Wednesday, 9 July 2025

(10.00 am)

LADY HALLETT: Ms Carey.

MS CAREY: My Lady, good morning. May I call, please, Professor Susan Hopkins.

PROFESSOR SUSAN HOPKINS (affirmed)

Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 6

LADY HALLETT: Thank you for coming back to help us again, Professor.

THE WITNESS: Thank you.

MS CAREY: Professor, your full name, please?

A. Professor Susan Mary Hopkins.

Q. Professor, you are now formally Chief Medical Adviser to the UKHSA. You were initially appointed to them on an interim basis in October 2021, formally taking up the role in June 2022; is that correct?

A. Correct.

Q. Your qualifications are many and varied -- I won't read them all out -- but prior to joining UKHSA, is it correct that you were the deputy director of the National Infection Service at Public Health England from 2018 to 2020?

A. Yes.

Q. That is a role that you shared. You are also a professor of infectious diseases and health security

at UCL in London?

A. Yes.

Q. And you maintain an active research portfolio?

A. Correct. And I also remain in clinical practice as well.

Q. Thank you. You have prepared a lengthy statement, over 181 pages, on behalf of UKHSA for Module 6, and I'm going to ask you about a number of different topics in your evidence that I hope will conclude this morning or very shortly thereafter.

Can I start, please, though, with a summary of PHE's, as it then was, role in respect of adult social care. And if it helps you, Professor, I'm at your paragraph 2.15. Because I think you make the point there that PHE and UKHSA does not have direct responsibility for delivery of adult social care, nor for its regulation?

A. Correct. So PHE's role in response to adult social care prior to the pandemic and UKHSA now, is really to provide advice and support to directors of public health, local authorities, and directly to care homes, where asked, in response to infectious diseases or other external threats. We do this through our regional health protection teams.

Our role is also to provide advice to the government

departments, the Department of Health and Social Care in the main, but any other government department can ask for our help and support.

We maintain and are the primary source of infectious diseases surveillance data for the country, whereby those infections are notified to us by a hospital or a community setting, and we have expertise in microbiology, epidemiology, and behavioural science and many other areas with over 30 different specialities working within our organisation.

Q. All right. If we just scroll down on the page that helpfully has been put up, I think the four bullet points there probably summarise PHE's role: obviously conducting scientific and clinical research; as you've just mentioned, collecting data on notified infection outbreaks; and as we're going to come on to look at in this module, producing the guidance on IPC measures and indeed supporting the production of guidance owned by others, and there are various other bullets that people can read for themselves there.

You mentioned there health protection teams, and we haven't heard a great deal of evidence about those. Can you summarise for us the role of health protection teams or, HPTs.

And Professor, can I just remind you to speak

a little more slowly and I will try to do the same.

A. Great. So, first of all, we in the UKHSA and our predecessor organisations have nine regional health protection teams corresponding to the sort of geographic regions of England. This covers England only. In those regions there are specialist consultants and health protection. By that, I mean a medical or professionally qualified public health consultant, not from an agency, who lead teams who provide advice and support to any range of outbreaks across any setting in that location-based approach. So hospitals, prisons, adult social care homes, et cetera.

They worked very closely with their stakeholders, particularly stakeholders in local government and local authorities with directors of public health. They work across the health system and health system network providing their expertise and advice on individual cases for any infectious diseases that may need follow-up or care, providing advice on outbreaks and incidents, particularly where the outbreak and incident cannot be managed through the routine measures by either a local authority or a hospital or, indeed, a particular environment themselves.

And they are there as our eyes and ears, if you like, as a national agency on the ground. They collect

data that is reported to them, which is aggregated up and then made available for our national surveillance reports.

Q. Just pausing you there. I think you said the HPTs were multi-disciplinary teams. Can you help with why that was important or beneficial?

A. Yes. Well, first of all, we have a range of different people who have come from a range of different backgrounds and locations, so many of the individuals will have previously worked in local authorities, for example, so will have a close working knowledge of how local authorities work. Some of the individuals will have worked in the NHS, for example in -- as infection prevention and control nurses or as other measures. Some of them will have been environmental health officers in local government, and as environmental health officers in local government, will have been helping to support local government in how they manage premises, a wide range of premises, and so -- and we have individuals who are experts at emergency response.

So all of that comes together to allow people to bring all of their expertise to bear in the work that's happening in that place-based approach.

Q. Can I ask you this: is it the case that a care home, perhaps let's take Liverpool, for example, an individual

care home could ring up the HPT for that region and get advice and/or support? Would it be that director and --

A. So it is -- can be that director link. It is also dependent on the local authority and their size of team and their capabilities in that local authority. So in some instances, that local authority may actually say, "Call us first and we'll deal with the majority, and we will escalate and work with PHE or UKHSA where we need additional expertise and support to manage the infectious disease outbreak."

It's very much hand-in-glove across the system.

Q. Right. Does it follow that then a provider who perhaps ran a number of care homes, if they didn't go down the local authority route and speak to them for advice, they equally could come to an HPT?

A. Correct.

Q. Right. What about domiciliary care? Do domiciliary care providers have a link in to the HPT?

A. So our numbers are available for everybody, actually, and if you are a domiciliary care provider and you want advice, you could equally call that number.

It is highly likely, though, that a domiciliary care provider might call the commissioner of that domiciliary care first, which may be local government, it may be the NHS, in order to get their first line of discussion.

But the point of the health protection teams is they are there for everyone in the region, and it is -- you know, it may be decided that they would redirect that to somebody who they know is better to answer that question in the region, based on that system approach at that place.

Q. I think you say in your statement that HPTs provided a 24/7 out of hours on-call service which is operated year-round?

A. Exactly. So all night long, all day long.

Q. All right. Can I, just before we look at the advice and guidance provided by PHE, just deal with a little bit background. And I think you make the point, Professor, in your statement -- I'm at paragraph 4.4 onwards if it helps you -- that pre-pandemic, there was guidance for managing outbreaks. And you set at a number of different pieces of guidance, going back to October 2012, coming right up to October 2018.

I wonder if we could just look on screen, or have on screen, please, page 91 of the professor's statement, and paragraph 7.9.

I just want to look at perhaps what the pre-pandemic position was, and then we can look at some of the guidance that existed during the pandemic.

Here are the guidelines from October 2012 on

management of outbreaks of an acute respiratory illness in care homes. It contained advice on discharging patients with flu and presumably other respiratory illnesses. And we can see there in the italicised part:

"Care home residents admitted to hospital with a diagnosis of [flu], or other [RVIs] such as ... (RSV), may remain infectious to others even after discharge from hospital, and infection control measures as outlined in PHE guidance are indicated to prevent transmission ..."

Then if we look down:

"Residents may be discharged from hospital at any point when the following criteria ..."

When they're clinically -- treatment is finished and they've recovered, appropriate treatment can be delivered after discharge, appropriate IPC measures to prevent transmission are in place, "including single room dwelling or cohorting".

By cohorting, do you mean that if they've got flu and someone else in the care home had flu, those two residents will be in a separate wing or area of the care home? Is that what you mean by cohorting?

A. Yes, we describe that -- we describe that in two ways. One is where you place individuals to sleep and reside and share facilities together. The other point is where

you can keep the staff segregated, though I have to say both in hospitals and in care homes, that is very difficult to do, because it is dependent on the number of staff. It isn't ideal, but placing individuals in -- sharing a room or a living space or a bathroom is what we try and do.

Q. And you can see there that if they are able to put the patient, or resident as they become when they come to the home, in a single room or dwelling, that will be continued outside the hospital and for a minimum of five days after the onset of symptoms?

So pre-pandemic there was already in place guidance for when flu patients are being treated, to have them discharged when it was appropriate for them to do so, but also guidance to the care home as to how they should treat that patient?

A. So, for an individual who had symptoms or was diagnosed with an infection, yes.

Q. Right. The point I'm making, Professor, is that the guidance when we come to look at it is not entirely novel to care homes, the providers, and the adult social care sector, more importantly?

A. Absolutely, and I would say that we tried to build on established guidance rather than doing 360s, because that would be very difficult in the middle of an

emergency, to explain and try to discuss with the very many providers. So building on established principles was our process for the majority of the guidance that we produced.

Q. All right.

That can come down. Thank you.

The UK IPC Cell guidance that we've considered in other modules as well as this one was primarily for the healthcare sector; do you agree?

A. Predominantly, yes.

Q. Right. So can I ask you, are you able to help with who was writing the guidance, generally speaking, from the perspective of the adult social care sector?

A. So in -- so in PHE we were utilising a team that we had put together especially for writing guidance, because there were so many different pieces of guidance, and trying to bring together the advice that was there for the public, the advice that was -- the changes in government advice, and the advice that we had pre-existing together. So we established a new team as part of the response that would write guidance.

That was supplemented, and in particular for adult social care, by our health protection teams, who had the local expertise and who worked with care homes on a daily basis for every other infectious diseases

outbreak.

So it was the guidance team who held the ideas and the centrality of what was happening across government, what was happening in guidance in general, and then the expertise locally and bringing those together were for the adult social care team.

As we went on, we developed a specific adult social care team who held up the core, but from January to April, that was how it was developed.

Q. Do you think, in the event of a future pandemic, there does need to be a particular cell focused solely on IPC guidance for the adult social care sector, rather than it being held by a UK IPC cell more generally?

A. Yes, I think from my point of view what we have done as start of the learning from the pandemic is established a core adult social care team in UKHSA, which we are maintaining. It's not the same size as it was in the pandemic but it means that we have individuals who are expert at a national level and who are regularly discussing with the care sector and the care sector fora, and the department, and who can bring in the relevant other expertise, but they hold the centrality of it. And we will maintain that and extend it and expand it in any future emerging infection.

Q. Just standing back for a second, can you help with why

there wasn't such a team in place pre-pandemic?

A. Well, I mean, I think predominantly the reason the team wasn't in place pre-pandemic is that we had not needed a specific team before, but also resources were extremely tight, and had been reduced over the previous 10 years and therefore we tended to establish teams as we needed them for the occasion, but where possible, we used the generalist knowledge across the agency to provide responses.

Q. Can we go back to January 2020, please. And PHE developed in January 2020, is this right, guidance primarily for the NHS? It consistently referred to a document known as How to Work Safely. Can you help with, what is, in a nutshell, the How to Work Safely guidance?

A. So my recollection, and I think this is the How to Work Safely guidance is guidance that was pre-pandemic about care home guidance, how to work safely in care homes, the general IPC guidance that was there for care homes about things they could do to prevent and reduce infections in care homes, things that they might do if they had infections in residents and that then developed subsequently into specific guidance related to adult social care and Covid-19.

Q. So the January PHE guidance at that time was called the

Wuhan novel coronavirus IPC guidance, and you say at that time it was developed for the NHS as that was the institution with the highest likelihood of dealing with Covid-19 cases as at January 2020.

Does it follow, though, that care homes and the adult social care sector, would still be applying 2018 or the 2012 guidance, whichever was more appropriate and applicable?

A. So to take us back to January 2020, we had no cases in the UK. Cases were predominantly identified in small areas in China, not even in wider areas in China at that point, when we released this guidance. And in addition, all of the cases that were being detected anywhere else, even through routine surveillance systems that existed, were not -- were always linked to China and that expanded over time.

So at this point it was really for the management of the NHS for a returning traveller, potentially, who was identified with Covid, why we produced that specific guidance.

Q. Am I right, though, that the first PHE guidance for the ASC, the adult social care sector, was the 25 February 2020 guidance?

A. Yes.

Q. Can we look at the February guidance, and if it helps

you, Professor, I'm at 4.434 onwards in your statement.

Now, can we have up on screen, please, the actual guidance. It's INQ000223341. It's the 25 February guidance.

And it's important to note that at this point there was no evidence of transmission at that time in the community, as it says there in the middle of the page, Covid-19 was still designated as a high consequence infectious disease at this time so it was thought that anyone with Covid would be dealt with in specialist settings within hospital, primarily; is that correct?

A. Yes.

Q. Notwithstanding that, can we see on page 2:

"This guidance is intended for the current position in the UK where there is currently no transmission ... It is therefore very unlikely that anyone receiving care in a home or the community will become infected."

And indeed I think there were only 13 confirmed cases in the country, none of which were transmissions in care homes as at the time this guidance was published.

A. All of them were linked to travel or cases associate with travel.

Q. Thank you very much. However, it's the sentence that says, "It is therefore very unlikely that anyone

receiving care in a care home or in the community will become infected."

Can you help me, Professor, with how that sentence has ended up in this guidance?

A. Well, I think it was a sentence, a statement at that time. I think it was to reassure care homes that if we were detecting infections that were more widely in the community or more in care homes, when we saw that signal, that the guidance may change again. So it was really highlighting that this was a moment in time and things were changing very rapidly globally and nationally.

At the point of this guidance, I think this was just the moment where we were starting to hear cases from Italy, so it was becoming closer. So it was trying to highlight that it was at this moment in time, this is what it says.

LADY HALLETT: Can I just press you on that, Professor Hopkins.

A. Yes.

LADY HALLETT: It's a future -- it's basically expressed to be in the future, it's "therefore very unlikely that anyone receiving care will become infected", it's not "At present we don't have evidence of people in care homes", but it seems to be rather more looking to the

future than "This is the current situation".

A. I have to say, I think that's probably language that is clunky rather than language that is meant to predict what is going to happen in the next month, two months, three months, based on what we knew in February 2020.

LADY HALLETT: But if it's clunky language that is meant to be reassuring care homes, it's a bit unfortunate, isn't it?

A. It is in retrospect, yes.

MS CAREY: My Lady has stolen the question I was going to ask.

LADY HALLETT: I'm sorry.

MS CAREY: Not at all.

But really, whether this was liable to provide false reassurance for the care homes, given that you didn't know what was coming across Europe and potentially going to land in the UK, do you -- and I don't want to be unfair in that criticism, but Mr Hancock told us, for example, he thinks it should have said, "Unlikely anyone will be infected" perhaps as a more accurate reflection. What's your observations on that, Professor?

A. I can imagine that these guidance were being written rapidly. I think one can always look and improve guidance, even after they've been written slowly, and I think that is clunky language and we would want to

improve that language in future events.
Q. Can I ask you about that, then, because let's imagine in ten years' time we are in the eye of a storm and it's not entirely clear what's coming down the track. What reassurance can we have that there perhaps will be as much put in place to prevent clunky or misguidely (sic) worded guidance, what's going to change in -- when we're in the panic situation that we were this time?
A. I think I would highlight that this is the first time in -- given that the last pandemic that we saw of respiratory viruses was in 2009, and actually, didn't impact society, community, or adults in care homes in -- to any significant effect, that this was the first time that we had seen such a thing on a global scale in this way.

My hope would be that what we have set up in UKHSA and what this system has set up more widely is more -- better prepared for what we might do in the future. I think we need to keep reiterating and working with the sector and across government, and across local government, to ensure that we are putting adult social care in the centre of future guidance and in thinking of it for pandemics and emerging infection preparedness. That's certainly what we're doing now. That's certainly what we aim to maintain to do and we need to ensure that

that's at the front and centre of future pandemic planning.
Q. Can I ask you, please, about page 5 of the guidance, and guidance on face masks as it then was at 25 February.

If we look at the top of the page, the paragraph beginning:

"During normal day-to-day activities facemasks do not provide protection from respiratory viruses, such as COVID-19 and do not need to be sworn by staff in any of these settings. Facemasks are only recommended to be worn by infected individuals when advised by a healthcare worker, to reduce the risk of transmitting the infection to other ..."

And then, again, perhaps now the unfortunately phrased sentence:

"It remains very unlikely that people receiving care home in a care home or the community will become infected."

I know there is an emerging scientific understanding about how Covid transmits, and we're going to come on to look at that, but, just practically speaking, how realistic was it to only advise that face masks were worn when advised by a healthcare worker for people in a residential care setting at this time?
A. So, I mean, I think this is, again, coming to the

preceding guidance that existed for infections in care homes, and particularly respiratory virus infections in care homes, where that was what was the standard guidance and that was what was being declared here.

I think when I look back, you know, the -- what we learnt through the pandemic was that face masks had a role. I think we still, as we remember in Module 3, don't quite know the extent of their role, but at this time in the pandemic, and prior to the pandemic, face masks were not used routinely, for individuals who were infected or even for the vast majority of individuals who were being cared for in the community by health professionals.

I would highlight that if we suspected somebody had Covid-19 in a care home, the UKHSA HPTs would have been expecting a phone call, and therefore they would have been healthcare workers and advising them, as would a GP or an NHS 111 professional as well. So if anyone suspected an individual, there were multiple healthcare workers who would have got involved in providing advice and care of those individuals.
Q. Can I just ask you about the second paragraph that we've got up on screen:

"PHE recommends the best way to reduce any risk of infection for anyone is good hygiene and avoiding direct

or close contact (within 2 metres) with any potentially infected person."

Now, Professor, I'm sure you appreciate that people receiving -- particularly in nursing homes, are receiving personal care for -- across the day, throughout the day. Given that, why is it that PHE are recommending that we reduce close contact when in reality all the care that they're being provided is predominantly close contact?
A. I agree, care that's being provided is close contact, but there's lots of other more social contacts that can be reduced, and we were at the time trying to highlight that keeping further away and the shortest possible time was going to do that.

And again, I think it's really important, and I would like to highlight, that individuals in care homes have social contact with the staff, and it's really important that that is enabled as much as possible. What we were trying to do was provide assurance to the care homes' staff about if they suspected an infected person, that if they removed themselves by 2 metres, that would start to reduce their risk.

So it was really trying to frame this in a particular -- given that we did not think there was

community transmission -- I mean, we actually, I think, in retrospect have found no evidence of community transmission at this point -- that the individuals were unlikely to infect others if they were kept at some distance.

Q. I'm just trying to think about how, practically, that works on the ground. They have a suspected Covid-19 or a patient with respiratory-like symptoms. They're not advised to wear a face mask unless advised, as you have set out there, but how, realistically, were they to provide any care if they then had to try to avoid being within 2 metres of the resident?

A. Well, I mean, if there was somebody with the potential infection at this time, we would expect individuals -- and in other guidance that was there -- to remove themselves by 2 metres and call NHS 111 or call UKHSA, where the individual would have been immediately conveyed for assessment.

Q. I think -- that can come down, but I think you are aware that there were a number of concerns raised with the 25 February guidance, and indeed I hope you've seen, Professor, a spreadsheet that was provided to PHE for their comment on.

Can I have up on screen, please, INQ000049518. We may need to expand it.

A. I'm afraid I don't know the answer to that.

Q. It just seemed to us that if there had been that engagement, perhaps some of the questions that were being raised would have been answered in the guidance before the guidance came out and then they had to do it in reverse, if you follow me.

A. I can see that.

Q. Can I have a look at one other of the entries.

Can we go to row 5, please.

It's picking up something we've just looked up, the National Care Forum also raised concerns about: the personal contact:

"... the section which details how the disease is spread -- either via being within 2 [metres] of someone -- or touching their hand -- are both cases that are extremely likely with front line care staff. The nature of the job will mean that the provision of personal care will mean they are close to individuals. The guidance writes as if this might be the exception -- therefore the expectation in the guidance that everyone who has had close contact with the person infected should self-isolate for 14 days is likely to include the [large] majority of staff within a home setting -- and potentially large number of a home care team if someone receives variable visits from different team members."

And if I use the column A numbering, can you see, down on the left-hand side of the page, row 2?

On 27 February, the National Care Forum, via Vic Rayner, had a query or a question about the guidance, making the point that:

"Care home residents are likely to have their own room, but in many cases they may be using [a] shared bathroom ... and the isolation of those or the proposed 'rota' approach to their usage will be very difficult with people who may need regular support and access to facilities."

And then the question is -- sorry, that concern of the National Care Forum is wrapped up into the question:

"How do we protect people who are using shared facilities such as bathrooms ..."

And if we control over the Excel spreadsheet, there's reference there to the 25 February guidance.

Then the answer is that the health protection team are going to provide advice on cleaning.

Can you help me, Professor, with these sort of queries that the NCF and indeed others were raising, were they -- were the NCF and others invited to comment on the PHE guidance before it was published to try to iron out potential unrealities with the guidance and the daily realities for their life in providing care?

Vic Rayner says:

"I am not disagreeing with the advice -- but ... [really] the way it is written does not in any way address the very significant implications of a case being identified in a care home [or] home care or in any way move forward to understand how the ongoing care of the individuals in that setting might be addressed."

A real concern there about the care. It's packaged as:

"What actions should people take when personal contact is unavoidable?"

And if we scroll over, the PHE answer is:

"At this stage of the response, residents in social care are unlikely to travel [presumably going back to the ingress of Covid from abroad] and so are unlikely to acquire COVID-19. Guidance based on a case-by-case risk assessment will be provided by the Health Protection Team ..."

Now, I understand the context in which that answer is given but clearly, the course of Covid was changing very rapidly as you've just said. What reassurance was given to NCF and people like NCF, where they're saying, "It's very difficult to implement this guidance on the ground."

Can you help, Professor, with what PHE did about

that or what advice they were likely to have been given?
A. Yeah, so I think, as always, the national guidance is there to set a framework. Our health protection teams work with care homes every day to manage any outbreak or incident in the care home from a very wide variety of infectious diseases. And so they would often understand, the particular care home, how it's built, how it's set out, what the staff are, and work with the local authority about what that might look like. And so in a national guidance scenario, setting out the principle of: if you've got a shared toilet what you do, if you've got this -- it would make the guidance very long and unwieldy. But there are some principles.

And what actually was happening at the time is the care homes were calling health protection teams with questions and the health protection teams themselves were, you know, utilising their knowledge and awareness to answer those questions and provide and support the care home in delivering their risk assessment.

I would also add that the risk assessments that -- on how infections spread in care homes were something that care homes did regularly for respiratory viruses or gastrointestinal infections that occur.

So they are, in some ways, used to this. And what we were trying to do at this point in February was try

and give them some important information that could be delivered in a national guidance setting while recognising that the main route for information was going to be through that established relationship.
LADY HALLETT: I'm afraid I'm not following what extra guidance, national guidance, you're giving. Basically you're telling people running care homes -- this is guidance directed at the adult social care sector, isn't it?
A. Correct.
LADY HALLETT: You're telling them don't use face masks, it's not necessary. You're saying don't have contact, as Ms Carey has just asked you, they can't avoid contact in most cases, certainly domiciliary care and a lot of residential care, and you're telling them to have good hygiene. Well, they're going to have good hygiene anyway. So I'm really not following what this guidance directed at the adult social care sector added to what the care home people would have known anyway.
A. So I think it was putting it together in one place in -- specifically for Covid-19, based on the good practice that was there before.
MS CAREY: Now, Professor, you've made the observation that as at the time this was drafted, there was no community transmission. By 2 March, SPI-M-O released a statement

on the 2 March saying, "It is highly likely there is sustained transmission of Covid in the UK at present", so within a number of days we'd gone from there being no community transmission to now "sustained transmission" and SPI-M-O said:

[As read] "It is almost certain that there will be sustained transmission in the UK in the coming weeks."

The next guidance that came out was on 13 March, and it may be observed that if SPI-M-O are saying on 2 March "We've got it now in the UK and it's coming", why did it take another 11 days for the second set of PHE guidance to be produced?
A. So just to (unclear), so SPI-M-O paper at the time would have been a paper to go to SAGE, so for a SAGE discussion, it wasn't publicly released, so I don't think those papers were publicly released for a long time and definitely even within government they were held quite tightly, so -- as far as I know.
I definitely didn't recollect seeing it as the incident director for Public Health England at the time.

Though, clearly, we'd had our first community case on 28 February. So that was our first detection in the community.

So from my point of view, the work that was done over that next couple of weeks, my understanding, from

the team's view I've discussed with when building this evidence statement as the corporate witness, my understanding is that they were then discussing this with the Department, were discussing it with the health protection teams, were discussing it with the care homes. So that, again, it was following on from the answers to the questions from the spreadsheet that you've shown me, trying to work and utilise all of the experts across the organisation and externally, to provide an updated and improved set of guidance for the next situation where we were seeing some transmission in the community.
Q. Do you think, had PHE been aware of the consensus statement that SPI-M-O had put out, PHE practically would have been able to respond quicker with guidance within a couple of days as opposed to 11 days later?
A. So perhaps, but I think as you've said already, that actually, there's a -- there's a balance between working with people ensuring that you're answering all the questions adequately, ensuring the guidance is meeting the needs of the sector that it's going out to, and the speed and haste, and actually, that was a difficult balance throughout this period.
Q. Before we then come on to the March guidance just thinking back to this time, do you think that the

February guidance perhaps should have highlighted the possibility that there may be transmission coming, and warned the care sector to generally monitor the position more carefully? I don't mean by them looking at the actual stats but just to say, "We don't quite know what's coming yet. Please be ready to deal with infection rates rising if we start reporting them in the press"?

A. I think in hindsight, yes. I think that's not what the general consensus was at that time. So it's important to try to put oneself back at that moment in February 2020. I think, as we go forward with the guidance, trying to have -- and working with care homes and the care home staff, to have an increased alertness over general infections is really important and I think that alertness, awareness, and the closer working relationships that have developed over the pandemic and since then actually stand us in good stead.

Q. In your statement at paragraph 3.29, Professor, you say:

"Asymptomatic infection was documented by the end of February/March 2020, however the available data remained inadequate to provide evidence of significant [either] pre-symptomatic or asymptomatic transmission."

Now, we're aware of the distinction between the two, I can assure you, but given that asymptomatic infection

was certainly being documented at that stage, do you think perhaps the February guidance should have been more cautious and alerted people to the potential of asymptomatic transmission, albeit you didn't know the precise extent of asymptomatic transmission at that point?

A. So I think it's really important -- I mean, we talk about how we build on the guidance that has gone before. I mean, we sit in this room now in a different time, but with many other infections circulating and, you know, what we are -- were doing at that point was trying to highlight the risks of this new and emerging infection of which we knew very little, but not trying to go into the world of what it was like in that middle of 2020.

From my point of view, we do not routinely and continue -- so post-pandemic -- do not routinely tell people to be particularly wary of asymptomatic infection, for any infections, because what we're trying to do with infections is to try and find the people who have got symptoms and treat that disease and prevent that spreading.

And I think Covid-19 was one of those first infections that we actually saw a very large amount of -- for respiratory infections, I say -- very large amount of asymptomatic transmission over time, but at

this point what we were doing was utilising the evidence in the past that said: if you have asymptomatic infection the likelihood of you transmitting the respiratory infection is very low, which we'd used for flu, which had worked as -- in good stead for many other respiratory viruses over many, many years. And trying to utilise that rather than change the basis of the science that we were utilising was what we did at the start.

I think we learnt a lot over those current months and I think we could consider how that learning would take us forward in a future infectious diseases respiratory-related pandemic.

Q. Can I come on to the March guidance that was published on 13 March. We know it was in three separate -- one for residential care, one for home care, and one for supported living. And I just want to look with you, please, at sort of the lead-up to that and at the actual guidance itself.

And in your statement, Professor, you say that on 2 March 2020 -- I'm at your paragraph 4.50:

"... Public Health England contacted DHSC to offer PHE's assistance in developing a response for the social care sector, particularly in respect of engagement on a local level with ASC stakeholders."

Can you help, what was PHE actually offering here?

A. So my recollection is that the chief exec of PHE at the time emailed the director of adult social care in the Department of Health, particularly because, as I've mentioned already, our health protection teams had a strong local link with the adult social care sector in the locality, with the providers and with the commissioners and local government. And I think it was generally reflected that the Department of Health and Social Care had taken on social care responsibilities in 2018 but did not have those strong, robust links with the sector at the time of the end of February/beginning of March.

And so we were offering our support in the guidance and any of the areas that the Department wanted to work with to develop the future adult social care guidance.

Q. You go on to say that on 8 March, DHSC had emailed raising concerns that the February PHE guidance was "not meeting the needs of the care sector". And no doubt reference, perhaps, to some of those entries we looked at on that Excel spreadsheet, and DHSC asked for a plan for updating the guidance.

Can we just have a look, please, at the -- really what was missing from the February guidance, if I can put it like that, and it might help you if we have

a look on screen at INQ000325229, page 2, please. Thank you very much.

This is an email on 9 March from Ros Roughton to a number of people in PHE talking about the draft guidance, but can we see in that first paragraph the "comments on the guidance headed 'Guidance for social or community and residential settings'", that's the 25 February 2020 guidance, isn't it?

A. I don't know --

Q. -- (overspeaking) --

A. -- if the comments on the guidance were on the 25 February or the new draft guidance that was being developed.

Q. Sorry, they are talking about, I think, changes that they are proposing for the 25 February guidance. All right. And you can see there:

[As read] "I recognise the guidance has been through several clearance procedures -- I minimise my comments."

The comments are about patients:

"We need to be clear it's not just elderly people who are vulnerable. It might also be children with complex conditions".

Setting:

"The language is all about care settings ... we should be clear that this applies to people being seen

at home by home care workers. It makes clear at one point in the background, but I think the reference continually to care settings seems odd. Could we say 'care settings or people's homes'?"

There's concern about the definition of close contact.

"Missing questions from the sector. This doesn't cover quite a lot of things that I know the care sector would like to see, if the Covid-19 becomes more widespread. This is where the need for more detailed guidance. So do we need to signal 'There will be further guidance on the management of Covid-19 ... settings, in the event that there is a wider outbreak'."

LADY HALLETT: Could you remind me, Ms Carey, the date of these comments?

MS CAREY: This is 9 March 2020.

LADY HALLETT: Thank you.

MS CAREY: So it's Ros Roughton raising with PHE a number of concerns about the guidance.

Do you know, was any engagement with the care sector being envisaged in the run-up to the publication of the 13 March guidance?

A. So, again, my understanding is that Ros Roughton and the adult social care team were leading that engagement, that's where the enquiries had come from, and they were

leading the discussion and engagement with the adult social care sector but that members of PHE such as Paul, as in this email, and others leading on the adult social care guidance, would have been attending those meetings with them.

I don't have records of what meetings took place and when they were.

Q. Now, the 13 March guidance said that if neither the carer nor the person being cared for was symptomatic, no PPE was required.

Given that by 13 March there is now community transmission and I assume PHE -- put the SPI-M-O document to one side -- I assume by 13 March, PHE knew that there was community transmission.

A. Yes.

Q. Can you help with why there was no reference in the 13 March guidance for the need for PPE if neither the carer nor the person being cared for was symptomatic?

A. So, again, this is based on the established principle which actually was the same in hospitals; in hospitals if neither the carer -- the patient or the carer had any symptoms, that would not have required PPE either. You only use PPE in hospitals or any other setting, in all the years prior, and at this point in the pandemic in all settings, for individuals who were symptomatic.

So I think this is not just as something specific to the adult social care sector; this was the widespread management of infectious diseases, and continues to be the widespread management of the infectious diseases post-pandemic, where PPE is predominantly used for those individuals who are symptomatic.

Q. Right. Thank you.

Now, clearly that guidance did not protect against asymptomatic transmission. Was there a reason why, as at 13 March, the protection against asymptomatic transmission was not written into the guidance?

A. So again, I would say that at this point asymptomatic transmission was thought of as highly unlikely still, not impossible, but actually, the balance of evidence was that that was not what we were seeing in the main. The reports were talking about individuals were being detected with asymptomatic infection but that is not the same as who is most likely to transmit, and the consensus at that time remained that the people most likely to transmit were those with symptoms and not those without symptoms and who were fit and well.

Q. For the avoidance of doubt, was the reference to there not being the need for PPE unless the person was symptomatic, or the carer was symptomatic, anything to do with the limited supply of PPE that was prevalent at

this time?
A. No, that was the way IPC was managed throughout all sectors. Before and during, at this point.
Q. Can I ask you about two particular pieces of the 13 March guidance.

If I could have on screen INQ000300278, page 3. And then we'll look at page 4. And if I could have blown up, please, the bottom paragraph:

"How care homes can minimise the risks of transmission."

As at 13 March, is it right that PHE advised care home providers to review their visiting policy by asking no one to visit who has suspected Covid-19 or was generally unwell, but there is no blanket ban certainly in this guidance; is that correct?
A. Correct.
Q. And can you help with why at this stage care homes weren't advised proactively to ban visitors?
A. So I mean, I think from my point of view where we stood at that point is that there was community transmission, and we were seeing rising numbers entering hospitals. It got extremely rising numbers over the following couple of weeks. I can't remember the exact number of cases on 13 March but it was definitely below 100 cases detected in the whole country. So that's quite a small

number for a population of 70 million so it was really in the small numbers. But we knew that there was community transmission happening.

And from my point of view, what this is again, trying to continue with the standard advice that would have been available in winter, where we ask visitors not to attend if they're unwell with respiratory viruses in general because they can transmit.

So in the sense this was trying to highlight for Covid-19 to continue that, to review that, and to highlight that individuals who were visiting should have good hygiene and not be symptomatic with respiratory illness.
Q. Can I go over the page, please, to page 4 and the guidance issued where a resident has symptoms of Covid-19. If we could just have the top paragraph blown up, thank you.

"Care homes are not expected to have dedicated isolation facilities for people living in the home but should implement isolation precautions when someone in the home displays symptoms of COVID-19 in the same way that they would if an individual had [flu]. If isolation is needed, a resident's own whom can be used. Ideally the room should be single bedroom with en suite facilities."

Now, Professor, can I ask, reference to "isolation precautions", what did that actually mean for the person reading the guidance trying to implement it?
A. Again, I think it will have had other elements mentioning that. In this guidance it did, as I recall, which is gloves, aprons, and a face mask. And that will have been in other parts, actually -- actually, it says "aprons, gloves and fluid repellent surgical masks" in the next paragraph, and:

"If there is a risk of splashing, then eye protection will minimise risk."
Q. So the isolation precaution was actually to put on various pieces of PPE?
A. As well as, in -- if isolation is required, a resident's own room should be used.
Q. Yes.
A. So it's a group of measures that you do to reduce the risk of infection.
Q. The reason I ask you this is, if the resident has symptoms of Covid-19, how is the care home to know if isolation is needed or not? I just wonder if this piece of guidance is explicitly clear about what you're telling the care home to do here.
A. So I think -- I mean, again, I would have to go through it, but I'm pretty sure that it's saying that -- in this

guidance -- if the individual has Covid-19, that the individual should be isolated, and that in further places in this guidance it will have spoken about calling the health protection team for advice.
Q. It certainly makes reference to calling the health protection team, but I have checked and it doesn't mention isolating the individual if they have symptoms of Covid-19, and that's why I wanted to ask you about it. Because the only reference to isolation is this paragraph here for people living with Covid-19, that they should implement isolation precautions, ie putting on gloves, masks -- (overspeaking) --
A. And if isolation was needed, a patient's own room can be used -- (overspeaking) --
Q. Yes, but how is the care home to know if isolation was needed? You're not directing the care home to isolate.
A. I understand that you're saying this. I think that with many years of experience in isolation precautions, adult social care would have --
Q. They would know?
A. -- would have done that.
Q. There is nothing in this guidance about how long the patient with symptoms of Covid-19 should be isolated for. Can you help us with why there isn't a time limit or a timeframe put on how long isolation should be for?

A. I think this was also trying to utilise the generic guidance that was available for the public that was issued approximately at the same time, which was that if you had symptoms of Covid you should isolate for seven days.

Q. Right.

A. Subsequently in care homes, that was lengthened because of evidence that elderly people shed the virus for longer.

Q. Just reading this, it doesn't sound very directive to care homes, if I could put it like that: you could do this, you can isolate -- have isolation precautions, if isolation is needed then isolate, but we're not going to tell you how long for.

Do you think this was sufficiently clear for care homes when it was drafted for dealing with people where they had symptoms of Covid-19?

A. I think, looking at this now in isolation, I'm sure we could improve the clarity. I think it's really about the discussions that were being had with the care homes and the health protection teams at the time.

Q. I ask, Professor, because four or six days later, depending on which date you look at, we have the hospital discharge policy coming out to NHSE -- from NHSE, I should say, on the 17th, and then the actual

guidance that accompanied it on 19 March.

So, given that we're about to have expedited discharges, do you think, on reflection, that the 13 March guidance should have been more explicitly clear about the need to isolate people with Covid-19 symptoms?

A. I would highlight that PHE did not know about the 17 March guidance at this time or on 17 March.

Q. Yeah. So you have the left hand and the right hand not necessarily knowing what they're doing?

A. I'm afraid so.

Q. Leaving the care home in the middle without the explicit guidance to isolate the resident if they have Covid-19, but the hope and expectation that they will know from previous guidance that they should be isolating; is that what it comes to?

A. Well, I think that -- I mean, I recognise the challenges looking at this guidance. I completely do. In hindsight, five years later, I look at it cold and it looks like this. I think it's important to acknowledge that. And important to build that into improved guidance for the future.

The point at the time was that there was established procedures for isolating individuals with respiratory infections, and this was building on this and talking about Covid-19, with the ability for every care home to

contact the health protection teams and have a discussion about the individual management, and recognising that it was really dependent on the care home shape, size, building, and that trying to write the guidance for the very wide variety and sizes, capacity, capability, was quite challenging.

So I think the words are not necessarily -- not as instructive as -- delivered as points of "you must do" in order to facilitate the various challenges that the care home sector might have had in delivering it.

Q. Now, two weeks after this guidance there was the Washington care home results published.

If it helps you, it's at your paragraph 3.30 onwards.

But on 27 March the Washington care home study published an early release of their findings. And without taking you to the precise detail, do you agree, Professor, it was an important study in relation to asymptomatic transmission at that stage because it tended to suggest that there was evidence now of asymptomatic transmission?

A. So that's not what the study had said, actually. The study highlighted that it referenced potentially asymptomatic infection. It said that this may suggest that there is and the relative contribution remained

uncertain. And so it's really important that it was actually the study that -- when it came out, there was a lot interest globally because it was the first care home study.

I would highlight that three out of the 23 that tested positive remained asymptomatic throughout, so it was really potentially highlighting that people were testing positive before they developed symptoms, and that gave us an early inclination on that.

Q. Right. Notwithstanding that, though, it was evidence now, of some asymptomatic transmission; do you agree?

A. I think there was potential. I don't think we can say for definite.

Q. All right, so you wouldn't -- (overspeaking) --

A. It was a single study in a single care home with a small number of residents, and where we needed to build on this and understand it better.

Q. Right. So what were the implications, if any, of the Washington study on consequent guidance?

A. So, I mean, I think that, first of all, the implications on that were really about highlighting -- I think the following week we released the sort of wider guidance about wearing PPE more regularly for all staff and residents in care homes and hospitals, particularly because of the asymptomatic infection risk. That's the

first thing.

Secondly, it really help us to ensure that we were developing our own studies that were larger and across a multiple variety of care homes, which was subsequently done at the Easter weekend, less than a couple of weeks later, as soon as we had testing capability.

And it fed into, then, the wider guidance that was subsequently developed on care homes, and to the idea that we would have wider testing in care homes at subsequent moments.

Q. Bearing that in mind, on 2 April there was the 'Admission and Care of Residents during COVID-19 Incident in a Care Home' guidance, more easily expressed as the "April admissions guidance", and I'd like to ask you about that please, and it may help if we look at it on screen.

Could I have on screen INQ000528401_4, please.

This is from the April admissions guidance, and I'd like to ask you, Professor, please, about the paragraph there with the bold highlighting in it.

It makes the point that the care sector is looking after many of the most vulnerable people in our society, that in the national effort the care sector plays a vital role in accepting patients as they are discharged.

"Residents may also be admitted to a care home from a home setting. Some of these patients may have COVID-19, whether symptomatic or asymptomatic. All of these patients can be safely cared for in a care home if this guidance is followed."

In this guidance, there was advice that symptomatic residents be isolated and cared for in a single room. There was no advice to isolate asymptomatic admissions to a care home. Can you help us with the sentence "All of these patients can be safely cared for in a care home if this guidance is followed"? Because many may think that was a rather bold claim to make. And so what does PHE say to that?

A. So, first of all, just my recollection of this guidance, this is the guidance that was led by the department -- coordinated by the department, with NHS, CQC and Public Health England.

Q. Yes.

A. So it was a consensus guidance across the four organisations. The final version of this guidance will have been reviewed by ministers and seen by the office for the CMO and reviewed by them as well.

So it will have had a lot of different views in it. I think -- again, on learning, there's very few times that I would say all or a hundred per cent or in

guidance now, because I think it's far too certain, especially as knowledge was evolving. I don't and I can't say why it was decided to put those exact words in there, and I think, looking back, it is potentially too reassuring to the sector from where we are right now.

But I would then also add is -- is when we talk about asymptomatic infection it could mean every single person in the care home and every single staff. So it's trying to weigh up the balance of finding the people who have got symptoms who you want to ensure they are not spreading, versus the rest of the care home residents and staff where you want to ensure that they can continue to live their lives as much as possible, and be cared for in the way that's right for them.

So it's always that sort of balance of risk and benefits in this.

Q. Right. You say now you can't answer now why or who inserted it, why it was included. Do you know whether it was designed to ensure that hospital discharges didn't get blocked by care homes? Is that really what the tenor of this was about?

A. So I definitely recall that there was a large amount of discussions about ensuring that hospitals had the space to look after the severely ill individuals of all ages

who required hospital admission, hospital treatments that are only available in hospitals. And at this point, there were increasing worries that we were going to run out of hospital beds. Nightingale hospitals were being built, for example, to try to provide extra capacity.

I also know that in the routine, as we set out at the very start of the looking at the guidance, care -- individuals are discharged from a hospital to a care home once they've had their initial acute episode treated, whilst they may still have elements of infection. And of course, on a normal basis, many individuals get discharged from a care home who may be asymptomatic as well, but we don't routinely test them for other infections.

Q. Can I ask you about PHE's work in the build-up to the consensus admissions guidance, if I can call it that.

Can we have up on screen, please, your paragraph 7.16 at pages 94 and 95. And if it helps you, Professor, I'm at paragraph 7.16 in your statement, because as I understand it, prior to the April admissions guidance, PHE had been developing its own internal operation guidance for healthcare protection teams to effectively manage outbreaks, and can I tell you where I'm going, just to help everyone else

following, what PHE were working on does not accord with what appeared in the April admissions guidance? Do you agree with that as a very broad proposition?
A. I think, actually, lots of it does. There are a couple of elements that do not and I think it's worth pulling those out a little bit more.
Q. Yes.
A. My understanding and, again, from the teams who were doing this, and from the health protection teams who were developing this, to help them in their job, that this was being done in -- to help the teams do -- in response to the NHS guidance that had been released.
Q. Right.
A. So my understanding is that this guidance had started to be developed on 22 March, so it was very much a first draft, while then the Department asked for the agencies to come together.
Q. If we look at paragraph 7.16, this is what PHE were going to -- in developing the guidance at that stage. They make the point that decisions on transfers need to be carefully considered, taking into account local epidemiology and capacity.
Put aside the healthcare tracking, but go down to the "General principles" if I may. Thank you very much.
"Transfers into the care home": where there is an

ongoing outbreak of Covid-19 in the care home, PHE were intending to advise against any transfers of asymptomatic patients into the care home to avoid, presumably, them becoming infected by the care home that's already got the outbreak; is that right?
A. Yes, and again, this would be predominantly people coming from hospitals or the communities. So it would affect both, where people are returning from a hospital or returning from the community. That is particularly challenging, I think, in the element where you're trying to ensure that you'd free up beds in hospitals. So it's recognising that, and I think, again, it's clunky language because it talks about patients. I'm not sure where those patients, if it's a hospital patient, for example, versus a resident.
Q. Right. But it was going to be PHE's position that if the care home has got an outbreak, you don't send anyone into that care home, in a nutshell?
A. That's generally regarded as the scenario that they would try and follow but I think you can see that if in -- if there is a situation where somebody needs to be admitted to the care home, where there is an outbreak, you would try and segregate those individuals from other individuals who are known to be infected.
Q. If we could scroll down a bit further, where the care

home has got a single case of Covid-19, ideally all transfers in should be avoided to protect new residents but if appropriate, facilities for isolation and cohorting of asymptomatic contacts can be assured, and transfers can be considered.
And if there's no Covid in the care home, previously confirmed cases of Covid who have no longer got symptoms and they've been isolated can then be transferred.
Now, do you agree that on any view that is a more restrictive approach than what ended up in the 2 April admissions guidance?
A. I absolutely agree this is more restrictive. I also think there are things in this that probably wouldn't have got through all the phases of clearance in the organisation because of some of the language that's been used, but I think that from my point of view, the point of -- the consensus guidance that came out was that it was bringing together the views of all of the organisations involved, the Department of Health, CQC, NHS England, and PHE, to agree the balance of the risks and benefits for both the discharges from hospital and to protect the care homes. So I don't think it was binary one or the other.
Q. In due course there are emails where NHS England certainly were concerned that this might create blocks

in the system, their phrase not mine, I hasten to add. Do you think, however, that PHE should have held a firmer line and said, "I'm afraid, if we've got cases of Covid-19 in the care home or no cases, there does need to be more restrictions on allowing admissions in"?
A. So I think this is always a sort of balancing act between organisations, and a balancing act of what the directions are from government, as well, actually, as an executive agency. So we can talk on the evidence, and we can talk on where we know there's evidence, and then where we have unknowns at the time. At this point in time, there was a priority to free up beds in hospitals for the -- and that was one of the priorities for government. I think when I look at this and balance it with the other component, the piece that I would say in retrospect, as we've moved on and understand more about the virus, is how can people come into the care home and then be safely isolated as much as possible in the care home, is the piece that could have been strengthened in this, rather than all of the elements that are sitting here in front of you in this guidance.
LADY HALLETT: Sorry to interrupt, but had PHE been more insistent about what precautions should be taken, it might have forced other government organisations or departments to consider step-down facilities or

something. In other words, not taking a Covid-positive patient because they were a patient before they're discharged from hospital, and putting them into a care home where you had a lot of very vulnerable people.

A. So step-down facilities were considered and were part of the plan, as I recall, both on the 17th and subsequent 19 March guidance that was released from the NHS. I think clearly it depends -- every day an individual, and especially an elderly individual who remained in hospital as hospitals were rising with the number of cases of Covid, also increased their risk of getting Covid. And so there was this worry at the time that if individuals stayed in hospital for prolonged period of times, then they were having an increasing risk of Covid.

LADY HALLETT: No, but we're talking about somebody whose had symptoms, who has already got Covid.

A. So the individuals with Covid who had symptoms, in the discharge guidance, they were only accepted into the care home if the care home had isolation facilities for them. That was the -- on the guidance that came out in April, individuals who had had Covid in hospital, confirmed and treated, unless they had completed a prolonged isolation period they were asked to be isolated in the care home or were sent to another

facility.

LADY HALLETT: Thank you.

A. So that's really clear.

LADY HALLETT: -- (overspeaking) --

A. No, no, we would not have accepted that. The challenge is the individuals who had been in a hospital who had no symptoms, and where the risk was rising. It's those individuals who had no symptoms that I think is the piece in the middle that there was an argument about.

LADY HALLETT: I follow. Thank you.

MS CAREY: May I ask you Professor, you mentioned there a number of times about the need for being able to safely isolate patients. Did PHE know how many care homes had the capacity to safely isolate?

A. I don't think -- I certainly wouldn't have had a number. We did know the structures of care homes and locally between the local authority and the health protection team. They could have had that discussion. Care homes were generally mixed -- some -- there was very few care homes that shared bedrooms but there were many more care homes that shared bathrooms and therefore it was, could you isolate a single bathroom to a single patient if they needed it? Could they use a commode in their bedroom for that short period, were all of the things that would have been considered. Or if they had to

share a bathroom, how could the bathroom be cleaned after their use? So it wasn't as binary as if they didn't have a bathroom they couldn't use a bathroom, but what are the elements that you could do that would clean and protect the bathroom from being a transmission risk to others?

And all of those require the care home to think about it for risk assessment, and this is not just for Covid, they would do this for norovirus in care homes or flu in care homes as well.

Q. You say in your statement that -- thank you that can come down -- that there was a meeting on 24 March between PHE officials and NHS England in which concerns about the guidance were discussed, and I think on 25 March you say this:

"... recognising the pressures on acute beds, PHE 'agreed that we go ahead with the NHSE proposed changes ...' ..."

In short, discharge anyone who was fit, as IPC guidance will be able to mitigate the risks, my paraphrasing.

Why did PHE agree to go with the NHSE position?

A. So I think what that's saying is that the -- as I've just already highlighted, if an individual had diagnosed Covid-19 and needed to complete their isolation period,

they would need to be isolated in the care home. But if an individual was asymptomatic, had not been clearly clarified as somebody who had symptoms with Covid-19, then those individuals would be able to return to a care home.

That was the bit of contention, and at the time, the challenge, as I understand it, was trying to find the balance of freeing up hospital beds and ensuring that we didn't keep people in hospital beds whose risk would increase every day they stayed in hospital for Covid-19. And also then ensuring that we protected the care homes in as much as possible at the moment in time.

We can look back at that and say we would take a different risk judgement now, but that was the risk judgement that was taken at the time.

Q. Can I just perhaps deal with one final piece of guidance before we take our mid-morning break.

On 8 April there was guidance for those who provide unpaid care by friends or family.

Can I have up on screen, please, INQ000327821_6.

This is guidance from 8 April. And one can see there that for unpaid carers, face masks were not recommended, they are not considered an effective means of preventing the spread of infection.

Is that right as of 8 April, Professor?

A. So at 8 April as unpaid carers, so this is people in the community, we were not recommending for the general population face masks in general. That came some time later. So clearly at this point in time, we were recommending widespread use for face masks in hospitals and care settings and other closed settings at that point, but we'd were not recommending them in the community.

And that follows the sort of general community guidance and written in the -- in respect of that for unpaid carers in the community, who were often family or friends of individuals.

Q. Yes. You say:

"Facemasks play an important role in clinical settings, such as hospitals, where staff are trained in the use of ... (PPE) but there is little evidence of benefit from their general use outside of these settings."

Can you help me, upon what was it based the phrase "there is little evidence of [their] benefit".

A. So clearly it wasn't any Covid-19 studies because it wouldn't -- there wasn't any time to do them at that point. But it was based on years of evidence for respiratory infection, about the use of face masks to prevent the spread of respiratory infections when

community outbreaks were happening, particularly flu, preventing infections in households, in transmission when the individual is infected where other members of the household wear a face mask, and there were multiple other attempts in both populations or in settings to see whether face masks reduced the risk of spread.

In the vast majority of them, actually in all of them at that time, there was very -- there was no evidence that these were an effective measure of reducing it.

I think what was different and what we came to recognise with Covid-19, going back to some of the evidence in Module 3, was even a small benefit of reducing spread was something that we should utilise, which is why we moved to widespread face mask use in the pandemic, and why I think in a future respiratory pandemic we would use them much earlier, be it cloth, if we had a shortage of paper ones, but that idea that there is an element of a barrier, and that we would take any element of a barrier to reduce spread.

MS CAREY: Thank you very much.

Would that be a convenient moment?

LADY HALLETT: Certainly. I shall return at 11.30.

MS CAREY: Thank you very much.

(11.16 am)

(A short break)

(11.30 am)

LADY HALLETT: Ms Carey.

MS CAREY: Thank you, my Lady.

Professor, we were in April 2020 and can I ask you briefly about the Easter 6 study which was conducted over 10 to 13 April. It's at your paragraph 3.31, but in a nutshell, this was a study of six care homes in London the result of which showed that 43% of the residents tested were asymptomatic. I know you give the full figures in your statement but time precludes me from going there today.

And you also say that the study showed multiple lineages in each of the six care homes suggesting there'd been an outbreak -- sorry, that in each outbreak there'd been multiple introductions of the virus. Just help me with what you meant by that.

A. Yes, so I'll take the background numbers as read in the statement, but the lineage is just to explain.

So viruses mutate as they spread from one person to the next and by doing generic analysis of those viruses we are able to look at the amount of times it has mutated, and we're able to then determine whether those mutations are related to each other, so it could happen from moving from one virus -- person to the next which

might have one or two minor changes in the virus where we see changes that are more than ten changes, or more than 20 changes, then we know those are very separate moments of entry.

What we -- what this was really important in doing and highlighting was that, in a normal outbreak where something comes in and spreads around the care home, we would see that all of the viruses that we detected were very closely clustered together, usually with zero to two or three changes in the virus genome. When we say that there's at least six, it means that at least six are so far apart from each other they have to have been introduced separately from separate events.

We can't say, there may be some that are on the borderline which is why we won't go and say, "We think there's ten", we will say where we think the minimum is. And I think it really highlighted to us, was that there were multiple ways the viruses could get into care homes -- which we knew before we started, but it really helped us. It helped us determine that, actually, across these care homes, the same virus was in different care homes, and those care homes could be linked by workers, they may be linked by a hospital, there were lots of differently linkages, but it showed that we weren't seeing something go into a single care home,

spread and then close down, that it was moving from care home to care home.

And it was the first time we saw that.

And also, and again, this is the important bit from an asymptomatic infection and transmission, we could see that individuals who were asymptomatic and also had the same virus with somebody who was symptomatic. And so it started to give us some more insights, recognising that this study was done at a point in time, so we didn't know who was negative at the start and when they became positive, but at least it made us understand that this wasn't one thing that happened to one care home, it was lots of things happening across care homes in general.

Q. And you said that each cluster of outbreak included a member of staff, indicating a strong likelihood that staff played a critical role as a vector of transmission of the virus.

A. Yes, and again, you know, if something had come into a care home by one route and then spread around the care home, for many other infectious diseases we would see that very few staff were infected, for example, whereas here we could see that there was lots of different incursions, and that each different cluster that we could see, clustered around a staff member rather than clustering around a group of patients, or sorry, a group

of residents who lived on a particular floor, for example, so it may be residents on different floors or it may have been in different ways.

And that gave us some insight into how the infection was spreading.

Q. Do you know, because on 15 April the action plan was published, did Easter 6 findings feature or factor into the guidance that came out on 15 April in the action plan?

A. So and again, I went through my records on the dates, I don't think we had the full data on the Easter 6 by the time that happened, but what we were seeing and the insights that people were talking about that weekend because when we -- we literally had people go out to the care homes and come back and report, that was definitely feeding in, because that was being reported on a daily basis to our calls that we had together, where people were reporting on what was happening.

So it was, in effect, the health protection teams who were dealing with the incidents and outbreaks that were reporting to the national teams, reporting to the individuals who were looking after adult social care nationally and in government, reporting to the CMO. All of that was coming together. But my recollection is that we first sent the report up on Easter 6 less than

a week after we did the study, which -- it might seem normal, but that's quite exceptional in trying to get something written up and sent up.

But we were getting insights on a daily basis.

Q. The 15 April action plan announced that there would be PCR testing for all patients discharged from hospital into care homes. It started with those admissions from hospitals and then it was rolled out from admissions into care homes from the community. Can you help, were there any statistics or data to support the decision to focus on testing patients from hospital into care homes first before the rollout into the community?

A. So I think -- and again, I think this is, you know, the information and the intelligence, and I use the "intelligence" word as a way of collecting information that was being highlighted to us from care homes. So care homes were reporting that they could see an individual come from a hospital and then some clusters.

Of course that was something they could recognise as an event. They couldn't recognise where the infection may be coming in by a visitor or by another resident or by a staff member, because those things were happening every day.

But we took that seriously, and in taking that seriously, we decided, well, that was one single

intervention that we could do. I will recall that there was quite a lot of discussion because there was worry that by doing a PCR test on a resident, patient turning into a resident when they get into a care home, it might give a false sense of assurance or reassurance. So my recollection on April 15 guidance or shortly thereafter, we also said to isolate those individuals coming from hospitals.

So we were trying to mitigate what we could as the knowledge and evidence was emerging, and we were trying to reduce the risk of infection outbreaks in care homes, through lots of different measures.

Q. There was some How to Work Safely Guidance published on 17 April, initially on how to work safely in care homes. It was, then, ten days later for how to work safely in domiciliary care; can you help as to why the two pieces of guidance were not published at the same time? Why was domiciliary care later?

A. I can't in absolute know why it was done differently. I can only speculate at this point that it was likely that the adult social care was prioritised, and that the work on that was therefore done first and then work with domiciliary care providers and others took place afterwards. But I don't know exactly why those were published on different dates.

Q. Two things, may I ask you to slow down, slightly, a message from the stenographer, please.
A. Sorry.
Q. And secondly this: you just mentioned there that the care homes were prioritised, can I just ask you Professor, there's certainly a sense by some of those working in adult social care that care homes were prioritised first, then domiciliary care was looked at and then unpaid care was thought of in third place, my phrase, not anyone else's. Do you think there was such a hierarchy in terms of getting out guidance for the different parts of the social care sector?
A. So I think the -- there was a recognition, first of all, that this was affecting all parts of society. And there was also recognition to prioritise areas where the most risk was potentially occurring and where the most infections were being reported. So that we managed the components of that.

I recall -- I think there's a note of a meeting with the Secretary of State where he asked the priority to be care homes, and as an executive agency and as agencies working, we would have therefore followed his recommendation.
Q. Right. Just sticking with the How to Work Safely guidance, can I have up on screen, please, INQ000571064.

Can we go to page 4.

This talks about the guidance that was issued, how to work safely for home care that had been published a few days before. And essentially there's an email here, Professor, to help you, from the Homecare Association. It's copying in PHE and DHSC.

But there were a number of concerns raised by the Homecare Association about that How to Work Safely guidance.

And we can see them there set out: suppliers were offering masks that don't conform to that published guidance. The specification wasn't right and they didn't have sufficient stocks.

There was said to be a disparity in the guidance between two tables that recipients of the guidance were asked to look at.

And thirdly, there, a massive discrepancy between the requirements of PPE and the available supply.

So this was brought to the attention of PHE. And if I could just follow the email thread back to page 3.

We can see -- sorry, page 2, it's my fault. There we are, page 2. If we see the bottom email in this chain, Ros Roughton asks colleagues of yours at PHE:

"Anything we can do to expedite a response [to the Homecare Association's concern]? It will really help

providers."

Then if we follow up on the email chain:

"Éamonn O'Moore is going to reply, saying:

"Thanks Ros -- [the PHE] and his team are having a further meeting about this but on the specific question on compliance [of the masks] with standards, I am advised that it is for HSE to advise on PPE standards and that there [is a single point of contact] SPOC is ..."

And he gives an email.

"... I suggest perhaps useful to go to them with your query?

Then if we go up the page just once more, Dr Jane Townson, on behalf of the UK Homecare Association says to DHSC:

"... [I'm] very unhappy to being fobbed off by PHE in this way, being signposted to a faceless generic email address. We consider this to be rude and dismissive."

And she points out the number of people that are in the Homecare Association:

"Thank you for agreeing to find a real senior person for us to engage with -- we very much appreciate your support."

Tensions and feelings may be running high, but

nonetheless, there is a concern brought to PHE about the practicalities in a number of respects of that guidance, and perhaps an answer that wasn't as practical as it could have been.

Can you help with why PHE weren't able to tailor the guidance or respond to Homecare Association's concerns perhaps as quickly and properly as they ought to have done?
A. I mean, I am looking at this not having been involved in any of it at the time, and can only -- look, the vast majority of the people involved in this are no longer in the organisation, so it's quite difficult to actually even go back and ask them their recollections.

I would highlight two things. The first is that the Health and Safety Executive were the people who decided the requirements for each level of PPE, and we just -- we had a lot of time discussing it with their chief scientist and with their advisers at the time, but of course we in PHE could not give out their personal email addresses. That would have not been the role for us as an organisation. And we ourselves were also using their SPOC email to contact them. Again, because it's a 24/7 response that they were doing, like many of us, so rather than individual -- emailing an individual who may be out or in meetings, trying to have SPOC emails

was considered good practice. So a single point of contact.

So I sort of look at that and go, well, we were all trying to have somebody who could answer an email promptly rather than give to it a named individual.

That's one aspect.

On the other aspect, I mean, I recognise and I really do remember the moment in time where the challenge of getting the right masks out to people, they -- varying differentiations of the masks, were they type 2, were they type 2R, were they type 1? What could be used safely, was a very big discussion point.

And actually, part of this came down to what was in health and safety legislation, and required in health and safety legislation, versus what we thought was good enough at the time. And actually, again, I think rather than looking at this and trying to understand what happened, I think the thing for us to is to have a clear listing of: if you don't have this mask, then use this, as a protection element.

And I think I would reflect that, you know, the more widespread use even at this time when there was a lack of proper high-quality fluid-resistant surgical masks of advising people to use a cloth mask as a measure, may have been helpful, but that was felt to be a line that

we hadn't crossed before and so people were very anxious about going into a new direction in this space.

This is the sort of element where I think discussing with the people, the population, and outside an outbreak setting becomes very helpful.

Q. Can I jump forward in time now, please, just quickly deal with a couple of different issues.

In your statement, you have a section dealing with rapid evidence reviews that Public Health England were asked to conduct. And in a number of different points -- at a number of points in the pandemic, starting on 13 May, PHE were asked to identify and examine evidence of transmission of Covid-19 within care homes, and in domiciliary care. But you made the point that in relation to domiciliary care, there were no studies identified and if I can wrap it up, that persisted through a number of different reviews into 2021?

Why was there such an absence of evidence relating to transmission in domiciliary care?

A. So I'll try and explain this and I'm sure domiciliary care providers would be much better at doing this than I could ever do it. But, if you like, domiciliary care providers are often commissioned by local authorities, by the NHS, to provide care in someone's home, but some

of them are also private providers so they may be commissioned by a family relative like you or I might do for our parents, for example, to provide care in their home.

And so from my understanding is that there was a very large number of domiciliary care providers. The majority, but not all, were CQC registered, depending on whether they met the CQC registration criteria. They were delivering care in different people's homes and it may vary from week to week so it wasn't clear, the individual. There were and there are no central records of who domiciliary care is being provided to in this country and that remains the case.

And so trying to understand who the care is being provided to, the level of risk to those individuals, trying to understand the way through to the domiciliary care providers and understanding, you know, they describe there are 650,000 individuals here, how we get that information to the right place was something that was really being built during the pandemic. It's wrapped up, to some extent now, within the adult social care and the social care forums that remain in place. But I still think it is a difficult and challenging area to understand what the guidance should be, and how the guidance for caring for somebody in their own home,

often for short periods of time, and where that line is between an individual and carer and provider line.

So I think it is the challenge of that, and it's also, I think, the challenge that the majority of this is outside central government, if you like, so it very much sits within local government and the local system in what is paid for by the local system versus what is paid for by the individual themselves.

Q. You've enunciated there a number of the challenges with conducting studies in the domiciliary care sector, but do you consider that UKHSA as it now is, is able to remedy that research gap or is there any work going on to try and understand better transmission routes in domiciliary care?

A. So it's really -- I mean, I maintain it's extremely different because it's essentially looking at transmission studies in individuals' own homes, which are again, when we talk about care homes and the complexity of who visits people in a care home and who is involved, that complexity is even greater in someone's own home where a domiciliary care provider may visit any time from a couple of times a week to multiple times a day, but for short periods, and they may have other family members living in that house with them who may have multiple ways of moving in and out of that

house, and other visitors.

So I think pinpointing routes of transmission in that setting will always remain complex.

What we tried to do during the pandemic and what we will try and do in any future pandemic is work with academic researchers to try and understand transmissions in households, and I think in looking at those studies, we will work with the academic researchers about whether they can have more complex households under study that may involve types of domiciliary care. But those studies require the consent from the individuals, and it also requires quite a lot of testing. So when we did household transmission studies, it required us to test the index case and all the household residents, every day over the course of a few weeks, and that can be quite challenging, especially if someone needs care themselves.

Q. Can I turn to Vivaldi, please. We heard from Professor Shallcross last week that you approached her on 8 May about the need for the Vivaldi Study. Are you able to tell us briefly, please, Professor, why you asked Professor Shallcross to set up Vivaldi?

A. So I'll put it in three ways if that's okay. The first is that the staff in PHE who are doing epidemiological studies, including the Easter 6 study, were working flat

out. We were hiring new people all of the time but we had a limited number of people to deliver the studies that we were already doing. We had people who were trying to do response and guidance, and as well as laboratory testing.

So people were really working at their maximum limit.

So that's the first thing.

Second of all, while we had done the Easter 6 study and while we have done some small studies in care homes before, I knew from Laura Shallcross's research and some engagement I'd had with her, that she had developed a very strong relationship with the Four Seasons care home, one of the reasons why it became known as the Vivaldi Study, as part of her research that she's doing on antimicrobial resistance, which is why we had interacted.

And thirdly, I also felt, a bit like the ONS study, there's quite some value of an external organisation in doing these studies as they have the ability to be independent and be seen as independent. While I believe, and continue to believe, that our research is independent and we are able to do research and publish research independent from government, I think at this point in the pandemic, with the care home work, I really

thought it would be beneficial to have somebody who was outside government conducting that work.

Q. Did you get any sense from others of your colleagues in Public Health England that they didn't want the Vivaldi Study to take place? Was there any reticence or reluctance about finding out just how bad infection rates were in care homes?

A. I literally do not recall that. I think there was some upset that I had gone externally, just because people consider themselves able to do all of these, but as the incident director at the time, I was balancing the resources of all our teams and what they were needing to do --

Q. Can I just interrupt you there. Does that explain why Vivaldi could not be done in Public Health England, as it were?

A. So I mean, it -- we would -- we were really limited by our resource at the time and I think the number of studies that we were trying to do were challenging. I myself was one of the people who raised the idea, but I had just started the SIREN study and I had got quite a lot of people engaged on doing it and I was worried that we were going to spread ourselves too thin and therefore using external partners, which we do all of the time and which many academic researchers were involved in a lot

of the research work in the pandemic, was a way of building that resource and expertise, and Laura is -- has training in public health and worked in adult social care so was the perfect person to take this on.

Q. We've heard from her about the results, I'm not going to ask you about them, Professor, but can I just ask you about perhaps the data sharing that led to the Vivaldi results. I think there is a concern that perhaps there was difficulty in getting Public Health England's data into the NHS Foundry, which was then used by Vivaldi. Were you aware of those difficulties?

A. So I was aware that there was generally difficulties in getting the data across to Foundry but that wasn't just for Vivaldi, it was in general, and it was trying to ensure that the COPI notice that came out originally that was --

Q. Control of patient information?

A. -- control of patient information, was directed to NHS Digital and was not including Public Health England and its data so we had to get specific advice about whether we could put all of this data into this domain. What I would say from that is we need better ways of sharing information across government departments and the health and care sector all of the time and not need to construct them in emergencies.

Q. All right. Was the COPI notice varied, then, to enable Public Health England -- (overspeaking) --
A. We were given legal advice that we could follow it.
Q. All right, fine. Just one other question, please, about Vivaldi. Mr Hancock, in this statement, made the observation that in the summer of 2020, Public Health England was the source for his view that staff movement was the main source of transmission. Are you able to help with whether there was any PHE research, paper, information provided to Mr Hancock which may have led to him believing that staff transmission was the main source of transmission as opposed to a source of transmission?
A. So clearly I listened to Mr Hancock's evidence last week and we asked the teams to find if there was a document. We cannot find a document that relates to that.

Clearly this will have been discussed, particularly in the adult social care ministerial meetings, I was not in those adult social care ministerial meetings so I don't know the word and framing that might have been used. I think the Vivaldi report, of which I was a co-author, so I was quite clear on it, highlighted the variety of different ways that infection could get into care homes, and was able to show that staff, movement across care homes, lack of sick pay and other factors

was a route, but as I recall it details that it couldn't determine the relationship with hospitals partly because of missing data.
Q. Do you know whether Public Health England tried to present the Vivaldi data as its own?
A. No.
Q. Just finally on guidance, I suspect we've talked about it enough, you may be familiar, Professor, with a concern that guidance came out either too late or last minute on a Friday, was not sufficiently clear, or was contradictory. From a Module 6 perspective, because I know we've discussed this before, were you aware of complaints and concerns like that?

And if it so, is there anything practically that can be done to try to prevent that in the event of a future pandemic?
A. Look, I recognise this, and it was really a difficult moment when basically, if people were releasing guidance on a Friday -- you'll recall that I discussed this a lot in Module 3 -- and we really tried not to release guidance on a Friday. What that meant was sometimes guidance was ready on a Friday and held over till Monday, which then talks about the delay of releasing it, but there was always nuances.

To move to the future, and I think the future is

really important in this setting, within our adult social care team and our infection prevention and control team in UKHSA, they are currently working with the adult social care sector, with a very wide group of stakeholders, to set up infection prevention and control guidance that will be the basis for anything for the future. And they're taking their time to do that, to do it right, and in consultation right now, in order to have the basis and principles for any future epidemic or pandemic, and which is what we would utilise in the future.

And I think that's the right way to do it: to have as much of this bedded in, to work through the problems, because trying to work through it in a week in an emergency with 10,000 care homes and lots of different organisations, is an extremely challenging time. And I can look back and reflect and say we could do it better, but I still think it wouldn't have been optimal.
Q. Different topic there, please, and hospital discharges. And I think you said this morning that you weren't aware of the NHS England letters that were about to come out on 17 and 19 March. In your statement you say you weren't formally aware. Does that mean that PHE were informally aware?
A. Well, I mean, we've gone back and tried to check.

I mean, I can't say somebody didn't receive a phone call or our comms team weren't made aware, but it was not emailed to us that we can find in our records.

The 17th was definitely a surprise, to me, as the incident director. I think the 19th, we were expecting something further to come out, given the 17th letter.
Q. Right. What I'd like to look at, though, perhaps in slightly slower time, because it's important, is the data linkage report, at INQ000234332.

And if I can have up on screen, please, the executive summary.

This was a data linkage report published on 1 July 2021, and -- thank you.

If we just scroll down, we can see there that from 43,398 care home residents who tested positive between 30 January and 12 October 2020, it ended up that 97 of those outbreaks, or 1.6%, were identified as potentially seeded from hospital-associated Covid-19.

I just want to hear from you, please, what one can deduce from this and why the data linkage report was asked to be set up and what it shows us.
A. So the -- the SAGE, so Scientific Advisory Group for Emergencies, and the Social Care Working Group, a subgroup of that, and also, as I remember, the National Audit Office report, brought together and said

that we need to look at the data that we have and try to understand -- what -- how best we can understand hospital-associated infections into care homes.

So this was a piece of work done by one of our epidemiological teams, where, as always, they set out very clearly the case definitions so they can track and follow things over time. And what they do in doing that is they define what they believe is a hospital-acquired infection versus a hospital-associated infection, associated meaning the individual may have spent some days in a hospital but some days in a care home, so you can't determine the cause and effect, whereas "acquired" means that they were in hospital for a period of time and then stayed in hospital and got this infection.

Q. Right.

A. So we have different ways of looking at those things.

And in this in particular, they also looked at whether the case -- the incident case that was detected, so the positive case, was detected -- is the first case in a care home or was detected within 48 hours of the first case being detected. So in that very immediate period where you might have missed it or they may have been potentially pre-symptomatic or asymptomatic, and transmitted to someone else and not tested first.

So it was trying to basically come up with robust

definitions, using the data that we had, which was the pillar 1 and pillar 2 testing data at the time, mainly pillar 1, of course, until late May, early June, but pillar 1 and pillar 2 testing, link those to a care home's residential postcode -- again, not the perfect, but the best that we could do -- and then utilising NHS Digital hospital records to determine which of those individuals had been in hospital in the preceding 14 days.

So quite a lot of data, linkage, all of the hospital records were looked at, all of the testing records were looked at, and using definitions that were pre-defined coming down and rolling through to meet this particular criteria.

Q. So are we essentially saying that if the person caught Covid in the hospital and then was discharged to a care home, you could track it through to work out whether that hospital-acquired infection ended up seeding infections in the care home? Or is that too simplistic a summary?

A. If they had had a positive test. So recognising we could only do this if they had a positive test. And I will highlight, and we did highlight in the report, and for any publication that followed it, that we recognise that particularly in March and April there was

less testing done than was done later when we started to do whole care home testing.

Q. Now, that's an important caveat, because clearly it's covering a longer period of time, but certainly in the early months there wasn't the capacity of testing that we had later on.

Can I just ask you that, though, do you think this executive summary, and I appreciate the full paper does add that caveat, but do you think there should have been that caveat highlighted in the exec summary? Or "limitation" might be a better way of putting it.

A. Usually the executive summary highlights the main facts that you find. There is usually a discussion section that highlights all the potential caveats, such as testing amount, the size of the care homes, and the other components.

Q. Now, some people may think that 97 positive cases, or 1.6%, call it what you will, seems a very low number of potentially -- outbreaks coming from hospital-acquired infection. Were PHE surprised by that number?

A. Yes.

Q. Did you think it was going to be higher?

A. Yes.

Q. What did you do when the findings came out -- (overspeaking) --

A. Well, we looked at all of the other data that we could find; was there any other data that we could find that we could see and look at? I think then we looked at the fact that maybe the individuals weren't tested when they came from hospital, maybe they remained asymptomatic, as asymptomatic infection transmission was definitely more on our awareness by the time this report was being done. We looked and checked that we had the best matching that was available, how we were missing things, and I think, again with all of that, we then continued the study for the rest of the pandemic, so that we could look at it over time.

I think -- the thing I would say, and I think it's really important, and I think there is what we call an epicurve in this report, there's definitely more epicurves in the final report. What that -- is clear is that the vast majority of the infections in the care homes and the outbreaks in the care homes occurred from mid-March to mid-April, and would say that was the period of the real challenge in testing but one of the reasons why we went on to continue to do this over time to try and understand it better. And even subsequently, when we were doing whole care home testing and whole care home repeat testing in outbreaks, despite there being other measures, care home outbreaks being seeded

by hospitals ran to 3-4% in the winter of 2020, when lots of other care home outbreaks were caused by other reasons.

So I think in time we were, like, clearly this was an underestimate, but we did not know and we cannot know in retrospect what the real estimate was.

Q. No, because of the lack of testing in that -- particularly in that key month.

May I ask you for your comment on this: Mr Hancock gave evidence that he considered it was a spurious level of advocacy (sic). What did PHE say to that? Accuracy.

A. Well, this is clearly delineated in the report, we report numbers in the reports. We often then go and look at what's called a confidence interval but I don't think a confidence interval would have helped us here, and, actually, given all of the variation and the explanations that we have talked about would not have really brought anything to light. It would have told us that the number of outbreaks in a care home ranged from 0.5% to 3%. I don't think that would have materially changed the outcome here, which is the reasons for this, at the time, were multi-varied and multi-focused and, if anything, the underestimate was based on the lack of testing rather than what the true estimate was.

Q. May I ask you, so that we can have your views on it, did

PHE want to show low figures of infections being seeded from hospitals given its role in formulating the guidance and perhaps some of the, with hindsight, flaws in that guidance?

A. So my belief, then, and my continued belief now is that my scientists have a high degree of ethics and propriety. They design studies and they publish the methodology for those studies, and then the reports they publish are related to those. They do not hide data and if they did so they would be up on ethical misconduct. I believed that then and I believe that now, and that is the expected behaviour of all our staff.

Q. Thank you very much.

Can I turn to visiting, please, Professor, and just a few questions on this. I know there was various guidance that was put out in due course in relation to visiting, but can I ask you, please, about your paragraph 8.22, and in November 2020 the SAGE Social Care Working Group published a consensus statement on family or friend visitor policy into care home settings -- thank you very much. It's on screen, if it helps you, Professor -- and the key findings from that: that there was a lack of evidence on the risk of introduction and transmission of infection from visitors, although this partly may be due to timing of

policy changes in the first wave.

Can you help, from Public Health England's perspective, was there any research done on how much infection was brought in by visitors or was it not possible to do so because of the ban?

A. So I think, you know, it was really challenging, wasn't it? So, first of all, in the early points in the -- there was always something about visitors, as there was always in preceding guidance, and reducing visitors in situations of incidents and outbreaks or infections. From my point of view, I think that in order to understand, like, the lack of evidence means that there was no evidence available for us to see. And when people looked at it, not just in studies that Public Health England had done, but other studies around the world, there was -- nothing had been published that said that visitors were bringing the majority of the infection in or even the minority of the infection in.

But there was clearly a risk to it, and remained a risk in both directions of visitors bringing the -- potentially bringing infection in and visitors also then potentially acquiring infection in visiting a care home and transmitting it to other members.

So I think that, you know, that's where we came to, that was what we talked about. I think this was really

at a point in November 2020 where the visiting restrictions had already been in place for quite a long time. The increasing social distress of residents, and of their families, was increasing as time went on. I know myself, I didn't see my parents for 20 months and that was a long time. And so at this point, I think we were trying to see how we could possibly get the right level of visiting in to keep the risks low, but to ensure that people had the right social environment for their longer-term care, because this is no longer an acute emergency. We could all see that this was going to last quite some more time.

Q. Two things, please, on that. Is there any work being done now by UKHSA, or anyone else, to perhaps try and work out the extent to which, if at all, visitors brought in or are capable of bringing in an infection?

A. I mean, this comes back to what I talked about really for domiciliary care. You would have to have testing of visitors all the time. I would say that in the following winter when Omicron was present and when Omicron was circulating in high prevalence in the community, we did get visitors to test going into care homes and we did detect, in visitors going into care homes, people with high levels of virus through those was lateral flow tests, and therefore they were excluded

from visiting.

I think that sort of approach was useful as a protective measure once we had a test that we could use in realtime.

I would argue that a PCR test was not good enough for that because the time to take it, get it to the laboratory, get the result, and then do the visit would have taken too long. But in, you know, it would be nice to be able to see when infection is circulating at high levels in the community, how we could enable visiting for the residents and for the individuals who are being visited, and reduce the risk of infection.

Q. The Inquiry has seen some evidence that makes reference to an ongoing piece of work being conducted by UKHSA to quantify the benefits and risks of visitors. Are you able to give us, Professor, any update on that piece of work?

A. Yes. So this was using a tool that was developed many years ago, as I understand, by researchers in adult social care, looking at quality of life tools in adult social care. It's called the ASCOT tool. And it's a piece that is there for adult social care managers, care homes managers, and other individuals who provide care to look at the risks and benefits of the care they provide and how that can improve the quality of life of

residents in care homes or in other settings.

What UKHSA commissioned post-pandemic is working with some individuals who are experts and developed this tool, is to develop a set of teaching slides and tools that could be used to get people to really understand the individual, and those training slides are now used by our guidance teams so that they consider the individual whilst developing guidance, and those training slides have been disseminated to local authorities and to care providers.

We can share those with the Inquiry, but what it really does is it puts an individual at the centre of the guidance and then asks what changes in the quality of life you're doing by each of the aspects, and gets you to do an assessment of that, and also asks you to think about what's the deprivation of liberty, what are the changes you're making, and how that might affect them and their family.

I think it's really good because it brings person-centred care to the centre of developing guidance, and so we are now utilising that to train people about when they write guidance, and using it as a training tool for others, and we're waiting for the formal academic report from it about how that tool is being evaluated with the sector.

Q. A different topic, please. I'd like to ask you about data and surveillance by PHE and now UKHSA.

I think you say in your statement at paragraph 11.8 onwards that there were clearly some weaknesses in this area at the start of the pandemic, either there was no data or the data that there was most not linked and not collected in a standardised way.

And indeed, last week, Mr Hancock made reference to one of his WhatsApp messages from July 2020 where, to use his phrase, not mine, that PHE -- he had no tolerance for "crap data", by which he was referring to PHE data.

Help us, please, with what were the real practical issues with either -- well, obviously with having no data, that's obvious, but the non-linkage and the non-collection in a standardised way?

A. Yes, so I would say that data improved quite dramatically through the open sharing of data and the COPI notice during the pandemic. But much of that, as I recall saying in Module 3 as well, has returned to baseline.

The -- first off, the data that we received from laboratories on confirmed cases often only has a name of the individual, the date of birth, as the required. We ideally receive the NHS number and their postcode, but

many of the postcodes of the residents of the individuals is not complete. That's preceding the pandemic and -- while it's better now, because systems have been put in place, it's still not perfect.

Q. Can I just pause you, Professor.

A. Yes.

Q. We've heard that from a number of different witnesses, and it sound so straightforward just to put on some of us postcode and the like. What is the difficulty here?

A. Well, for example, say the care home or the GP in the community is sending the sample with the form, and they don't include some details, then the hospital laboratory or the laboratory receiving it don't have those details. We try to utilise being able to link it up to what's called the NHS Spine, but sometimes the details are wrong on the form, and therefore you just have missing data.

We would all like if it was better, and it is much better than it was, but it's still far from perfect.

But it doesn't say if the individual is residing in a care home when we receive the sample. And so, as I mentioned earlier, we have to infer that sometimes from using the postcode.

Q. Yes.

A. But that's not perfect, because for those of you who

have studied geography and geographers, usually 30 houses are within the same postcode. Sometimes a bigger care home would have its own, but that's the challenge that we have in trying to make those assumptions.

Q. And do you know if anything is being done to try to remedy what, on any view, is potentially quite basic information, pieces of information being included?

A. Yes, there is stuff being done, but not enough. And there are some components that I think we could improve on. It might, you know, require more than gentle encouragement, but I think -- so, for example, at the moment GP records don't include, by definition, whether somebody is residing in a care home when they're looking after them. That's pretty straightforward. We could improve that we knew if someone was being admitted to hospital that they were in a care home, because at the moment it can be recorded that they're coming in from a care home, but it can equally be recorded they're coming in from their own residence, which of course they are.

So those sort of things would make at least linkage of data easier and better. I do think, though, we need to think through what we would like to see from care homes and --

Q. That's what I was going to ask.

A. Of course.

Q. Two things then, please, when you delphically said that they might need more than gentle encouragement, what do you actually mean by that, Professor? Do you mean legislation, regulation, what are -- (overspeaking) --

A. Yes. I mean, you know, if you want something to be done, even though it might not be done perfectly, legislation is where you start, because that requires people to deliver something. Everything else is on best endeavours.

Q. We've heard there's no national -- or no relevant national data system. What do you say on behalf of UKHSA that it should cover?

A. Well -- so, for example, we hold an NHS number, uniquely, each of us, and we hold that from cradle to grave. And I recognise people come into the country at different ages, but they get given an NHS number. Somehow linking who was in a care home and the CQC registration number with that NHS number would be a huge step forward in allowing us to understand infections better.

And that's, I suppose, where I come from, is at least recording that in GP records and making it available would not be as big as infrastructure change

than asking for a new, separate care record system to be introduced. Because everyone in a care home should have a GP and, therefore, including it on the GP records and being able to extract that easily from the GP record would be a big step forward.

Q. And would that -- it sounds obvious -- play an important role in UKHSA being able to track infectious diseases, track other data trends that they needed to monitor? Is it really that straightforward? It helps you -- (overspeaking) -- surveillance?

A. If we were then able to access all of the -- so if we were able to access that data and we had permissions to utilise it, we can link it with all of the infection data that we receive, and are able to generate reports.

Q. Is access now difficult in the absence of a COPI notice?

A. So -- but, again, that can be delivered by regulation.

Q. Mr Hancock said to us that he thought there should be a national centralised database on all communicable diseases run by UKHSA. Does UKHSA have a view on that, Professor?

A. So UKHSA, as did prior organisations, collects data under the Health Protection Regulations, which are regulations that allow us to require individuals with potential syndromes of disease, which are the suspected Covid, calling us, or GPs who see someone with

chickenpox or measles. We also have the ability to collect laboratory data from a variety of infections that are listed.

It is -- we do not have all of the infections that can occur. Those -- each of those infections that are put on and each of the laboratory have to go through a system of review, public consultation, and, ultimately, secondary legislation in order to deliver it.

Personally, it would be of great help to us if we could collect all of the both positive and negative data, because that would allow us to know who was tested. And what we did during Covid-19, but what we only have at the moment for Covid and flu and a small number of respiratory viruses -- tests data that was performed. Because that would allow us immediately to track who's being tested and who's being positive and be able to link that.

That does require not just regulation and legislation, potentially, but also technological funding, both to the laboratories that are doing it at the moment and to UKHSA. The scale and size of that may be too large for the current financial climate, but that's what is required: regulation and technology to interface this.

Q. Moving aside from care homes for a moment, you say in your statement that whilst rapid progress was made with outbreak surveillance for Covid-19, this was intrinsically much more difficult for domiciliary care", I suspect for the reasons you already outlined.

But is there anything that can be done or is being done in relation to trying improving domiciliary care data?

A. So, again, I think this is even, you know, a step more complicated than care homes, because while, as I said, GPs will know who's in a care home and each GP will be looking at it, domiciliary care can be transient, so it can be in one week and it mightn't be on the next. So that will be much more difficult to record.

We are not recording anything centrally in UKHSA, partly because our focus is on infections. So I think that question on domiciliary care would probably be best answered by the Department, and on what they may wish to collect in that setting.

Q. Couple of final topics, please. You mentioned at the beginning of your evidence that UKHSA has now established a dedicated adult social care team, albeit the size may expand or contract depending on any outbreak. Do you know whether that team includes considering, the views of stakeholders, including those

who are recipients of adult social care?

A. Yes. So the adult social care team works with the social care and adult social care stakeholder fora which has patient representative groups on it and resident representative groups on it. My understanding is that, where possible, they are looking at the views of residents in care homes, and I think it's really important that it's not just the residents in care homes but their families who can often express their views, especially if they've got dementia or complex care needs, very well, in advocating for the care that they require.

Q. A couple of observations, please, that we've heard about in evidence that I'd like UKHSA's comments on. Mr Hancock told us that he found it difficult to get PHE to take on board planning assumptions based on asymptomatic transmission, and he was critical of the advice not changing until April. What do UKHSA say about that?

A. So I wasn't in meetings with Mr Hancock in March and April. I started meeting him in May, as I recall. I think that, as always, we were being driven by the evidence that was -- we knew from prior infections and from before. This evidence was also getting discussed with expert advisory groups so we had multiple experts

from across the country, through NERVTAG, New and Emerging Respiratory Viral Threat Assessment Group, through SAGE, Science Advisory Group for Emergencies, and I think the consensus view at that time, that asymptomatic transmission was a small part, or a very minimal part to play, really changed over that time period and I think by mid-April we were recognising it more in the UK, but I would note that WHO were reluctant to mention it and I think their first mention of it was probably three months later.

So I think we were trying to follow the science, trying to learn the evidence as we went along, and trying to express that.

I think I might reflect that ministers were learning a lot of new things at that time and we know that not everything can be taken in through rapid meetings, often 30 minutes, covering a lot of components. We were trying to express that evidence in the best way that we knew, and it may have been that some people were more certain about the evidence that they knew than they might otherwise have been.

One of the things that I learned in communicating was to communicate my uncertainty, and, you know, we increasingly use the probability yardstick as a way of identifying how certain we are about things in a way

that we can describe on a visual scale, as well as making a sentence and stating it.

And I think that's really important in emergencies, that when you try and write it down, you try and state how certain you are of it and how confident you are in it, and you try and communicate uncertainty, and perhaps if we'd -- if that had been clearer, then ministers may have changed their decisions but may not have either.

Q. Do you think that communication of uncertainty is something that perhaps should have featured, to some extent, in some of the guidance that we looked at earlier this morning?

A. I agree, and I think that the challenge always in guidance is to simplify it and boil it down to the simplest things, but I do also think that communicating uncertainty in the face of an emerging pandemic is really important, and also trying to ensure that people are aware of what we're trying to do to improve our uncertainty.

Q. Finally this: in your statement you set out a number of different recommendations, and I wasn't going to take you through all of them, Professor, but is there one particular one you would urge her Ladyship to consider? It doesn't even have to be one that's included in your statement.

A. Well, I will always go to -- can I go to two? Is that okay?
Q. Yes, you've got five minutes.
A. I'll do it quickly. So the first one is -- I mean, I think developing guidance because this was such a big part of this, pre-pandemic, and having principles for guidance laid out in advance of an emergency, so that we are able to bring in stakeholders' views, the lived view, into that guidance, so that people understand why we're saying things, for me is really important.

And the second, I think, is everything that we can do to improve data allows us to assess things better in those early days, and ensure that we're able to evaluate the interventions in the best way possible.

Where I think the first is, we can do within the resources that we have in UKHSA, the second requires a whole-of-government and a whole-of-system approach and does require additional finance for technology and data and digital to put together, but, you know, data is critical in being able to make decisions, especially in emergencies.

MS CAREY: Thank you very much.

My Lady, they are all the questions that I ask.

LADY HALLETT: Thank you, Ms Carey.

Ms Morris.

Ms Morris is just there.

Questions from MS MORRIS KC

MS MORRIS: Thank you, my Lady.

Good afternoon, Professor Hopkins. I ask questions on behalf of the Covid Bereaved Families for Justice UK. I'm going to ask you questions on three topics. I'm grateful to Ms Carey for covering in some detail one of my topics I was going to address with you, that was around domiciliary care.

I'm going to focus my questions first of all back on the March 2020 hospital discharge policy.

You've used the word in your evidence today that you were "surprised", on 17 March 2020, by the DHSC policy. Should, in your view, Public Health England have been cited on that policy at the ground level rather than being surprised?

A. So it was an NHS England, not DHSC, just to -- so clearly, as organisations who send out information, we don't see all to the information that goes out on a routine basis -- today or any day, that goes out to organisations. However, what we learnt in the pandemic and what we learnt really in events like this, was that we needed a single clearing system, which is what we developed, it was a single clearing system for all guidance going out that was clear on who saw what, when,

and how it went. But that was not in place in March.
Q. So the learning was: yes, we need to be sighted. Does it follow then that you should ideally have been sighted on this when it happened?
A. We should have been. I don't think it would have necessarily changed what we could have done at that time, but I think we should have been sighted.
Q. Thank you.

In her statement for Module 3, Amanda Pritchard, the then chief operating officer of the NHS, said that on 17 March discussions took place at the NHS National Incident Response Board meeting about the hospital discharge guidance -- I think you were also at that meeting with Ms Pritchard -- and there was discussions in that meeting around consideration to be given about testing practices at the discharge point to support safe care home discharges. Did PHE take that issue further, that consideration of testing before discharge?
A. So I don't recall that meeting. I don't know if I was at that meeting. I definitely don't have any recollection more than five years later on anything that you're mentioning now.
Q. Okay. So do I take it from that answer that you don't recall PHE being tasked to consider anything regarding testing from hospital discharge into care homes?

A. No.
Q. Were you involved in any conversations at PHE about whether discharging policy could be deferred, pending further capacity building around testing?
A. No.
Q. Ms Pritchard went on to say in her statement that by 1 April, NHS England understood that a large number of hospitals may already have moved to be testing symptomatic and some asymptomatic patients before discharging them into a care home. Was PHE made aware of that?
A. So not that which hospitals were, but I think I included in our statement, and we have records, of numbers of people saying, "If you can test and you have capacity, then please do."

This is not a decision of no testing required, but it's a balance of prioritisation of your testing needs. So I don't know what individual hospitals were deciding at that point.
Q. Okay. So her evidence is that she -- that they thought some -- that may have been -- but you say that PHE weren't aware that -- (overspeaking) --
A. So we wouldn't have known which hospitals.
Q. Okay, all right.

My question is, then, does -- if there was some

testing going on, does that indicate a recognition by clinicians within the hospital at that stage that there was an on-the-ground appreciation that it was inappropriate to discharge patients to care homes without that testing where there was capacity to do so?

A. So I think what we were trying to do was understand where we could test more. So, for example, in hospitals at that time, individuals may have been tested because they were developing symptoms in hospital, they may have been developed because they were a contact of a case in hospital, and they may have been tested because that, if there was capacity, it would be good to know before they were discharged.

But this was a balance of ensuring that the individual was at the right place of -- for their residence, for their ongoing care, and ensuring that the testing capacity was prioritised to the individuals who needed it for their own care.

Q. So whilst recognising that testing doesn't remove all risks associated with, for example, asymptomatic transmission, do you agree that the requirement to test before discharging into care homes should have been introduced before April 2020 -- 15 April?

A. So, first of all, when we introduced it on April 15, 2020, it was really important that it was

introduced not just as a test and discharge; it was a test, discharge, and continue in isolation. Partly because we really did not know at that point in time what a negative test meant. So, for example, a positive test we were very clear on, but we did not know how long a person would be negative before they became positive, and so there was a lot of anxieties about -- the false reassurance of a negative test at that time, and it continued for some time.

So I think, from my point of view, this was a balance on what capacity there is in testing, where do we prioritise that capacity which we were prioritising to test in care homes, in hospitals where they had capacity to test. We had a list of criteria that we had sent to them in early March about how they would prioritise testing in hospital, which included being a contact of a case, et cetera.

So that would have been part of the considerations, I think, rather than just purely discharge testing into care homes. It would have been one of the many considerations hospitals would have done in prioritising their testing.

Q. Moving, then, to the April admissions guidance. You have been asked some questions about that 2 April, you've termed it consensus guidance. And Ms Carey

King's Counsel has touched on some of the underlying emails that were exchanged around 24 March on the topic.

One of those emails referenced from the deputy SRO for PHE, Professor Johnstone, who noted that, quote "mustn't be pushed into agreeing with the consensus guidance". He also said that he had only found out on 24 March that this guidance was being written at all, so there seemed to be some surprise expressed that this additional guidance was being prepared.

The internal PHE emails record that in a meeting -- there was a view expressed by Mr Winn, the NHSE Director for Aging in his team that:

[As read] "The overall balance should be about reducing the risk of care homes not taking back existing residents or new transfers."

And it was noted in the email that their words were:

[As read] "It should be made clear to care homes that they should only refuse patients in the most extreme cases."

An email chain the following day shows that you reviewed the NHSE changes and that ultimately they were agreed by the PHE.

So do you agree that the NHSE insistence that social care should only refuse to admit transfers "in extreme cases" was incorrect, having regard to ASC governance

arrangements and their providers' duties to safeguard residents within those care homes and their staff?

A. So I think at the time there were two very diametrically opposed components that we were trying to bring together in that consensus guidance. I think it's really important that care home providers are able to do an adequate risk assessment for their -- the individuals who they are admitting and that, equally, where -- the NHS needs to understand the views of the wider sector whilst they're developing guidance, as well.

I think it's really important that we remember the moment where the hospitals were worried that they were not going to have sufficient beds to care for individuals, and we had seen that take place in other countries in Europe and in North America. So it was a real, live risk.

However, I think my view is that coming out of this pandemic, and where we are now, we should really look at what we can do to balance the needs on both sides, and that needs to bring together the care sector more eloquently into the centre of this conversation, rather than aside.

Q. I appreciate that forward-looking recommendation, but on 24 March, between then and 2 April, you're very clear to say you're trying to find a balance but was the reality

that PHE was pushed into adopting this wording with fewer safeguards for the adult social care sector?

A. So I think this is, as I've said, a consensus. So it's not being pushed one way or another. PHE, I think at the time, highlighted when somebody with Covid or known to have Covid was coming back, what that needed to be done. It highlighted what needed to be done for individuals who were asymptomatic who developed symptoms, and it was trying to draw that balance between ensuring that there were spaces in hospitals and safety in care homes, and a recognition in care homes in what they could do.

So I think there's a balance on both sides and, as always, being brought together by the Department of Health to look across the different systems and bring the whole system together.

Q. My third and final topic is returning to the issue of data, please, and in particular, the PHE linkage report. Because you say in your statement that the evidence suggests that hospital discharge was not the dominant cause of outbreaks, and that outbreak levels were broadly consistent with infection rates in the community. There's no caveats in your statement, and you mentioned, in answer to Ms Carey's questions, about whether there were any caveats in the PHE linkage report

from July 2021 itself, and that can, of course, be checked.

You accepted, in response to Ms Carey's questions, that the PHE data linkage report was based on the Pillar 1, in part on the Pillar 1 data that PHE had been using in 2020, if I've understood that correctly.

A. The data in the reports is Pillar 1 and Pillar 2.

Q. Yes, but the Pillar 1 data is limited up until May 2020 -- (overspeaking) --

A. That's the only data that was available till the start of April, but from April it was Pillar 1 and Pillar 2.

Q. And the important caveat to that is that the Pillar 1 data had limited testing capacity available to it?

A. Pillar 2 had none before that started in April. So Pillar 1 was the only capacity that was available to the country until April.

Q. Understood. So, and you have accepted, as well, this morning that it's likely that that 1.6% is likely to be an underestimate and the limitations, the caveats are around the testing capacity at that point, that data point?

A. Correct.

Q. Thank you. So there are limitations, there are caveats that can be applied to it. Mr Donaldson, who is an official at the heart of the Covid-19 response, an

office responsible for creating the Vivaldi Study, suggested that therefore extreme caution should be utilised when trying to understand the PHE linkage report; would you agree with that?

A. So I think the initial report was developed, and the subsequent fuller reports that are in peer-reviewed publications were also developed, and actually, they look at the same data and as it was developed over time, over a prolonged period of time. So even in the winter of 2020/2021, and the subsequent period of time, the amount of infections that were able to be diagnosed coming into care homes was extremely low, despite the whole care home testing being available.

So, of course, we should always be cautious on data, we are cautious on all aspects of data, and particularly in the data from -- any data from March, April, where there were limitations in testing. However, the data, as I've said previously, lays out the definitions that's utilised, lays out how the data was analysed, and applied that consistently over a prolonged period of time to try and give the best assessment they could from the routine data.

Always you should have caution in the data, you always need to understand how the data is developed and delivered, but it's clearly described in the reports and

in the final peer reviewed publication.

Q. All right, thank you. Mr Donaldson goes on in his witness statement to tell the Chair that he:

"... repeatedly witnessed how relevant members of PHE and SAGE who had overseen and failed to warn against or properly mitigate the tragic initial errors consistently used inadequate methods and extremely faulty data which played down the seriousness of the problem in care homes."

Would you agree?

A. So I'd like to see Mr Donaldson's evidence. I don't recognise that.

Q. In his concluding remarks, and it may be helpful, a lengthier paragraph, for this to be put on the screen, please.

It's INQ000598578, at page 35.

You are likely to be able to read quicker than I can speak.

A. It's not up on the screen yet.

Q. It's paragraph 111 of Mr Donaldson's statement. Thank you very much.

I'll just read it for the record. He says:

"In summary, we had to create Vivaldi because PHE and DHSC ASC Policy teams had failed to do so. We had to use outsiders because they wouldn't and perhaps

couldn't do it themselves. Parts of PHE and DHSC ASC effectively tried to stop Vivaldi happening, then tried to stop it reporting, then tried to avoid acting on the results, then tried to stop the creation and use of our data dashboard. Having tried to stop our initial report, PHE first tried to ignore it, then tried to steal it and present it as their own, then tried to re-interpret it as just identifying its own previous policy failings. DHSC refused to share data, even when ordered to by ministers, and regularly proposed not telling ministers important information. I believe that this all suggests that a pattern of disfunction that helps to explain why things were so bad with care home policymaking at the start of the pandemic, and gives a broader clues as to the systemic problems Covid revealed."

What's your response to this statement?

A. So clearly, when we talk about PHE and DHSC, it talks about large umbrella organisations. They -- organisations were increasing in size very, very rapidly. I was at the centre of the Vivaldi creation, as I've said in my previous statements in -- for Module 7, and also I've seen Laura's statement for Module 6, which I had not seen until it was released. So, from my point of view, clearly, as a member of PHE

staff and as the incident director, I was involved in its construction. So some of it just doesn't clearly recognise to me.

I discussed its development and its production with the adult social care policy team. As I would, because I wouldn't do these things by myself. And clearly, I already highlighted why we went outside, resourcing numbers of technical experts, and the availability of studies like that is to have independence.

I did everything I could to facilitate it personally and I know that lots of other people did too, in order to get it through ethics committee, right protocols, ensure that we get the data across.

So, you know, what I would say is the organisations were very big and they increased very, very rapidly in this time, and I have no doubt there was friction, and I have no doubt that there were individuals who were worried about components of it.

Is that how it felt to me as the incident director? No, people were by and large trying their best. Sometimes you had to get things done a bit faster, and sometimes you had to mobilise resource from here to there, but that was part of acting in an emergency and a response.

In terms of the results, I thought the results were

really important. They were presented at the data group which John Hatwell, one of the officials in the department leading pillar 4 brought together, where I was presenting the SIREN results at the same time. So we were presenting the results in real time, often off the top of our heads in doing it. We were relying on lots of people to share those data across organisations, and we were putting them into SAGE and to other components as fast as possible.

Clearly, sometimes it was not fast enough, right? I completely sit back and go: how could we have done things faster? But people were really working very hard. I never saw people steal data, though I'm sure that people were presenting slides that other people had utilised for another presentation over here, or there were two meetings going on and different people did it.

So, for me, this just doesn't recognise and feel how I worked throughout the pandemic, and particularly in those early months of Vivaldi.

You know, we continued to support Vivaldi as NHS Test and Trace, and we continue to support Vivaldi now as UKHSA. I think it's an important study. It was the first of its kind in the UK and globally. And, for me, everyone was there to support it, and I just don't recognise this.

MS MORRIS: Thank you. Those are my questions.

Thank you, my Lady.

LADY HALLETT: Thank you, Ms Morris.

Ms Beattie.

Ms Beattie is over there.

Questions from MS BEATTIE

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

You tell us in your statement that the PHE existed to protect and improve of the nation's health and wellbeing and reduce health inequalities; is that generally right?

A. Correct.

Q. Now on 15 May 2020, the ONS released data on deaths involving Covid-19 in the care sector, and that covered deaths among care home residents and deaths of recipients of domiciliary care.

And if we could have a particular page brought up on screen, please, it's INQ000252648, page 16. While that's coming up, that showed that, for the reporting period, there were 3,161 deaths of recipients of domiciliary care in England.

And this -- it's the second paragraph in that page, if it could be highlighted, please.

So there were 3,161 deaths of recipients of

domiciliary care in England. This was 1,990 deaths higher than the preceding 3-year average for the same period.

And just to make that easier to understand, I think that's a 2.7 times increase in the rate. But the ONS also said that the proportion of the increased deaths which involved Covid was lower for domiciliary care than for care home residents.

So my question is, did the fact that there was a much higher rate of death, 2.7 times in domiciliary care, but a lower proportion of deaths which involved Covid, require further investigation to identify whether that significant increase in domiciliary care deaths was due not only -- or not to Covid infection, but to other aspects and indirect impacts of the pandemic response?

A. So I'll start this by the framing. I think the CMO, Chris Whitty, has used that is in the past.

So when we'd were considering the impact of the pandemic and the impact of Covid, not only did we direct consider the direct harms of Covid-19, but the indirect harms of the fact -- of things that we were doing in order to reduce the risk of transmission of Covid-19, and balancing those and trying to look through them at those different lenses at different times.

So I don't know why this was, but one can speculate

that it is -- if individuals were having less domiciliary care, if they were having less family and friends visiting them, then they may have got sick and died or -- and not been recognised.

It also may be that these were not quoted on the death certificate, because that's what ONS would have utilised, as being suspected Covid. So recognising that at the time and all the way through the pandemic, on the death certificate, when you use the words "Covid-19", you can use them where the clinician who verifies the death considers that Covid-19 is either causing or at least partially responsible to the death of the individual.

So the individuals just may -- who were certifying the deaths, may not have recognised that Covid-19 was an influence, or it may have been another cause. Clearly there's lots of different reasons for this.

Q. Right. So, Professor Hopkins, you have said there that one can speculate. Aside from speculating now, what further review or investigation did the PHE carry out at the time, once it was known that there was this very significant increased death rate, but possibly due to other factors?

A. So again, we looked at lots of different death statistics and we produced excess mortality death

statistics throughout the pandemic, from PHE. That's now done by the Department of Health with the Office for Health Improvement and Disparities, looking at excess deaths for lots of different reasons. And we know that excess deaths in the community were also related to other causes, such as ischaemic heart disease, such as other pneumonias.

So I don't know on the exact cause of each of these domiciliary residents which we would have utilised the ONS data to try to understand this better. But clearly the key component is that the -- Public Health England would have utilised the data that was available in order to try to understand all of the causes of excess deaths, which were wide ranging.

Q. Did it result in any changed guidance on domiciliary care and how that was being managed as part of the pandemic response?

A. I can't tell you whether this exact report resulted in a piece of guidance change at this distance, I'm afraid.

Q. And I'd also like to ask about visiting restrictions and the March residential care guidance which you were taken to before. It doesn't need to be brought up, but that said that care home providers should review their visiting policy and that the review should also consider the wellbeing of residents and the positive impact of

seeing friends and family.

People with learning disabilities, people with dementia and those with communication needs may be especially reliant on their family and friends, including for daily communication about health and welfare needs, to communicate fundamental things like experiencing pain and discomfort and, indeed, to receive care itself, and I think you commented on that earlier in your evidence about families often being able to express those views of people with dementia or complex care needs.

Is it right that beyond that broad reference to the wellbeing of residents and the positive impact of seeing friends and family, that March guidance was completely unspecific about those needs that would need to be taken into account by residential and care home providers in deciding on visiting?

A. So again, I think this was building on evidence and guidance and how care homes managed care home admissions all the time, so I think that it would have been something in this emergency guidance that we would have gone into, how they would do that and what they would do that. There would be an expectation on care home managers that they would be able to do a risk assessment and decide which residents might need a family or

visitor to visit them, which residents would be able to do that via -- remotely, via phone, or others, and that would really be to the local authority, directors of adult social care, local authority directors of public health, as well as the health protection teams, to support care homes if they had questions on that.

Q. So in the context of all the messaging about stopping visits, was it enough to rely on homes to do, I think what you're saying, that they -- you think that they would have always done, rather than expressly setting out that where visits were not possible following risk assessment, there needed to be alternative means provided so that those communication needs could continue to be respected and people would not be isolated?

A. So I think that that is a valid point that I think came through in future visiting guidance as I recall. At the point this was trying to reduce infection in care homes, so it was not the focus of this guidance at that time.

Q. And I think you say in your statement that you consulted the Department's group of trusted stakeholders on guidance and included -- including specifically on getting feedback and suggestions on guidance content. Was that done for this visiting guidance -- or what was said in this guidance about visiting?

A. So as I recall and as it says in the statement, the March 17 had some stakeholder group involvement. I think the stakeholder group involvement got better over time, so I don't think it was probably optimal at that point.

MS BEATTIE: Thank you, my Lady.

LADY HALLETT: Thank you very much, Ms Beattie.

That completes the questions we have for you, Professor Hopkins. I'm not allowed to make guarantees but I'm fairly confident that we won't have to burden you again, and I appreciate it's not just a burden on you but it's a burden on the colleagues who help provide the statement and then support you in coming here today. So thank you for all the help you have given so far.

THE WITNESS: Thank you very much.

LADY HALLETT: And I hope it's the end. I'm sure you do.

1.55.

(12.54 pm)

(The Short Adjournment)

(1.58 pm)^sp checked

LADY HALLETT: Hello again, Professor Harries.

THE WITNESS: Good afternoon.

MS CAREY: My Lady, may Professor Dame Jenny Harries be sworn, please.

DAME JENNY HARRIES (affirmed)

Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 6

MS CAREY: Professor, your full name, please.

A. Jennifer Margaret Harries.

Q. Not your first time here, we all know, but I do that have a number of questions to ask you in particular about the adult social care sector, and for those who are perhaps not familiar with this module or the evidence you have previously given, you are, I think, still the chief executive of the UKHSA?

A. No, so I retired at the end of May, so I'm here in my own right and no longer a senior civil servant.

Q. Thank you very much for correcting us.

You were Deputy Chief Medical Officer for England from 15 July 2019 to 31 March 2021?

A. Yes.

Q. And it's in that capacity that we have asked you on behalf of M6 to provide a witness statement, so my questions are going to be focused on your role as the DCMO, as it is colloquially known.

You set out your professional background in your statement. You are a clinical doctor with specialist training in public health medicine; you hold a number of different degrees and qualifications, but perhaps pertinently to your role and indeed your role in social care, before your appointment as DCMO, you were the

regional director for the south of England within PHE from 2013 to 2019; is that correct?

A. Yes.

Q. You, had also, before that, I think, worked as a Director of Public Health?

A. Yes.

Q. In both Norfolk and Waveney, Swindon and, indeed, Monmouthshire?

A. Yes.

Q. Can you just help us, is there anything in particular, in your former role as Director of Public Health which has helped you with your advice that you gave in the pandemic?

A. Yes, definitely. In fact, the reason I ever came into the centre of government was because I would sit as a Director of Public Health and think: how is this guidance or this plan or policy going to work here? And it was actually to try to ensure that the visit of local, if you like, was imparted to national decision makers, which was generally very well received, so there's been -- it's good but it's -- it means that the working, for example, as part of -- as the chief officer in a local authority, you work alongside the Director of Adult Social Services. In some local authorities, the Director of Public Health actually is the Director

of Adult Social Services and will oversee them and vice versa.

Q. You have been involved in a number of UK public health responses and health protection incidents, and indeed, your previous roles in hospital health boards and in local authorities you say:

[As read] "... afforded me experience of both health and care services ..."

A. Yes.

Q. "... their commissioning and their delivery and indeed the functions of local councils."

A couple of things on that before we descend to some detail. In your role as Director of Public Health in Wales in Monmouthshire, was there anything in particular about your experience there that might have meant there are particular vulnerabilities in the Welsh adult social care sector that you're able to speak to?

A. So it's a little bit difficult, because I think the time period from when I was working, whereas my most recent posts have been in England, so I think that would probably not be appropriate to comment. I can comment on data in due course in relation to -- (overspeaking) --

Q. We'll come to that.

A. Thank you.

Q. Throughout your time as DCMO, did you get any sense of whether there were other people you were working alongside who had both a hospital or healthcare aspect within their knowledge, and the social care or were you a sort of rarity, if I may put it like that?

A. There are people -- and when we talk about the Department of Health, obviously there are organisations aligned to that, so in the start of the pandemic, Public Health England, for example. And some of the people working in UKHSA now are ex-directors of public health, so they have quite a lot of knowledge from the ground, in the same way that I did.

But equally, the standard Civil Service model is that somebody moves around a department, and they tend to, not always -- because people come with different skills -- they tend to move between departments to get experience of that department's function and role, and I suppose the point to raise is I was quite surprised.

My DCMO role was the first where I had actually worked directly in government, in the centre of government, and I was quite surprised at how focused the Department of Health was on my -- at the time of the start of the pandemic, on health, and NHS, and clinical topics, in comparison to adult social care.

I know that's a topic, and I think that is a point

that I found.

Q. All right, we're going to come perhaps to look at some examples of the focus being on perhaps the healthcare side as opposed to the social care side.

Before we do, though, you summarise the deputy chief medical officer's role as primarily being one to provide advice.

A. Yes.

Q. Often at short notice?

A. Yes.

Q. And working with tight deadlines. And I think throughout the pandemic, you had engagement with both Mr Hancock and, indeed, Helen Whately, the minister?

A. Yes.

Q. You also had engagement, you say in your statement, with directors of public health. And I'm at your paragraph 3.7, Professor, (v), if it helps you. You said you actively linked with directors of public health, many of whom you had worked with, presumably in some of your previous roles?

In what way did that assist you in advising as DCMO?

A. It's always good to have a -- two-way flows of information, I would like to check if somebody said, "This is what the directors of public health think", it is always good to check with the directors of public

health that that is what they do think.

I had a number of them who would provide information, almost what I would say, what's the real picture on the ground, and I would speak to some of them in different parts of the UK because clearly the pandemic hit different places in different ways, and the infrastructures were different.

I think the key thing that I did at the start, bearing in mind that the CMO was relatively new into the -- into that role, as well, was to encourage the establishment of a CMO to directors of public health meeting which continues to this day, but was not in place routinely prior to that. If the CMO wasn't there I would chair that meeting and it acted, I felt, as a conduit and professional airing space, if you like, so that directors of public health could hear directly from the centre on professional issues but also raise some of those issues back.

Q. May I ask you, then, please, about an email.

Could we have up on screen, please, INQ000151538. It's an email exchange including you, Professor, from 6 March, 2020, so relatively early on. And if I could just help cite you, perhaps, on page 3 there, thank you very much. There was work under way about a meeting that we're going to come on to look at the minutes of,

involving -- sorry:

"... works underway including in [Public Health England], NHSE [and] I ... DHSC issues ... include identifying the categories and identifying the individuals; the model for those in domiciliary care; mental health and avoiding isolation ..."

Are you able to help now, what was being referred to as "the model" for those in domiciliary care?

A. So this is now a very long time ago --

Q. I know.

A. -- and it's quite difficult to remember the detail. I don't remember the detail of a model. What I see in that email is me -- in that advisory role what I also tried to do was connect people across the system, so it usually wasn't my role to do things but if I was aware somebody was considering something to make sure they were aligned and not duplicating.

So I -- it probably just refers to developing guidance, effectively, I would think.

Q. All right, and if we go to the bottom of page 1 and I'm afraid the email continues into page 2 -- thank you very much. This is an email at the top of the page from you. You've thanked the recipient.

"Definitely needs to come back through CMOs office. A key point on this -- both for safe management of

patients, but also links to imminent potential messages on communities -- is to clearly identify (and show we have identified) the linkage into [local authorities] and Directors of Public Health.

"I am quietly working very hard to keep all 152 of the latter behind CMO so that they can be a sensible extended arm of the scientific message in top tier and unitary councils."

Now, you may have sort of alluded to this in your earlier answers, but what was the quiet work you were undertaking, and why was that necessary?

A. Well, it was basically to ensure that -- directors of public health are really important. They will be the CMOs, if you like, of their local authorities, and they know how the top of the system works as well as local system, whereas some parts of national won't, and vice versa. So, actually, using -- working with them so that they understood why decisions were being made on what scientific evidence meant that they could act as a conduit of good evidence-based intervention back to their local authorities.

So it's not so much that they was -- there's always a risk that people will go in different directions if you leave an information space, and it was really to do that. And so the meeting that I referred to was one of

those.

What this is actually doing is flagging politely: will you please remember directors of public health and local authorities.

Q. Why do you think people might -- or the department might have needed that polite reminder?

A. For the reasons which I started with, which is most of the department's work, for very good reasons, was highly focused on the health side and often on political imperatives. Waiting lists. We only need to think what people see on the front of the pages.

But I think there's an important point here, as well, which is, as I think many witnesses have said before, the department did not actually have control over local authorities or directors of public health, so the sort of standard Civil Service expectation generally is that you put something up on one department, you take the message across, and then it goes down the other department side.

But where you have a professional direct linkage, I felt that it was one that needed to be used, particularly right at the start of the global pandemic.

Q. You make the observation in your statement, Professor, that there was no dedicated team in place at the start for the adult social care response. And if it helps you

there, it's a meeting on 11 February 2020, where you make the observation:

"... there was no substantive dedicated G6 [role] (a role below a Deputy Director role) or team in place for the adult social care response."

I'm not suggesting it was your responsibility, but do you know or have any sense of why there wasn't a team already in place dealing with adult social care?

A. So I think I was asked to comment on a paper, so just -- on an email, so just for clarity, there clearly were people working on adult social care. I would not like the Chair to think that there were no resources. But when it came to a sort of emergency response like this, it's very clear from the chain that that sort of capacity was not there, whereas if you looked at the health side, there were immediately people to identify, to respond or prioritise their existing work.

Q. And you say there that indeed at that meeting -- we don't need to look at it, but there were a number of slides put up at that meeting which mentioned social care only briefly, and the predominant focus at that point was on healthcare.

Now, one can understand the need to look at the healthcare aspect, but did it mean that there was less people saying, "But what about the implications of this

on social care?"

How did it actually play out without having that expertise and that knowledge?

A. So, again, this is difficult because it's a long time ago. My sense, actually, was that the ministers, so the Secretary of State and the Minister were very, very observant on to what needed -- actually, because there wasn't so much of a routine cadre of officials working to this in the same way or the same intensity routinely on the health side, that -- there wasn't -- as I say, there wasn't a group to turn to.

Usually if you're challenged to do something, you find the group nearest to that topic, that policy topic, and actually what happened here was there was a recognition that more staff and more resource was needed, hence the comments about appointments, but there wasn't an existing team there to bulk up, if you like.

Q. Did that not hamper the response, though, if you haven't got that team to turn to? That's what I'm --

A. Well, I think, going back to the point about understanding, and this comes through, and perhaps why you will see my name appearing more frequently at the start, and then I sort of drop back more to my usual role was, I -- and it could be a personal perception -- I sensed that officials often did not appreciate how

care systems worked, how they were commissioned, what the data flows were -- or not, as we might come on to -- and therefore there's a risk of not engaging the right people to take that forward.

Now, again, this changed dramatically through the first few months, but this is what I felt was the existing position. It wasn't just for social care, though. I think this issue about the departmental -- so there was an incident very early on around declaring a very major incident in the Wirral, when passengers were coming back, where I personally -- I volunteered and said, "Shall I ring the chief executive and see if we can avert this?" Because it didn't feel necessary, to me.

What I realised was, people -- they understood the theory of the emergency response, they didn't quite realise why the Chief Executive in the Wirral, who was totally responsive, would be worried, and how they could help.

So it's kind of this lack of tangible understanding of how people would feel if they were sitting in a local authority or a care home or wherever it might be, and that was the national local disconnect.

Q. "Disconnect" was going to be the word I used. I understood -- thank you, Professor.

I think in a number of places though, in your statement, you make the observation there was limited understanding in the Department about adult social care generally. Other people might put it as adult social care being an afterthought. Is that something you would agree with or not? I see you pull a face there.

A. So that's quite a pejorative statement. I think what I would say is, departments tend to be driven by political imperatives. They have to, reasonably, respond to the requests of ministers, and as I say, I wouldn't like to suggest this was an issue of individuals at that time. The fact is, which we might come back to at the end, there is a wider imbalance historically between the attention that has been paid to the National Health Service and the attention that has been paid perhaps even to community services in comparison to hospital services, but certainly into care services. And to my mind, they are very, very firmly linked and should be on a continuum.

Q. Can we go to the meeting, please, of 11 February of 2020, and could I have up on screen, please, INQ000049363.

It's an adult social care coronavirus meeting. We can see that you are present, along with a number of other names that we are familiar with, and Ros Roughton

says this -- stated:

"... there is a tripartite plan to dealing with Coronavirus and Social Care."

One:

"Raising awareness in the sector to promote prevention."

I know it's difficult now looking back five years ago, but raising awareness about what? What particular aspect of Covid-19 needed raising awareness in February 2020?

A. I honestly can't remember. I would be guessing, I'm afraid.

Q. All right. There was a plan to deal with preparing for the reasonable worst case planning assumptions, and then putting in place the appropriate staffing and resourcing and, in fact, Professor, we know from DHSC that the team exponentially increased over this period of time.

But could we go to the second page and action 1:

"The Adult Social Care team is to work with David L to draft clear lines on who has responsibility for response (noting [the secretary's] steer that primary planning responsibility is for [local authorities]), ahead of the planned publication of [the Covid] plan. [Chris Wormald] noted that this should be framed in the context of how we will support planning nationally."

Did you agree or have any observations into input into the clear lines of responsibility lying with local authorities?

A. I, yeah, I can talk to the action below, which is to my name, but in a meeting like this, I would be there, I would put in comments and have them always listened to, and challenged or accepted as appropriate. I don't remember anything particular about this.

Q. All right. If we go to the action that involved you, I think it's paragraph 6 and action 3:

"There is a need to provide some clinical advice to cover what should happen when there is a case in a care home (to include vice on isolation, delay of transfer of care out of hospital, moving patients). This should include an assessment of the practicalities of the option, so will require input from the [Chief Social Worker] [is that] and the ASC team"?

A. Yes.

Q. And it says:

"DCMO to draft clinical advice on response to a case in a care home ASAP. This will likely to require input from [those]."

So this is in February, pre the hospital discharge policy.

A. Yes.

Q. But can you help us with what was being discussed here and why DCMO was being asked to draft clinical advice?

A. Well, she shouldn't have been. So in fact I think there is a subsequent email afterwards where I politely say this is not what I would normally do, and this is usually a role for Public Health England, but obviously try to align things.

Actually, at this time, Covid was a high-consequence infectious disease, so in fact it would have been very clear what would happen and was already in guidance, which is any case would not be managed in a care home.

So there's a slight -- and I think when I responded it was all along those lines. There were two points. One is what would happen now and then there is a longer-term wider issue about planning for cases when there are a number of cases across the country.

Q. Bullet point 8:

"JH noted ... there are some difficulties around informal carers ..."

Do you mean unpaid carers?

A. Yes. I mean, basically I think I was highlighting, just to reinforce, that not all care happens in hospitals, and not all social care happens in care homes, and there were a large number of other care recipients who needed to be considered.

Q. Yes. So you're noting there the difficulties around how unpaid carers and domiciliary care in particular -- around how isolation would work in those particular settings, and lack of information flow between private sector providers and the local resilience forums and what the triggers would be in a reasonable worst-case scenario.

Can I break those down, Professor. The lack of information flow between the private sector providers and the LRFs, do you know what was being spoken about there?

A. So this goes back to did people understand? So, as I know you've heard many times before, adult social care is effectively a large private sector model. Now, it's -- if you're thinking of in people's wellbeing and health, that can sometimes be a tricky way of thinking, and it doesn't feel very person-focused, but that is the reality of the provision model which has been in this country for decades.

And so when I'm talking there about private sector care providers, these are all individual providers of different sizes, or potentially chains, most of whom will have contracts with local authorities. And the local authorities will have data but they will not necessarily have data which is relevant to this. So

they might have contract data, how many people have gone through and have they paid the right things, but actually what you wanted to know here are all the things that you have been asking questions before.

The other point here is that it mentions LRFs, and in the early discussions I think there was a sense that the local resilience fora would be the focus of controlled support and distribution. And they did play a really critical part in things like testing and some PPE distribution, but -- and again I think there is an email. The problem with the LRF -- so I used to go to LRFs as a chair on STAC, so a scientific group, but also, on occasion, my chief executive in Swindon, for example, would delegate the role to me, so I would go as the chief executive of the local authority, and people centrally did not seem to understand that the LRF was just made up of people who did their jobs routinely and then came to the LRF on top of it. So that they didn't have a routine system, usually, of receiving data, they would work together to make their routine data streams beneficial for an incident.

So it was really trying to highlight some of those issues.

Q. Picking up on that answer, you say in your paragraph 5.12 that:

"... in the early phase of the pandemic few people in DHSC had direct or practical experience of having worked in or with care homes, the commissioning of care home services, understanding the local connections which would underpin the ASC emergency response ..."

And so is this perhaps an example of that they didn't really understand how the LRFs worked and -- not the limitations of them but just how they weren't geared up for a pandemic response?

A. I felt there was an over-expectation because if you look into a pandemic approaching, every single senior representative, whether it be the police or the chief executive from the hospital or the chief executive of the local authority, has already got all of their work cut out, and so to expect -- you know, the group would work well together, I'm sure, but there was no extra resource, it was a potential of double-counting, was how -- I was trying to warn people not to rely too much on it.

It's not a body in itself, I think that -- and it doesn't have an -- it has a very small funding stream. But it's not another big organisation that you're suddenly going to pull to respond a pandemic.

Q. You said that in your view, lack of data, which we'll come on to, and the limited understanding of how the ASC

sector practically operated meant that the ASC response required considerable and urgent efforts in that early period.

A. Yes.

Q. Are we talking February, March --

A. Yes.

Q. -- April?

A. Yes, I mean, I think this -- whenever it was -- this meeting and then I think there was another one at the start of March --

Q. Yes.

A. -- where it was absolutely recognise by ministers that there was a lot of work to do and then things really moved.

Q. As at February 2020 and in the lead-up to the expedited discharge from hospitals policy, I think you said in your statement that you were -- you contacted colleagues at NHS England and PHE to request further information on their pandemic preparations and how they would interact with the adult social care sector.

You said:

[As read] "I was concerned that the two would be developed in isolation, given the usual higher focus on acute hospital care."

Can you just help us with, if you're able, to give

us a little bit more detail about why there were potentially being plans developed in isolation given that if there were expedited discharges, inevitably some of those discharges would result in people being discharged to the adult social care sector?

A. So I will be moderately outspoken in this. The routine thing is that the health -- having worked in local authorities, the health service tends to be quite -- the hospital service, I would say, tends to be quite dominant, historically, and therefore actually the system would tend to work from the hospital health service side. I think PHE colleagues who were linked into the health protection -- you know, they have their own health protection teams in the regions, were very used to working on outbreaks and with colleagues in care settings or with local authorities. But there's always been a natural sort of divide somehow between -- I say this on a long career as I leave it now -- between the health side and the community elements.

And so what tends to happen is that everybody goes off to do their work, which is entirely right, because they all have different skills, but then the tricks not allowing the two bits to develop independently too far because you then can't join them together successfully, and you tend to end up with disparate messaging and

slightly incoherent messaging, as well.

Q. In your statement, at your paragraph 5.19, you said:

"It was clear [to you] from both the technical public health knowledge and practical experience of work in the ... hospital sector, that demand on hospitals would rise rapidly ..."

A. Yes.

Q. Understood. And that:

"... in the event of a severe COVID-19 wave ... there would be a foreseeable need to free up capacity by discharging [of patients] ..."

And you said:

"To this extent, it was something which was always known to be a realistic possibility as soon as it became apparent that [Covid was on the increase]."

But was it realistic to the ASC sector? Do you think they could see or were they ever told: it is really likely, as at February into March, before the actual letters went out from NHS England, that the discharges were coming?

A. I'm going to state the obvious which is probably that is a question to ask the ASC sector. There is, going back to previous planning, clearly there is an expectation through flu planning, for example, or whatever the issue might be, that if cases rise in one part of the system,

people need to move. But there are other reasons for doing that, as well, which we might come on to, which is you do not want elderly, frail people sitting in a hospital waiting for a rising tide of cases.

So whether the adult social care sector either had been advised or had absorbed, because I think they're also quite different things -- I think lots of people realised why theoretical plans that had been discussed over many, many years had been discussed when they were hit with the reality of a pandemic.

Q. Did you ever get any feedback given that you had a number of contacts from your previous roles, a sense of it was a surprise to them that there was going to be an expedited discharge policy?

A. I don't think I can comment on that. What I can comment on, though, is from feedback which I did include, for example from directors of public health, which is probably my more direct link into some of the conversations at the time, was that actually even the LRFs were standing up their -- we could see a big pandemic coming. Even the LRFs were not standing up their strategic coordination groups uniformly across the country. So that, to me, meant some people had logged the enormity of the task ahead, and others had not quite done it.

Q. Your statement sets out, and I'm not going to go through it all, the rationale and the reasons for potentially why an expedited discharge policy is required, but you do say this, you say:

"Lastly, I did not consider it inherently an unreasonable ask of [the adult social care sector] to isolate infectious cases."

Can you help, from your perspective as DCMO, why you didn't consider that to be an unreasonable ask.

A. Because actually, basically -- I recognise this was a novel disease, but basically, the asks of isolation and the hierarchies of control around IPC are the same that you would apply for any -- for any respiratory infectious disease. And so I think PHE guidance on flu had been updated in 2018, all of the isolation requirements and risk assessments were there, and care homes did link with, and would report outbreaks into, health protection teams and to CQC.

I mean, there is a wider issue as to, if you like, how far the country has questioned the capabilities and capacity for care homes to do that and what levels have been accepted historically. But based on what had been accepted routinely, then yes, there was a reasonable expectation, I think.

I think also, again we might come to this, in that

guidance also, it has never been the expectation that if a care home cannot isolate effectively, that there was always -- it wasn't a requirement to accept, it was a requirement to put your hand up and say, "Actually, we can't do this."

Q. Please say if this is an unfair question, Professor, but did you get any sense, as DCMO, whether those that you were advising understood that there may be care homes that couldn't isolate?

A. I think I can't answer that. I mean, even -- this is where the national/local comes in, because if I, for example, went to an individual consultant in disease control at one of the now UKHSA health protection teams, they would know probably which of their care homes were better able to do that or not, because it is so dependent on things like building size, whether there's sufficient staffing, how good the IPC training is. A whole host of things. And so it's very difficult to say that. What you can say is it would be variable across the country. And I think at national level people would understand that.

Q. Some of the guidance, and you've set it out in your statement, you were sighted upon and asked to advise upon, but not necessarily every single piece of guidance that came out, but can I just ask you about this: the

13 March guidance advised that a care home should implement what they called "isolation precautions" when someone displayed symptoms. By 2 April it said expressly symptomatic people should be isolated. And by 15 April it said isolate whether they're symptomatic or asymptomatic. So it varied across that six weeks or so period.

From your perspective as DCMO, do you think that variation was a reasonable response or should it have said from the get-go, "isolate everyone"?

A. So this will go back to discussing what was known about asymptomatic infection and, completely separately, asymptomatic transmission over that time period, and we may well come on to some of the studies because that time period was actually quite critical. It was -- I'm trying to remember my dates now, but at the point that lockdown was called, which was right in the middle of that, the preceding week, the testing was prioritised, actually identified how -- what level of community transmission there was, by increasing the testing of those patients coming in and effectively extrapolating backwards.

We then had exactly the same -- we started to have, initially, sort of, rumblings of reports from the US, for example, on long-term care facilities, and then over

the Easter period, so they're all starting to come together, were the first proper UK studies, and they got stronger, so there was sort of an initial test, how many people have we got here, then we had a period prevalence study, then we've had cohort studies.

So this is a rising tide of information, and coming through that period, and I think -- so I think it's right that the guidance changed. I think the differentiation is right in the progressive term. One can look back and start to query precisely on which date which person knew which piece of information on whether the timing was right. It feels about right, to me.

I think we also need to remember it's hugely difficult to get practical information out, so, for example, if the NHS or PHE was publishing guidance, it would need to be gridded on the national slot so it aligned with political announcements of changes, and that's very difficult. So you can have guidance ready, or almost ready, or whizzing around the system, or being signed off by different ministers in different departments, and then going out.

Q. I jumped ahead a little. I just want to ask a few questions about pre-pandemic planning to the extent that you can help as DCMO, and could I have up on screen, please, INQ000151466. It's back on -- it's actually

Valentine's Day, 2020. It's an email from you to a number of people in NHS England, and you say there to Keith Willett:

"[The Secretary of State] is, entirely appropriately, becoming very focused on the ASC planning in" -- is that reasonable worst-case scenario?

A. Yes.

Q. "... you may remember/be aware this was a significant weak interface when we exercised Operation Cygnus."

And are you able to, briefly, explain to us: what was the weak interface?

A. Well, largely, that -- actually, I have checked back on the -- what the objective of Operation Cygnus was, and I won't get the terminology quite right but the objective actually was around looking at the policy implications of a pandemic rather than actually the operational side. So I may be slightly moving ahead, but obviously if you haven't got clarity on the policy, you clearly won't have clarity on the operational side.

And so what I was signalling here was, this wasn't very well defined when that was exercised before, so can we try and do something now, ahead of it, and stay together? Which again, this was the whole point about if you can see there's going to be high demand in health services and care services, making sure that the

messaging and the actions are all aligned.

Q. Can we come on to one of the meetings that perhaps looks at a little bit more of the potential planning, and the "Coronavirus [and] Social Care meeting" on 6 March 2020.

And can we have up on screen INQ000049530 in the first instance.

Professor, you were present at that meeting along with Mr Hancock. I think Chris Wormald was there, Helen Whately was there. We can see other names with which we are now familiar. And the secretary opened the meeting by stating:

"... the impact of coronavirus [has posed] a complicated set of problems ..."

And essentially calling it, in his phase, needing to be "gripped", and Helen Whately noted "we needed to ramp up preparedness around social care".

Now, as DCMO, did you have any role in preparedness for social care or were you simply just advising on plans if they were brought to your attention?

A. So there was a social care department, if you like, group. I wasn't part of that. Obviously I would be called in to advise as appropriate on anything that they felt I could.

Q. You had noted in that meeting reference to the Washington State study in nursing homes, where there was

mortality rate of 30% in that study. Now, in fact, the study didn't come on to publish various other results --

A. No.

Q. -- until the end of the month, but you'd obviously got sight of an early indication of --

A. Well, we always are looking across the world and linking with other professions to try to get early insight, but it's important, when you do that, that actually the final publication or final data is there, or you sometimes get misinformation.

But in this case I think it was around 27.2% for residents. But noting as well, which I think Ros did, that this was a long-term care facility in the US and the demographic and the health status of those in it may well be different.

So this was a signal that says, in exactly the same way that the Secretary of State and minister for care had said was, we need to really be looking at this. It doesn't necessarily say that is what would happen in the UK.

Q. No, I follow that, but this is a warning shot, if I can put it like that --

A. Yes.

Q. -- of potentially significant numbers -- (overspeaking) --

A. -- starting to be early feed coming in.
Q. All right. So, this is us at 6 March.
Then if we scroll down the page a little bit we can see there Chris Wormald's asking for more data about the reasons why people are staying in care homes.
And then the next bullet point you flagged that:
"... the majority of the people that we're talking about are receiving domiciliary care too. [Secretary of State] agreed that we should be thinking about this in the following hierarchy: residential Home, nursing homes, domiciliary care."
Can I break down the constituent parts of that, please. You were flagging that the majority of people were receiving domiciliary care. Why would you need to bring this up in this meeting?
A. So I would flag -- I've gone back to look at this minute. I don't think this is a well expressed minute, let's put it that way. Might have been because of the urgency.
So I think what that sentence was saying, I was flagging that actually the numbers in domiciliary care were enormous. More so than in care. There are different risks to it, but it was just to make sure that we got the proportionality of approach across the whole of the sector and we didn't only focus on care homes.

Q. Can you help at all with the next sentence, which says:
"[The Secretary of State] agreed that we should be thinking about this in the following hierarchy ..."
Do you know what the "this" was referring to?
A. My sense is it was actually what we needed to do, so a very general one, but again it's a long time ago. I'm sure your next question will be on the word "hierarchy".
Q. It is.
A. And I have reflected on this because -- for -- two things, which is what made me look at the rest of the email, because there's some very strange expressions in this email. For example, somewhere further down I think it talks about "excessive deaths", whereas in fact it should be "excess deaths". So I'm not reading a lot into the word "hierarchy". I think whoever was doing the minute was probably quite new at the minutes. I do -- I am very comfortable that all of those groups were being actively considered and discussed.
Q. Did you get any sense, though, that there was a priority being given to residential homes over nursing homes?
A. Not between residential and nursing, no. I mean, the risks that were coming through, partly because of the data, were very much focused on residential and nursing, but that felt proportionate.
Q. Right. Was there any, can you recall now whether --

A. Sorry, can I just add one thing to that?
Q. Yes.
A. The only other differentiation that might come up is because -- actually in a nursing home, of course, there are theoretically -- we might come back to -- more, there's more clinical capacity, and so when you're looking at a whole nation trying to say where are you going to have respiratory care particularly or step-down clinical facilities, then obviously a nursing home in theory should have more clinical capacity to address that. So that might be another differentiation. But that's not the order, of course, in which they're described here. I think that -- to my mind, that's probably just a red herring.
Q. Thank you.
Down the page you updated the meeting on your call with the directors of public health, I think we've discussed that.
Can I go over the page, please, to the second bullet point:
"[The secretary] summarised ... a lot of work to be done ... [across] 10 different areas: workforce, financial support ... excess deaths ... data, support for non-Covid illnesses, equipment [which included PPE] [and] LRF readiness [and] collaboration ..."

Do you know how much, if at all now, IPC and isolation was discussed in this meeting?
A. I don't think that level of detail would have been discussed. Clearly PPE is mentioned, and sometimes people write that instead of IPC, that's a, sort of, shorthand. It clearly isn't the same thing. But I don't think -- the detail of isolation facilities would not have been. But bear in mind this is quite a high-level meeting.
Q. All right. And just a little bit further down, there is a bullet point starts:
"There was a discussion on how we stop carers making uninformed decisions and sending people to hospital unnecessarily."
Do you know now what the reference to "uninformed decision making" was about?
A. I don't, I'm afraid. I can't remember this. I don't think it's associated, I can see my name at the next bit.
Q. Yes.
A. I can explain the next sentence.
Q. Well, can I come on to the next sentence --
A. I don't think they're necessarily linked, is my point.
Q. Right. So you don't think necessarily the sentences are linked and, in any event, you can't, at this remove,

recall now what the reference to the uninformed decisions was?
A. No.
Q. All right. The next sentence is:
"DCMO JH noted not all LRFs have SCGs ..."
Strategic --
A. Coordinating groups.
Q. "... coordinating groups stood up at the moment, the local context is probably not playing through, flagging [local authorities] are getting FOIs ..."
Is an FOI a request --
A. Yes.
Q. -- "[Freedom of Information requests] on excessive deaths. This is having an impact on capacity."
A. Yes.
Q. Can you help explain there what is going on in that sentence?
A. So take that as a separate bullet from the "DCMO JH", and then I can explain it. This goes back to the point I just made which is that, actually, different parts of the countries were not seeing the risk coming at the same intensity and understanding.
So some of the LRFs were stood up and in active mode planning avidly, but I had reports back, you know, privately through directors of public health that not

people but I think that was accepted. What was perhaps, I felt, needed reinforcing was, the fact that the cadre of workers who were critical to this part of the service, actually, if they weren't able to isolate and have the right incentives, not only would they be an increased risk to themselves and others but they would effectively have no incentive to stop working. They wouldn't be able to because they wouldn't have any pay coming in.
Q. Thank you. That concludes what I wanted to ask about that particular note.
We know that thereafter, there was various guidance issued in mid- March and early April, and indeed in mid-April. Clearly the testing developed and capacity for testing increased throughout that six-week or so period. But can I ask you, please, about your paragraph 5.5[0] in your statement, and in particular your concern about the advice given to residents about isolation.
A. Yes.
Q. Because you say:
"[You] continued to advise on that point up to 2 April where, working directly with PHE, I reviewed and advised on the isolation period in care homes and whether it should be required for 7 or 14 days."

all of them had quite -- were quite in that active phase yet. And then, it's probably saying already that some of the questioning coming back into the local authorities was starting to have an impact on people's capacity to respond to things. So -- which was an inevitable feature, I think, going through the pandemic.
Q. And just finally on this meeting, a little bit lower down the page, you are flagging:
"... these are really vulnerable people."
Were you talking about staff or --
A. Both.
Q. -- recipients of care? Both?
A. Both.
Q. Right. You reiterated:
"... that these workers are low paid, they need protection that they receive pay otherwise these may continue to work at risk."
A. Yeah.
Q. Were you essentially saying there that you were worried that they might continue to work because if they didn't they couldn't afford not to?
A. Clearly the articulation is also a bit awry in that sentence, as well, which makes me worry about the rest of it. But yes, that's the effect of it, I mean, firstly that the people being cared for were vulnerable

Perhaps if we could have up on screen your paragraph, it might help those following.
Can we have up INQ000587394_0029.
You've set out there in italics various -- what the agreed position was, which isn't entirely replicated in the 2 April guidance or indeed in the 15 April guidance, but can you just help us now, just standing back, Professor, why, from your perspective, was it so important that there were isolation periods written into the guidance.
A. Well, obviously you needed an isolation period. We were writing -- that applied to the whole population, if you tested positive. And that's good -- it was good clinical practice. The issue here, as you've seen here, is we had an elderly and potentially frail group of individuals in a care home setting with high contacts, a vulnerable group, and then the immunosenescence, so the decrease in the effectiveness of your immune system as you age, is also an important point.
What I had just flagged in picking up -- so I would be sent guidance quite frequently and I'd try to spot things, particularly to align them or to try to spot anything that was inaccurate.
What I've spotted was that we -- in fact that PHE had written in a 14-day period of isolation, which was

fine, but it actually wasn't consistent with what we were doing for the rest of the public.

So the reason I queried it was: are we saying that this is what we would want to do? Or, you know, are you advising something different for this group because -- actually, is that fair, if you're advising a care worker that they need a seven-day isolation period after infection and you're advising a 14-day period for an elderly person? Is that fair in equality? Or is there a good rationale for advising something differently? And what the rationale was: we need to protect this population. And the 14 days went in.

Q. And on 2 April, guidance that came out advised that there should be isolation of symptomatic residents. It didn't say anything at that time about isolation of asymptomatic individuals --

A. So we are getting slightly confused, I think, because this, I think, relates to individuals who had tested positive and were running out their isolation period.

Q. Right, okay.

A. So this will be -- I know there's a separate issue but this will be either when they are discharged well, or to complete a period of isolation after they were positive, I think. But it's not clear again in this chain, actually, and again, it's difficult five years later to

be precise.

Q. Right. So from your perspective though, as DCMO, clearly you were cognisant of the need for there to be isolation periods for the symptomatic patient who was being discharged to a care home?

A. Or the well patient who had been discharged to the care home.

Q. All right.

A. And I felt that. This longer period, we'll surely come on to this, but the -- recognised that an extra seven days of isolation can be quite disabling for all sorts of other reasons for an individual, but it's not just the individual, it was everybody else in the care home who had to be considered.

Q. From your perspective, though, the need for isolation was blindingly obvious, if I may put it like that?

A. Yes.

Q. And I think you said to M7 that one of the reasons for that was the test only told you that you were negative at any --

A. The focus on the test is really -- I class it as an adjunct to an intervention. It's quite good to know, it might change some people's behaviours in some ways. You know, if you know somebody is absolutely positive, then it might actually pay more attention to them, but that

shouldn't be the thing. The really important thing is the isolation, not the test.

Q. Yeah. In fact you said --

A. The test is good for clinical care. That's exactly why it's a priority.

Q. Yes. You said, I think in M7, it's an adjunct but it's not the main intervention for keeping an individual safe.

A. Yes.

Q. Given that that is your view on this, do you think in advising the ministers you pressed home enough the need for there to be isolation written into the guidance, particularly given we didn't even have testing and testing is not the sole answer anyway?

A. So I've tried to go back over some of my emails. I don't know if we're coming on to this later, but in the 2 April guidance -- I mean, often what would happen, I would see these, I would put comments in, and then I wouldn't necessarily see the final version. So the final version of 2 April did not come past my desk, nor did come of the comments, but I had contributed.

And in the feedback to the minister, who was quite -- minister for care, who was absolutely asking all the right questions: do we want to do this? Should we be discharging patients with Covid into a care home?

I had gone back and said that we should -- there was an expectation for risk assessment to ensure that appropriate isolation facilities are available.

That I don't think has somehow come into a last version.

Q. In your statement, around this time, at paragraph 5.54, Professor, you make reference to on 1 April you and others provided comments to the Department of Health on a "Dear colleagues" letter that was being drafted go from the secretary to MPs to update them on the response:

"The content was centred on acute health sector."

And you flagged both the omission in the draft and the critical importance in ensuring the care sector -- sorry -- care staff and critically (sic) of their work to the response was recognised in the correspondence.

And I just want to ask you about why now in April, we've been flagging now for a while, if I may say, the need for the care sector to be considered, you've been trying to raise its profile, ensure that people are aware of the diverse needs of that sector. Can you help with why perhaps that message hadn't landed and you needed to rephrase the "dear colleagues" letter?

A. So I'll preface this with there were some very, very brilliant people working in the social care team in the

Department of Health, hugely hard, who did recognise theirs. But a bit like some of the work on shielding, you can say things once or twice or three or four times but you struggle to reach everybody in big departments and right across government, as well.

So, yes, you can see -- I think I've got a few emails here where I start them by "I know I sound like a stuck record but". It was important and people didn't get the intonation right at all.

I used to think if I received this sitting in a care home, sitting with my dad, who I had just commissioned services for, sitting as Director of Public Health, how would I feel about it? And often the language did not feel right. And I would usually try and comment on them but clearly I wasn't seeing -- it wasn't my job to be clearing every letter or seeing things. Where I found them, I would comment.

Q. One other topic, please, about your paragraph 5.63, and the extent to which the ingress of Covid into residential settings could have been foreseen and considered prior to April, and you say, perhaps if we could have it on screen, it might help those following; could I have page 34, thank you very much.

You were asked, Professor Harries, to what extent the ingress of Covid into care settings had been

foreseen and considered, and you said:

"It was logical that a virus which could be transmitted from person to person via the respiratory route was likely to ingress ... what was not known ... was the extent to which the elderly would be disproportionately affected by COVID-19."

May I ask you about that, because we've heard a number of pieces of evidence to suggest that actually those living in care homes and in those settings were always more likely to be considered to be more vulnerable, to particularly respiratory illnesses, and I don't want anyone to misunderstand what you were saying there, can you help with why it was phrased what was not known initially was the extent to which the elderly would be disproportionately affected?

A. I think it's the proportionality of the risk. So yes, we would expect that; yes, for the reasons of immunosenescence and the high contact environment, all of those things, those are longstanding risks for the future and need to be paid attention to. They are well known to a large degree because it happens with flu every year and we might want to reset our expectations of how much flu we can prevent and what interventions we should take, but I do think here the startling difference in age, particularly as you get above the 75

to 80 year one, this is not, I realise there will be sensitivities around age but, actually, this is just a risk factor. It is a huge risk factor which was not predicted, I think, to the extent that it affected that group.

Q. You say that:

"Whilst ASC settings would be expected to manage respiratory or gastrointestinal infections ... IPC skills and capacity were probably weaker than in the NHS. In most geographies specialist IPC skills and training capacity previously offered by some public health teams had decreased since the transition of public health from Primary Care Trusts to [local authorities]. Even in residential nursing settings, the majority of care was provided by non-clinical staff."

If that was recognised that there was a lack of training and skills around IPC, clearly that was another factor to be borne in mind at the time of the expedited discharge policy. Do you think people understood, the ministers that were making the decisions, that perhaps there were -- there was a weakness in the IPC skills in the sector?

A. So I think where I've put "recognised", I recognised, many public health colleagues recognised, I'm not sure everybody recognised and, actually, even now if you say,

IPC to most people, which is why I commented on the earlier letter, they think PPE and that is not what infection prevention and control is. And so there was definitely loss. I know with my own move from the -- having a public health team in a health primary care trust, and moving it to a local authority, I worked very hard to retain two very experienced IPC nurses, but most teams were not that lucky and most teams don't have them now. And I think, for others to confirm, that in the NHS now, there has been a gradual tailing down of infection prevention and control -- I think it's now starting to pick up again because people realise how critical it is.

Q. I understand that in the NHS, but just thinking about the adult social care sector, do you have any views, Professor, on who should be responsible for delivering IPC training in both pre- and normal -- in both pandemic and non-pandemic times?

A. So there's a formal and an informal answer. The reason I use my example, for example, of my team was because although it wasn't their formal responsibility, they used to do quite a bit of training, both on -- for things like vaccination and for infection prevention and control.

The actual answer to the question is, if you have

a private provider provision, it is up to the manager of the services and the provider to ensure that adequate IPC controls are in place, and if they are accepting patients in, for example, in flu seasons and things, then I think they have that responsibility. The practical problem comes -- and I'm sure many will understand this -- which is if you have a fragile system of care, you then have a problem which is if a standard or an ability is not there, you do need to look after those people and so I think sometimes, I've been in conversations where, you know, care homes are about to be closed down, and then you have to balance the risks of the care to the individuals who are losing their home, effectively, over what standard you're trying to implement for different parts of systematic provision.

But I think the actual answer is the provider of the service, and so all services should have that and I think the CQC should be ensuring that they do.

Q. Well, that was my next -- who should be responsible for checking that the training is in place? That's with the CQC.

May I just ask you this, though, I think there's been an acknowledgement that there is a significantly high turnover of staff in the adult social care sector, and given the high turnover, therefore, a need to

presumably roll out training with increasing frequency.

Do you think there needs to be any changes or amendments to the view that it should be the manager who conducts the training or is responsible for ensuring there is training, and the CQC for ensuring that the training is in place, given that high turnover?

A. I'd come up with a different answer, which is, if you reduce your turnover, have better career pathways and proper recognition of care workers, you will retain them longer and the education and IPC and the pride in the work that they do. I think the turnover is the problem. It's the same, actually, it's a turnover of patients in hospitals. You get risks and this is in staff in social care settings.

Q. May I move before we break, my Lady, to one slightly different topic, and I'd like to ask you about a SAGE Social Care Working Group paper from 12 May.

It's at your paragraph 5.64 in your statement, but can I have on screen INQ000587394_35.

We can see there that, as at 12 May, the SAGE Social Care Working Group presented a care home analysis paper of the 35th meeting of SAGE and you were at that meeting. And as at May the minutes record that there was:

"Extensive testing of both residents and staff is

crucial both in care homes which have reported cases and those which have not."

We've concentrated a lot on those that had positive outbreaks. Why was it important that SAGE was recognising the need for testing in those homes which did not have outbreaks of Covid 19?

A. Well, because by 12 May, some of the evidence now has been properly collated and come through, and it was very clear that there were significant rates of asymptomatic infection and, likely, transmission, I'm not quite sure proportionate of that, but -- and that therefore actually testing all of these was the case.

As the -- just a couple of points, actually. On 12 May it was actually the Care Home Working Group, so this is an error on my part --

Q. Ah, not the Social Care Working --

A. And I was not the co-chair at this point, yes, because it changed, partly because I changed it, so we might come on to that later.

Q. Right.

A. But yes, but I think by this time, by May, because of the studies that had come through, so the Easter 6, the first tranche of the Vivaldi work, which was being reported as it was being done, then it was very clear that we needed to do that.

As time went on, and when it was the Social Care Working Group and I was chairing, actually it became very evident that what we needed to be doing was testing staff regularly. And you could test patients, residents, for whom actually it was quite an invasive test with the PCR, much less frequently and still be safe.

Q. Can I just pause you there. So there was the -- initially, a SAGE Care Home Working Group, as I understand it, which then became the Social Care Working Group. And you were the co-chair of which, Professor?

A. The latter. So I think what happened -- I wasn't involved -- SAGE had a number -- SAGE saw the numbers rising and set up a small group, largely of modellers and data scientists, to see if they could see what was happening and look at some of the causes. That was set up under Professor Ian Hall, who I think you're speaking to later this week, and he, and it was called the Care Home Working Group, because it was just looking as a task and finish group at care home numbers.

Q. Right.

A. When it became obvious that there was a problem, and I was asked by Patrick Vallance to come in and chair from -- I think I was asked on 2 July, I came in towards

the end of that month, and then I recognised this was not just a care home issue, we needed to look at social care, renamed it, reformed the terms of reference, and then set in -- (overspeaking) --

Q. So essentially you broadened the remit of the group?

A. Totally, to recognise this broader area of investigation.

Q. Thank you. I diverted just to make sure we had that clear in our mind.

So this is the SAGE Care Home Working Group making this presentation?

A. Yes.

Q. Hence the focus on the care homes. Paragraph 21 there states:

"Workforce management and behaviours are key factors in transmission. SAGE reiterated the need to minimise, and ideally avoid completely, staff moving between homes. This presents a challenge to the operating model of many care home providers."

Professor, may I just forward, because we know there were many attempts throughout 2020 to either potentially bring in legislation, to restrict staff movement, but generally a move towards trying to do so. And I just want to understand from your perspective as DCMO, were you asked to advise at all about how, practically or

otherwise, it was going to be to restrict staff movement?

A. So that wasn't my responsibility. I mean, clearly I recognise this, I promote it, if you like, and advise there's a clinical risk, but that was well recognised in the department as well. Ministers were working very hard to try to understand how they could implement something whilst keeping people safe.

So, on the one hand, you had a safety risk around infection but if you can't provide a service, it's so fragile it falls over, that is a risk in the opposite direction.

Q. Just finally, dealing with the minutes of this, a little bit further down the page, paragraph 25, SAGE Care Home Working Group made reference to:

"Further targeted studies, including to understand [the] variation in scale of outbreaks between different care homes and the reasons for this, are needed."

Was DCMO or the office of the CMO involved in any way that you can recall now in asking for further studies to be undertaken, and if so can you remember what those studies were?

A. So I was aware there was work on this, and in fact I think you heard from Professor Laura --

Q. Shallcross.

A. Yes. So the Vivaldi Study was one of those that has come out of that and obviously in different capacities I have supported and funded where we could, going forward.

But there were other ones. So PHE obviously did the Easter 6 study in the earlier one, there were studies in barracks, which is not a care home, but it still gives a sense of trying to understand how ingress of virus is occurring.

MS CAREY: My Lady, would that be a convenient moment for --

LADY HALLETT: It would, certainly. I shall return at 3.20.

MS CAREY: Thank you very much.

(3.05 pm)

(A short break)

(3.20 pm)

LADY HALLETT: Ms Carey.

MS CAREY: Thank you, my Lady.

Professor, can I turn to September 2020 onwards and a few questions, please, about that.

Could we have on screen pages 40 and 41 of your statement -- thank you very much -- and that's at the bottom paragraph, 5.79. You say on 13 September you advised colleagues within DHSC and Public Health England with respect to protection of care homes. You were seeking urgent further investigation, given the

significant impact of the first wave and the rapid approaching winter and what you describe as a relatively short window of opportunity to understand, take action on any risks that could be mitigated.

And have I got this correctly, when we look at what you have set out in your statement, you were summarising where you were at for DHSC and PHE?

So if we have a look at where you were at and we go further down that paragraph, there's some italicised points. As at 13 September, or thereabouts, there wasn't any very strong evidence that hospitals were a causative risk factor in care homes through transmission of infection via discharge policies.

Upon what evidence was that assertion based, please?

A. So if I just go back to the Care Home Working Group and where I took over. So there was a lot of concern generally amongst clinicians, ministers, about the care homes particularly, and the risks. I was asked to chair what was then the Care Home Working Group. I reviewed the group there. What I wanted to do was go back completely in an unbiased way to basics and say: hang on, there's a lot of noise about this; what do we actually know? And coming completely fresh to the evidence.

So although I'd been in the SAGE group when work was

presented, I hadn't been part of that.

And so I had gone back and run a summit which included colleagues from right across the UK, it included virologists, it included people who'd done research in the care sector, so worked alongside care, it included people like Laura, who had been working -- Shallcross, who'd been working on the first stages of the Vivaldi Study. And just trying to put every head in the room, whether the work had been published or not.

The easiest way to say what we knew is that the consensus statement from May '22 -- now, I know this seems a long way down the line but there is a reason for this because, actually, the evidence that is in that was broadly presented in person, even though it was not yet published at the symposium in September.

Q. Right.

A. So that statement broadly aligns with the early evidence coming through from all of the different studies across the UK, in particular things like genomic studies in East Anglia.

Q. But this document is just designed to give an overview to DHSC and PHE of where you are at as at --

A. So this was not -- this email, I think I'll need to go to the bottom of it, but I'm pretty sure this was not actually really trying to -- I think I was a bit

agitated there actually. What I could see was some early new data coming in that said what the infection rates were in staff and residents that had just come in, and what you were starting to see was after a lull, there was quite a steep rise. Given the information, which is broadly listed here, it's just a summary version of it, there's evidence elsewhere, this was just a summarised thing, what I actually wanted to do was say: at this particular point we have an opportunity to look at this care worker force and say why are the rates going up so much? But there was -- as soon as, of course, they go up everywhere then you've lost the opportunity to investigate. So I was really trying to say, is anybody working to really ask these people what they're doing, so that we could see if there was any mitigation ahead of the winter that we hadn't thought of.

Q. We can see there that one of the bullet points says there is not any strong evidence that visitors are particularly high in disease transmission risk, if any.

A. Yes.

Q. And I'm going to come back to visiting in a moment but just remember that was in this document.

A. Yes.

Q. You make the observation that you didn't know what the

risk of transmission was for what are described as other peripatetic professionals, ie GPs going and out of care homes.

A. Yes.

Q. The association between the size of the home and the risk of the outbreak, I think we've heard evidence about that before. And can I just ask you about one of the bullet points further down the page. You say:

"We know there are cases/outbreaks in care homes where no visiting has been allowed in recent weeks which still suggests that the workforce is a particular risk."

And it may be worth keeping those points in mind when we look at visiting in a moment. Does it follow, though, that as at September there is still a concern that there is -- a main risk of transmission was still coming from staff?

A. Yes, I think that was -- I mean, there are different ingress routes, which I think have been identified, but all of the pointers were moving in that direction. And this is not to single out staff, it's actually because they were part of their local communities, and actually what you saw was, when the community rates rose, the staff rates rose as well. So the trick here was to make sure not only that the care residents were protected but the staff were protected as they came in.

The really important -- the reason I sent this was, you'll see in the -- two bullet points down from that it said there were over 1,800 positive cases last week in care homes, compared to just over 600 the previous week. So what you were seeing was this rise. And what I wanted to do was try and see if we could stop it.

Q. Right. I think though it did rise as we went through --

A. Yes, it did.

Q. -- the autumn of 2020 and into that winter?

A. This was an investigative window, though. This is why I might sound slightly agitated in the email because I was trying to say: is anybody doing anything?

Q. Later that month, on 21 September, you called together what was called a symposium?

A. Yes.

Q. A care symposium, which you organised as the co-chair of the SAGE care working group. And what was the aim of the symposium? What was it trying to do?

A. This is what I -- what I'd said further -- it was really a very strong narrative and belief, for many good reasons that you can see without deep investigation, that discharge from hospitals was seeding infection into care homes. What I wanted to do was just strip the whole thing away and say: let's put every single piece of evidence that we have, what evidence is growing,

different types of methodologies for reviewing that, and put it all in one place. And the September or November consensus statement was the outcome from that symposium.

Q. Right.

A. But the May '22 one, there's a reason for why it was so late, actually says the same thing, and is articulated much more -- it highlights the methodological soundness of the different studies we were looking at.

Q. Since you mention it, are you able to help us there, Professor, with why it was that the consensus statement that came out in 2022 so late when in fact it was based on findings from much earlier on?

A. So it will be good thing to ask Professor Hall tomorrow -- and there are some interesting points on this, so I come from a position where I'm an unbiased public health critical analyst, and you're looking to see what evidence is there and not be sidetracked by red herrings or pre-considerations. You absolutely need to say: what does this mean? What could it mean? Two or three different things, and then follow down each path.

One of the problems I think with the consensus statement, because it happened a little bit with the first one, was that although there was very significant consensus, there was One Voice, I think, which found it quite difficult to sign up to the consensus.

Q. Yes.

A. And so much of the wording, I think looking back now and reviewing that and the one we put out, is quite carefully managed. I understand the sensitivities around that, but for me, it is really important that we look honestly at the evidence and not -- because otherwise we put in the wrong protections and miss the opportunities.

Q. Well, can I pause you there, Professor, because it may be that Mr Hall is better placed to deal with the sensitivities and differing views about the -- (overspeaking) --

A. He was -- (overspeaking) --

Q. So perhaps we'll leave that for him to answer.

A. Yes.

Q. But you set out in your statement a number of the participants, not all of the participants. Can I ask you, did anyone representing the Welsh Government or public health bodies in Wales participate in this care symposium?

A. Yes, I think that was not an inclusive list that's there and there is, on the '22 statement, there is some Public Health Wales evidence which was actually included then, particularly people working on the SAIL data, I think. But I wouldn't be able to say precise names just now.

Q. But was it a UK-wide symposium?

A. It was basically anybody who had -- it was a really wide invitation. Anybody who was working on this area: can you please come and let's share thoughts and push them around and challenge each other to see what the evidence says.

Q. Right. We'll look at some of the key findings.

Can I have on screen, please, INQ000074994_0002 and you set out, I think there are four -- there were six key findings, we won't, perhaps, go through them all, but 4.1:

"Although staff-to-staff transmission has been observed to have been a contributory factor in specific outbreaks, it is important not to generalise to all outbreaks and emphasise one route over another without clear evidence -- studies undertaken so far indicate multiple introductions are common."

Indeed, Professor Hopkins told us that, Professor Shallcross has told us that, so that's not particularly new to the Inquiry now.

A. No.

Q. "Clusters ... have been observed ... many outbreaks involve cases that are spread out over a longer period indicating multiple introduction ... different lineages."

Then there is:

"The retrospective genomic analysis and seropositive studies in care homes ... find evidence for multiple routes of virus ingress ... but [again] are not systematic enough to quantify the relative frequency of different routes of ingress."

May I pause there, Professor. Professor Shallcross has told us there's at least, I think, six or seven potential routes in, and it's not easy to test visitors or necessarily to test, perhaps, healthcare professionals coming in, but do you think from now looking back, there should be more research done perhaps on the more obvious routes --

A. Yes.

Q. -- (overspeaking) -- visitors?

A. This to me, in fairness, actually NIHR funding, whether it be in social care, whether it be more in community, has tended to be focused on hospital and obvious healthcare systems and there is a definite move now into funding research, which is much more community-focused including social care.

Q. And just on next page, 4.3:

"The weight of evidence is stronger in some areas than others, however. Evidence of staff to staff transmission has emerged in the genomic analysis ([with]

high confidence). [But] Weak evidence on hospital discharge and modelling the impact of visitors ... does not suggest a dominant causal link to outbreaks from these sources."

The "weak evidence on hospital discharge", can you help us now with what research or studies that was referring to?

A. Yeah, the -- and we need to -- don't assume that the evidence -- so the evidence can be not compelling, if you like, not robust in one study, or it might because there isn't much of it, albeit -- there's a whole load of reasons for writing "weak", but what we're saying is, you can't say definitively a specific number on all of this at any particular point.

But actually there were two main studies. There had been a request from the Public Accounts Committee, I think it comes through the statements more as being commissioned in November but, to be honest, that's what we were working on as well. And the approach at that point, separate from the other studies across the UK, was to look at the data in two different ways. One was to follow confirmed cases out from hospital, and that was the PHE study.

Q. Yes.

A. Recognising not everybody got tested. The other one was

to do it the other way around, and almost look from care homes back in to those who'd been in hospital. So the two different lenses.

And what you would anticipate was either they'd say much the same thing, in which you'd have confidence, they wouldn't be exactly the same, or they'd come up with startlingly different ones, in which case you'd say: what's our hypothesis here? And then you add to it, you build a picture from different studies.

Now, NHSE/I worked on the Care Home In(?) study. It's not reported here but it was being reported as it was done into the care group at that time on a weekly basis, as was the Vivaldi Study as well.

So one of the good things about that working group was we could pick up information. If there was something really strong and robust -- later on, on testing protocols, for example -- it could go rapidly through to the care minister and change policy.

So those were two key pieces of research. And then at that symposium we had very strong evidence from the genomic analysis because you need to follow the cases through, and look at the lineage, to see how they're related, if you like, to other cases.

And then there were a number of other studies which are in the May '22 paper, from Scotland, where they'd

looked very specifically -- they'd even gone to pulling out clinical case records, and from Northern Ireland, and then there was a paper from Wales as well.

Q. Right. Thank you. That document can come down.

But you -- the symposium considered a number of things may contribute to future improvements, and one of those that was further research was carried on into the extent to which the physical layout of the care home influenced transmission.

Do you know what research, if any, was in fact carried out on the physical state in the care home?

A. So I think it would be a good question to further explore with Professor Hall, because it was actually one of the things that was picked up by the environmental group of SAGE, and he took the -- so there was a linkage through to make sure the right questions were asked. I'm not quite sure where the detail of that is now.

Q. All right. Well, we can follow that up with him, thank you very much.

Does it follow, though, if we just stand back, as at September 2020 there simply wasn't enough evidence to say which route of transmission of Covid into care homes was the most dominant. You know, there were a number of them, but not which of any of them were the most dominant.

A. No, I wouldn't say that. I think whereas you couldn't have a very precise number, I know we -- you know, the PHE one says 1.6%, but actually it's -- whatever numbers you're using, you're bound to come up with some sort of precision estimate. It's 1-2%. And what was interesting was, when you looked at studies which had been done with different data in different UK countries, they all came up with roughly 1-2%. That will be an underestimate, but actually when we look at the genomic studies, I think it was around 5%. So I think somewhere, by putting all of this together, it's definitely not the dominant ingress route.

When you -- the reason for -- and I think there is confusion about why we're using size of outbreak, but actually, there was a very, very consistent trend that when you started to do -- I don't know, tell me if I'm getting lost, but you do multivariate analyses, so you're looking at lots of different characteristics of the care home or the staffing together, or you do univariate, you just look at one thing. When you put them together to adjust, all of that difference -- the thing that really stands out is the size of the care home and then the -- which effectively is the number of contact -- people coming in and out of the care home.

Q. We may have been slightly at cross purposes. I think,

if I understand your evidence correctly, you are saying when you look at all of the various studies that are looking -- were looking at the extent to which hospital discharges were a route of ingress, they were definitely not the dominant.

A. Yes.

Q. But my question to you was, was it possible to say, having looked at all of the studies, which was the dominant route?

A. So this is what I'm saying, I think the -- from -- you have to build a picture, this is the issue with science, you're building a picture in a different direction all the time, so there's definitely -- I'm sure there were some cases from hospital admission in, that would depend on how good isolation control was, all sorts of things, but the dominant route from the evidence that we have is through staff.

Q. Staff. Thank you very much.

May I ask you, please, briefly about designated settings, and I think you'd deal with this at your paragraph 5.86, Professor, but clearly we know that in the winter of 2020 into 2021, there was a move towards identifying care homes that could be a designated setting to receive a Covid-positive patient being discharged from hospital, and did you have some concerns

about the designated settings policy and, if so, what were they?

A. So it was a policy that was suggested and on the face of it, it looked very sensible, but I tend -- I always look from both sides and say what are the benefits and what are the risks? And if you, perhaps, shine a different light on it to the one which is the one most people see, you start to build a picture of potential increased risk. So if I put all -- I did support the policy in the end, but if I just put the increased risk position, so number 1, if, you know, in theory, people were worried about discharge from hospitals, what you're doing is taking everybody from a hospital and putting them in one place. So I which case you might build a new hot bed of cases where they're all -- if the infection control is not absolutely perfect, you will actually build a higher-risk environment.

Number 2, the individual will, often elderly/frail, every time you move that individual, their mortality statistic goes up, regardless of what's going on. So you're then moving them twice.

The second point is if you put them into that environment and then want to move them on back to their care home, they will have had two 14-day isolation periods, so they are out of society for two weeks, and

what you're likely to be doing then is deconditioning them for the care home, their final, familiar destination, if you like, to support them.

The point I make is not to say that not all of those are overwhelming risks, and it depends on -- you do need really good infection control in that designated setting, the point is there are -- as with all of Covid, there are balanced arguments and risks and they all need to be considered.

Q. Speaking of balances, may we turn to visiting, please.

We've looked at a number of pieces of or little excerpts from documents which have suggested, essentially, there was an absence of evidence regarding the risk that visitors pose and the amount of Covid that they brought into care homes. And it's really, you set out in your statement a number of ways in which you were asked to advise about visiting, but given that absence of evidence that visitors were a, certainly a significant cause of infection in homes, do you think that the balance of the visiting policies were right?

A. So number 1, it's an absence of evidence it's not evidence of absence. That is really important. When, because there was a shutdown of visiting for quite a few months, as we all know, and clearly that caused concern for other reasons, but during that time you could draw

very little conclusion.

We looked at this, and I again, a second big piece of work, was to actually try and do some work in the care group which tried to assess what that risk was and then what the balance of risk was in the opposite direction, taking into account quality of life, isolation, all of those sorts of things which people have spoken very eloquently of.

There is some modelling in that and there is an email here somewhere which was very, very rough, so do not take this as modelling, where we estimated how many times a visitor might come in in comparison to the risk that a staff member comes in, and then tried to attach a number to it to quantify.

On that basis it was an insignificant risk, but you need to bear in mind both there is a theoretical risk, and two, the data was just not available.

Q. Given that there was an absence of evidence about the risk that a visitor might pose to bringing in -- by bringing in Covid into a care home, do you think, when you stand back and look at it, that the trajectory of visiting guidance as it was across 2020 into 2021 and 2022 struck the right balance now? And I'm asking you with the benefit of hindsight, I appreciate.

A. I think it's very difficult, because the biggest problem

with care homes is when a visitor comes in or whenever there is an intervention about stepping across the care home threshold, you are not only looking at the individual; you are looking at everybody else who is frail and living in that environment, and therefore, trying to, you know, an individual elderly person, my father, for example, I was commissioning services for him right before the pandemic, he would have dropped all the risks and said, "I just want a visitor" and I'm sure we will hear that many times, but if there is -- there is a real risk of people bringing in infection regardless of whether we have the data every time community rates rise.

And so the trick I think in getting this right is to recognise that and not say it's not existent, but to say how much are we able to tolerate? There's a societal or a care home or a family question. And then, what is the balance? The thing which I've heard but is probably not true in my experience, is that people didn't understand the real harm that can be done and people did, and you can see that coming through the advice that was going up to ministers, and there is a quantifiable harm level which we tried to include. But it's very difficult, at the end of the day if you want to balance these things, it's very different because it comes down to individual

values and the people we most need to understand values of are those people in care homes and actually trying to elicit a value for them is also very difficult.

Q. If anyone would like to read any more about this, at your paragraph 9.11 you make the observation that:

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

I'm not going to ask you about that any more, but I would like to ask you about lateral flow tests in relation to visiting, and your paragraph 6.16, Professor.

Could we have on screen, please, INQ000153358. It's an email chain, I hope. And could we go to page 2 into 3.

We are jumping now into the -- we can see there -- late November of 2020. And Vic Rayner from the National Care Forum is writing to DHSC colleagues, and I think in due course you end up being copied in on some of this thread, but to put it into context, lateral flow tests are now available, and Vic Rayner says:

"Morning all -- and apologies [for emailing] at the weekend. We have ... been informed by a member that at

least two authorities in the North are advising homes not to use the [lateral flow test] ... for either staff, relatives or visitors as they are not assured of the accuracy of the tests."

I don't need to descend to the detail, but can you help us, Professor, was there an issue with the accuracy of lateral flow tests?

A. In short, no. It's the understanding of what they were being used for. So a lateral flow, for example, for an -- is relevant for a short-time period for those people who were most infectious and most likely to transmit infection.

So, for something like a visitor coming in, it was brilliant. It was like an open opportunity, I think, for -- so this was actually quite sad, in many ways, that people who wanted visits -- it's still an adjunct, but for a short time period. They're not perfect, as is any test, but they were a good adjunct to safe visiting. So it moved the risk dial in a slightly -- in a more positive direction.

The problem here was that the -- as with many things, that the communication around the risks and the utilisation of them was going in different ways. And so I think, when we go to the next page probably, you'll see that the people in Test and Trace, effectively,

under Dido Harding, were rapidly, for good reasons, trying to get these out to care homes and get the logistics going, but they'd gone well ahead of assuring people like directors of public health, who would understand that, what was happening.

Q. Can we just follow the email thread. It is, minister emails Susan Hopkins, basically copying in the email from Vic Rayner. And if we go up, it looks like, then, that DHSC are preparing a response to Minister Whately, and we can see there:

"The letter from Sheffield [local authority] to care homes in their area arose from their lack of information on the rollout of [lateral flow devices] to care homes ..."

A. Yes.

Q. "... and asked for care homes to pause their rollout until they had further clarifications."

And they'd spoken to the director of public health:

"... who concurs with the view that LFDs in addition to PPE and IPC, where visiting is occurring can reduce risk further. However, he wishes to be assured that the training and education of care home staff and the operational delivery of these pilots is of high standard."

And we can see the response the minister concludes:

"We believe that the introduction of [lateral flow devices] for visitors where the visit is planned in the best interest of the residents will further reduce the risk of COVID transmission, when used appropriately with the other risk mitigation measures ..."

Was there a concern that it might be an either/or, that people would have the test and then they wouldn't use IPC measures or PPE --

A. There was a lot of unhelpful media noise around LFDs. It's very difficult to control. These people were anxious. The tests need interpreting carefully and their use case needs explaining carefully. And I think it all settled down. Of course we all ended up using them, I think with the recognised limitations of them.

So this was a draft -- a letter draft response for Minister Whately to sign off to send out to give that assurance.

Q. And I think you were asked, if we just follow the final page, page 1 of this, you were asked by Susan Hopkins to have a look at the email thread, and can you just help us with -- you're saying there:

"I've been working with Eamonn [who I think is in PHE] and Jane to urgently revise draft visiting guidance to get the right balance in the wording and advice between legal rights/responsibilities, detriment from

isolation, and then the introduction of visiting with LFDs which we are all aware is an increased risk to care homes rather than a reduction."

Why did you phrase it in that way, Professor?

A. So just to reinforce the minute you do start opening up to further footfall you are increasing the risk. So it's not -- because there was a slight anxiety that everybody would just say: ooh, we've got a test here now, no problem, don't worry about the IPC, we're all safe.

And of course, actually, what we wanted to do was have visitors come in and still recognise that there was an increased risk if we are going in and out, theoretical, small probably, but we needed to manage that. And we needed to support those visitors to learn good IPC practice as well, because then -- and they're actually very positive intervention that way, because they're totally motivated on keeping their loved ones safe.

So it was to flag that at the start, but then to go on -- and in fact what I was trying to do, you'll see this email, it went back to Susan, but what I was trying to do was quietly -- it went to Dido Harding as well, and what I was trying to do was politely say: please can you make sure that when you're rolling out services and

designing them, you link them -- it's the alignment issue -- back with clinicians or public health experts and people who understand what is happening on the ground. So everybody understands the purpose and ambition, the risks and limitations. And then it can all go out safely.

Q. I don't wish to minimise it, but it's a communications issue here --

A. It's an alignment issue. And it's different because -- I mean, you will know, I came in behind -- it's one of the motivations for taking -- going for that role was to actually try to pull it together. Because both parts independently were doing fabulous things, but they weren't aligned, and it caused quite a lot of controversy.

Q. A slightly different topic, please, and your paragraph 7.4, if it helps you, Professor, but the age-old question of data in the adult social care sector. And you say in your statement that particularly -- the data systems in Wales particularly were more comprehensively linked but with a much smaller demographic, presumably because there's fewer people in Wales; is that what you meant by that?

A. So the population in Wales is about 3 million so it is only like a couple of counties here, if you like. You

have to keep this in mind because sometimes, if you're, as I say, as a self-confessed Welsh resident now, you need to bear that in mind, things that work in Wales will not necessarily work elsewhere.

But what they have done, and for many years, they have SAIL data, and I can't remember what the acronym stands for, but effectively you are linking much more health service into community-level data and so the automatic linkage is there and therefore exploring some of these sorts of problems is generally easier.

Q. And did -- do you know whether that -- not necessarily the same system, but the way that the data is linked in Wales could be replicated in England, given its vastly bigger size?

A. So data, as we have heard, is really challenging. If we're getting on to the "what would you do in the future" sort of question, I'd want to be even more ambitious than that. For the reasons that we've just said, I think the care sector is under-researched, so when we get these questions, we don't know. There is a movement to move health services more into the community and if we're going to improve health and the quality of life for individuals in an aging demographic generally, then we should be much more ambitious on the data.

So, for example, what we actually need is not just a care home link, we need care homes and GPs and hospitals and pharmacies all linked together, and local authorities, sorry, I shouldn't miss that out. So that, you know, if you're in a -- and I don't mean to position any of us because I'm now in the aged group -- let's take me as an example. If I'm now an aged person in my community, and I go into hospital and get transferred to, you know, a care home and then back home, I want people to know where I am, and at which point I went, because that transit point or what treatment I've had is critical to understanding where I may have acquired an infection or not, or whether a treatment has been successful, and until we get that linked, we're not going to have the answers and we're still going to be asking the same questions.

Q. It brings me on to your reflections and lessons learned part of your statement, Professor, and you say at your paragraph 9.2:

"In [your] view, the division of responsibility and the ownership of risks in respect of ASC as between providers, local government and central government, needs to be given proper consideration."

Now, bearing in mind we can't change the entire make-up of the system but can you just help us, are you

able to give us an example of how a better division of responsibility would help the pandemic response?

A. I think if the data systems were as I've just described, it's not even just the pandemic response. I mean, if we have demands(?) I think we could have better health and better health outcomes, particularly for those in more deprived areas. So there is a wider health issue here and we shouldn't just be preparing for pandemics --

Q. It's not that I disagree with that but the terms for this Inquiry are --

A. No, I agree, but it will help pandemics and it has a bonus, a benefit, it does help pandemic preparedness, because if you're trying to -- let's suppose we had a treatment for something, or we need -- we've got a new vaccine. They will automatically be aligned. We won't have regressed back to the position we had pre-pandemic.

I think on this there is a wider issue for me. So clearly government can or -- it's a government decision where they put responsibility for this, but having -- I don't think there has been adequate recognition of the private provider provision for adult social care. You can't suddenly have, in my mind, a private provision and then expect a national response, unless there is something in between. So either somebody has to design something which is a national consideration at which

point everybody flips to national control, or you have a different care provision for the country.

I personally, if I'm allowed -- my second point, which is I firmly think that the care sector is just not recognised as an equal component of the health and care system. So that is the first thing that can be done within the Department of Health. It is now, I mean, I think huge progress has been made by the ministers, actually, and particularly Helen Whately in leading the work, she moved it right forward and things like the Capacity Tracker are still operational, and has moved it a long way.

But it needs equal recognition because it will give better outcomes for people and better outcomes for health and care services.

Q. One other matter that we have touched on in your evidence, Professor, was the difficulties in potentially restricting staff movement between the care settings and I just wondered whether you had any reflections or observations on what could practically be done to try and limit or restrict staff movement during a pandemic.

A. So it's still very difficult because it will still require a balance of risk to individuals. If you have no workforce to look after elderly, frail individuals, that's worse than -- probably than having a potential

risk of infection. I go back to my first point which is if you equalise the opportunity, the career progression, which again, ministers have been doing recently, to try and improve and equalise the recognition between Health and Care, then some of those issues will go away.

MS CAREY: Thank you.

My Lady, they're all the questions I ask.

LADY HALLETT: Thank you very much, Ms Carey.

A few more questions, Professor.

Ms Morris who is just there.

Questions from MS MORRIS KC

MS MORRIS: Thank you.

Good afternoon, Professor Harries. I ask questions on behalf of the Covid Bereaved Families for Justice UK. A few short topics, please.

First of all, I want to ask you a bit more about preparedness. At the beginning of your evidence, it may feel like a long time ago, Ms Carey asked you about earlier response plannings and, in particular, a meeting on 11 February 2020. It's not going to be a memory test, I appreciate you may not have a direct memory of it but you did say in your statement that the meeting slides from that meeting said that social care will need central oversight that covers local authority and private providers. So my question is, do you agree that

as of February 2020, and really before -- even before the emergence of Covid-19, there was no plan in place to ensure that effective oversight and support to the sector?

A. I don't think that's quite the same thing. So I think first of all, the comments are actually what came out of the meeting -- they weren't mine -- just for clarity. I think they were coming from the meeting. I think what that was saying was that was a mechanism that needed to be focused on.

My comments earlier about the recognised provision of care in the country is one where there needs to be some sort of systematic oversight. There was a system. It predominantly came, if you were looking from a central government position, it would be local authorities who contract with those providers and then MHCLG who oversee that area of work.

But I think there is opportunity to improve it by some substantial way.

Q. Thank you. My second topic, planning for safe discharge from hospital, and moving forward in time from the 11 February, I think after that meeting you were sent a follow-up email about some actions that were allocated to you, namely to draft clinical guidance on a response to Covid in care homes. And there was an email exchange

that you've looked at already with Ms Carey, the Valentine's Day emails, Professor Willett, was one of the recipients of that.

But in your initial reply on 12 February, you said that there were two elements to the task that you'd been given. The first was about containment, the containment phase of handling of cases within social care; and secondly, managing large numbers of patients in the face of an epidemic, and you said that second part in particular would include decanting as clinically safely as possible large numbers of patients from the wards to the community and social care sector and then potentially onwards, so it's that decanting which envisages discharge from hospital.

You said in those emails that those two tasks should run in parallel, and you raised the issue of decanting patients in subsequent emails to Professor Willett at the NHSE, so despite this very early consideration by you of the importance of clinically safely decanting patients from hospital, you say that you didn't then have any significant input into the 19 March discharge requirements, so I kind of want to explore with you what you did do, having been tasked with it, and identifying those two workstreams in parallel, what did you do between February and March to look at that the hospital

discharge?

A. So I think, I haven't got the paper up on the screen but I think that the one thing I was specifically charged with was the management of the case, if you like, and that actually belonged to PHE so that should not have been tasked to me and I think you can see that back and in fact that's what PHE did.

The second one was, I wrote to Keith Willett, so the DCMO role does not do things usually, this was actually inappropriate tasking because usually some other operational part of the system will do, and then I will comment or challenge on behalf of ministers.

Q. I see.

A. So the first one was PHE did it, and I linked with them. The second one was that email, and I linked with Keith Willett, and you will see through many of the things we've discussed what I was trying to do, although I'm not operational, was trying to make sure the things, as the work was progressing, there was alignment. And ministers also were doing that, because you can see on that 6 March meeting which the Secretary of State called was trying to, I think, NHSE were in that meeting as well, I was trying to make sure all these moving parts were moving together.

Q. So given your role in that February and March period,

would you have been expected to have been consulted in any way about the impact on the adult social care sector by the discharge policy?

A. Not specifically -- normally -- well, actually, at that stage, this was pre triple lock, I would not necessarily see guidance. It depended on whether people who were -- normally, if you were developing policy in slower time, you would expect something to come up to CMO's office for a view, or sometimes an early meeting to set a direction, but in this case we were in the middle of a -- or we'd got a pandemic brewing, and so I would not normally -- some of the guidance, as we've seen, came across my desk. Many of the final copies, I was not in the final emails to, and that's how it worked, until we got to around 21 May when the triple lock came in.

Q. All right. Moving then to the admissions advice, so the 2 April and that guidance, I just want to clarify with you, if I may, some of the evidence you've given in response to Ms Carey's questions and in respect of isolation in particular. Are you saying that it's obvious that anyone discharged from hospital, whether positive, negative test or untested, should be isolated? Have I understood that correctly?

A. No, that's not what -- I think the comments that I sent back -- the minister raised some very sensible questions

and was quite persistent in the email exchanges that were coming back and she would often copy me in to get my view, as well. So the questions she was particularly concerned about was a discharge of a Covid-positive patient, into a care home, and what -- whether this was a reasonable thing to do, and what -- whether it was safe to do it.

So my responses on those was to flag that we expected -- I expected a risk assessment to be done by the local care home -- receiving home, that there were adequate isolation facilities. Now, as long as there are, then it is a reasonable thing to do, and the debate about the seven and 14 days was, actually, to extend the normal period of isolation to make sure that the frailty of people in that environment was recognised.

Q. I understand that, but in your statement you say that onward isolation was of more importance in transmission control than a single negative test.

A. Yes.

Q. You explained the limitations of --

A. Yes.

Q. -- of negative tests. And you said the strongest mitigation was a robust isolation period regardless of whether the patient or resident had tested negative or positive at the point of discharge.

A. Yes.

Q. So I'm asking whether we can infer from that that your advice was isolation was the key measure in respect of -- (overspeaking) --

A. So I think -- I know everybody has got very hung up on testing. I mean, importantly, there was not enough testing and that was not the main prevention. It comes back, then, to a more general issue which is what was the probability or likelihood of an individual having Covid when they left and what was the balance of risk? So I think one of the things we haven't discussed here is if, for example, you put in a policy that says every individual who leaves hospital is going to go into 14 days' isolation even if they are unbelievably well and ready to go, they need to come out of hospital because, actually, they're sitting in the path of a pandemic and they're likely to decondition.

The question then is, given all the comments we've just had about the visiting, do you want to put somebody in 14 days' isolation when they have no symptoms and are otherwise well, and we know it will be harmful in other ways to their health? And that is a -- we're back to this balance question of what is the right thing to do. And that right thing to do starts to change when the evidence around asymptomatic infection starts and then,

the important one, the asymptomatic transmission, and they are not the same thing. Somebody who is asymptomatically infected but not transmitting infection is not going to be a risk to others.

Somebody, once you have discovered a high proportion of asymptomatic transmission, then the policy changes.

I have actually, it's quite interesting because I have looked at international comparators on this and one, for example, which I was quite surprised at, was Singapore because I was trying to see where were we in the asymptomatic transmission line, and actually they didn't change their policy until the month after the UK changed heirs on hospital transmission.

Q. So we're talking about 2 April guidance in my question.

A. Yes. I'm saying Singapore changed theirs in May.

Q. Understood. Okay.

My last topic is around data. You've given your reflections already about how data can be better utilised going forward, but I just want to ask you this as the then co-chair of the SAGE Social Care Working Group. In his statement, Alasdair Donaldson, who was working with the Vivaldi Study, tells the chair that he:

"... repeatedly witnessed how relevant members of PHE and SAGE who had overseen and failed to warn against or properly mitigate the tragic initial errors

consistently used inadequate methods and extremely faulty data which played down the seriousness of the problem in care homes."

What's your response to that?

A. So I had to -- I don't remember Mr Donaldson from this, and clearly the lead investigator was Professor Shallcross, for Vivaldi, who came and gave evidence, I think, in the last couple of days.

I think, from the statement, Mr Donaldson himself says he has no background, I think he is -- has a history background. There is no science, epidemiology, or data background. And I think that is important, because understanding the methodology behind these things, like confidence intervals around outcomes and the problems with data, are absolutely critical to understanding the validity of research.

And all of the data issues -- there are numerous data issues -- they are all outlined in -- particularly well -- they were alluded to in the -- in the early 20 consensus statement. They are very clearly outlined in the May 22 statement. They were all known. And that's why there were two studies looking in different directions and why we don't use one study alone.

What we're looking at is information which is either diverging -- evidence which either starts to diverge or

connects together, and in this case we've got about seven different pieces of information studies which start moving in the right direction -- all in the -- sorry, not in the right direction, all in the same direction. And so all of the -- there are big problems with the data. They're all outlined and they're all taken into account.

MS MORRIS: Thank you.

Thank you, my Lady.

LADY HALLETT: Thank you, Ms Morris.

Mr Straw, I think.

Mr Straw is over there.

Questions from MR STRAW KC

MR STRAW: Good afternoon, Professor. I represent John's Campaign, The Patients Association and Care Rights UK.

At paragraphs 5.7 and 5.36 of your statement you draw attention to the fact that many of those who draw on care outside care homes receive it from family or community carers, and you note that this support is vital, and that you cannot safely isolate somebody who needs assistance with their activities of daily living.

In your view, did the government sufficiently understand the vital importance of this support, particularly early in the pandemic?

A. Yes, I think so. In many areas of pandemic response not

everything will be written down. This is slightly problematic. It doesn't mean it wasn't recognised. And it doesn't also mean there's an easy answer to it.

And I think that when guidance was created -- I've seen some of the comments back -- I think one from Age UK in one of the statements, for example, which says -- almost says: well, does government not realise you can't give care in a 15-minute patch, for example?

But I think this is an interpretation issue. So what you want to do is try to minimise risk whilst recognising that some risk is actually not able to be taken away completely. And clearly, if you have people who, on a daily basis, need support with their daily living, then you have to have prolonged close contact and you need to make that as safe as possible.

Q. There is a linked question, in that at paragraph 5.36 you discuss dementia wards, and note that, there, "personal contact is essential ... wellbeing and demise imminent without it".

A number of stakeholders consider that often during the pandemic, Covid infection control was prioritised and the need for this essential care for people with dementia and similar people was given insufficient weight.

Would you agree with that?

A. No, but I do -- I mean, I think what we saw throughout the pandemic, people understood that. You'll have seen from many of the statements that have been exhibited today, certainly I was making those comments and I know many are equally, if not more, able to do that in different parts of particularly Public Health England at the time.

The difficulty is what do you do and where do you draw the balance? Because we've also noted that individuals with dementia had a higher mortality rate. And that's almost inevitably linked to the fact that they may well not be able to understand or implement control measures as well, that their life might be more chaotic, if you like, in some ways, when you're trying to control for infectious disease. And so trying to -- the balance goes back to this point, whether it be visiting or whether it be infection control, that -- that then becomes an issue of where does the risk need -- and risk line need to be drawn?

So I don't think it's a lack of recognition; I think it's a lack of a not very easy answer.

Q. Later in your statement, at paragraph 5.69, you explain that you gave advice that risk assessments should occur to determine visits policy and perhaps to try to find that not very easy answer, in specific settings. And

you note that some residents' lives would be at risk for reasons other than Covid-19.

Firstly, are you aware that in the first wave in England, the majority of residents in care homes' deaths were caused by non-Covid causes?

A. I don't think I could -- I think we need to specify that much more carefully before I could agree with that, because, as we've heard on lots of the data issues, there were excess deaths in the first wave. Some of that is still not entirely clear. There are direct deaths, there are indirect deaths. So I think that's quite -- I wouldn't concede, if you like, to that particular statement. I think it's much more nuanced than that.

The point that I think you are drawing the fact to is, and I have acknowledged, is there is a risk of mortality and morbidity alongside a pure risk of infection and infectious disease. And again, the problem with care homes is that risk pertains to not just the individual that's being considered by their family or their visitors, but actually the transfer of that risk on to a whole care home of residents again.

So I'm very empathetic, as I think you can see, to the risks, and aware of them. Trying to draw that line is more of a societal or individual care home issue.

I think also what happened -- I mean, a couple of things that need recognising. Number one, I don't think there was ever any legal denial, if you like, of visiting. I think this is quite important. So I know in one of the studies I think something like 93% of care homes had stopped their visiting by 23 March, if I remember. That wasn't on an edict that came out from government. And I know that many care homes were very worried, which I understand as well, about things like their insurance and trying to have some sort of backstop, if you like, some sort of delineation between where you should veer on one side of infection safety and where you should veer on the other side.

So the -- if somebody was at the end of life or at risk of life, which I think is where you're going, then there was always a recognition in -- I think in each of the guidance documents that went out. How it was implemented, and the difficulties of that for individual providers, is quite tricky.

Q. Going back to your recommendations for site-specific risk assessments, there's evidence that they were often not carried out. Are you aware of that? And can you give any views on what more could have been done to ensure that they were carried out?

A. Is this risk assessment for visiting?

Q. Yes.

A. I mean, again, this is a whole -- you cannot have a blanket statement from a national level -- or to my mind -- I'll rephrase that, I'm now an individual, not a representative of government -- you cannot have a blanket statement that goes out that says: absolutely this is what's going to happen in every single care home across the country.

For all of the reasons which you've just said: because you will have mixed populations of residents with different risks and different needs.

And the only way to do that -- it's the same, in some ways, as the infection control in hospitals, because in the background you will have different epidemiology with very high rates at some points in the pandemic of infection in some areas, and almost nothing in another, and those risk profiles are different.

So I would not know, in all of the thousands of care homes, when I was sitting in the Department of Health, how many, or not, care homes had done formal risk assessments. I do know that what we tried to do was get a system where -- which directors of public health could almost help with, because they would have a sense from local authorities how robust the care home provision was. So things like how good was their infection

control usually, if you like, but they'd also have an understanding of the epidemiology as well. And then the care home itself would have a very good idea, one would hope, with relatives, of the individual risks attached to an individual resident.

But none of these are easy answers, which I think what is clearly established.

Q. Slightly different topic. You explain later, at paragraph 5.74, that in July 2020 you asked the Social Care Working Group to examine whether balanced guidance could be produced which specifically included wider exploration of quality of life considerations.

Now, firstly, by "wider exploration", do you mean the adverse impact of the restrictions themselves, for example non-Covid deaths, non-Covid illness and so on?

A. No, more on an individual. So this was saying, as you've just described, if you had any individual resident, they would be at risk of infection, but they would equally, to different degrees, depending on their underlying health status, physical status, conditioning, you know, be at risk from deterioration for others reasons.

So, for example, an individual who will not eat unless they have an assured member of their family with them is at immediate significant risk if they are not

maintaining an adequate dietary intake.

What we were trying to do, though -- there was a holistic wellbeing issue. What I had heard from the ground up was -- was that care homes particularly were concerned about insurance. I'm not saying they -- they clearly were concerned about their residents, but that was seen to be quite a negative angle on whether they felt able to open up a little bit more to visiting.

So what we tried to do was say: okay, if we could produce some -- what might look like quite scientific evidence, but some really strong evidence that highlighted where the balance of risk was, that then care home managers would feel comfortable to use that to open up their visiting proportionately.

The difficulty we found, and you'll see it when it comes around to that November guidance, was -- we had all sorts of people in the room who had worked on quality of life in care homes with elderly residents -- was this issue of, for every kind of expression of it, you need a value to be derived from the individuals themselves. And that's incredibly difficult from somebody with dementia anyway, and really difficult in the middle of a pandemic.

Now, the work which I think Professor Hopkins referenced around the ASCOT study, so using an adult

social care outcome tool, starts to try and address some of those issues, when we do not have a pandemic raging, so that we can perhaps develop better balanced guidance for the future.

MR STRAW: I think that's my ten minutes, thank you very much.

LADY HALLETT: Thank you, Mr Straw.

Just the last few questions from Ms Beattie, who is over there.

Questions from MS BEATTIE

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

On 5 March 2020 you attended a social care coronavirus meeting with the Minister of State for Care, Helen Whately, and senior department officials. And just to be clear and to avoid any confusion, this is not the 6 March meeting which Ms Carey took you to, but the day before, 5 March. It's also not a memory test so I'll proceed with the questions but if the document could just be brought up to assist Professor Harries, it's INQ000595303.

And this meeting considered local authority planning. At that time the Minister for Care expressed concern about the only two plans she had seen, a process was still being set up to assure local authority plans,

and the second-last bullet point on that page shows that you had a call lined up locally to get some soft intelligence on plans.

So what soft intelligence did you get on local authority plans?

A. Rather predictably, from memory, and I think it also was where the SRG, the strategic -- sorry, SCG coordinating group information came back, which was this was variable. There are -- there were plans because I think in this one I did give some assurance that for individual care homes there are sometimes very detailed plans because if care homes have had a flu outbreak, for example, they will be working with local systems and have some very detailed knowledge, but at this sort of level, trying to get plans for every care home right across a system and pull it into an LRF, as the minister found, it was -- well, many were absent, and the quality, I think, was variable, as well.

So, in theory, there should be plans there. In practice, it's not -- it's not as immediately available, if you like, in -- for the pandemic as it was.

Q. Sorry, Professor Harries, I think your answer is referring to detailed plans at an individual care home level rather than a local authority level; is that right?

A. Yes, so --

Q. And --

A. So in the bullet above that it says:

"There are hugely detailed plans sitting at local levels that may not surface."

So as in, there is some information there but if you send a message out from the LRF you might not find it all, but equally, I think what Minister Whately found was, which is part of the problem, actually there weren't plans sitting above that and I think this, this comes back to, at the end of the day, the -- there is a care home provision in an LRF area is still a private business.

I mean, I was trying to think through how this related. So for example, I know this is slightly diverging but just an example, if you will indulge me, there are risks, for example, around meat producers, cold meat producers. We do not go to private businesses generally and expect them to have plans. They have plans for some safety issues. The issue here is, if you have a private provision model where the responsibility is sitting in normal times with that provider, it won't always be available to an LRF and it won't almost be known.

Q. Well, Professor Harries, I think there was

responsibility sitting at local authority level not just at individual care home level and obviously an individual care home plan wouldn't be of any use for covering domiciliary care, for example, would it?

A. Well, it depends on what the type of provider was. If they were contracted to provide domiciliary care, then it would be.

Q. Did you ever see a domiciliary care plan?

A. Well, I would not be operating at this -- I have seen them historically when I've worked in local authorities, but not in my recent role, no.

Q. So is the, sort of, upshot that you didn't get any assurance about the existence and adequacy of plans either at local authority level --

A. So this wasn't -- (overspeaking) -- this was for the Minister to get assurance and for me, then, would have been, had I been -- seen some plans, she may have asked me how adequate those plans were in relation to public health or risk prevention.

Q. But sorry, from the call that you had to get some soft intelligence, is the upshot that the intelligence you got was either no plans or not adequate?

A. So the call was -- I was having general calls with directors of public health to understand what it felt like on the ground to see whether the plans were

available and whether they were coming forward, and so the answer, as I started with, was, there's a variable response. In some areas it would be quite good; in others, there would be very little. Inconsistent.

Q. I think in your statement you said in any event the majority focus of the 2018 pandemic plans was theoretical, rather than practically exercised; is that right?

A. I think that is a fair comment for which we've heard in earlier modules, which is, you do need plans and they need to be ready to respond, and you don't necessarily need one that is this pathogen-specific because you don't have the response.

But actually, having something which nobody has exercised, so I would doubt that many care homes across the country, even if they have their own plans, have actually exercised them.

Q. So given that was your view of those 2018 plans and what you learned of the plans from the soft intelligence call, was it not misguided, in your view, to be relying on them at all for the Covid response?

A. Well, I think the minister didn't. That was -- what they -- particularly, I mean, the Under-Secretary of State, but that's exactly what was coming out of this meeting. And the meeting on 6 March was actually

looking at these, that was felt to be not adequate for where we needed to go and so that is why the Secretary of State and Minister called the meeting on 6 March, to actually move the thing forward and if the plans weren't there, then actually we needed a different approach. So that was why they then moved to the meeting the next day.

Q. Right. And so I think we'd seen, in the Covid plan that had been published already by then, that a reassurance that LRFs had plans and that was what was being relied on, but one, when we get to the action plan for adult social care which was published on 15 April, we don't see any reference to local authorities plans. So does that reflect what you've just told us, that they were in a sense abandoned for these --

A. Again, I need to be very clear what my role is. I would advise on things if asked, so the adult social care plan is probably one to ask of Minister Whately or members from the Department of Health, but I think, as you have identified, that actually, the Minister and the Secretary of State called the meeting the next day partly because actually they weren't comfortable and they did not feel fully assured, and they wanted to make sure that there was action. That's why they put in the meeting the next day.

Q. Moving to visiting, you've been asked already some questions about what was happening in July 2020 and that you asked the working group to begin work, then, to see if a balanced approach to guidance could be produced which explored wider quality of life considerations. How, at any times, did the homes' visiting guidance take into account that reasonable adjustments were needed so that disabled people, including people with learning disabilities, people who have hearing impairments, are deaf, those who use British Sign Language as their first language, or have visual impairments, could have equal access and contacts with their family and friends and external carers?

A. So it's a probably a question that you should probably have directed to Professor Hopkins this morning because again, without trying to appear not responsible -- it wasn't my area of responsibility -- I do know, obviously from previous roles, that the guidance in terms of trying to, you know, it was produced in different scripts and what have you. There is an access issue to information generally, and there is always, in guidance, a clause that seems, to my mind, perhaps, to have been misinterpreted, which is if it is essential for visiting, there has never been a block to visiting. There is a balanced risk about it, which has to be taken

into account, but government did not sit at the top and say nobody can visit somebody who is disabled, or what have you.

The issue is, about getting the balance of that right.

And so I don't think any of the guidance, which again, was not my personal responsibility, actually absolutely forbids. There is no legal reason for people not to -- (overspeaking) --

Q. You accept, Professor Harries, there is a difference between absolutely forbidding and actually setting out what steps might be needed, and also that I think in your previous evidence you were explaining that a lot of these decisions about visiting come back, I think you said, to individual values, risk appetite being ultimately a personal decision, and that it's difficult to try to elicit a value for those things. But would you accept that some of these are very objective, very real barriers which don't need any eliciting of personal values -- (overspeaking) --

A. Well, I think two things, which I -- I feel as though we're perhaps going over the same ground, so my apologies, but I'll perhaps say two things.

So, number one, the work I tried to do in the care working group was completely novel and was proactive on

my part to try to get some sort of framework around this for guidance going forward, that actually worked for guidance, but actually worked for those supporting individuals, whether it be in domiciliary or whether it be in care homes.

So that's the first one, because that has not been produced before, and it was extremely difficult. We broadly had to stop trying to do it at that time, and then it's now being taken forward as long-term issue -- a long-term programme.

And then the point I made earlier which is around individual local assessment. It is -- you could not possibly write at national level a whole list of things which would work for every single person across the country. It just doesn't work. And hence my point of reinforcing that the guidance that is there does say, I'm pretty confident, that if it is a detrimental issue, if you like, of significance, then visiting should be allowed.

I cannot control, and neither could anybody at national level, precisely what was happening in each care home or each service across the country.

I think probably where we would very clearly align is to try to improve that going forward, and my approach to that was to try to establish some sort of evidence

framework which allowed people locally to be confident in the decisions, balanced decisions about opening up and risk to visiting.

MS BEATTIE: Thank you, my Lady.

LADY HALLETT: Thank you very much, Ms Beattie.

I'm fairly confident, Professor, that that completes the demands that we will be making on you personally.

I think we're probably making demands on the departments for which you work again, but I think that's the end for you. Thank you very much indeed for all your help to the Inquiry. I appreciate we've called on you -- how many times now?

THE WITNESS: Quite a lot. I think every module but one.

LADY HALLETT: Anyway, I wish you a long and happy retirement.

THE WITNESS: Thank you.

LADY HALLETT: Very well, I shall return for 10.00 tomorrow.

(4.31 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X