their residents, because of the very nature of an elderly population with existing comorbidities.

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

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

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

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

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

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

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

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

Q. Thank you. That document can come down.

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

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

And at paragraph 35 of your statement you say:

"At the end of March 2020, we issued a press release about care homes being treated as collateral damage, as a result of the discharge policy. During this time, many members were resisting pressure to take new admissions directly from hospital unless they had been tested -- often insisting on two tests to allow for false results."

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

A. Sorry, the decision to --

Q. To discharge.

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

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

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

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

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

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

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

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

communicating throughout the piece, as it were, so that everybody has the same understanding of the information.

Q. In fact, one of the things you raise in your statement is that there were difficulties with version control?

A. Mm.

Q. So sometimes it was not clear what had been updated. Would that perhaps be one way of rectifying the difficulties?

A. Absolutely, because unless you had the two versions side by side you wouldn't know what had changed. And when people were working in such difficult circumstances, the last thing they needed was to be spending a long time trying to work out what they should be doing.

And I did raise it a few times with Welsh Government, but the impression I had was that it was actually a problem with the Welsh Government central communications team, who didn't like to have, sort of, scrappy track changes documents online.

But I think things have improved. I noticed the other day that Public Health Wales had put something on their website, with -- and CIW had tracked changes, so ...

Q. I think the Inquiry has seen some examples of updates being given on page 1, for example, so it can be quite quickly seen.

A. Mm.

Q. So there is an importance in being able to rapidly identify --

A. Yes.

Q. Again, dealing with the rapidly changing guidance, are you aware if there was, somewhere, a forum that Care Forum Wales could go to identify all relevant guidance in place at any given time?

A. Eventually it came to be held on Public Health Wales's website.

Q. And do you think that was something that was helpful, so if somebody could go in and go to one place?

A. Yes, definitely.

Q. Now, a SWOT analysis was undertaken in July 2020.

And if we can, please, have on screen INQ000183763.

Firstly at page 1, and this gives an overview of this analysis, and it says:

"In June 2020 a group of social care and support providers were brought together by Care Forum Wales [and to others] to discuss and reflect on the shared response to the initial outbreak of Covid-19 in the first half of 2020. The purpose of this exercise was to provide a space for shared reflection, to identify what worked well and less well during this initial period to inform future action."

Does that give a general overview of the -- (overspeaking) --

A. Yes, yes.

Q. Can we have then, please, page 5. And one of the issues identified was that:

"Some local authorities were *too* keen to get on top of it quickly. Some wrote their own guidance, and this rapidly was out of date, particularly around PPE. There needed to be a balance across local authorities in how quickly they responded. At the same time some local authorities waited for instruction and specific policy guidance, and expected 'the system' to take care of supporting providers, rather than taking action themselves."

And so it's whether you have any views on where the balance may lie in respect of local authority action.

A. I think it's probably a situation that's worse in Wales, because it's a population the size of Manchester but we've got 22 local authorities. So very quickly you'll find that a provider has got residents who are commissioned by -- from about three different local authorities. So that need for a sort of consistent and early approach is, I think, particularly relevant for our members.

Q. Do you think perhaps greater stakeholder engagement or

early stakeholder engagement with, for example, Care Forum Wales, might be a way to -- (overspeaking) -- those?

A. Yes, I think so, and I think it's probably a little bit like the engagement that we were talking about earlier. And it is one of the issues, as well, with relying too much on local authorities to do things, sometimes.

Q. And that document can come down, please.

In fact we're going to be staying with the topic of local authorities, but in respect of funding provisions over the pandemic. And at paragraph 56 you say:

"Members welcomed the extent of the hardship funding provided by the Welsh Government during Covid to support providers with the additional costs of Covid, without which many would not have been able ... to operate."

But in a similar vein, you explain:

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

Do you have any ideas or thoughts as to how that could be avoided?

A. I think a greater degree of direction from government about how local authorities should distribute the funding, because they all came up with their own

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

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

A. Yes.

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

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

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

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

Q. And do you have any view on how it could get to the

front line quicker beyond what we've just discussed?

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

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

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

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

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

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

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

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

examples of what you were hearing about the situation in care homes?

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

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

A. Mm.

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

A. What -- well, I think they established a really good method of administering and circulating PPE further on, which, you know, would have solved the problem if it had been there at the start. But we didn't have the volumes that we needed and I think, you know, it partly goes back to social care always being the, sort of, junior member of the partnership, shall we say, and, you know,

protecting health.

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

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

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

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

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

Q. Mr Hancock said in his evidence to the Inquiry that:

"Everybody's got a cupboard, and so it's totally

reasonable to require a degree of PPE, say a month's supply, you know, you can pull any time period out of a hat but a month would seem reasonable."

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

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

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

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

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

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

How wide-scale an issue was that?

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

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

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

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

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

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

Can we have the SWOT analysis back on the screen,

INQ000183763, at page 7.

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

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

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

It then goes on to say:

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

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

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

they shouldn't be there. So, yeah, that sort of thing was very regular.

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

A. Yes.

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

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

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

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

Q. And just the final line of this:

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

Now, the Inquiry understands lateral flow devices were a point-of-care test. Did that resolve any of the problems or did problems still persist?

A. Lateral flow certainly speeded things up dramatically.

Q. Staying with testing, please, and can we have your statement on screen, INQ000517219, paragraph 68, which is on page 24. You explain:

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

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

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

how issues like this could be avoided?

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

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

A. Yes.

Q. -- to -- (overspeaking) --

A. -- and fit for purpose, yes.

Q. Thank you. That document can come down.

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

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

A. Yes.

Q. Mr Hancock said in his evidence to the Inquiry his big recommendation now was that every care home needs to have isolation facilities.

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

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

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

A. Yes, potentially, potentially.

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

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

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

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

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

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

A. Yes.

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

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

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

A. Yes.

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

A. Yes.

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

At paragraph 51 of your statement you explain:

"We were involved in detailed discussions on the

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

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

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

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

A. At the very start, yes.

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

the view of providers?

A. No, I think if we'd had guidance as well, because it was left very much to care homes to make their own decisions, which of course put them in the middle between health and the need for people to be able to see their families, and so on.

Q. So where does the balance lie between keeping people safe and facilitating those visits? Is it the initiatives that were set up? So greater use of essential caregiver status, outdoor visiting, and ensuring that there is guidance, as you've discussed?

A. I think so, but I think also that the pandemic went on for so long that those measures weren't enough of themselves, because people were beginning to deteriorate when they weren't able to access their families. So they could only be short-term measures. But I think the Welsh Government came up with a raft of some good visiting policies, but also support for things like the visiting pods were really helpful.

Q. And do you think that there is an importance to risk assess each individual visit or each individual resident regarding what they might need?

A. I think it would be really difficult to do it on an individual basis because it's the footfall into the home that is the problem, and, you know, it was very

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

So it's a very difficult thing to balance.

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

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

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

A. Mm.

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

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

contacted the NHS Mental Health team and asked to postpone the planned meetings or to do these via Facetime and instead of an understanding approach my ... Manager was told that it was going ahead and they were coming to the home regardless in no uncertain terms. This means that there will be 4 social workers/mental health coordinators from different offices in Wales coming into an environment which we consider high risk. My staff feel they can manage the Coronavirus situation and protect the high risk people we care for but I cannot express now unhelpful this approach from the local authority and NHS is."

Then, on the other side, the Inquiry has heard evidence from Every Story Matters and an example of a care home worker who told the Inquiry he would have doctors completely refusing to come in or, if they did, you would have to wait absolute hours for them to come in and certify the deaths.

So a similar question: where does the balance lie? Because, of course, both are attempts to keep people safe.

A. Yes, I think the balance is that people who are visiting for genuine health needs, clinical needs, should be able to visit, and certainly should make the option -- I suppose that's the issue, is that in many cases care

homes and residents weren't given the option. They were just told the district nurse isn't coming or the GP isn't coming.

And I think some of the issues expressed about the number of local authority people coming in was probably more where -- it was to do with a planning or assessment of needs type thing, which is quite a sort of bureaucratic thing rather than actually something that would help someone with their actual health needs.

Q. Final question, please, on visiting medical professionals. Particularly in regards to lack of access to clinical support at the end of life, now of course that would be distressing for staff, it may cause residents to experience a lack of dignity, and of course the impact on families that couldn't be there. In respect of end-of-life care, do you have any thoughts on how it could be ensured that these traumatic events don't happen in the future?

A. I think it improved. I think probably the most horrendous examples were from early on in Covid, and it's about that lack of messaging.

We had -- I think I used an example of a care home in North Wales where they couldn't get the GP to come out, the staff were having to take observations that they weren't trained, because there was no one else

there to do it. The person was in horrendous pain, and they had to --

Q. Sorry to interject. Would training, for example, in those circumstances have been something that may have helped?

A. I think, yes, it would help if we prepared social care workers to step up further, and I suppose there are elements of that happening. But I think, you know, it was that nobody knew what was going on so nobody would go in and offer help.

Q. So advanced planning?

A. Advanced planning, again.

Q. In terms of training, who would deliver training in those scenarios? Or who should deliver training?

A. I think there are some good modules probably from health that could quite easily be rolled out. I mean, certainly, we're doing more and more with medicines, administration and so on, for care workers and domiciliary care workers so ...

Q. So Care Forum Wales itself delivers --

A. We don't deliver training, no, but we do work closely with PHW and Social Care Wales who, sort of, sign off on most of the training.

Q. Other than, for example, clinical support at the end of life, what other areas of training do you think would

have assisted those working in the sector?

A. Possibly some level of palliative care training because I know a lot of people who died were in residential homes where you wouldn't expect someone necessarily to die in the care home unless they were supported and had that wrap around service. And I think the counselling for care workers themselves probably came later than it should have done.

Q. Just two final short reflections if I can, please. Do you have any thoughts on the impact of staff movement within the sector and any views on if that can be addressed, and if so, how?

A. Do you mean around the sector or --

Q. Yes, so the Inquiry has heard evidence about the risk of staff movement in terms of transmission.

A. Yeah.

Q. Is that something that practically could be dealt with, or is that just the nature of the sector?

A. I think most -- one of the issues is the heavy reliance on agency staff and I think most people cut down on agency staff by using -- by staff volunteering to move into the home by changing the way the rosters worked. So there was that element of it but I'm -- I don't think we are at all prepared for anything similar to happen in the future when we've got such a reliance on the

overseas workforce and that's an issue in itself.

Q. So perhaps when we explored earlier about central guidance and having options and ideas, might that be one anyway to help?

A. Yes, yes.

Q. And just finally, please, beyond any matters we have already covered, are there any specific recommendations you would urge the Inquiry to consider in particular?

A. I don't think there are. I think we have probably covered them all, thank you.

MS PAISLEY: I'm very grateful.

My Lady, I have no further questions. I believe there are some Core Participant questions.

LADY HALLETT: There are, and I think Mr Stanton, who should be directly across the hearing room.

Questions from MR STANTON

MR STANTON: Thank you, my Lady.

Good afternoon, Ms Minty.

A. Good afternoon.

Q. I ask questions on behalf of the Covid-19 Bereaved Families for Justice Cymru. I have a question in relation to paragraph 66 of your statement, which I'd be grateful if it could be brought up on screen, please, and that's at INQ000517219_0023.

Hopefully you see that on your screen, Ms Minty?

A. Yes.
Q. Halfway through the paragraph, there is a sentence that begins "The early focus of care home testing." Do you have that?
A. Yes.
Q. And it continues:
"... was on larger homes with symptomatic residents on the basis of 'evidence' that Covid spread more readily in larger environments."
The use of inverted commas applied to the word "evidence" would tend to suggest that you have doubts about the focus on larger care homes and I wonder if that is correct. Please could you explain them?
A. Yes. I think the view of most providers would be that there was very little evidence of anything during Covid, because advice and medical opinion changed constantly, and we were aware of outbreaks in small homes, as well. So I think -- I suppose there's a likelihood of it spreading more in a contained situation just because it was bigger, but then again, some of the bigger homes would also have had more facilities to isolate people and keep the residents safe, and smaller homes would have found that more difficult. So I don't think we ever believed that there was a strong enough basis to deny that sort of same level of testing and so on in

smaller homes. It felt as if we were sort of leaving them to it.
Q. Thank you.
My next question relates to a Care Forum Wales submission to the Health, Social Care & Sport Committee on 7 May. This is at INQ000183754 but we don't need to bring it up on screen.
Within that submission, it is stated on behalf of Care Forum Wales that anecdotally, most outbreaks in care homes can be traced back to asymptomatic residents and staff.
And my question is, are you able to indicate when Care Forum Wales was first aware of the risk of asymptomatic transmission on such a significant level?
A. I can't honestly say how early it was. It was very much anecdotal information, but it was something that people on our WhatsApp group were saying that, you know, they hadn't had any signs of anything. So how else was it getting in if people weren't already carrying it when they were asymptomatic?
Q. Thank you.
And final question, back to your statement, please. If we could have up on screen, please, paragraph 58 of your statement, which is at INQ000517219_0021.
Here you address the issue of DNACPRs. And it's

dealt with fairly shortly at paragraph 58 and you indicate that:
"This does not appear to have been a particular issue in Wales."
You may have heard the evidence given earlier today by Heléna Herklots, and which indicated a slightly different position. She obviously considered it to be an issue, and it is a very big issue for my clients.
I wondered whether there's any explanation for the statement you make to the effect that you didn't think it was a big issue?
A. I think it's not something that was brought up particularly by members on our WhatsApp group. I didn't mean it to sound dismissive, because obviously it's a massive situation when it does occur. The only one I was aware of was a GP surgery in Bridgend. But it wasn't flagged up by most of our other members and Welsh Government fairly quickly set up a task and finish group looking at them, which I was involved in, and I think it was clear that we needed to do much better about that in future. That's one way that we can definitely plan.
And I think one of the problems that we found was that it should be a function of a doctor, primarily, to discuss this with someone before it becomes necessary, but a lot of the training hasn't been done, so it was --

so we were aware that -- in pockets, that people were being asked to carry out the conversations, but we weren't -- I wasn't aware of it being a blanket "You need to get all your residents to sign these."
Certainly, as I said in my evidence, our members would have been horrified by that.
MR STANTON: Yes. Well, thank you, Ms Minty.
Thank you, my Lady.
LADY HALLETT: Thank you, Mr Stanton.
Mr Straw, who will be the other side of the room again, but slightly further down, towards the back.

Questions from MR STRAW KC

MR STRAW: Good afternoon.
A. Good afternoon.
Q. I represent John's Campaign, The Patients Association and Care Rights UK.
In your witness statement, in paragraph 103, you say the lack of protection given to people in care was "symptomatic of prejudice, in particular towards older people"?
Do you know where that prejudice towards older people in care came from?
A. I think it's a societal thing. I think it's just the way, as a society, we treat older people, as if they don't seem to matter once they hit a certain age and

they're not considered to add particular value.

I think in Wales we're very lucky that we've got the Older People's Commissioner, and a very sort of firm rights base. But even then, I think it's easy to overlook the older generation. And my perception sometimes is that if you're in a care home, it's considered that that's what you need, and nothing more. And there's little investment in all the things that make it fulfilling.

Q. Thank you. A different issue. In your statement and earlier on today as well you noted that there was guidance which wasn't appropriate to domiciliary care, to put it broadly.

Can you explain what adverse consequences this had, so the inappropriate guidance, for people in domiciliary care?

A. I think a lot of it was sort of practical, around the donning and doffing of uniform. If you're doing that in someone's house, you know, where do you go to do it? Or are you supposed to do it in the car when you get there?

So it was confusion, which probably ate into the time that someone was actually supposed to be there giving support direct to the individual.

But also, when PPE was needed to be worn out in the community, and when it wouldn't necessarily be required

by other people, it just made the whole experience for the individual more unpleasant than it needed to be.

Q. And that's on PPE. Were there other areas of guidance which was inappropriate, unclear, and that caused problems for people in care?

A. I don't -- I think perhaps there wasn't a great deal of specific guidance for domiciliary care, generally. I think probably the worst issue was the lack of testing, and the general -- generally forgetting that when you're a domiciliary care worker you're in someone else's home, and it's therefore very difficult to enforce certain things that you would in a care home, and quite rightly so, because, you know, it's the individual's right to have the care provided the way they need it.

Q. Thank you.

At paragraphs 47 and 49 you explain that care homes had certain difficulties in accessing medical services and the necessary clinical support. Again, this is an issue you touched upon earlier.

Firstly, what were the consequences for people needing care of this?

A. Well, I think we've already touched on probably the worst elements, which was the lack of a sort of -- of professional palliative care in care homes, which

weren't equipped to deal with that sort of end-of-life situation.

We know that some GPs refused to visit. It was difficult to access GP surgeries. There should probably have been attempts to set up direct lines to make it easier for people to get through. Generally speaking, I think there was support in a lot of areas, but in other areas it was things like the district nurses not being allowed to visit, so they couldn't help residential homes, where there's no nurse on duty, with things like insulin. So the routine medication that a care home isn't allowed to do, they were suddenly having to work out how to do it. So it comes back to that training thing that we were talking about earlier.

Q. Yes. My next question was going to be, can you help what caused the difficulties? You've mentioned training there. Are there other factors that caused those difficulties?

A. A lot of it's down to the regulations. There are certain things in a residential home that care workers can't do because there's not a nurse to supervise or to delegate duties. In a residential home, things like medications administration is delegated by a GP, so, of course, when the GP isn't visiting, that's an added complication.

Q. And just taking -- going back a little bit further, so that's what -- the immediate cause of the difficulties within the care homes, but do you know what was the cause of the difficulties of medical care coming into the care homes?

A. I think there was -- it was perceived, rightly or wrongly, I think as a fear of actually catching it from the care home, possibly also a concern about spreading it. And it wasn't all bad, because, I mean, it did come up with some fairly good ways of doing virtual examinations where that was appropriate. But some of those were probably also where it wasn't appropriate, and where a physical presence would have been a better solution for the person.

MR STRAW: Okay. Thank you very much.

LADY HALLETT: Thank you, Mr Straw.

Thank you very much indeed, Ms Minty. That completes all the questions that we have for you. Thank you very much for your help to the Inquiry and for being with us today.

THE WITNESS: Thank you, my Lady.

LADY HALLETT: I don't know if you're going back to Wales. Are you still living in Wales?

THE WITNESS: Yes.

LADY HALLETT: Safe journey back whenever you go back.

THE WITNESS: Thank you.

LADY HALLETT: Very well, that completes the evidence I shall hear today. I shall return at 10.00 tomorrow.

(4.22 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X