

Wednesday, 16 July 2025

(10.00 am)

LADY HALLETT: Good morning, Ms Hands.

MS HANDS: Good morning, my Lady. If I may call Ms Caroline Abrahams this morning.

MS CAROLINE ABRAHAMS (sworn)

LADY HALLETT: Welcome back, Ms Abrahams.

THE WITNESS: Hello.

LADY HALLETT: Thank you for your continuing help.

THE WITNESS: Thank you.

Questions from COUNSEL TO THE INQUIRY

MS HANDS: Ms Abrahams, good morning. You have, of course, already provided evidence to this Inquiry on behalf of Age UK as its charity director in other modules, and I echo my Lady, we're very grateful for you attending again today speak to some of the experiences in the adult social care sector.

For those following, your statement for Module 6 can be found at INQ000509808.

Dealing briefly, before we start, with the remit of Age UK, you have provided a statement for Age UK England, but there are branches in each nation of the UK, known collectively as the "Age network".

A. Yes.

Q. And they have also provided statements to this module,

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through our helpline and through written advice on our website.

But our local Age UKs and, to a degree, in the other nations as well, provide direct support to older people. Some of that, a small amount relatively, comes under the formal definition of social care. So personal care, help with getting in and out of bed, getting meals, those sorts of things. But also a lot of lower-level support, so help with cleaning, making the bed, doing shopping. Those things that help older people to retain their independence.

So they do all of that, and also some local Age UKs provide activities like lunch clubs or day centres that an older person, say with dementia, could go to, spend a day, gives their carer at home a break. So an awful lot of activity in the social care world.

Q. Thank you. And you have set out in your statement in quite a lot of detail the state of the adult social care sector before the pandemic.

A. Mm.

Q. So, in summary, is it right that there has been a year-on-year increase in older people applying for adult social care and care, but a decrease in the number of people receiving it?

A. Correct.

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and I may ask you to speak to some of the issues raised in those statements today.

A. Yes.

Q. But is it right that generally the issues facing older people in England, experienced by Age UK, that you may speak to, were reflected in the devolved administrations too?

A. Yes, absolutely. To a degree, there were some slight differences in how the governments responded in each administration, but the issues were identical. And we met weekly online throughout the pandemic and shared experiences and insights.

Q. And before we start, can you provide a brief summary of the roles of the Age network in the adult social care sector.

A. Yes. Age -- for older people, adult social care is a huge issue because so many use it, or feel that they would like to use it. And so Age UK inevitably has a big role in supporting that.

The first thing we do nationally, and in some of those other countries too, is we provide information and advice about how to go about getting social care, because, as I'm sure the Inquiry has already heard, it's quite a complicated process. So, understanding what to do first, who to talk to, we provide a lot of that

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Q. And just briefly, why is that?

A. Essentially the provision of social care in our country is fiercely rationed, and that's because of the amount of money that goes to councils to fund social care. There are always more people who want social care than are able to get it. So over time, as that trend has continued, the threshold, the amount of need you have to have to be eligible for social care from the state, has gone up.

So that's why that has happened.

Q. And you also say in your statement that one in ten older people who are aged over 65 years old were in receipt of formal help or home care prior to the pandemic?

A. That's right.

Q. And in your view, how did the state of the sector at the start of the pandemic impact its ability to respond?

A. It made it very fragile and not resilient to cope with the sort of battering that the onset of a pandemic brought. In particular, there wasn't enough staff in many places. Staff, as you will have heard, are on fairly poor terms and conditions. There's a lot of flux, a lot of change, people coming in and out of care homes and home care, often trying to do too much without enough time, and not enough money to actually fund the social care that everybody needs.

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1 And very, very fragmented. Not -- really, in many
 2 ways, social care is an essential public service, but
 3 because of who offers it, a combination of the private
 4 sector and the not-for-profit sector predominantly, it
 5 doesn't feel like it, and it's not organised like it.
 6 And that meant there was no infrastructure, not the
 7 systems and processes in place that would have helped to
 8 support social care and all the people working in it and
 9 also using it when the pandemic came along.
 10 **Q.** And you have prefaced your statement by saying that some
 11 people reported a positive experience during the
 12 pandemic and that some of the innovations and good
 13 practice should continue.
 14 Can you provide a couple of examples of those
 15 innovations and good practice that you say should
 16 continue?
 17 **A.** There was, for some companies, a greater use of
 18 technology to try to communicate with their staff to
 19 help with rota-ing. Of course, that's a trend that is
 20 continuing with the advent of AI, but I think it
 21 accelerated it for some companies that were progressive
 22 and also probably weren't as fragile and cottage
 23 industry-like as some others. So that was helpful.
 24 There's no doubt that many care workers worked
 25 incredibly hard, put themselves at risk, were prepared

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1 needs of older people within it, was very limited, as
 2 they themselves admitted at the start. And there was
 3 a lot of catching up having to be done very quickly.
 4 And there weren't the structures in place, there
 5 weren't the people in place on committees, for example,
 6 at a time of crisis, to help the government make
 7 informed decisions about older people in the context of
 8 social care.
 9 **Q.** And at the very start of March, on 10 March 2020, Age UK
 10 issued a statement which said that the government has to
 11 step up to advise on how the sector can plan a more
 12 coordinated and resilient response. So is that,
 13 essentially, in response to what you were saying there?
 14 **A.** Absolutely. And a lot of the focus, inevitably, and
 15 understandably, was on the NHS, and that was quite
 16 right. But even early on it felt as though social care
 17 had been forgotten.
 18 **Q.** And you made a further statement on 10 April, so a month
 19 later, and you've said in your statement that you made
 20 that because the sense of unease had turned to real
 21 alarm. So would it be fair to imply from that that the
 22 action that you had asked to be taken a month earlier
 23 that not in fact materialised?
 24 **A.** Correct.
 25 **Q.** And at that point in time, so the middle of April, what

7

1 to do things we shouldn't really have asked them to do,
 2 without sufficient protection for themselves and their
 3 families.
 4 And I have personal experience of that too. It's
 5 not in my statement, but throughout the pandemic I was
 6 also caring for my mum at home, who was dying, with
 7 a package of care. So, as well as doing my job for
 8 Age UK and seeing these issues from all our information
 9 sources, I was experiencing them day by day in real life
 10 as well.
 11 **Q.** And you have also identified in your statement that
 12 Age UK witnessed systemic failings during the pandemic
 13 which led to the perception, particularly during the
 14 early stages, that older people were an afterthought and
 15 sometimes their lives were considered less because they
 16 were older. Why do you think that perception developed?
 17 **A.** Because of the facts as they became apparent. I think,
 18 quite early on, we could see the pandemic hitting other
 19 countries first, particularly Italy, for example, and
 20 America, where there were already stories in the media
 21 about the care sectors in those countries being impacted
 22 by the pandemic in a very adverse way, and we weren't
 23 quick enough in our country to pick up on those, and
 24 really, the amount of knowledge and information held by
 25 government about social care generally, and about the

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1 were Age UK's key concerns?
 2 **A.** That we were hearing about many deaths of people in care
 3 homes. It seemed that in particular, that the virus,
 4 once it got into a care home, was causing havoc. And
 5 yet there was no coordinated response from government.
 6 We weren't being able -- we were trying to persuade them
 7 to do things, but I think because it was a time of
 8 crisis, they sort of circled the wagons, by which I mean
 9 they were less open to comments from outside, and it
 10 made it very difficult for organisations like mine to be
 11 able to give what we would hope to be good advice. But
 12 you could see it playing out, and from what we were
 13 hearing from older people and their families, and from
 14 professionals too.
 15 **Q.** A few days after that statement, so 16 April 2020,
 16 a government strategy for the adult social care sector
 17 was issued. You've perhaps answered it in that previous
 18 answer, but had your organisation been consulted on that
 19 before publication?
 20 **A.** I don't think we were. I'm trying to remember.
 21 Subsequently, later on, as the pandemic continued, we
 22 were much more heavily involved but early on, no. Much
 23 less so.
 24 **Q.** I think you've given some examples in your statement of
 25 the ways in which communication certainly improved

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1 during the second wave, and you provide the examples of
 2 the Capacity Tracker in England --
 3 **A.** Yes.
 4 **Q.** -- and that Age UK were also part of the UK Government
 5 Social Care Sector Covid-19 Support Task Force. Both of
 6 those occurred in 2020, later in 2020, sorry. So are
 7 those examples of how that two-way relationship
 8 improved?
 9 **A.** Yes, but it was also to do with people. So when
 10 Sir David Pearson was appointed to come into government
 11 and support them on social care, that made a huge
 12 difference because he knew everybody, and we could talk
 13 to him. He understood what it was like in local areas.
 14 He had been a Director of Adult Social Services himself.
 15 He had a much better, granular understanding of the
 16 needs of social care and he had the relationships with
 17 people like us, and many others, to be able to draw us
 18 in and gain our help, which I think was really helpful.
 19 **Q.** Would it have been useful if somebody like Mr Pearson
 20 had been available sooner, or in post sooner?
 21 **A.** Absolutely it would.
 22 **Q.** And do you think that that role that he held, and the
 23 representative groups that were set up, as well, with
 24 stakeholders would be helpful in a future pandemic?
 25 **A.** Yes, probably, depending on what the existing structures

9

1 bring in intelligence from the world back into the
 2 department. So it was a win-win.
 3 **Q.** Finally this, on the early pandemic period. You have
 4 said at paragraph 63 of your statement that promises of
 5 a protective ring around care homes did not materialise
 6 in terms of policy or practice in early stages.
 7 **A.** Mm.
 8 **Q.** What, in your view, was missing?
 9 **A.** Partly the fact that the nature of social care as it
 10 operates in many care homes with staff coming in and
 11 out, coming from home, not living on site -- some do but
 12 most don't -- that meant that there was an immediate
 13 risk in the care home, made worse if care workers became
 14 unwell and were then unable, financially, to stop work
 15 because of the need to put food on their own tables at
 16 home. So the lack of sick pay for care workers was, I'm
 17 sure, a big gap that unfortunately contributed to what
 18 happened.
 19 But there were other problems as well, just
 20 a general lack of money, really, to go round. The lack
 21 of access to PPE, to infection control, and sometimes
 22 some naive assumptions, I think, by government about how
 23 well equipped a care home in particular might be to care
 24 for people with medical needs as well as care needs.
 25 **Q.** We're going to come on to some of those issues no doubt

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1 are within government. It was unfortunate that the
 2 leader of social care in the department stepped down
 3 very soon into the pandemic and there was then a gap, I
 4 think, before someone else was appointed. That's not
 5 a criticism of that person at all, but if there had been
 6 somebody in post who had the knowledge and
 7 understanding, right from the start, who had stayed,
 8 perhaps someone like Sir David wouldn't have been so
 9 needed although he was always going to have made a big
 10 difference.
 11 **Q.** And do you think there's also benefit in those groups
 12 meeting and that joint endeavour taking place in
 13 non-pandemic times, as well?
 14 **A.** Definitely. Absolutely. And over time, as the pandemic
 15 continued, there was a group that continued to meet very
 16 often, sometimes on more specific issues, such as
 17 visiting in care homes, for example, and that also
 18 interacted with the Minister of State at the time, Helen
 19 Whately.
 20 **Q.** Yes.
 21 **A.** And all those conversations, I think, were very useful.
 22 They helped us at Age UK be able to be clearer with
 23 older people and their families about what the policy
 24 was, which they very much wanted to know, and which was
 25 changing quite quickly, but I think we were also able to

10

1 in your evidence but before we do so, the statements
 2 that the Age network have provided provide many examples
 3 of the ways in which they stepped in to provide support
 4 to older people.
 5 I'd like to ask you about just a couple of those, if
 6 I may. A common theme that arose was the use of
 7 telephone helplines, some of which received government
 8 funding --
 9 **A.** Yeah.
 10 **Q.** -- to increase their capacity. Although the service
 11 they offered differed slightly between each nation, they
 12 all provided a form of practical support and compassion
 13 for older people that wasn't just online, but in
 14 a different format as well. Was there high demand for
 15 those services during the pandemic?
 16 **A.** There was huge demand. It absolutely spiked.
 17 Particularly after any particular government
 18 announcements or something said in a press conference
 19 that may not have been entirely clear, or when new
 20 guidance came out, which it did very frequently. Then
 21 we often saw, I think, right across the UK, large
 22 numbers of older people, and also their families,
 23 calling for clarification, for reassurance, just in
 24 despair sometimes, depending on their own situations.
 25 **Q.** And did the people that were managing those services

12

1 have the information available to them in good time in
 2 order to be able to provide that advice and support that
 3 people were asking for perhaps quickly after those
 4 announcements were made?

5 **A.** Generally speaking, it would be fair to say that they
 6 didn't, because very often it was a matter of trying to
 7 listen to a press conference or get a new piece of
 8 guidance, digest it, and then put it into the sort of
 9 language that ordinary people could readily understand.
 10 And I think that is another thing to learn from the
 11 pandemic: that the officials who in good faith had to
 12 keep changing the guidance were not at heart
 13 professional communicators. And the Civil Service skill
 14 at writing guidance is not generally done at that pace
 15 and for a public audience, it's often for professionals.

16 And I think they could have done a better job, with
 17 better communications expertise, in explaining quite
 18 complicated things in a simple way for people. As it
 19 was, that turned out to have to be the job of
 20 organisations like Age UK.

21 **Q.** I think you have referred to that in your statement,
 22 that there were various times when you made offers to
 23 support with communication but there was a mixed
 24 response as to whether they were taken up or not. So is
 25 that something that you think could be improved, perhaps

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1 lonely and isolated, often, in their positions, were
 2 able to come together and support each other. And
 3 I know that Age UK took part in some of those
 4 conversations in England as well.

5 True too of people like nurses in care homes. Quite
 6 a niche group of people. And, you know, they were
 7 absolutely at the forefront of dealing with lots of
 8 these issues through the pandemic.

9 **Q.** Do you think that there is a role for more support or
 10 perhaps even a service for care home managers in
 11 a future pandemic, or that support?

12 **A.** I think there's room for more support for care home
 13 managers, full stop, all the time. And the more that
 14 can be put in place to help them to support each other,
 15 to learn from each other, to identify problems, even
 16 when there isn't a pandemic, I think would be very
 17 useful.

18 **Q.** The Inquiry has heard about changes to the Care Act
 19 which meant that duties on local authorities in relation
 20 to care assessments and reviews could be suspended or --
 21 known as easements.

22 **A.** Yeah.

23 **Q.** They were not widely used, which you've acknowledged in
 24 your statement. But what you do say is that there was
 25 a widespread perception that some local authorities took

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1 in advance of a future pandemic, but then also during as
 2 well, if there is the need to communicate difficult
 3 information?

4 **A.** Yes, I think so. One police force told us they were
 5 using Age UK's guidance and advice rather than the
 6 government's because they found it much easier to
 7 communicate to the public. So I think that's just
 8 a good example of, just the lack of a skill at that
 9 particular time in government.

10 Of course, they have many communications people in
 11 government, and I'm sure they will do a great job, but
 12 they weren't deployed, I don't think, in helping to
 13 write guidance, which was viewed as a policy job.

14 **Q.** You have also described how Age Cymru partnered with
 15 Care Home Cymru and others to develop a platform that
 16 offered peer-to-peer support for care home managers.
 17 Was there widespread uptake of that support and any
 18 feedback as to whether it was useful or not?

19 **A.** I can't comment in detail on what happened in Wales but
 20 I think it would be fair to say that similar sorts of
 21 things happened in England too, where people were
 22 learning to use technology to talk to each other online
 23 in a way that was quite new. It accelerated the use of
 24 those techniques. And it did mean that people like care
 25 home managers, who were very exposed, and also very

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1 action along similar lines, but informally. What did
 2 you mean by that and what led to that perception?

3 **A.** We heard anecdotal stories from a few places of areas
 4 that were taking decisions to, for example, reduce care
 5 packages for people living in their own homes, and using
 6 the pandemic as a reason for that, but where those
 7 councils had not actually gone down the legal route to
 8 do that.

9 Not a lot, but some. And we were expecting rather
 10 more to take advantage of the new legislative
 11 opportunities they were given than actually did. But it
 12 looks -- it felt to us and seemed to us that some had
 13 chosen to forego that route and to do something rather
 14 similar instead, but unofficially.

15 **Q.** You may not be able to answer this but did you hear in
 16 those stories as to why they took those more informal
 17 routes?

18 **A.** We didn't. We might surmise as to why they did, but we
 19 can't say for sure.

20 **Q.** Thank you. And did Age UK have any concerns about the
 21 easements if they had in fact been implemented?

22 **A.** Yes, it was something that we and other organisations
 23 working in social care looked at with, you know, some
 24 concern when the changes were made, and wondered just
 25 how big an impact this would have. But of course, this

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1 was also at a time when we weren't aware how long this
2 pandemic would go on for and how grave its impact would
3 actually be.

4 **Q.** Did you raise those concerns?

5 **A.** Yes, we did, in discussion with officials at the time.
6 I remember us doing that.

7 **Q.** In your statement you have also described the impact on
8 many older people in receipt of care as safeguarding
9 failures and specifically physical deconditioning and
10 loss of cognition as a risk for many older people and
11 that one of the reports that you conducted during the
12 pandemic found that one in four are less able to walk as
13 far as they could by the end of the pandemic compared to
14 before.

15 So what were Age UK's concerns around access to
16 health and to care services in the community for older
17 people and what do you think were some of the reasons
18 for those concerns arising?

19 **A.** So to a great extent, when people get older, their
20 health often declines and they will need access to
21 healthcare, and of course, one of the things that
22 happened during the pandemic was that access to routine
23 healthcare became much more difficult, or even
24 impossible or stopped. So people with health
25 conditions, quite serious ones, went for quite long

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1 **Q.** And in your experience were some of those issues
2 considered adequately, or at all, either in the early
3 stages of the pandemic or as it went on in the drafting
4 of guidance and information?

5 **A.** I think it would be fair to say that as the pandemic
6 went on, the unintended consequences of lockdowns on
7 older people became -- and on everybody really -- became
8 better appreciated and more consideration was made of
9 those sorts of concerns. But certainly not very much
10 about older people per se, and certainly not nearer the
11 beginning of the pandemic.

12 **Q.** And in November of 2020, Age UK produced a consultation
13 response setting out lessons learned from wave 1 in
14 regard to access to healthcare and what needed to be
15 improved for older people in wave 2 by the Department of
16 Health and Social Care. What were some of those key
17 lessons and what were you asking for, and did that
18 improve the situation for future waves?

19 **A.** I think it continued to be patchy afterwards, and that,
20 of course, is characteristic of the pandemic more
21 generally. Some places managed things better than
22 others. But certainly visiting services often had
23 stopped, professionals had stopped coming to older
24 people's homes, there was more reliance on virtual
25 consultations, for example in care homes. In some

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1 periods of time, often, without seeing their consultant,
2 without having their regular check-ups. And inevitably,
3 in some cases that caused those conditions to get worse
4 more quickly than they otherwise would have done.

5 The sheer absence of social care will also have
6 contributed to that. It may have made it more likely
7 that some people stopped taking their medication, for
8 example. That would have been definitely another
9 problem. Or that people became very depressed and
10 anxious. Mental health conditions definitely got worse
11 during the pandemic, made worse by the isolation and the
12 loneliness and the fear of watching the news and
13 realising that, for older people, this was a pandemic
14 that was taking many people's lives. So not a good
15 combination of things all coming together.

16 And, of course, many people living at home were told
17 to stay put largely, and people were frightened to go
18 out very often for fear of contracting the virus. And
19 in later life, if you don't move around, you stiffen up,
20 you lose your muscle mass. That's what deconditioning
21 really means. And so it was just a very unfortunate set
22 of combination of issues that together meant that many
23 older people came out of the pandemic, if they survived
24 it, considerably less well, less fit than probably would
25 have been the case without it.

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1 places, those worked really well but by no means
2 everywhere.

3 There were problems, of course, with access to
4 drugs, medication. There were no medication reviews.
5 So all the normal things that happened weren't there.
6 And of course, the more those could be put in place or
7 put back or, alternatively, replaced by online or
8 telephone methods, the better. But I think the way that
9 actually panned out in practice was very variable.

10 **Q.** Moving on to consider in-person visits of professionals
11 in care homes. In your experience, to what extent was
12 the provision of in-person healthcare in care homes
13 considered and planned for in advance of the pandemic or
14 again in those early stages?

15 **A.** There's no evidence that we saw to suggest they were --
16 that was thought about or planned for at all.

17 **Q.** And are you able to help us as to whether there are any
18 reasons why older people in particular might benefit
19 from an in-person visit from a healthcare professional
20 that perhaps they are already familiar with, instead of,
21 for example, a remote or telephone consultation?

22 **A.** Well, the first thing to say is that most older people
23 with care needs also have significant health needs. And
24 particularly for frail older people, those approaching
25 the ends of their lives, they may well have conditions

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1 like pressure sores, skin integrity problems, that do
 2 require a district nurse in particular, or maybe
 3 a physio or somebody like that, to come in and help.
 4 And that sort of service pretty much dried up for large
 5 parts of the pandemic, particularly nearer the start.
 6 So, in the absence of those things, of course, those
 7 conditions, which can prove to be very serious for
 8 people, often got worse.
 9 **Q.** And what was the impact on the staff working in those
 10 care homes?
 11 **A.** We heard awful stories about staff who felt overwhelmed
 12 by having to essentially try to plug the gap that health
 13 professionals not visiting was unintentionally leaving.
 14 People who didn't have the skills or qualifications to
 15 have to take a lot of responsibility for very unwell
 16 older people, sometimes older people who were dying, not
 17 just one, as is not unusual in a care home, but many
 18 people all at once. And I think that must have been an
 19 absolutely shattering experience for some. And it
 20 caused some, we know, to leave the care sector
 21 afterwards. Great professionals, but who just really
 22 needed to get away.
 23 **Q.** I would like to ask you, if I may, about a letter that
 24 was sent by a GP practice to a care home resident in
 25 Scotland, in which the recipient was informed that the
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1 to an extent, I think this practice deserves some credit
 2 for it being upfront with people about what it was
 3 intending to do, even though we wouldn't necessarily
 4 agree with it.
 5 Certainly the issue of whether an older person in
 6 a care home would be taken to hospital if they became
 7 unwell was something we heard quite a lot about right
 8 across the UK, and I think I put in our written evidence
 9 about talking to a very senior clinician who had had to
 10 intervene personally with the hospital to enable an
 11 older person with a very routine respiratory problem to
 12 be admitted. It was absolutely something the hospital
 13 could help with, but had he not intervened, there would
 14 have been no possibility of that person attending.
 15 **Q.** Yes, I think you've described concerns about
 16 non-conveyancing practices during the pandemic.
 17 **A.** Yes.
 18 **Q.** So, again, were they quite widespread, from the evidence
 19 that you've received?
 20 **A.** Very much so, yeah.
 21 **Q.** And did you try to bring such issues to the attention of
 22 national decision makers or even local governments or
 23 practices?
 24 **A.** Yes, we very much did try to raise this as a real
 25 concern, as a concern about the way older people were
 23

1 practice would be ceasing visits.
 2 So if we may have on screen, please, INQ000591762.
 3 And starting with the second paragraph.
 4 Now, the quality isn't particularly good on this
 5 version, but I will read out the part that I would like
 6 to draw your attention to. So the second paragraph, it
 7 states:
 8 "... we need to minimise patient contact to all
 9 unless absolutely essential."
 10 And then in the fifth paragraph, in regard to
 11 patients that get Covid-19, it states:
 12 "We would plan to continue to nurse our patients ...
 13 and not to transfer them to hospital. Sadly if they are
 14 so unwell as to require breathing support from
 15 a ventilator it is unlikely that given their frailty
 16 they would survive."
 17 Firstly, is this the type of letter or the approach,
 18 one, that Age UK heard people experienced during the
 19 pandemic in Scotland or elsewhere in the UK?
 20 **A.** We heard these kinds of things right across the UK.
 21 What is unusual about this is that the practice actually
 22 wrote it down and took the trouble to communicate with
 23 patients and care homes formally about it. More often,
 24 I think, these things happen informally, or they were
 25 conversations. They weren't actually documented. And
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1 being viewed and treated, and the lack of respect for
 2 their human rights and their ability to access
 3 healthcare, alongside everybody else of all ages.
 4 Regardless of whether you're in a care home or living at
 5 home or in hospital, we all have the same right, and
 6 that right was not being observed.
 7 And we shared those concerns across our Age UK
 8 family and with the commissioners in Northern Ireland
 9 and Wales, and we published a statement actually saying
 10 that. And there was some response to it, but I think,
 11 from what we heard, there was patchy implementation
 12 thereafter on this issue, as indeed many others
 13 throughout the pandemic.
 14 **Q.** I'd like to ask you now just briefly about end-of-life
 15 care and medications.
 16 What concerns did Age UK have about the changes to
 17 medications and prescriptions generally, in care homes,
 18 and in the community during the pandemic?
 19 **A.** Well, especially at the beginning and the early stage of
 20 the pandemic, it was a degree of disorganisation, a lack
 21 of process and system which meant that it became very
 22 difficult to get hold of end-of-life medications to ease
 23 people's suffering, as would routinely happen. And the
 24 rules were in place, of course, to protect the public,
 25 but they turned out to be very unhelpful during
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1 a pandemic when much more urgency was required, and it
 2 took the government time to change those. And sadly,
 3 during the months that happened, that led to people
 4 dying in care homes not in a dignified way, not in
 5 a pain-free way, and it put the professionals working
 6 there, sometimes nurses, very often not medically
 7 qualified people at all, in a horrible, horrible
 8 position when they had a lot of people there who needed
 9 those drugs, they weren't able to share them from one
 10 person to another, either, for fear of breaking the
 11 rules.

12 Over time, those rules were changed, but those
 13 things were not in place and perhaps they could have
 14 been planned for.

15 **Q.** And can you recall, and don't worry if you can't, but
 16 when those rules changed or when the situation improved?

17 **A.** I can't recall for sure but it was during that year,
 18 I think, quite quickly, but the damage had already been
 19 done for so many people.

20 **Q.** The Inquiry has heard a substantial body of evidence
 21 regarding DNACPR notices, but if I may ask you this:
 22 what were some of the issues that Age UK heard or
 23 observed around communication about DNACPR decisions
 24 with the patient, but also with family members too?

25 **A.** I think it's important to say from the outset that

25

1 society not just as something to be used in extremis.

2 So how do you think we can achieve that in normal
 3 times and then how do you think that can also -- we can
 4 ensure that that continues to apply during a pandemic as
 5 well?

6 **A.** I think it's a very difficult thing to do from where we
 7 are now, rebuilding that trust, and I think I should
 8 also say that now that our country has voted to legalise
 9 assisted dying, that changes the context as well, and we
 10 know at Age UK that some older people right now are
 11 reluctant to engage in advanced care planning for fear
 12 that it's something to do with assisted dying, which,
 13 actually, it isn't. But I think this whole area has
 14 become more complicated for people, and we will need to
 15 do a lot as a society to support people in understanding
 16 the benefits of advance care planning, what it is, what
 17 it isn't, and enabling them to take part as early as
 18 possible.

19 **Q.** And how do you think that will help in a future
 20 pandemic, if we'd had those conversations beforehand?

21 **A.** It would mean that there wasn't a perceived need by
 22 professionals to rush people into having these
 23 conversations, which perhaps was an understandable
 24 reaction, given the stress that they felt under, and as
 25 they looked, early on particularly, at how their medical

27

1 communication at all times about this issue is often not
 2 very good. That's the broader context. But during the
 3 pandemic, it was arguably even worse, with people
 4 receiving phone calls out of the blue, telling them that
 5 this had been put on their file, which is completely
 6 improper, and against practice, because the whole point
 7 of these decisions is they are personal decisions for
 8 all of us to take for ourselves, and they should be
 9 decisions we take well in advance of actually needing to
 10 implement them. Ideally when we're fit and well and
 11 younger.

12 Of course, that wasn't the situation in the
 13 pandemic. I think there was a widespread fear amongst
 14 clinical professionals of services becoming overwhelmed,
 15 and the result was sometimes a knee-jerk reaction,
 16 a desire to get all the paperwork in place in case the
 17 worst happened. But that was, again, in denial, really,
 18 of older people's rights and caused a lot of upset and
 19 fear amongst older people and of course their families.

20 **Q.** I think during your evidence to Module 3 you were asked
 21 how trust can be rebuilt between healthcare, government
 22 and older people to ensure they have the confidence to
 23 ask that their healthcare needs are met in a future
 24 pandemic, and in response to that, you said that advance
 25 care planning needs to be taken more seriously across

26

1 services were getting quite close to being overwhelmed
 2 by surging demand as a result of the pandemic.

3 **Q.** And just on the topic of visiting of loved ones in care
 4 homes, again, an area the Inquiry has received a lot of
 5 evidence about, but you describe in your statement how
 6 it was the most common concern that was heard through
 7 your helplines. And so can you provide some examples of
 8 the impact on older people and their loved ones that
 9 your organisation observed, perhaps in particular those
 10 receiving palliative or end-of-life care or suffering
 11 from dementia.

12 **A.** Well, those were exactly the groups who were hit the
 13 hardest, arguably, if they were living in a care home
 14 and were unable to have face-to-face contact with their
 15 loved ones. For people with dementia, may have not much
 16 understanding of who they are, where they are, but
 17 retain a strong affectionate bond with the people
 18 closest to them, that provides reassurance. And of
 19 course, for people like that, visiting is often not just
 20 coming and saying hello, it's also helping with eating
 21 and drinking, and very important things like that. So
 22 the absence of that support for that group was terrible,
 23 and I think, in some cases, led to people deteriorating
 24 very quickly, dying faster than would otherwise have
 25 been the case. As well, of course, as being very

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1 painful for their relatives.

2 And then, for people at the end of life, the time at
3 which, for most of us, we would want to have our loved
4 ones close to us, and definitely, for loved ones, the
5 time when they would often think it most important to be
6 present, the inability to be there. Something that will
7 probably scar the people who lived through that for the
8 rest of their lives, a continuing source of deep regret
9 and sadness, experienced by very many people,
10 unfortunately.

11 **Q.** And picking up on something you said there around
12 visitors perhaps not just being there in person but also
13 undertaking tasks whilst they're there, and I think
14 you've said in your statement how the term "visiting"
15 fails to capture that role of family and carers not only
16 supporting the care recipient but also supporting staff
17 as well. So was that understood in the guidance, do you
18 think, and if not, how could it be in future?

19 **A.** I think it wasn't really appreciated. More generally,
20 I think the people writing the guidance often had very
21 little practical experience of what it's like in a care
22 home. They weren't usually former professionals. I'm
23 sure they took advice and insight from people who were,
24 but the officials themselves were servants, policy
25 officials, good at doing policy, not necessarily with

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1 meant that that evidence weighed as heavily as the
2 medical evidence about the transmissibility of the
3 virus. And it felt like banging your head against
4 a brick wall.

5 And I think it put officials and ministers in
6 a really difficult position, because the public health
7 advice for a long time was so anti anything that might
8 be perceived to enhance the transmission of the virus.

9 Of course I completely understand the importance of
10 that, but what wasn't seemingly weighed alongside it was
11 the damage to older people of not having visitors, and
12 less emphasis was being placed on what we know now to
13 have been a big cause of transmission, which was care
14 workers going home at night to their families, where
15 their children had gone to school. That -- so much
16 emphasis was placed on keeping loved ones out in a way
17 that was disproportionate and, I think ultimately, as we
18 look back on now, a big mistake.

19 **LADY HALLETT:** Can I just interrupt -- sorry, Ms Hands.

20 Ms Abrahams, I totally understand the point you're
21 making about the impact of visiting restrictions on
22 recipients of care and on their loved ones. On the
23 other side of the coin, I have heard from some loved
24 ones that they didn't want anybody visiting the home for
25 fear of the virus being introduced by them, whoever they

31

1 the understanding of the context.

2 So the more hands-on professional experience/advice
3 that the government can benefit from by having either
4 people on its staff in that position or excellent links
5 to groups of professionals outside, the better the
6 policy will ultimately always be.

7 **Q.** And in 2021, Age UK were invited to join the Care Home
8 Visiting Stakeholder Group in England. I think that was
9 around February to March 2021, and Age Scotland were
10 invited to join the Scottish Government subgroup on care
11 home visiting in December 2020.

12 Age Scotland in their statement have described this
13 as very useful and that their input shaped the care home
14 visiting guidance.

15 So does Age UK consider that its input into the
16 group in England also had the same positive impact?

17 **A.** I hope so. I have to say, my recollection of it is it
18 was a hugely frustrating experience, because what
19 happened over the months was that we at Age UK and all
20 charities working externally got lots and lots of
21 evidence of the pain and suffering being caused to
22 people living in care homes by the lack of face-to-face
23 contact with their loved ones. And at the same time, we
24 were constantly told that there was no empirical
25 evidence, there was no randomised control trial, which

30

1 may be. So they didn't want visits to take place from
2 family members. But could you help me on that point,
3 please.

4 **A.** We heard that too, and there's no doubt that different
5 families took different views, often within a single
6 care home, which would have made life very difficult for
7 care home managers and their staff trying to come to the
8 right decision about what was best. I think, on the
9 whole, those people were in the minority, but there
10 undoubtedly were those voices.

11 But I suppose one thing we have to take into account
12 is that as the months went on, there was greater use of
13 PPE, there was more access to PPE, there was more
14 understanding about this being predominantly an airborne
15 virus. Some care homes much better able than others to
16 provide pods in gardens, and things like that, for safe
17 visiting that would still allow some kind of contact.

18 But I think it would be fair to say we were quite
19 slow, generally, to get on that bandwagon, and it felt
20 like for a long time there could be no discussion of it
21 at all. And therein lies my frustration, I think.

22 **LADY HALLETT:** Thank you.

23 **MS HANDS:** Thank you, my Lady.

24 I was going to ask you whether you think that the
25 type of groups that were set up later in the pandemic

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1 would have been helpful earlier in the pandemic, and if
 2 you had been invited to join them earlier on it may have
 3 been helpful. Would you agree with that?
 4 **A.** Definitely.
 5 **Q.** You may not be able to answer this but, to your
 6 knowledge, were there any groups or representation for
 7 the Age groups in Wales or Northern Ireland?
 8 **A.** I can't answer that directly.
 9 **Q.** That's not a problem. Thank you.
 10 A final topic before coming to your recommendations.
 11 Age UK produced a report in November 2020, Time to Bring
 12 Our Care Workers in from the Cold. What were some of
 13 the key themes that were identified in that report and
 14 recommendations?
 15 **A.** I think our view then, and continues to be at Age UK,
 16 that the business of providing social care is a highly
 17 skilled task undertaken by people who are hugely
 18 committed. It's a much more difficult, demanding task
 19 than our usual systems for accreditation tend to
 20 recognise, and that care work deserves to be
 21 professionalised, and people who do it deserve the terms
 22 and conditions that go with it.
 23 Part of professionalising the social care workforce
 24 probably means putting more structures and systems
 25 around it, more expectations of training that you are

33

1 **Q.** And do you have any views on who should be responsible
 2 for collecting or holding that data and information?
 3 **A.** I think it would need to be someone or an organisation
 4 that was reliable. It could be a bespoke organisation,
 5 a new organisation. As the current government starts to
 6 think over the next few years about what a National Care
 7 Service might look like, you can imagine some body being
 8 set up -- I mean a body being set up to do a number of
 9 tasks to do with social care, including that one.
 10 **Q.** Ms Abrahams, are there any further recommendations that
 11 we haven't already discussed today that you would like
 12 to draw our attention to, either on behalf of Age UK or
 13 the network more generally to improve the situation for
 14 older people in a future pandemic?
 15 **A.** Well, I suppose, on reflection, being in a care home
 16 turned out to be almost the worst place you could be
 17 during the pandemic, simply as a result of unintended
 18 consequences and the nature and behaviour of the virus.
 19 Part of the problem, I think, was that thought was
 20 given to the needs of people in their own homes and to
 21 people in hospital, and people in care homes and using
 22 social care more generally fell down the gap in between.
 23 And a lot of what didn't happen, I think, is because of
 24 that.
 25 So what that tells me is that, in future, we do need

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1 then accredited for having taken, which might help you
 2 to earn more money, which is important in attracting
 3 more people to do this very important work.
 4 And if we're going to do that, we probably need
 5 a register or something that writes down in one place
 6 who a care worker actually is, so we can -- the public
 7 can monitor what training has that care worker got?
 8 Have they got the skills to help my mum? Are they the
 9 right person? It would probably, we think, improve --
 10 it would certainly be more transparent. It would help
 11 to identify, perhaps, people who shouldn't be doing care
 12 work, and we think would increase public confidence in
 13 social care as part of professionalising this career.
 14 **Q.** And how do you think such a register would help in
 15 a future pandemic?
 16 **A.** One of the things that was noticed at the start of the
 17 pandemic was how little access directly to people
 18 providing social care the government had. As I'm sure
 19 you've heard, they didn't even have a list of what all
 20 the care settings were, let alone any way of
 21 communicating directly to care workers, for example
 22 about the importance of getting the jab at the right
 23 time and things like that. Or of access to PPE. Had
 24 a register been in place, that would have been much
 25 easier.

34

1 something much more like a genuine national care
 2 service. We need more national infrastructure to
 3 support it. We need quality standards. We need
 4 transparency. That would have supported a stronger
 5 social care system when the pandemic hit.
 6 The second point I would particularly draw attention
 7 to is the need for much more recognition of the rights
 8 of older people, particularly, for example, in care
 9 homes, where they have no rights, really, at all.
 10 It was a source, I think, of great sadness and
 11 surprise to families who had always thought they were
 12 partners in their loved ones' care with the care home,
 13 that once the pandemic struck, it didn't feel like that
 14 at all. And that their loved one didn't have any
 15 rights, really, either. So that definitely needs to be
 16 addressed.
 17 And then thirdly, and finally, you'll be pleased to
 18 hear, important that we put some more structures in
 19 place to hear the voices of older people and those who
 20 represent them in government. As I have said, when the
 21 crisis hit, there's an absolute understandable tendency
 22 in government to circle the wagons, to look inwards.
 23 You're much more inclined not to listen to people
 24 outside. There's a lot of tension and anxiety, and
 25 there's some confidentiality too. And that didn't help

36

1 older people during the pandemic because there was no
2 one inside government thinking particularly about older
3 people, and not enough people thinking about social
4 care.

5 So, addressing that through appointing
6 a commissioner for older people, probably a minister
7 with more responsibility setting up a cross-cutting unit
8 of officials, these are all the types of things that
9 could easily be done, and they would have made it less
10 likely, I'm sure, that older people would have been
11 forgotten too often during the pandemic.

12 **MS HANDS:** Thank you, Ms Abrahams.

13 My Lady, that's all of my questions. I believe
14 there are some further questions.

15 **LADY HALLETT:** There are, and I think its Ms Morris who is
16 first to go, who just to your right, Ms Abrahams.

17 **Questions from MS MORRIS KC**

18 **MS MORRIS:** Thank you.

19 Good morning, Ms Abrahams. I ask questions on
20 behalf of the Covid Bereaved Families for Justice UK.
21 Just two topics for you to expand on, please.

22 The first is around structural inequalities and the
23 impact of the pandemic on ethnic minorities. You
24 describe in your statement how older people from
25 minoritised ethnic communities have experienced higher

37

1 All these things are obvious when you look at them
2 now. I don't think they were thought about before the
3 pandemic.

4 **Q.** Thank you. So looking forward, what is needed to ensure
5 that structural health inequalities are addressed in
6 advance of a future pandemic?

7 **A.** I think there just needs to be a more strategic look,
8 really applying a safeguarding lens, for example, to
9 older people who -- where is the threat? And who is it
10 most likely to hit? And if you apply those two prisms
11 to thinking about your planning, that would have taken
12 you inevitably to thinking much more about people in
13 difficult circumstances of all kinds.

14 **Q.** Thank you.

15 My second topic is around discharging patients from
16 hospital into care homes, although you deal with
17 discharging into domiciliary care, as well.

18 You said that:

19 "The first wave of the pandemic was witness to
20 particularly devastating outcomes in care homes and
21 places where people were receiving domiciliary or
22 home-based care."

23 You said:

24 "The policies and guidance at the time ..."

25 And you're referencing there the discharge of

39

1 mortality from Covid-19 for the majority of the pandemic
2 than white older people. So I wanted to ask you whether
3 you believe the government did enough to recognise that
4 disproportionate impact of the pandemic at an early
5 stage?

6 **A.** I do not think the government did enough to recognise
7 the importance of structural inequalities on the impact
8 of older people's experiences.

9 You have quoted particularly the issues around
10 people from minoritised communities, but more generally
11 there was, I think, no evidence of people thinking
12 strategically about: who are the older people going to
13 be at greatest risk? How do we identify them? What can
14 we do to better protect them?

15 And of course, anyone subject to a structural
16 inequality is going to inevitably have been hit harder.

17 For example, people from minoritised communities
18 tend to be on lower incomes, more likely to have had
19 problems accessing, buying PPE if they were at home,
20 being able to afford those things, probably less able to
21 advocate for themselves, having less access to external
22 support during the pandemic. And if in a care home,
23 more likely to be in a care home in a deprived area,
24 a state-funded care home, less well staffed, more
25 subject to churn.

38

1 untested patients into care homes:

2 "... failed to consider the highly relevant risk to
3 care home residents or staff from asymptomatic
4 transmission until mid April 2020."

5 You go on to identify that between 2 March and
6 12 June 2020, there were more than 19,000 deaths of care
7 home residents attributable to Covid-19.

8 And you say in your statement that, in your view,
9 older people's rights were breached through unsafe
10 discharge of infected Covid-19 patients into care home
11 facilities. You say:

12 "In future, discharge to vulnerable settings should
13 only happen where measures are in place to ensure the
14 safety of the patient leaving hospital and the safety of
15 the people at the discharge address."

16 So I wanted to ask you, do you agree that it was
17 a fundamental failure of government at the outset of the
18 pandemic to allow discharge of patients from hospital
19 into care settings without confirmation by way of
20 a negative test?

21 **A.** I do.

22 **Q.** Was Age UK consulted about this policy before its
23 implementation in March 2020?

24 **A.** Not as I recall.

25 **Q.** Are you aware of government considering the obvious and

40

1 inherent risks of that policy?

2 **A.** That wasn't obvious to anyone outside government, I
3 believe, at that time.

4 **Q.** Right. In your view, were care homes equipped to deal
5 with those new admissions who had not been tested? For
6 example, did they have sufficient facilities to isolate
7 or quarantine returning residents? Did they have
8 sufficient bed, staff or resources, PPE, and was there
9 necessary training in place to make that safe?

10 **A.** I think it would be fair to say that some care homes
11 were better placed to do that than others. If they were
12 new buildings with separate rooms, with lots of space,
13 that would have given them an advantage. But even for
14 them it would have been very, very difficult without
15 enough access to enough PPE, without having the trained
16 staff always in place.

17 So for almost every care home it was a very bad
18 idea.

19 **MS MORRIS:** Thank you, Ms Abrahams. Those are my questions.
20 Thank you, my Lady.

21 **LADY HALLETT:** Thank you, Ms Morris. And I think its
22 Mr Foley, who is probably across the hearing room.

23 **Questions from MR FOLEY**

24 **MR FOLEY:** I am, my Lady. Thank you.

25 Good morning, Ms Abrahams, I ask questions on behalf
41

1 to us. So thank you very much.

2 **THE WITNESS:** Thank you.

3 **LADY HALLETT:** I was going to suggest we break before the
4 next witness, but we are ahead of time. Shall we go to
5 the next witness? Sorry, having told the team that --

6 **MS HANDS:** I will just check, my Lady.

7 Yes, we can move straight to the next witness.

8 **LADY HALLETT:** Sorry for the confusion. Thank you.

9 Ms Jung.

10 **MS JUNG:** Good morning, my Lady.

11 **LADY HALLETT:** Sorry, it is probably my fault there's
12 a delay in bringing the next witness in. I suggested we
13 would have had a break before the next witness.

14 **MS JUNG:** My Lady, the next witness is Ms Emily Holzhausen.

15 **MS EMILY HOLZHAUSEN (sworn)**

16 **LADY HALLETT:** Good morning, Ms Holzhausen.

17 I'm sorry if there was a confusion about whether you
18 were going to give evidence after the break or not. My
19 fault entirely.

20 **THE WITNESS:** Not at all. That's absolutely fine. Thank
21 you.

22 **Questions from COUNSEL TO THE INQUIRY**

23 **MS JUNG:** Good morning. Could I ask you to confirm your
24 full name, please.

25 **A.** Yes, my name is Ms Emily Holzhausen.
43

1 of the Covid-19 Bereaved Families for Justice Cymru.

2 I'm conscious of your earlier comments about not being
3 able to answer directly in regards to some issues in
4 Wales, but I just have one topic to raise with you
5 regarding measures after the pandemic that -- if I could
6 see if you can help us with.

7 May I ask, please, to your knowledge, again, since
8 the pandemic, has Age Cymru had any interaction with the
9 Welsh Government, Public Health Wales or any other
10 government or public health organisation -- in Wales, of
11 course -- to address the lessons learned from the
12 pandemic with regard to older people in care homes?

13 **A.** I'm sorry, I can't answer that on behalf of my
14 colleagues at Age Cymru. I don't want to get it wrong.

15 **MR FOLEY:** Okay. In that case, I'll leave it and I thank
16 you.

17 Thank you, my Lady.

18 **LADY HALLETT:** Thank you very much, Mr Foley.

19 Ms Abrahams, that completes the questions we have
20 for you. I think you're, in my book, one of the most
21 perfect witnesses you can have. You're not only
22 extremely informative and very, very helpful, but you
23 are also a stenographer's dream. Thank you very much
24 for your clarity and the content of what you provided to
25 the Inquiry, and much of it was really, really important
42

1 **Q.** Thank you. And could I ask you just to keep your
2 voice up a little bit, please. Thank you.

3 Is it right that you have come to give evidence as
4 the Director of Policy and Public Affairs at Carers UK?

5 **A.** I have.

6 **Q.** And that is a UK-wide charitable organisation that
7 represents nearly 50,000 unpaid carers across the UK.

8 Carers UK has an affiliate network of local carer
9 organisations which covers many millions of unpaid
10 carers across the UK; is that right?

11 **A.** That's correct, and we have -- the 50,000 refers to our
12 individual membership, so we really are here to
13 represent all of the millions of carers in the UK today.

14 **Q.** Thank you. And is it right that you have offices in
15 each of the devolved nations?

16 **A.** That's correct, and they work very directly with the
17 administrations and elected parliaments and assemblies
18 in those nations, as well.

19 **Q.** Thank you. So although the work of Carers UK is
20 UK wide, in terms of the evidence that you can provide
21 and the assistance that you can provide, is it right
22 that aside from the matters relating to devolved nations
23 in your statement and documents, you otherwise aren't
24 able to assist with specific issues that arose in the
25 devolved nations?
44

1 A. That's correct. I'll be concentrating largely on
2 England, but there are important divergences in some of
3 the nations which we need to learn from.

4 Q. Thank you, and we will go on to deal with some of those
5 matters in due course. Thank you.

6 Can I start, please, by asking you: who are unpaid
7 carers?

8 A. So unpaid carers are people like you and I. They are
9 family, friends and neighbours. And there's around --
10 it depends which study you look at, but about
11 5.8 million people who are unpaid carers in the country
12 today. They're not people who are paid to do it as
13 a contract, neither are they volunteers. And the types
14 of support that they provide can range from more intense
15 emotional support, prompting, it might be somebody with
16 mental illness, and they're caring for somebody who has
17 a disability or a long-term condition or need support
18 because they're older. But it can go right up to caring
19 for somebody 24 hours a day, seven days a week. It can
20 include some quite complex care including health tasks,
21 as well, that you might expect a trained nurse to do.

22 So we have a very broad spectrum of people who are
23 unpaid carers today.

24 Q. Thank you. Sorry, did you --

25 A. Well, one of the points I wanted to say is that most

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1 Q. Thank you very much.

2 Is it right, I think you said earlier in your
3 evidence that there are about 5.8 million unpaid carers
4 in the UK. In your statement you say that it's
5 estimated to be between that and about 13 million. Why
6 is there so much uncertainty as to how many unpaid
7 carers there are?

8 A. There's -- it really depends on how you construct the
9 research. So you will see, for example, the census
10 is -- we quote those figures quite a lot. That's where
11 we now get a slightly updated figure of 5.8 million, now
12 that Scotland completed its census one year later.

13 Q. Sorry, just pausing there. The figures that you are
14 discussing, are they -- so there's 4.7 million in
15 England?

16 A. In England.

17 Q. 311,000 in Wales, 222,000 in Northern Ireland and
18 627,700 in Scotland, according to the most comprehensive
19 censuses in each of those countries?

20 A. That's right. The census in Scotland has been -- was
21 a year later, so those figures have shifted slightly,
22 and they're higher. But the reason, if I come back to
23 the figures, about why over 13 million -- and that is
24 down to polling.

25 So we polled the general public with a slightly

47

1 people don't consider themselves to be called carers or
2 unpaid carers. They are primarily, you know, fathers,
3 mothers, brothers, sisters, partners, sons, nieces,
4 nephews, good neighbours, good friends, and that's
5 a term that people don't always associate with, but it's
6 very important in law, and in policy guidance, as I'm
7 sure we'll come to later.

8 Q. Thank you, and is it right that research carried out in
9 2022 showed that over the period of 2010 to, I think,
10 2020, 4.3 million people across the UK became carers
11 every year, I think that equates to about 12,000 people
12 a day becoming carers? And is it right that more than
13 4 million people also left their caring role, leave
14 their caring role every year, and does that show how
15 dynamic the group is, really, with people moving in and
16 out of caring roles all the time? Is that right?

17 A. That is correct. So you can think of it, quite simply,
18 as one-third of the population become carers every year,
19 and one-third of the people stop caring. And that's
20 quite important, because it affects how we identify
21 carers, it affects the support they need. So some
22 people's caring can be relatively brief and other people
23 are caring throughout most of their lives, and for some
24 children it can be a very long time indeed, or parents
25 of disabled children.

46

1 expanded question, so we were able to explain a little
2 bit more about what we meant by unpaid caring and that's
3 why we get a different figure.

4 Q. Thank you.

5 A. But the polling was very important because we needed to
6 measure exactly what was happening to this very dynamic
7 population in a very unprecedented situation, and it
8 told us a lot.

9 Q. Thank you. And can I just ask you, the figures that
10 I've just quoted, do they apply to children as well as
11 adults? And if so, are you able to help us as to the
12 proportion of adult carers or not?

13 A. That's right, they do also apply to parents of disabled
14 children and children with long-term conditions, but
15 other studies suggest that 92% of people caring are
16 caring for an adult. So where I'm looking at these
17 statistics, we can take a large degree of confidence
18 that they -- the majority of people they will refer to
19 are caring for adults.

20 Q. But the carers themselves are all adults, are they, in
21 those figures?

22 A. Yes.

23 Q. Thank you very much.

24 A. There is a smaller count of young carers within the
25 figures, of about 175,000.

48

1 Q. Thank you.

2 Can we look at terminology, please. This is
3 a matter you discuss in your statement, and you say that
4 unpaid carers are at times referred to as a "workforce"
5 or a "sector". You say that that can be misleading.
6 They are individuals who are not formalised, not paid by
7 the state, and are not protected like paid workers by
8 employment legislation in relation to their unpaid
9 caring responsibilities.

10 You also say that, very often, families do not have
11 a choice about caring.

12 Is the point that you're making that they are not
13 a formal -- a group with formalised peer support or
14 protections under employment law, and therefore it's
15 important to distinguish them from the paid workforce
16 who do have certain protections under the law?

17 A. It's hugely important. And if you think when people are
18 talking about organising workforces, it's a very
19 different matter when we're talking about relatives and
20 friends who are untrained, who don't necessarily -- who
21 quite often become experts in conditions, but certainly
22 don't start out that way, who are thrown into situations
23 when they're caring for people with some very complex
24 conditions when care is withdrawn.

25 So it's very important to see this group as -- very
49

1 You can provide additional care to the disabled
2 person, the person needing care, if that then helps
3 achieve -- the carer to achieve the outcomes they wish
4 to achieve. But the sorts of other support -- there's
5 very flexible direct payments or grants. So the carer
6 is effectively able to pay these -- to buy anything that
7 supports their outcome, so it's anything from a laptop,
8 it might be taking up a hobby, that kind of thing.

9 They tend to be quite small grants, sometimes it's
10 referrals to different advice and information or
11 different support groups. There's a whole range of
12 different support but for carers it tends to be more
13 modest than it is for disabled or older people.

14 Q. Thank you. And the Inquiry has heard evidence,
15 including this morning, about the effect of easements on
16 assessments and the impact of that on people receiving
17 support, including carers.

18 Could I ask you this, please: is it right that in
19 each of the UK nations there's a slightly different
20 definition of carers under the applicable legislation?
21 In England, is it right that unpaid carers at the
22 beginning of the pandemic and prior to the pandemic were
23 just referred to as "carers", but during the course of
24 the pandemic, because there was some confusion arising
25 with the paid workforce also being referred to as

51

1 differently. As you said, they don't have employment
2 rights, they aren't covered by health and safety
3 legislation in the same way, and their benefits -- if
4 they are unable to work, for example, their benefits are
5 the lowest of their kind.

6 Q. And in terms of the protections that would otherwise be
7 available under employment (unclear), do they cover
8 matters such as Statutory Sick Pay, working hours --

9 A. No, there's nothing.

10 Q. So those are things that they don't have
11 access -- (overspeaking) --

12 A. They don't have access to those, there's nothing to
13 cover them in that way. So that's why we see people
14 caring for 24 hours a day, seven days a week, and going
15 without vital breaks as well.

16 Q. And in terms of the support that they do have, is it
17 right that they are eligible to have a carers
18 assessment, and then, depending on the outcome of that,
19 they may receive support through the local authority?
20 And what kinds of practical support would a carer be
21 eligible for?

22 A. Well, the care -- the carer's assessment looks at
23 a whole range of different areas, for example people's
24 ability to work if they wish to, health and wellbeing.
25 They're supposed to look at breaks.

50

1 "carers", you decided to change the name, so you now
2 refer to them as "unpaid carers".

3 Why is it important to distinguish, aside from the
4 reasons you've already given, is there anything
5 additional you want to say as to why it's important to
6 be clear with terminology?

7 A. It was hugely -- it was -- the rights were, for carers,
8 has been hard won over the years, and it's a term that
9 although people don't initially associate with it,
10 people take great value in that, as carers. But when,
11 in a pandemic situation, you are talking about
12 communications, you need to be utterly clear when it's
13 very -- it makes those messages very confusing to know
14 are you talking about paid carers or are you talking
15 about family members, you know, as defined by the law?

16 Unpaid carers felt very strongly that this was
17 their -- the term was being appropriated. So when we
18 heard about "Clap for Carers", they were very clear that
19 it was not for them, that it was for health workers and
20 then a bit later on for care workers, and some of them
21 sort of wanted to do a move to sort of recognise
22 themselves under that heading, as well.

23 Now we tend to refer to carers as "unpaid carers" to
24 be very clear, but I just want to be clear about the
25 legislation, still remains the same. "Carer" is still

52

1 defined, as I just said, not by contract of employment
 2 and not as a volunteer, and we would like to keep that
 3 in the future but we feel the need to define carers as
 4 unpaid carers, to be absolutely clear that it's not
 5 about workers.

6 And some of this sort of confusion around
 7 terminology we see in some of the PPE guidance and in
 8 some other areas where we're not entirely clear exactly
 9 who it is that we're talking about.

10 **Q.** Just to clarify, when you say that there was confusion
 11 during the pandemic about which group of people were
 12 being discussed or the guidance applied to, do you say
 13 that there was confusion amongst decision makers and
 14 people drafting the guidance as well as the public?

15 **A.** Some of the guidance that came to me didn't make that
 16 distinction, used it for the paid workforce. And then
 17 certainly when the communications was going out
 18 nationally, that was also confusing for people locally
 19 and a lot of local services use the term "Carers", as
 20 well, to mean unpaid care. So you can see that in
 21 a pandemic it's critically important to make sure you
 22 have clear communications, and even more so when you're
 23 talking about unpaid carers and the general public,
 24 as well.

25 **Q.** Thank you. You said that you're not suggesting that

53

1 If I may, I'll just read you an extract from
 2 a Department of Health and Social Care document from
 3 November 2020, and it described unpaid carers being
 4 fundamental to the sustainability of the health and
 5 social care system:

6 [As read] "During the pandemic, unpaid carers have
 7 been invaluable to the health and social care sector,
 8 preventing people from entering formal care for
 9 preventable conditions, absorbing or reducing strain and
 10 burden on the NHS, and providing care and support for
 11 those they care for in their own homes."

12 Would you agree with that description?

13 **A.** We would agree with that description, except that they
 14 felt invisible, quite often, because of the national
 15 messaging. And I'm sure we will come on to the impact
 16 and the cost of providing that care, to them.

17 **Q.** Yes. You say in your statement that it was a common
 18 pre-pandemic scene for unpaid carers to feel invisible
 19 and undervalued but is that something that continued
 20 through the pandemic?

21 **A.** Yes. And I think that comes down to national messaging,
 22 clarity about who we're talking about, carers, you know,
 23 they felt that their word had been appropriated.

24 **Q.** Thank you.

25 **A.** And about the support that they were given as well, very

55

1 that should be done by legislation. How do you say that
 2 that clarity should be achieved during the next
 3 pandemic?

4 **A.** We would say by using a slightly different term for paid
 5 workers, whether "care workers" or "social care", "paid
 6 social care staff". There are other terms that can be
 7 used other than "carer".

8 **Q.** Thank you.

9 **LADY HALLETT:** Would you like to break now, Ms Jung?

10 **MS JUNG:** That would be a convenient moment. Thank you,
 11 my Lady.

12 **LADY HALLETT:** Thank you. I shall return at 11.35.

13 (11.18 am)

(A short break)

14 (11.35 am)

15 **MS JUNG:** Thank you, my Lady.

16 **LADY HALLETT:** Ms Jung.

17 **MS JUNG:** Thank you.

18 Ms Holzhausen, we discussed before the break the
 19 identification and definition of unpaid carers. Can
 20 I just briefly ask you about recognition.

21 In your statement you say that the value of support
 22 of unpaid carers is estimated as equivalent to the NHS,
 23 and that unpaid carers outnumber health and care workers
 24 by 2:1 as a minimum and 4:1 as a maximum.

54

1 directly.

2 **Q.** Thank you. And you also say in your statement that
 3 there was a mix of awareness between political and
 4 administrative decision makers understanding the role
 5 and/or importance of unpaid carers.

6 So, in terms of impact, then, please could you
 7 explain what the impact was of decision makers not fully
 8 understanding and recognising the role and importance of
 9 unpaid carers.

10 **A.** So I just want to -- if I just start by explaining how
 11 people felt at the beginning of the pandemic, in that --
 12 if I just read some of the words from a carer, if that's
 13 okay?

14 **Q.** Thank you.

15 **A.** "I am terrified to the point of suffering a panic attack
 16 that either Mum or I will become infected and I'll
 17 either have to battle to keep her isolated, or worse,
 18 I might get ill and won't be able to keep her safe
 19 because I will have to self-isolate."

20 I've been speaking to some carers over the last
 21 week, to go back to remember what the times were like
 22 first of all, and the responsibility that families felt
 23 towards keeping their loved ones safe was immense, and
 24 there was a huge level of fear and anxiety, and that
 25 continued throughout the pandemic and took a real toll

56

on people's mental health and wellbeing.

The physical impacts were also visible. So when we looked later at carers, 81% were providing more care. And that was because of the withdrawal of services, because they had refused services out of fear of keeping people safe at home. It -- you know, some of them had had very poor experiences of care, especially with the lack of PPE in the early days. Services had closed and gone online, particularly day services, and so people were becoming very isolated.

We saw -- we -- just this year, when we look at the GP Patient Survey, for example, which measures carers' health and wellbeing, we've seen an increase in poorer health and a difference between carers and non-carers.

Q. Thank you. If I may, can I just focus the topic a little bit. So you've just told us that there were rising levels of care need during the pandemic. I think you said 80%. Is it right that that was broadly similar across the devolved nations as well?

A. Yes, it was, yes.

Q. Is it also the case that the needs of people receiving care increased during the pandemic?

A. They did. And it was very distressing to see, for example, people talking about a learning disabled son who was extremely distressed, agitated, sometimes

57

was extremely concerned about risk of infection, transmission.

That's a key reason why people refuse services because they were worried about transmission, and when we come to look at the guidance which suggested that carers themselves might need PPE, it was impossible to buy on the open market. And when we look at carers on benefits, it was a large proportion of their daily income. So, you know, when gloves cost £5 for just 12 pairs of gloves, and your income is £66, you know, you're struggling to buy food and pay for the heating. It's impossible to get gloves on top of that.

And that's why, you know, we need to see, sort of, very clearer rules around PPE and targeted --

Q. Thank you. And just for context, you say in your statement that pre-pandemic, unpaid carers didn't normally have access to PPE. And so I think you've explained that during the pandemic, they were having to purchase it themselves. To what extent did they gain access to PPE through local authorities during the pandemic?

A. There were some local authorities in England who devised systems for triaging carers who really needed it. And it also has to be said that not everybody lives with the person that they care for, or even if they do, they

59

challenging behaviour because couldn't understand why he couldn't go to his clubs and activities. Some people who were very active, young people, were not able to go out, and that manifested itself at home with people's cognitive decline, with people's physical decline.

People stopped being able to do everyday activities like eating themselves. Speech and language declined across lots of different conditions, dementia, learning disability, mental illness as well, and that fell on carers' shoulders.

Q. And I think in the very helpful reports that you've exhibited to your statement you set out in detail all of the impacts, but is it also right that one of the key themes that arose during the pandemic were concerns about PPE?

A. (Witness nodded).

Q. Could you tell us specifically what the impact was in relation to the access issues to PPE?

A. So first of all, carers, being ordinary members of the public, couldn't access PPE. And we know that there were key issues, first in the NHS and within social care and social care being very late to get PPE, and one carer spoke about this very well, for example. He said that, you know, the NHS staff coming into the home had full PPE, the care staff just had flimsy aprons, and he

58

might go out of the home and come back, and we've got families sharing care and travelling distances to care for people. So it's not true that they're, sort of, totally isolated sometimes.

So some local authorities provided PPE but really, it wasn't -- in England, the systems weren't really set up until 2021 whereas in Scotland they had systems set up at the end of April. And it was very targeted and triaged, and those services were not overwhelmed, either, and so this was one of our central calls that continued. It's very -- it's extremely distressing for carers to be told they should be having PPE when they can't get it.

Q. In Scotland, was the distribution through the local PPE hubs? Do you know?

A. Yes.

Q. And when you say that they were triaged, do you know if they had different data to the data that was available in England? Is the system that was applied in Scotland something that could have been applied here during the pandemic?

A. Yes, it could have been applied here. The triage system was really talking to individuals about what they needed and who they were, and working between carers organisations and local authorities, and that system

60

1 could have been applied here and indeed, sort of, that
 2 similar system was adopted here but much later. Nearly
 3 a year later.

4 **Q.** Thank you, and just sticking with the impact of that,
 5 I think you said that because people were worried about
 6 transmission from care workers without PPE, that they
 7 were cancelling their services, is that right? But is
 8 it also correct, you say in your statement that
 9 providers themselves were sometimes cancelling services
 10 because they didn't have the PPE?

11 **A.** That's right. There's a good example of an older woman
 12 who had a temperature and so care workers were withdrawn
 13 because they didn't have adequate PPE and they were
 14 concerned that the temperature was a sign of Covid. It
 15 might have been a sign of something else, but, you know,
 16 they didn't know that, so they protected their workers.
 17 And the carer was left without support.

18 **Q.** Thank you. And before we move on, just in terms of key
 19 impacts of the pandemic on unpaid carers during the
 20 pandemic, it's right, isn't it, that because of the
 21 impact of the easements and the reduction in the support
 22 provided to carers and also the closure of support
 23 services like day services and respite services, there
 24 was an increased burden on carers resulting from the
 25 fact that they didn't have breaks and were effectively

61

1 another matter.

2 **Q.** Do you consider that the drafters of that guidance with
 3 whom you are communicating had adequate understanding of
 4 how that guidance would be implemented in practice and
 5 how things operated on the ground?

6 **A.** I don't think so. So it's important -- I think it's an
 7 important demonstration that carers were included,
 8 because there have been a number of instances where
 9 carers have been left out of key policies to do with the
 10 pandemic when really they should be included as
 11 providing significant amounts of care. So the fact that
 12 they were included is a good thing, but the practical
 13 application of it, I think, is -- was just a challenge.

14 **Q.** How do you think that could be improved in a future
 15 pandemic?

16 **A.** I think -- I mean, the bottom line is, with a future
 17 pandemic, PPE is absolutely critical to maintain
 18 infection control and to give families the confidence
 19 that they will be safe when workers are coming into
 20 their home or giving them care in whatever care setting,
 21 and I think that's the fundamental, the fundamental
 22 principle.

23 We still need carers to be supported and included.
 24 We would need those distribution mechanisms set up far
 25 earlier for carers and for carers to be factored into

63

1 exhausted from caring; is that right?

2 **A.** Yes, they talk a lot about being overwhelmed, a large
 3 proportion of people being overwhelmed, burnt out,
 4 stressed, exhausted. One was talking about where they
 5 would normally get 84 nights of respite but were getting
 6 none, and some of these people, as well, are caring into
 7 their eighties, and, you know, still having to provide
 8 all that care themselves.

9 **Q.** We discussed PPE, in terms of the access. Can we just
 10 discuss the PPE guidance, please. What involvement did
 11 you have in the production of that guidance?

12 **A.** I saw, I think, a later draft of PPE guidance.

13 **Q.** And did you have sufficient time to meaningfully input
 14 into that guidance?

15 **A.** A lot of the guidance was very, very quick turnaround.
 16 I mean, there are examples when you just have a matter
 17 of hours to turn something around. And I think part of
 18 the challenge of commenting on guidance such as that is
 19 feeling, well, you might be giving instructions to
 20 carers about how to use PPE, but -- but they can't
 21 necessarily -- or use it, but they can't source it. So
 22 this is quite challenging, when you have a direction
 23 that you think a family should be taking, or government
 24 thinks a family should be taking, but the ability for
 25 families to actually follow that or do it is completely

62

1 the delivery of PPE. Not everyone will necessarily need
 2 that, but there are some examples where it's absolutely
 3 critical.

4 **Q.** And do you have any recommendations as to how,
 5 practically, distribution should work in a future
 6 pandemic to ensure that unpaid carers were able to
 7 access PPE in a timely manner?

8 **A.** I think the models that were set up where they were
 9 looking at who really needed PPE when supply is tighter
 10 is critically important. And those models could work in
 11 the same way.

12 The real issue is that there's very poor data on
 13 carers and identification of carers across different
 14 services doesn't necessarily match up. So in the
 15 future, one of the fundamentals that we need is very
 16 good data linkages, so that we know who might need this,
 17 and for those triage systems to come through local
 18 resilience forums, through local authorities, to be able
 19 to work well.

20 I mean, carers were sometimes advised to get them
 21 through their local domiciliary care provider, and they
 22 didn't have enough for their staff let alone the
 23 families that they were going into.

24 **Q.** Yes, and we'll go on to deal with data next, but before
 25 we leave this topic, in one of the documents that you've

64

1 exhibited you suggest that the local authorities could
2 hold a stockpile of PPE. Is that something you would
3 recommend in the case of a future pandemic?
4 **A.** Yes, I think so. Unless somebody comes up with a better
5 solution, we need to have resources that can be
6 distributed quickly.

7 **Q.** We know that guidance was issued, I think, on 13 March
8 to residential care settings, to supported living, and
9 homecare settings but not to unpaid carers. That
10 guidance came the next month, I think, on 8 April.

11 What impact did the delay in guidance being issued,
12 specifically for unpaid carers, have on them and the
13 response?

14 **A.** There's a lot of confusion about what should be
15 happening, and that's very hard when you're talking to
16 the general public. The guidance in particular when not
17 just about PPE but around some other really critical
18 factors like the ability to still travel to provide
19 essential care. The definition of essential care, that
20 was very important. I would like to come back and talk
21 about that as being a key factor at some point, if
22 that's possible.

23 **Q.** Sorry, about?

24 **A.** The definition of essential care.

25 **Q.** Essential care -- I think that's going to be dealt with

65

1 what the real practical challenges were for unpaid
2 carers?

3 **A.** I think, I mean, the social care sector was under such
4 pressure, that understandably took quite a lot of the
5 time and the energy and the effort. So I feel that
6 sometimes comments made were not really then followed up
7 and perhaps PPE is a good example; testing, for example,
8 when -- people coming out of hospital back into
9 someone's home, people needed to know whether there's --
10 somebody coming back into their home had Covid or not to
11 know, you know, they had also sometimes other, more
12 vulnerable people in the home.

13 So I don't always feel that those issues were taken
14 forward.

15 I do want to say, though, that the adult social care
16 taskforce that was chaired by David Pearson, he did make
17 sure that carers were a priority and we did have an
18 equal voice, and asked me to set up a specific subgroup
19 on unpaid carers, and that was given proper and due
20 consideration, and it was very positive.

21 **Q.** Thank you. That's the carers advisory group that you
22 co-chaired. And you made a number of recommendations in
23 that report. To what extent were those recommendations
24 implemented?

25 **A.** So some of them took quite a long time to implement, and

67

1 later.

2 **A.** Thank you.

3 **Q.** Thank you. So we've discussed the fact that the
4 guidance that was specific for unpaid carers came later
5 than for other settings.

6 **A.** Mm.

7 **Q.** Do you consider that unpaid carers were not prioritised
8 in decision making and in the production of guidance?

9 **A.** Yes. So there was very, very good knowledge at sort of
10 a policy level and very good working across NHS England
11 policy leads on carers, and the Department of Health and
12 Social Care policy leads, Department for Work and
13 Pensions, but there were delays in getting that guidance
14 out, so -- things were drafted fairly quickly but it
15 took a little while for it to be signed off, and so, you
16 know, that then impacts on the ability -- our ability to
17 support people through their journey of caring in the
18 pandemic.

19 **Q.** You say in your statement that you were party to some of
20 the working groups that the government set up, and that
21 included the adult social care taskforce. But you also
22 say that, understandably, these groups were primarily
23 focused on care homes and hospital discharges in
24 particular. Do you feel that you had an equal voice in
25 those sorts of forums to help decision makers understand

66

1 our recommendation here would be, now we know what we
2 know about the pandemic, do that far earlier. Some were
3 implemented quite quickly. If I look at the ones that
4 weren't, our recommendation was that carers should be in
5 a priority group for the vaccination, for example, and
6 they were left out on the list on 2 December, and it
7 took a lot of work to get them included and recognised
8 by 31 December.

9 And the reason for -- you know, the reason why
10 that's so important is -- the first is because of risk
11 of infection, and the second is because if the carer is
12 unable to care, that puts far more pressure on health
13 and social care services. And the fact that we
14 recognise this for flu but it wasn't with the
15 vaccinations -- and that sort of lack of recognition
16 came each time.

17 We also made a recommendation about care bubbles,
18 for example, which came a lot later, and there were some
19 which didn't really get implemented in terms of day
20 services returning in the way that they did, breaks,
21 and GP -- you know, systematic identification of carers
22 by GPs.

23 **Q.** Thank you. That brings us on to the topic of
24 identification and data infrastructure. I will turn to
25 those recommendations, but could I start by asking you,

68

1 please, pre-pandemic, what systems were in place to
 2 collect data on unpaid carers at a local level?
 3 **A.** So the data sources are all really disparate. At
 4 a local level we have GP identification of carers where
 5 they have specific codes, and at the time I think there
 6 were over 100 different codes used. They've been
 7 condensed now into three or four, but --
 8 **Q.** What do you mean by codes?
 9 **A.** They're on the GP patient system. So GPs could identify
 10 carers, and it's usually used for flu vaccination and
 11 some public health measures, but that's not systematic.
 12 And then local authorities, of course, keep records of
 13 carers where care assessments, joint assessments or
 14 carers' assessments have been undertaken, and sometimes
 15 they have other records. We have local carers'
 16 organisations that keep records, whoever provides the
 17 local carers' service. Within council tax, for
 18 example -- you can get a council tax discount if you're
 19 a carer. That's another record.
 20 And then nationally, of course we have the
 21 Department for Work and Pensions and claimants of
 22 Carer's Allowance, which is the main carers benefit.
 23 But locally they can't access that personalised data.
 24 So we've got a range of different data sources, but
 25 none of them are linked.

69

1 themselves as unpaid carers, and Gypsy, Traveller and
 2 Roma communities, for example, have issues about trying
 3 to access health services.

4 So there are some equality considerations, but that
 5 kind of linked data could be used earlier.

6 The other point I wanted to make as well was the
 7 role of the DWP, who was, as a national data holder of
 8 all of these carers getting Carer's Allowance and some
 9 linked benefits, they were -- they moved very
 10 positively, very fast to pull those -- pull those
 11 datasets in so that we had the best dataset we possibly
 12 could for vaccination.

13 **Q.** Thank you.

14 **A.** Now, that procedure, data protection was an issue --
 15 some -- you know, people -- between sharing of lists
 16 sometimes with local carers organisations, so that needs
 17 to happen earlier --

18 **Q.** Thank you.

19 **A.** -- and those data linkages need to be made.

20 **Q.** The study that you alluded to, the Health Foundation
 21 study, was that one that's been conducted recently,
 22 I think, in 2024; is that right?

23 **A.** That's right, yes.

24 **Q.** And that looked at what data was available in the
 25 GP records as against what data was available in the

71

1 **Q.** Thank you, you've answered the question I was going to
 2 ask next. So nationally, it was just -- it's just that,
 3 there is nothing else.

4 And what gaps do you say there were in data, then,
 5 at the start of the pandemic that would have been useful
 6 in informing the pandemic initial strategy and response?

7 **A.** So I think one of the -- what we saw when we started to
 8 look at pulling data lists together for vaccination,
 9 that is where we started to see some fantastic practice,
 10 and we should have seen that at the beginning of the
 11 pandemic.

12 So some brilliant work done by the Health Foundation
 13 as part of their Networked Data Lab looked at overlap
 14 between the lists of local authorities and GP practices
 15 in local areas. And they saw the overlap of -- being
 16 actually quite small. The GP lists tended to be
 17 slightly more likely to identify people of working age,
 18 and that might be linked to flu vaccination. But still
 19 a significant number of older carers.

20 Had these datasets been linked earlier, it would
 21 have been far easier to have identified a cohort of
 22 people who you could get public health messages out to,
 23 you could triage for support, but recognising, as well,
 24 who isn't on those lists. So people from ethnic
 25 minorities much more -- much less likely to identify

70

1 local authority records, and is it right that neither
 2 set were seen to be comprehensive?

3 **A.** Yes, neither set is comprehensive, and what was
 4 surprising was the lack of overlap, actually, between
 5 them. Some areas did better than others so this is --
 6 when we're looking at the -- building the future, this
 7 is something that needs attention.

8 **Q.** Thank you. And could I just go to one document, please.
 9 It's at tab 4 in your bundle, but it's INQ000239455,
 10 page 2, please.

11 And this is your statement made jointly with the
 12 Carers Trust on 11 March 2020.

13 And if we look at the third bullet point, you can
 14 see there you were recommending that:

15 "Data and intelligence pooling could be a real asset
 16 to ensure that we get the best picture possible of those
 17 most in need. Carer identification needs to be a core
 18 part of this.

19 "Information systems, like 111 should start
 20 collecting data on whether someone is a carer and ask
 21 this question to anyone who either reports symptoms or
 22 has to self-isolate, ie if they provide an important
 23 level of care to someone who might be vulnerable in the
 24 community. This should then lead to an appropriate
 25 response from the authorities."

72

1 So were you suggesting there that, as well as the
 2 data being collected by GPs and local authorities, that
 3 the government should ask services like the 111 to also
 4 start collecting data, and do you know whether that was
 5 done?

6 **A.** It wasn't. And it was -- it's the kind of thing where,
 7 with those critical services, we, having a data flag
 8 means that, first of all, you can target appropriate
 9 responses and secondly, you can pull the data later for
 10 learning, and that's what we need to do with systems, is
 11 constantly learn.

12 **Q.** And had this been done and had all the data sources been
 13 linked together, what impact do you think that would
 14 have had on the pandemic response? Do you think that
 15 would have allowed for more targeted policies, for
 16 example?

17 **A.** Definitely. We would have seen far more targeted --
 18 first of all, carers would have felt recognised and
 19 especially with communication, you can push
 20 communication messages out. You could have treated PPE
 21 differently, with getting food parcels to people who
 22 were isolated and had challenges, that would have been
 23 easy. You would have seen in evidence that that was
 24 very difficult to identify who people were in need of
 25 support. So it would have -- and the health response,

73

1 carers early on?

2 **A.** Yes.

3 **Q.** And are there any other recommendations you would make
 4 in terms of improving data infrastructure or data
 5 collection for the next pandemic, and who do you say, if
 6 so, should have oversight of that?

7 **A.** So the first thing on data collection is that we still
 8 don't have systematic identification of carers on their
 9 patient record. And this is -- we have
 10 misinterpretation from GP practices, sometimes blocking
 11 access, and it's critically important carers are able to
 12 do that. There's the potential for the NHS App in the
 13 future for, you know, if you had a function built in,
 14 you could get carers to identify themselves, but not
 15 everybody is digitally connected.

16 That is a very important source. Local authorities
 17 sources, it's a basic question when you're collecting
 18 demographic statistics, you can ask somebody whether
 19 they are an unpaid carer. And if we are able to look at
 20 that, we're far more likely to get a comprehensive
 21 picture of who is an unpaid carer, where we see
 22 equalities issues come up, you're then able to respond
 23 to them appropriately.

24 But we don't have the structures still in place, and
 25 I don't feel -- I feel that that has been a real missed

75

1 as well, we could see that in later research, we found
 2 that carers were less likely to get through to places
 3 like 111, and they were more likely to have their own
 4 health treatment cancelled.

5 So this builds up a data picture of risk, as well.

6 So --

7 **Q.** Thank you.

8 **A.** -- it's, you know, seeing that we called for that in
 9 March 2020.

10 **Q.** Thank you. I think you also recommend that a list be
 11 drawn up of who in the local community is particularly
 12 vulnerable, and at risk. Is that something that you saw
 13 implemented?

14 **A.** When it comes to carers, that didn't really happen until
 15 later. So some local authorities were trying to
 16 interrogate their data around disabled and older people
 17 and people with conditions. But that, you know, that
 18 happened in different places, but carers weren't always
 19 part of those lists.

20 **Q.** The Inquiry has heard that when early decisions were
 21 being made about PPE, it was a consideration that unpaid
 22 carers were vast, were vast numbers. If that list had
 23 been drawn up earlier on, would that have allowed
 24 policies to have, for example, targeted initially the
 25 most vulnerable people, so a smaller sector of unpaid

74

1 opportunity as a result of the pandemic when we used
 2 those data so well that that has now been lost.

3 **Q.** Thank you.

4 And finally, can I ask you about funding during the
 5 pandemic, please. Is it right that in some of the
 6 devolved nations there was a one-off emergency fund
 7 issued for unpaid carers? Such a fund wasn't issued in
 8 England, but is that something that you would recommend
 9 for any future pandemic?

10 **A.** Yes. So just to explain, in Scotland they have an
 11 additional payment called the Carer Support Payment, and
 12 they very quickly doubled it. And because of the
 13 slightly different legislation in Scotland, which
 14 basically denotes that if they spend from their own
 15 coffers, their -- it doesn't affect their means-tested
 16 benefits. So they reacted very quickly, and that made
 17 carers in Scotland thousands of pounds better off.

18 Wales did £500 for carers, but because of
 19 means-tested benefits, it was a problem, so it was only
 20 people who didn't get that.

21 Northern Ireland wanted to do it but it wasn't
 22 within their powers.

23 So England was the only place that didn't give or
 24 want to give carers an additional payment.

25 Now, people who were on Universal Credit, they got

76

1 an uplift, but carers who were on the old system of
2 benefits -- or outside of that system, rather, who got
3 Carer's Allowance, didn't. And it's something where we
4 saw people were talking about being under additional
5 financial pressure, unable -- you know, costs had gone
6 up, heating costs had gone up because people were at
7 home for longer, and we did not address carers' poverty
8 in those groups. And that is something we would
9 absolutely recommend. We would like to see
10 a fundamental review of carers' benefits, of course --

11 **Q.** But in terms --

12 **A.** -- (overspeaking) -- that's outside of scope.

13 **Q.** Yes --

14 **A.** But in a pandemic we need to be able to ensure that
15 carers do not face additional poverty because of the
16 extra costs of caring, and shouldering these
17 responsibilities.

18 **MS JUNG:** Thank you very much.

19 My Lady, I'm conscious that I haven't turned back to
20 essential care but it's in fact one of the topics that
21 one of the Core Participants is going to be asking
22 questions on.

23 **LADY HALLETT:** Oh, right.

24 **MS JUNG:** So those are all my questions. Thank you.

25 **LADY HALLETT:** Thank you very much indeed, Ms Jung.

77

1 insight into their lives and wellbeing.

2 If we're talking at home, they're the main
3 deliverers of care. And it's absolutely essential that
4 they're part of the integrated team. When they are not
5 consulted and not involved, decisions are made that are
6 not necessarily optimal and actually can be negative for
7 the unpaid carer themselves. They are deeply frustrated
8 by that. And I think at the point of hospital
9 discharge, for example, we quite often see where carers
10 are not included. And I think that is a factor of the
11 pandemic as well, with -- the guidance that was issued
12 didn't include carers' rights and entitlements.

13 And that had a long legacy after the pandemic, where
14 we saw that carers weren't included in official guidance
15 at the point of hospital discharge, even though it's in
16 primary legislation. So this is -- it's absolutely --
17 it's absolutely essential.

18 And I just wanted to come back to the whole
19 definition of essential care, because this was something
20 which people were allowed to do early on in the pandemic
21 and -- to be able to travel to provide essential care.
22 And because it wasn't really defined, families and
23 carers were unsure about their -- about whether they
24 were allowed to do this. And sometimes the
25 interpretation of the police, of neighbours and others,

79

1 Right, I think it's Ms Jones, who should be across
2 the hearing room and slightly behind Ms Jung.

Questions from MS JONES

4 **MS JONES:** Thank you, my Lady.

5 Ms Holzhausen, at para -- I'm sorry, I should tell
6 you who I ask questions on behalf of. I represent
7 John's Campaign, Care Rights UK and The Patients
8 Association.

9 At paragraph 13 of your witness statement you
10 explain that unpaid carers often know the person they
11 care for better than health and care professionals and
12 that over time they become real condition experts.

13 Do you agree that their expertise should have been
14 better recognised, and that they should have been
15 integrated into care teams to ensure that high-quality
16 and person-centred care could continue to be provided?

17 **A.** Quite briefly, yes. And that's what they want to be.

18 They not only know the person and their characteristics
19 but they very often know the different -- their
20 different needs.

21 It's absolutely vital on two ways: knowing the
22 person incredibly well, and the second reason is because
23 they are the people who have most contact with that
24 person or are able to have an insight -- if we're
25 talking about care homes, for example, have a different

78

1 was not the same as carers.

2 So that is something that we really need to ensure
3 with the next pandemic: that those exceptions to travel
4 rules to provide essential care, or perhaps families to
5 come together, several people, when that might not look
6 like it's within the rules, to be really clearly
7 defined.

8 **Q.** Thank you, yes. You do cover in your witness statement
9 that, although the lockdown rules did permit essential
10 care to continue --

11 **A.** They did, yes.

12 **Q.** -- to be provided, unpaid carers themselves didn't
13 understand that, but also other people like neighbours
14 and the police didn't understand it, which led to
15 instances of unpaid carers being wrongly reported to the
16 police and even fined for continuing to provide care.

17 But, of course, also it caused some carers to adopt
18 a self-denying approach, where they didn't provide the
19 care that was necessary even though in fact that would
20 have been lawful to do and the person for whom they
21 cared really needed that help to continue to be
22 provided.

23 So you've spoken about the negative impact that the
24 lack of clarity obviously had on people there. But how,
25 in your view, could public communications have been

80

1 undertaken better, so that people understood more
2 clearly precisely what was permitted within the confines
3 of the law?

4 **A.** I think a -- clear permissive definitions and examples,
5 that was communicated. I think in public
6 communications, as well -- I've said about how families
7 felt invisible -- to recognise what they had done, as
8 well, or were doing to protect people and keep people
9 safe within their community and providing all of that
10 care. That -- if those definitions had been provided,
11 then organisations like ours would have been able to,
12 because -- advise people correctly and give them
13 confidence that you could travel tens of miles to care
14 for your mum with cancer and share that care with your
15 sister, you know, you on, you off, and then her provide
16 that.

17 I think one of the things that is very clear is that
18 there's perhaps little understanding of how much people
19 travel to see relatives to provide care. How much
20 families take turns to provide care. How daughters come
21 in to support Mum, who is principally the carer caring
22 for Dad. You know, all of that could have been done
23 much earlier like these care bubbles that we're talking
24 about, could have been put in place much earlier, and
25 a clearer definition would have supported us and it was

81

1 very hard to pin down who was responsible for that. But
2 it's something we definitely need in a more concrete way
3 in the future, should this -- you know, we hope that we
4 won't be in another pandemic, but -- or a situation like
5 this, but if we were, that needs to be there in place
6 quickly.

7 **Q.** Finally on that topic, can I ask, what do you think the
8 role that organisations like yours and those I represent
9 can play and how receptive did you find government to
10 involving you in those - in providing those kinds of
11 definitions that were needed?

12 **A.** So our organisations, we're critical providers of
13 information and advice out to people, so we often
14 translate government guidance and that's where we need
15 to be assured that the definition or our interpretation
16 is in fact in line with what the government is
17 suggesting, and that people aren't going to be caught
18 out by it or -- and it's putting things in terms that --
19 in, sort of, everyday language, as well.

20 Some of those, some of those things didn't work
21 quite as well, I would say, at the beginning. When we
22 look at vaccination guidance, for example, who should be
23 vaccinated, that's when they listened very well to how
24 to think about carers because, of course, it was defined
25 as the primary carer, but as I've explained, quite often

83

1 impossible to get that, really.

2 **Q.** Just arising from that, can I ask, to what do you
3 attribute the failure to provide that? We've heard
4 different pieces of evidence to the Inquiry about the
5 fact that guidance was being produced at speed, but also
6 about governmental lack of knowledge about the care
7 sector. Was it the urgency with which responses and
8 guidance were being produced? Was it the fact that
9 decision makers simply didn't understand the shape of
10 the adult social care system and the reliance on unpaid
11 carers and the kind of patterns of care they provided?
12 What do you think meant that that wasn't done at the
13 time?

14 **A.** I think all of those things, actually, it's
15 a combination of things. And now we know what we know
16 now, we would not operate in that way again, I would
17 hope, and that we would get clearer direction.

18 Furlough is another example, again, where if you
19 were caring you were able to be on furlough. Again,
20 getting that definition, it was not clear. We got
21 a definition through our colleagues that we worked
22 closely with in the Department for Business and Trade,
23 as it is now, and they got a definition from
24 Her Majesty's Treasury but you didn't find that expanded
25 upon, you didn't find it in communications, and it was

82

1 there are numerous people who care for one person. They
2 don't all live together. So it's a commonsense approach
3 that I think we as organisations understand our
4 populations and people and take a commonsense approach
5 to this.

6 So to come back to your original question, I don't
7 think there was the engagement or the understanding that
8 we needed. We did get to a part of that better as we
9 went along. I would say that the voices of some
10 organisations were not listened to in relation to
11 contact in hospitals and care homes for quite a long
12 time, and I think people have expressed their views,
13 members of the public have expressed their views very
14 clearly about the impact that that has had on them and
15 their families.

16 **Q.** Thank you.

17 Then you explain in your witness statement that the
18 reports that your organisation produced during the
19 pandemic were entitled "Caring Behind Closed Doors"
20 because that's what carers feel: that their work and
21 their care is invisible. In your view, is there
22 anything that can be done to improve visibility of those
23 who provide and need care to ensure that they don't feel
24 invisible in any future pandemic and that their needs
25 are properly taken account of?

84

1 **A.** So, first and foremost, it needs leaders to talk about
2 families and unpaid care. That is critically important.
3 And then we need to see them not at the bottom of the
4 list, but further up in the list. We need to have all
5 of those things that they feel are important --
6 identification, the messages, the information and
7 advice, clarity about that -- so that they feel more
8 confident about caring, and to have the mechanisms in
9 place like PPE for care workers coming into the home and
10 health staff coming into the home, as well as families
11 who really need it.

12 So those things. You know, it's not just words,
13 it's actions too. And the Caring Behind Closed Doors is
14 a very good description of how they felt, is invisible,
15 and we can't have that again in another pandemic.
16 **MS JONES:** Thank you very much. Those are all my questions.
17 **LADY HALLETT:** Thank you very much, Ms Jones.

18 Those are all the questions that we have for you,
19 Ms Holzhausen. Thank you so much. I think [Caring]
20 Behind Closed Doors is perhaps almost the best way to
21 complete your evidence, because it sums it up.

22 During the course of this Inquiry I've learnt about
23 other sectors who do vital work, and recognition seems
24 to be such an important part. I suppose from
25 recognition flows a number of other things, as you've

85

1 **Q.** Would you mind sitting a little forward so the
2 microphone can pick up your voice. Just take a moment
3 to arrange yourself. There's no difficulty.

4 You, on behalf of the Department of Health and
5 Social Care, have made five statements today. I won't
6 read out the INQ references for all of them. And
7 I think for your benefit and those following, the main
8 one we will be asking questions about is part C, but all
9 five will be published.

10 Just a little bit about you, please, before we start
11 with some of the topics.

12 You are now the Director General for Adult Social
13 Care, taking up that role, initially on an interim
14 basis, is that right, on 17 September 2020?

15 **A.** Yes.

16 **Q.** And you were permanently appointed in May 2021?

17 **A.** Yes.

18 **Q.** Can I ask, were you in DHSC, the department, at the
19 start of 2020 or --

20 **A.** No.

21 **Q.** -- did you join from somewhere else?

22 **A.** I was in the Department for Education.

23 **Q.** Right. I think you are aware that certainly one of the
24 witnesses to the Inquiry has described that when he
25 arrived in the Department of Health at the end of

87

1 said. So, thank you very much for all your help to the
2 Inquiry and for your excellent advocacy on behalf of the
3 sector of unpaid carers.

4 **THE WITNESS:** Thank you.

5 **LADY HALLETT:** Thank you.

6 Well, thanks to the efficiency of Counsel to the
7 Inquiry and our witnesses this morning, people are going
8 to get an extra 15 minutes' lunch, because the next
9 witness, at my last check, wasn't here, and counsel will
10 need time to speak to them. So I shall return at 1.35.

11 Thank you very much, Ms Jung.

12 **MS JUNG:** Thank you.

13 **(12.20 pm)**

(The Short Adjournment)

15 **(1.35 pm)**

16 **MS CAREY:** My Lady, good afternoon. Can you hear me?

17 **LADY HALLETT:** I can, and see you, thank you, Ms Carey.

18 **MS CAREY:** May I call, please, Michelle Dyson.

19 **MS MICHELLE DYSON (sworn)**

20 **Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 6**

21 **LADY HALLETT:** Ms Dyson, thank you for coming along to help
22 us.

23 **THE WITNESS:** Thank you.

24 **MS CAREY:** Ms Dyson, your full name, please.

25 **A.** Michelle Sarah Dyson.

86

1 April -- there being complete chaos. Obviously you
2 can't speak to April, but by the time you took up post
3 in September, was there a sort of sense of chaos still
4 pervasive at that time?

5 **A.** Before I get into that, could I just say a sort of
6 overarching point --

7 **Q.** Of course.

8 **A.** -- since this is my first time in front of the Inquiry?

9 **Q.** Yes.

10 **A.** So I would like to say to everyone how sorry I am about
11 all the terrible things that happened during the
12 pandemic in relation to adult social care.

13 I remember a conversation I had with a group of
14 unpaid carers in 2020, hearing about their devastating
15 experiences. I remember about a friend of mine telling
16 me about his nephew who had learning disabilities who
17 died in a care home without seeing his family. And
18 I remember being sent a booklet, I think by Rights for
19 Residents, of stories of the terrible impact of lack of
20 visiting. And then there are the care workers who went
21 out to work when everyone else was locked down at home,
22 and in some cases lost their lives because of this.
23 A really terrible time.

24 **Q.** Ms Dyson, thank you, and we are going to pick up on some
25 of those tragedies and some of that sadness as we go

88

1 through but thank you for your comments.

2 Can I just jump back, then, to you joining the
3 department in September, and do you think, from your
4 perspective, it was still rather chaotic in the
5 department at that time?

6 **A.** I mean, shall I comment about April?

7 **Q.** Yes.

8 **A.** Because I have talked to others about what their
9 experience was then. I mean, it was the case that the
10 department had to massively scale up, including, and
11 maybe in particular, in adult social care. So there
12 were a lot of people joining from -- volunteers coming
13 in from other departments to help. It was also the case
14 that people had to change jobs overnight. I mean, it
15 was the same in the Department for Education, where
16 I was at that time. We had to create new functions on
17 PPE, on testing, et cetera. So there was a lot of
18 movement, and so we didn't have time to do things that
19 you would normally do, like organograms and induction,
20 et cetera, we had to set up new decision-making
21 structures.

22 So it was a very, very fast-moving environment where
23 people were working all hours. But from what I've
24 heard, I wouldn't describe it as chaotic. Rather, very
25 fast moving. And it wasn't so dissimilar in September,

89

1 are today in 2005?

2 **A.** I think it's 310.

3 **Q.** Right. And is there any capacity or plan in place, if
4 there needed to be an expansion of those numbers?

5 **A.** Not explicitly, but there's lots of capacity within any
6 government department to flex. So I think from a decent
7 size of 300, you know, that's a good starting point.

8 **Q.** Perhaps to help you as we go through your evidence,
9 I just want to summarise some of the numbers involved in
10 the adult social care as at March, and I think you say
11 in your statement there were 15,525 care homes in
12 England, the majority of which were not nursing homes;
13 there were 450,000-odd beds, not all occupied, but
14 estimated occupancy was just under 85%; there was just
15 under 10,000 homecare agencies; 1.2 million posts for
16 workforce with about 112,000 vacancies, we
17 understand it; and depending on which definition you
18 use, certainly in the 2021 census, approximately
19 4.7 million unpaid carers.

20 I just thought that context might help as we go
21 through.

22 Now, can I just ask you about unpaid carers, because
23 Mr Hancock gave evidence last week and told us there
24 were -- the policy around unpaid carers was different
25 because of definitional issues, to use his phrase. And

91

1 although I'm sure it was slightly calmer by then.

2 **Q.** Thank you. Well, it brings me on to one of the things
3 I was going to ask you about, because, as I understand
4 it, the Director General of Adult Social Care was a new
5 post, it having previously, I think, been joined with
6 director general for adult social care and primary care,
7 and then they split the two director generals.

8 Do you know why there hadn't been a specific adult
9 social care director general post prior to its
10 inception?

11 **A.** I suppose it was just -- it was felt that there hadn't
12 been a particular need to have a separate post. I mean,
13 it's important to remember there was still, you know,
14 there was a Director of Adult Social Care, there was
15 still focus on it, but during the course of the
16 pandemic, particularly in those early months, it became
17 clear that, you know, we needed a bigger function for
18 adult social care.

19 **Q.** I think you say in your statement that pre-pandemic,
20 there are around 90 staff in the care and transformation
21 directorate where adult social care sat, but that grew
22 to 319-odd personnel, and hence that might feed into,
23 perhaps, some of the more fast moving and perhaps less
24 structured response at the beginning.

25 Can you help now with the size of the ASC team as we
90

1 I think Ms Keegan, who was in the department, said that
2 there was no robust system for identifying unpaid carers
3 and she thought that if there was a better system for
4 identifying them then they could have been better
5 supported.

6 Just your reflections, please, Ms Dyson, and
7 obviously it's difficult because who is an unpaid carer
8 might depend on whether you provide one hour, the
9 circumstances, whether you're doing it, effectively, as
10 a full-time job, but is there any work being done to try
11 and define unpaid carers to help in the event of
12 a future pandemic?

13 **A.** I felt we did some very good work on this around the
14 vaccines issue, because unpaid carers were prioritised,
15 I believe they were in group 6 for vaccines, and so we
16 needed to identify them at that point, and the work that
17 we did was about looking at the GP record because GPs
18 have records of unpaid carers, and the DWP record from
19 Carer's Allowance, I think there are about 900,000
20 people or so on Carer's Allowance, and local authority
21 records on carers. And then we worked with Carers UK to
22 see if we could sort of develop that list further so
23 that we were sure that we were not missing people.

24 So that was really quite innovative work, led from
25 the department's point of view by David Pearson, working

92

1 with Carers UK to try and get to that list.

2 **Q.** And so is there now a list of unpaid carers? I'm not

3 suggesting it's going to be perfect by any stretch of

4 the imagination, but if we wanted to in July 2025 look

5 at how many the department thought were unpaid carers,

6 would we be able to find that number easily?

7 **A.** I mean, not to my knowledge. We rest on the ONS data

8 that you mentioned, the 2021 data.

9 **Q.** Right. I'd like to start with a few questions, please,

10 about pre-pandemic preparedness. And there are a number

11 of groups set up to address this, but can I have your

12 assistance, please, about what is called the

13 Cross-government Pandemic Flu Response from April 2017.

14 And could I have on screen, please, INQ000022748.

15 Ms Dyson, I'm conscious that obviously you weren't

16 in the department in 2017, but I think you have had

17 a look at this document in preparation for giving

18 evidence, and we can see the second box there deals with

19 the outline work plan, and then an objective was to

20 achieve an appropriate capability to provide adult

21 social care in England during a severe pandemic.

22 And as we go across the row, there is reference at

23 point 2 in the middle column to reviewing "existing

24 plans for providing community-based healthcare for

25 patients who would ordinarily receive inpatient care."

93

1 Can you just help me, what plans arose as a result

2 of this outlying work plan?

3 **A.** So I think it's, just by way of context, important to

4 remember that adult social care is a locally-run system.

5 So when you're talking about planning you're thinking

6 about yes, what the department is doing, but more so, at

7 least at this point in time, what is happening locally.

8 And it was always assumed that a pandemic would be run

9 by the local resilience fora with the department

10 supporting but the response would very much sit at local

11 level.

12 As I see these actions, they're very much focused

13 on: is there going to be enough capacity in adult social

14 care in the event of a pandemic? So will there be

15 enough care home beds? Will there be enough homecare

16 capacity? And will there be enough staff to support

17 them?

18 The things that happen that I'm aware of as a result

19 of these actions is, first of all, there's some really

20 quite detailed policy work that is done within the

21 department. I've seen the paper that was written in

22 2018, which looks at things like workforce shortages, it

23 looks at things like hospital discharge, it looks at how

24 you would prioritise local government services in the

25 event of a worst-case scenario.

95

1 Can you help with who those plans were held by or

2 should have been held by?

3 **A.** So I believe this point should have been directed and

4 maybe was directed towards NHS England because this is

5 about community-based healthcare as opposed to adult

6 social care.

7 **Q.** So this would be not necessarily -- we can see DH and

8 DCLG, presumably DH was the Department of Health, as

9 then called?

10 **A.** Yes.

11 **Q.** And the former, I think it's -- it was -- Ministry of

12 Local Government now. So this could be, essentially, at

13 a number -- aimed at a number of different departments

14 or organisations to help bring together a cohesive plan

15 for adult social care.

16 Can we go over to the third column, because there's

17 what are set out to be said the deliverables, and there

18 needed to be an adequate means to measure and monitor

19 adult social care capacity, which is clearly something

20 that was partly the response of -- the responsibility of

21 the Department of Health; a capability requirement;

22 a range of policy and practical options; an overarching

23 plan; and then again, potentially, policy and practical

24 options for the patients who would ordinarily be treated

25 as inpatients in the community.

94

1 The other thing that's going on in the department at

2 this time, maybe not so related to this, although

3 indirectly it is, was the work on what became known as

4 the Coronavirus Act, because it's related to this

5 because of the care easements part of that.

6 So then -- that's what happened within the

7 department. Separately from that, the department

8 commissioned ADASS, that's the Association of Directors

9 of Adult Social Services, to do some work on all of

10 this. And again, I've seen what they did. They did

11 a big survey of local government, they produced a suite

12 of products that looked at how you would do statistics

13 at a local level in the event of a pandemic, how you

14 would do communications at a local level in the event of

15 a pandemic, how you would try and recruit volunteers,

16 and then they produced some guidance.

17 **Q.** Can I ask you about the work being done with the local

18 authorities, though, given that in that answer you've

19 just said a lot of the planning lies essentially with

20 them, and I think you've said in your statement that

21 adult social care was fully incorporated into pandemic

22 planning, but you did say that there were some

23 challenges that were identified, and could you just help

24 us, what were the main challenges as the department saw

25 them with the pandemic planning?

96

1 **A.** I mean, I don't recall that paragraph precisely and
 2 exactly what it was getting at, but there is an
 3 underlying issue in adult social care at this point in
 4 time, which is -- was being flagged, which is the
 5 fragility of the system, that there were workforce --
 6 you've already mentioned there were, sort of,
 7 significant vacancies in the workforce. There was real
 8 concern about whether the funding going into the
 9 publicly funded part of adult social care was
 10 sufficient. The department was doing a lot of work on
 11 looking at the potential for major provider failure,
 12 that is that a big care home provider could fail, and
 13 there was contingency planning going on around that.

14 **Q.** Can I ask you something about that answer you just said
 15 there. You spoke about the fragility of the system and
 16 you're not the first witness, Ms Dyson, I dare say you
 17 won't be the last. Underfunding and a workforce that
 18 is -- there is vacancies, and indeed a retention
 19 problem, as we understand it.

20 A number of witnesses have spoken about that but no
 21 one has, as yet, sort of, said what the department has
 22 done or across-government has done to try to address
 23 those issues. It's sort of an acknowledged problem but
 24 where's the solution, or who was trying to solve it as
 25 at the time of January 2020?

97

1 predictions that there would be another, I think, about
 2 11% or, to put it in old money, 176,000 staff that might
 3 be absent due to illness.

4 So clearly, was there a real concern that some of
 5 the large care providers might not be able to provide
 6 care, might have to close their care homes? And are you
 7 able to give us a sense of the scale of the worry that
 8 care homes might have to shut?

9 **A.** So this was very much the concern going into the
 10 pandemic, and it reflects the document we just looked
 11 at: you know, would there be enough capacity?

12 In the event, actually, workforce capacity was not
 13 the issue in that -- I mean, there were many issues, as
 14 I'm sure we'll come on to talk about, but it was not the
 15 issue in the first few months of the pandemic.

16 Workforce capacity became a very big issue in
 17 January 2021, and even more so in the last sort of
 18 quarter, the autumn of 2021. That's when it really hit
 19 the workforce capacity issues, but not in those first
 20 few months.

21 **Q.** All right. We'll come back to 2021 if we may.

22 Can I return, though, to the question of planning,
 23 because -- and ask, please, to have on screen
 24 INQ000595344.

25 This is some minutes from the national steering

99

1 **A.** So I mean, first of all, I think we should just get it
 2 in context. I mean, there was a funding issue, and that
 3 had been particularly between sort of 2010 up to 2015.
 4 Actually, quite a lot of money had gone into the adult
 5 social care system from 2015 onwards. The vacancy rate,
 6 I think it was 8% at the time.

7 **Q.** Yes.

8 **A.** I mean, you can have care homes that are growing so they
 9 would then be flagging vacancies, you know, it's not
 10 necessarily a problem. We now measure, actually, the
 11 size of the workforce. So alongside the vacancy rate
 12 which is measured by Skills for Care, we -- internally
 13 we measure the size of the workforce to see how much
 14 it's growing or otherwise. I don't underestimate --
 15 there is an overarching problem but I just don't want to
 16 get it -- you know, we had very significant workforce
 17 problems during the pandemic. They weren't so
 18 significant at this point in time.

19 In answer to what are we doing about the fragility,
 20 I mean, the government has appointed Baroness Louise
 21 Casey to do an independent review into adult social care
 22 and that will, no doubt, look at these issues.

23 **Q.** You mentioned there the 120,000 vacancies as we were
 24 going in. I think there were higher vacancies in London
 25 and the south east in particular. And there were

98

1 group that was in existence at that time.

2 And if we -- it was on 12 February 2020. We can see
 3 reference in that top box -- so:

4 "The main headline [being] for [local authorities]
 5 to revise local ... flu plans in light of new
 6 information and anything that is different for CV ..."

7 Was that shorthand for "clinically vulnerable"?

8 **A.** I think for coronavirus.

9 **Q.** Thank you.

10 "... and these plans can incorporate advice [from]
 11 the centre."

12 And if we just scroll down to the bottom of that
 13 page there's reference to "Contingency plans". Perhaps
 14 if we can just -- there we are. Thank you very much.

15 Is that the same things as the local authority plans
 16 that were spoken about in the box at the top of the
 17 page? I don't want to conflate two different types of
 18 plans.

19 **A.** I would have thought so, yes.

20 **Q.** Right. Given that we are dealing here with local
 21 authority plans, clearly there was, in February, a plan
 22 to revise them, and indeed:

23 "Is there anything ... DHSC can do to assure that
 24 local plans are robust."

25 And someone comments that LGA and ADASS had --

100

1 neither of them have the assurance skills.
 2 "[Local authorities] are accountable to
 3 members/population and the assurance role sits with
 4 members. They can help, perhaps work on a checklist
 5 with [questions] to ask when checking the plans are fit
 6 for purpose so [local resilience forum] can be
 7 confident."
 8 And that was agreed by another member of the
 9 committee.
 10 "Are there plans for all [local] ... have they ...
 11 been refreshed?
 12 "Could we share best practice if we know of a good
 13 quality plan?"
 14 And I think you're aware, Ms Dyson, that, in due
 15 course, Minister Helen Whately asked for a number of
 16 local authority plans and received two, which in her
 17 view were inadequate.
 18 Can you help with what was done between
 19 February 2020, when there were clearly attempts to look
 20 at the plans and see if they were robust enough, and
 21 then what happened to the -- reviewing the local
 22 authority plans thereafter.
 23 **A.** So the plan that there was, was to use MHCLG, that is
 24 the local government department, to help with assurance
 25 of plans. I think that may have -- I think that was

101

1 **A.** I think that will be picked up in our pandemic
 2 preparedness strategy that the department is going to
 3 publish.
 4 **Q.** And do you know when that is going to be published, or
 5 roughly?
 6 **A.** I'm not sure exactly but I know we're planning to
 7 publish that, and then alongside it there will be five
 8 plans for each of the five different routes of
 9 transmission, starting with a respiratory plan.
 10 **Q.** We may come back to that in a moment.
 11 Now, sitting under the local authority plans,
 12 though, is it right that providers themselves were
 13 supposed to have plans?
 14 **A.** Yes. I mean, I wouldn't necessarily describe them as
 15 sitting under the local authority plan, lots of
 16 providers don't actually have a relationship with the
 17 local authority if they just take privately funded
 18 individuals. So they have to have plans. That's part
 19 of the sort of CQC requirement.
 20 **Q.** Can I ask you then, please, about -- perhaps it's my
 21 phraseology, but not the local authority plans, but
 22 plans at provider level.
 23 Can we have up on screen, please, INQ000595342_0002.
 24 This is from a coronavirus steering group meeting,
 25 the following week, on 19 February. So on the 12th,

103

1 discussed at the Helen Whately meeting in early March.
 2 In the event, that got overtaken by events. You
 3 know, we were quite swiftly -- you know, plans were left
 4 behind and we were very much into a full-blown pandemic.
 5 **Q.** So you're quite right, there was a meeting on 5 March
 6 where the minister set out her concerns about the two
 7 plans she'd seen, and indeed reference to trying to find
 8 a good one that we could then perhaps copy and replicate
 9 across the local authorities.
 10 When you say "events overtook us", does that mean
 11 that essentially work wasn't done on checking whether
 12 local authority plans were robust enough?
 13 **A.** So I wasn't there at the time, so I've been asking
 14 questions, and the answer that I have had on this is
 15 that the intention was to use MHCLG for this but my
 16 sense is it didn't actually happen because, you know,
 17 that would have been quite a big deal, I guess, to set
 18 up a whole infrastructure to do this. And then the
 19 pandemic, you know, was developing very, very fast at
 20 this point in time.
 21 **Q.** That explains the position back then. What about now?
 22 What, if any, efforts have been done from the
 23 department's perspective to ensure that local authority
 24 plans are robust enough, adequate enough? Pick
 25 whichever word you choose.

102

1 they've looked at the local authority plans and whether
 2 there's assurance or robustness. Here in the middle,
 3 looking at contingency plans, we can see we're talking
 4 about 19 providers have confirmed their pan flu
 5 preparedness plan was up-to-date. Of those, 16 had
 6 plans that covered how the organisation could manage if
 7 20% of the staff were absent, and three providers had
 8 plans to cover staff absences, but this did not extend
 9 as far as 20%.
 10 Now, can I just ask, in ordinary times, do
 11 provider-level plans, are they something that is not
 12 ordinarily looked at by the Department of Health?
 13 **A.** No.
 14 **Q.** And you mentioned there the CQC. We can see there two
 15 of those three providers express an interest in further
 16 guidance from the CQC on how to prepare for the event
 17 that only 80% of the staff were present, and it looks
 18 like -- was -- is there -- was there going to be a CQC
 19 review, or you were going to ask the CQC to -- sorry,
 20 had they done one or were you going to ask them to
 21 do one?
 22 **A.** I don't know the answer to that. I mean, I would just
 23 say this looks like a sort of small dip sample, you
 24 know, you've got 18,000 registered providers, this looks
 25 like a small dip sample, and I can't see how we could

104

1 possibly have asked the CQC to get into reviewing plans
2 at scale at that point. I mean, obviously, what we did
3 do was we put out guidance on 25 February about pandemic
4 preparedness, not particularly on this issue, but just
5 more generally.

6 **Q.** The national steering group minutes that we've just
7 looked at, for a couple of weeks' worth of minutes, was
8 replaced by the national adult social care Covid group
9 on 6 March. And could you help, Ms Dyson, with why was
10 the NSG stood down and the social care Covid group
11 stood up?

12 **A.** So the NSG was a standing group to deal with big issues
13 of this kind. So it had looked at Brexit, it was
14 looking at the major provider failure issue that I
15 mentioned before, and then it was looking at Covid in
16 the early days. But it became clear that you needed a
17 very focused group, and hence why the new group was set
18 up, which was jointly chaired by Ros Roughton, who was
19 my predecessor, and by James Bullion from the
20 Association of Directors of Adult Social Services.

21 **Q.** Now, that social care Covid group, in due course, lasted
22 until the taskforce was set up, and again, why was there
23 the change three months later to set up the taskforce?

24 **A.** So I think the taskforce was really quite different in
25 kind.

105

1 is very much also about these issues.

2 **Q.** Yes. Now, a lot of those policies, though, effectively
3 were driven by PHE and the advice about who should
4 isolate and the testing and what PPE was needed.
5 Obviously, the department co-produced or co-published
6 them, but is there anything in particular that you can
7 point to the department did to help implement them,
8 aside from issuing the various iterations of guidance
9 that we're aware of?

10 **A.** I mean, Capacity Tracker, sort of, almost came into
11 being at this point in time. So this is the tool that
12 50%, I think, of the sector already used as a way of --
13 so this is of the care of providers, they already used
14 this as a way of flagging what vacancies they had in
15 care homes to support hospital discharge, but at this
16 point, from the end of March, beginning of April
17 onwards, we said -- essentially, we said: this is
18 obligatory, please fill in Capacity Tracker as a way of
19 supporting all of this.

20 **Q.** Now, we might look at the Capacity Tracker in other
21 respects but as I understand it, the tracker, it's not
22 mandatory to fill it in; is that correct? We've heard
23 that perhaps some funding was dependent upon the
24 provider filling in the tracker but do you know, is
25 there sensibly any way that the department could make

107

1 **Q.** Right.

2 **A.** So that was about bringing in an outside expert, David
3 Pearson, you know, from the sector, to lead a really
4 sort of significant piece of work to implement what had
5 already been put out in terms of action plans, but also
6 to prepare us for winter because everyone knew that
7 winter was going to be difficult.

8 **Q.** Can I turn, please, to some more questions about the
9 March 2020 hospital discharge policy.

10 And you say, in fact, in part E of your statement,
11 don't need to turn it up, that the discharge policy was
12 a key priority for NHS England, and that throughout the
13 pandemic, the department worked collaboratively with
14 NHSE and, indeed, Public Health England to create and
15 implement the policy.

16 I just want to ask, can you help, I know you weren't
17 there, but what did actually the department do to help
18 implement the policy?

19 **A.** So obviously there's the discharge guidance that goes
20 out on 19 March. The department would then have been
21 communicating with local government because when you
22 discharge people from hospital, there's sort of the NHS
23 side of it but obviously there's the local government
24 and provider side of it. So the department would have
25 been -- I mean, you then have the 2 April guidance which

106

1 data returns to the Capacity Tracker mandatory?

2 **A.** So we have done so now, and that stems from a direction
3 that was given in 2022. When we first started using
4 Capacity Tracker for these purposes at the beginning of
5 April, it wasn't mandatory, exactly as you say. We then
6 tied it to the Infection Control Fund which went out in
7 May -- on May 15 2020. We said: here's £600 million,
8 which 75% of it must be passported on to care providers
9 on a per-beds basis, but only if those care providers
10 are filling in Capacity Checker. And I believe that by
11 June we were up to about 98% compliance with Capacity
12 Tracker.

13 **Q.** Absent, though, the, kind of, financial incentive to
14 fill in the Capacity Tracker, is there now any work
15 being done to ensure that the Capacity Tracker is filled
16 in and kept up to date? Does DHSC monitor that?

17 **A.** Oh, absolutely. As I say, it is a requirement now.
18 It's a legislative requirement. You have to fill it in
19 once a month and we publish some of the data from it,
20 I think on a quarterly basis.

21 **Q.** On a quarterly, did you say?

22 **A.** Quarterly, I think.

23 **Q.** Thank you. Thank you. I misheard you.

24 In your statement you refer to a Social Care
25 Institute for Excellence report on some of the

108

challenges and solutions about commissioning for social care. And if it helps you, Ms Dyson, I'm at paragraph 203, but that report highlighted perhaps some of the limited options for care facilities, making it challenging to avoid placing patients in care homes that had been rated as inadequate.

Does the department know how many people were discharged from hospitals to care homes rating as inadequate?

A. No, we don't. I mean, it's worth saying, though, that the next paragraph of my statement there does talk about CQC support for care homes that needed improvement or were inadequate.

And the other thing to remember in all of this is that the local authority has an important role. They really -- well, they are obviously experts in adult social care, but they also have a statutory duty to monitor -- to manage their care market, which means that they really know their care providers. And there might be issues that they would be aware of that hadn't been flagged by CQC. So, for example, it might be that the improvements that were needed, that CQC had flagged, they might have taken place, but CQC might not have gone back or the local authority might have done its own assurance to make sure that it was a suitable place for

109

And I think at the time, in January 2021, when the policy came in, about 37% -- there was a 37% vacancy rate.

Does the department know how many people were discharged to designated settings or is that something again for the local authorities or the CQC?

A. I think we do know how many people were discharged into designated settings. I mean, it's worth noting that it was always possible also to discharge someone into a normal care home if that care home felt that they could take the person, and that might well be a better solution. You know, if you could be discharged back to your own care home, that would be better than going into a designated setting.

So the designated settings were -- I don't want to say last resort, but just a fallback. So if there were vacancies there, that was okay, as long as people could be discharged safely.

Q. I think in due course the dashboard had data about designated settings and the number of beds that were being utilised, there certainly did become that data available.

Generally though, in relation to the designated settings policy, I think you say the department considered it to be a success and a policy that would be

111

that -- for that person.

Q. I understand all of those additional -- that additional context, but do you think the department should know that if it has to discharge people to care homes rated as inadequate for whatever reason, whether that's fundamentally care issues or perhaps some kind of governance issue, do you not think the department should know that there may be potentially discharges to care homes that are -- have a lower rating?

A. So I think fundamentally this is a local authority issue, but we've now introduced what is effectively CQC inspection of local authority Care Act duties, and it may be that that is where this should be looked at, rather than sort of collating data at a central government level.

Q. Later on in the pandemic we know that there was the designated settings policy, and indeed I think the plan was that there was to be a 14-day isolation in specific care homes that had been approved by the CQC as having the requisite isolation facilities, and every local authority was to have at least a setting where the designated accommodation could be utilised. And you say in your statement at paragraph 249 that during the second wave there were 159 approved designated settings, providing 2,169 beds.

110

considered in the event of a future pandemic, subject to clinical advice.

Can you help, Ms Dyson, with why the department takes the view that that policy was a success and why it might be considered again?

A. I think it was important to be able to discharge people safely. As I say, it was better if they could be discharged back to their own care home, but if that was not possible, if that care home didn't feel that they could safely care for that person, then it was impossible to get them out of hospital, because we know that being in hospital is not a good place for people who don't need to be there to be. And so this was -- this was a way of achieving that.

Q. You said, however, there were concerns about designated settings which are recognised by the department, not only a limited number available, but the placement may be less tailored to the specific needs of the person being discharged, and indeed, it may be geographically nowhere near their friends or family.

You say the department doesn't hold data on the designated settings policy on infection rates or morbidity and mortality. Do you know, does any organisation or department hold that data? Because if we're sending patients to a designated setting with the

112

1 idea that they are isolated and safe, doesn't one need
 2 to know that there isn't an infection in that home and
 3 we're not bringing in an infection into that home?
 4 **A.** I mean, I would have thought that we could get that
 5 data, because we were able to see by every care home
 6 what was -- you know, we could see what was going on in
 7 terms of the infection rates in every care home across
 8 England, and that would apply equally to care homes that
 9 were designated settings.
 10 **Q.** Do you know whether there is any work being done to
 11 ensure that designated settings remain available if
 12 needed? Because it took, clearly, a number of months to
 13 set up the designated settings policy. But in the event
 14 of a future pandemic, is there a plan in place to be
 15 able to quickly roll out a designated settings policy?
 16 **A.** So I'm sure we could do it again. The things that you
 17 needed to make it work were we needed the funding. That
 18 came from the discharge funding that NHS England had.
 19 You needed each local authority to identify a place.
 20 You needed to get the infection prevention and control
 21 right in that place. You needed CQC then to assure it
 22 and sign it off. So I'm sure we could do all of that
 23 again.
 24 **Q.** I'd like to ask you some questions, please, about
 25 restricting movement of staff between care homes. And
 113

1 department and, indeed, the Secretary of State, but that
 2 the consultation that was announced was overwhelmingly
 3 against bringing in any regulations to restrict staff
 4 movement.

5 In your statement you say there was a proposed
 6 compensation scheme to try and ameliorate some of the
 7 financial difficulties that staff may face if they were
 8 restricted in the number of homes they could work at,
 9 but that was rejected by HMT at the time. And we know,
 10 in due course, legislation didn't come in, but there was
 11 the Infection Control Fund and a number of tranches of
 12 that funding.

13 I suppose it's a rather big question to answer, but
 14 in the event of a future pandemic, what's the
 15 department's thoughts on how best to restrict staff
 16 movement if that becomes necessary in a future pandemic?

17 **A.** Just to make one overarching point before I get into
 18 that, which is, I know there's been an awful lot of
 19 focus on staff movement, but actually, just staff moving
 20 from the community into care homes was a really big
 21 issue and that's why, when you look at this list, the
 22 final point on the list about would there be staff who
 23 would actually be prepared to move into a care home,
 24 that would really help.

25 So even if we could have eradicated staff movement,
 115

1 if it helps you, I'm at paragraph 461 in your part C
 2 statement, Ms Dyson. But as the Inquiry understands it,
 3 the Infection Control Fund, which you've already
 4 mentioned, was designed in part to be used to prevent
 5 transmission by paying the wages of staff who were
 6 isolating and trying to ensure, insofar as possible,
 7 that members of staff only worked in one care home.

8 That's a fairly broad summary, but not an inaccurate
 9 one, I hope.

10 Can we just have look, please, at the
 11 INQ000325286_0032.

12 This is an annex from admissions guidance from
 13 August 2020. And if we can see the bullet points there,
 14 they set out a number of ways of trying to spread the --
 15 prevent the spread of the virus. There you've got:
 16 ensuring that members of staff only work in one care
 17 home wherever possible; extending those restrictions to
 18 agency staff; limiting or cohorting the staff; and if
 19 additional staff are needed to restrict movement between
 20 or within care homes, to actively increase recruitment
 21 of staff.

22 And then there are various other steps set out
 23 there.

24 The Inquiry is aware that there was possible
 25 legislative restrictions being considered by the
 114

1 you would have still had the issue, the obvious issue
 2 that staff would be moving from their communities into
 3 care homes and, you know, what we saw throughout the
 4 pandemic is as soon as there was transmission in the
 5 community then it would follow, it would come in through
 6 the care homes.

7 In terms of should we restrict staff movement in the
 8 future, what we did do, as you can see here, and
 9 actually, this list is from August but it was, I think,
 10 the identical list was -- it was there earlier, as well,
 11 and this list also, as you've said, went alongside the
 12 Infection Control Fund as these are the sorts of things
 13 you should be spending money on, and then we put out
 14 a lot of guidance saying: please, please don't do staff
 15 movement. I think we went a long way to reducing staff
 16 movement even without legislation. So for example, I've
 17 taken this from the taskforce report, on 29 May, 78% of
 18 care homes were saying that they were restricting staff
 19 movement. That was in Capacity Tracker. By 20 July,
 20 92% were saying they were restricting staff movement.

21 So we went a long way to restrict -- you know,
 22 people understood the importance of restricting staff
 23 movement. We gave them guidance on that. We gave them
 24 the money to do it. We could see in Capacity Tracker
 25 what was going on, and so where we were concerned about
 116

1 staff movement we could use the regional assurance team
2 that we built up in the autumn to make phone calls to
3 care homes to say, you know, if they still seemed to be
4 doing staff movement, you know, can you think about
5 maybe restricting it?

6 So I mean, I understand why we thought that
7 legislation would be a good thing but I think we went
8 a long way to, sort of, reducing -- I can't say
9 eradicating, but massively reducing the practice. Of
10 course, the thing that went against us was staff
11 shortages.

12 Q. Yes.

13 A. And that, it was -- it was that issue plus the
14 compensation issue was why we didn't go ahead with the
15 legislation. We -- 68% of people who responded to the
16 consultation said that they would have to make an
17 exception every week to allow for staff movement,
18 because otherwise they wouldn't have safe staffing
19 levels.

20 So I think we went a long way without legislation,
21 and our focus became on the: what can we do to address
22 the workforce shortages? And we put out a Workforce
23 Capacity Fund in January 2021 of 120 million to support
24 those staff shortages.

25 Q. But doesn't that come back to, if you enter the pandemic

117

1 heard from a witness this morning who represented unpaid
2 carers, who spoke about the need for the unpaid carers
3 workforce to be recognised.

4 Can you give us any more details about what work is
5 being done to recognise the contribution, not just of
6 unpaid carers but of the adult social care sector
7 workforce?

8 A. I think this will be a Baroness Louise Casey issue.
9 I very much recognise it.

10 Q. Back to restricting staff movement, can I just take you
11 back, then, to the question that I asked before we dealt
12 with some of the other matters, but what are the
13 department's thoughts on how best to restrict staff
14 movement in the event of a future pandemic? Does it
15 rely on having a fund available to allow them to take
16 taxis, allow self-isolation on more pay? If it can't be
17 legislation, what's the solution?

18 A. I mean, I think it could be legislation, but I would
19 almost start from further back. I mean, we're assuming
20 that staff movement is the issue. As I said, I think in
21 this pandemic, staff movement was a part of the issue
22 but there was a bigger issue about how to prevent
23 community -- the virus coming in from the community into
24 care homes, through staff.

25 And it might just be -- there might be different

119

1 with staff shortages, and a fragile workforce, it's
2 going to be exacerbated by this? And however you want
3 to try and do it, if you can't legislate, there's still
4 going to be that tension between restricting staff
5 movement to prevent the infection spread but equally,
6 not having care homes not being able to run because they
7 don't have enough staff in them.

8 What I suppose it comes back to is, how, now, are we
9 going to increase the resilience in the workforce
10 sector? Can you help with that?

11 A. So we're passing some important legislation at the
12 moment on the Fair Pay Agreement, that is paying care
13 workers above minimum -- you know, creating a new wage
14 for care workers and clearly, I mean, and particularly
15 in -- towards the back end of 2021 when we'd lost a lot
16 of care workers to the retail and hospitality sectors,
17 that was because of pay. So I think that will help.

18 I mean, there's a big move to professionalise the
19 care workforce and to recognise their amazing
20 professionalism, because what they do is incredible, but
21 to recognise it in terms of the qualifications,
22 et cetera. So I think all of that will help, and again,
23 I would expect that Louise Casey will want to look at
24 this.

25 Q. Can I ask you about recognition, because her Ladyship

118

1 issues in a future pandemic, but I wouldn't rule out, if
2 the issue is staff movement, in a future pandemic,
3 I certainly wouldn't rule out legislation. I think we
4 came very close to legislating, but the two reasons why
5 we didn't, was -- one was the staff shortages at that
6 point in time, in particular, and also the fact that the
7 Treasury wouldn't -- didn't agree to a, sort of,
8 ring-fenced fund to support care workers who would lose
9 one of their jobs.

10 Q. One of the matters that we have considered is whether
11 it's possible at all to restrict staff movement in the
12 domiciliary care setting when workers clearly maybe
13 visiting a number of different houses and different
14 people that have care needs every single day. Do you,
15 on behalf of the department, think that there does need
16 to be work done to try to address the risks posed by
17 staff movement in the homecare setting?

18 A. I mean, the proposals we had on the table did cover the
19 situation where someone moved from a homecare setting
20 into a care home, but not where they moved from one
21 homecare setting to another homecare setting, and the
22 reason we did that was because care homes were so
23 particularly vulnerable in this pandemic to the virus,
24 because of the people who were living there and because
25 of the way in which the virus transmitted within the

120

1 care home. People who were living in their own homes
2 were less vulnerable to Covid, there were fewer people
3 there and you didn't have this issue about the virus
4 sort of transmitting so easily within the setting.

5 **Q.** Did the department take any steps to try and address
6 staff movement by domiciliary care workers from -- not
7 care -- home to home, not care home into a home care or
8 home care into a care home?

9 **A.** Not explicitly. Of course we introduced testing for
10 domiciliary care workers which would have helped
11 on this.

12 **Q.** You mentioned the role of the Infection Control Fund.
13 Can I ask you about that. It was, I think £600 million
14 you said, ring-fenced, to tackle the spread of Covid-19,
15 and clearly the providers had to complete the Capacity
16 Tracker to be eligible for the ICF funding which
17 Mr Hancock described as a lever of sorts over the
18 sector.

19 And I think you said in your statement that the
20 department asked all local authority chief executives to
21 provide a return which outlined the allocation of funds
22 to care homes as well as what it was spent on. And you
23 say in your statement that local authorities had taken
24 different approaches as to how they used the money, but
25 the National Care Forum are concerned that, roughly,

121

1 homes on a per-bed basis?

2 **A.** Well, I suppose if you think about the sorts of things
3 we were saying that needed to happen with it, if you
4 look at the list we were looking at before, it was --
5 some of the things would apply only to care homes, for
6 example cohorting to floors or wings, ensuring that
7 members of staff only worked in one care home, providing
8 accommodation to staff who chose to move into a care
9 home. So a number of those things were only for care
10 homes, but I accept that some of them were for both care
11 homes and for home care.

12 **Q.** May I ask you this, Ms Dyson, there's a perception at
13 least that always home care was a lower priority than
14 care homes. Sometimes it's been said to be an
15 afterthought. That might be pejorative to some but you
16 understand the sense I'm using those phrases.

17 Was there a sense in the department that there was
18 less priority given to home care?

19 **A.** The risks were greater in care homes than they were
20 in -- for people living in their own homes, so hence why
21 regular asymptomatic testing was rolled out for care
22 homes from July onwards, but only for NHS staff and
23 homecare staff from November. I think it was -- and the
24 same with the vaccine. It was just consistent with the
25 scientific consensus on where the greatest risks lay.

123

1 home care was relatively underfunded relative to the
2 need.

3 Can you help with what, if any, part of the ICF,
4 Infection Control Fund, was meant to be spent on home
5 care?

6 **A.** So in the original Infection Control Fund from May 2020,
7 75% of it was -- had to be part -- and this was the
8 innovation, that you were giving money to local
9 authorities which had to be passported through to care
10 providers. 75% of it was passported through to care
11 homes on a per-beds basis and then the remaining 25% was
12 for the local authorities to use, including for home
13 care.

14 **Q.** Right.

15 **A.** In the next version of the Infection Control Fund, which
16 was in the autumn, which I think might have been
17 586 million, that was -- the percentage that had to be
18 passported through was increased to 80%, and that went
19 on both a per heads -- sorry, a per-bed and a per-user
20 basis. So it had to be passported through, as
21 I understand it, to both care homes and to homecare
22 providers, so they should have got more money from that
23 point onwards.

24 **Q.** Do you know why, in the initial round of funding, it was
25 deliberately decided that 75% of it was to go to care

122

1 **Q.** Clearly, one of the ways of preventing the spread of the
2 infection would be by use of PPE. So can I ask you
3 about that, please.

4 The Inquiry is familiar with the supply shortages
5 that were extant at February 2020, and we know that the
6 stockpile, the pandemic influenza preparedness
7 stockpile, did not contain gowns, for example, and there
8 was a worldwide shortage. So please take that as
9 a given.

10 Clearly, by 13 March 2020 there was a huge demand
11 for PPE within the NHS, and as far as care homes were
12 concerned, PPE was to be worn by care workers if the
13 resident had symptoms but no PPE needed to be worn if
14 the resident or the worker were not symptomatic. And
15 then there were various iterations thereafter of the
16 guidance which did end up asking for more PPE to
17 be worn.

18 But can I ask you, please, to have a look at, on
19 screen, INQ000587737_0023.

20 It's from your actual statement, but it's some of
21 the steps that the department took to try to meet the
22 needs of the care sector in terms of PPE.

23 There was a one-off direct supply to CQC-registered
24 care homes using the stock from the stockpile.

25 Can I ask, was this in part the issuing of a number

124

1 of face masks to the care homes that happened in
 2 mid-March of 2020, do you know?
 3 **A.** Yeah, this was what happened on 13 March, when every
 4 CQC-registered provider got at least 300 face masks.
 5 **Q.** Right. That is what we're talking about here?
 6 **A.** Yeah.
 7 **Q.** All right. And can I ask you about that, please.
 8 Clearly, one doesn't want to sniff at it, but NACAS in
 9 particular, or a member of NACAS, has commented that
 10 300 masks don't go very far if you've got 50 staff
 11 members.
 12 Do you know why 300 was alighted upon? Was it
 13 simply that was all the stock there was to supply at the
 14 time?
 15 **A.** I imagine that was the answer. I mean, it's worth
 16 saying that the emergency response -- (b) on the list
 17 here -- that was stood up on 16 March, so these other
 18 steps happened really quite quickly after that.
 19 **Q.** All right. We'll look at some of those.
 20 That one-off supply of the masks though, as it sets
 21 out there, was only to care homes. Do you know whether
 22 there was any thought given as to whether there ought to
 23 be a one-off supply to people working in domiciliary
 24 care?
 25 **A.** I don't know.

125

1 items of PPE were dispatched.
 2 **Q.** But it was meant to be an emergency response there for
 3 that hotline. So just standing back from the emergency,
 4 where you're down to your last three days' worth, can
 5 you help, please, with the point (e) there, developing
 6 a new, direct, small volume distribution channel for
 7 PPE, the e-portal or the PPE Portal. Was it also known
 8 as the Clipper system?
 9 **A.** I think that was one of the logistical providers
 10 behind it.
 11 **Q.** And help us, Ms Dyson, what was the aim of the PPE
 12 Portal? If it helps you it's at paragraph 121 in your
 13 part C.
 14 **A.** The aim was to just get PPE on to a sort of sustainable
 15 footing. So these other, you know, we shouldn't neglect
 16 paragraphs (c) and (d), which were also very, very
 17 important in sort of April and May, but from June
 18 onwards, we got the small -- we started with the small
 19 providers, registering them on the e-portal because, as
 20 I say, they were the ones we knew who were having the
 21 most problems. By September, all social care providers
 22 were registered onto the portal and this became the way
 23 that everyone got their PPE.
 24 I mean, should say I arrived in the department in
 25 September 2020. PPE was not an issue that was sort of

127

1 **Q.** Right. There was the -- paragraph (b) -- an emergency
 2 response of PPE when a provider had less than
 3 three days' worth of PPE remaining. And I think in your
 4 statement you say that on 16 March the National Supply
 5 Disruption Response hotline, NSDR, was set up. And
 6 providers could obtain emergency supply. And in fact
 7 there was such demand that it had to become
 8 a 24/7 hotline; is that correct?
 9 **A.** Yes.
 10 **Q.** You say in your statement that the department is not
 11 aware that that hotline could not meet requests, but
 12 data available for the week commencing 6 April showed
 13 that there was daily over 1,084 daily contacts to that
 14 hotline, and by far the largest number of requests came
 15 in March to October 2020 from the adult social care
 16 sector; is that right?
 17 **A.** I mean, that sounds right. I know that the biggest
 18 adult social care providers on the whole managed --
 19 continued to be able to buy their own PPE, and it tended
 20 to be the small providers, which would be the large
 21 numbers --
 22 **Q.** Of course.
 23 **A.** -- who were calling.
 24 I mean, it's worth saying is that in the first full
 25 week of operation of this hotline, over half a million

126

1 loud and red and flashing on my agenda from that point
 2 onwards. So it clearly had been a very big issue in the
 3 early part of the pandemic and I really feel for
 4 providers, you know, the fear they must have had with
 5 the pandemic spreading and not being able to get PPE,
 6 but by the time the portal was up and running, I think
 7 that worked well.
 8 **Q.** I don't want to misunderstand you. Are you saying that
 9 the portal was deliberately rolled out in such a way as
 10 to prioritise the smaller providers --
 11 **A.** Yes.
 12 **Q.** -- because it was more difficult for them to obtain PPE
 13 in bulk?
 14 **A.** Yes. We knew that they were struggling more.
 15 **Q.** I say that because the LGA are slightly critical of the
 16 absence of larger providers being able to get onto and
 17 register for the portal, but it sounds to me like that
 18 was a deliberate decision by the department to try to
 19 help the smaller providers that were struggling?
 20 **A.** Yes, and the larger providers, you know, everyone was on
 21 it by September.
 22 **Q.** Earlier on in the pandemic, before you joined the
 23 department, though, there were reports received by the
 24 department that PPE was being diverted to the NHS, and
 25 I think you're aware of those reports, Ms Dyson. Is it

128

1 correct that there was no policy from either government
 2 or, indeed, the NHS that such supplies should be
 3 diverted?
 4 **A.** Yes, that's absolutely correct.
 5 **Q.** Can I have a look on screen, please, at INQ000608140,
 6 page 4. This is an email from the National Care Forum,
 7 and it's ... just give me one moment. 9 March 2020.
 8 And the -- Nadra Ahmed of the National Care Association,
 9 forgive me, has emailed the Department of Health. Can
 10 we have -- thank you -- page -- perhaps my paging has
 11 gone slightly awry, but there is a reference in the
 12 email to the Department of Health where there is -- the
 13 National Care Association are aware that "suppliers are
 14 only supplying handfoam and handgel to the NHS,
 15 a government directive, apparently", says the email,
 16 although clearly that's not correct.
 17 [As read] "If that's true it is outrageous and
 18 they're bringing it to the attention of the department."
 19 You've dealt with the fact that there was no
 20 directive, certainly as far as the Department of Health
 21 is concerned. But can you give us an idea of the scale
 22 of concerns that were brought to the department's
 23 attention about supplies going to the NHS over
 24 preference to adult social care?
 25 **A.** There was a lot of anecdotal evidence of this at the
 129

1 unpaid carers would not use the PPE properly and without
 2 direct training and supervision it could create
 3 additional risk or a false sense of protection.
 4 Do you know why there wasn't training rolled out to
 5 unpaid carers at that stage as there was later on in the
 6 year by various online resources?
 7 **A.** It wasn't felt to be necessary at that point in time,
 8 and then when we looked at it again in July, by that
 9 point, the rates of Covid were very low and so it really
 10 wasn't felt to be necessary then. So SAGE was
 11 commissioned to look at the issue for the purposes of
 12 the winter and then it was taken forwards in the autumn.
 13 **Q.** I think the -- either the DCMO and/or Public Health
 14 England were also worried about supply issues. From the
 15 department's perspective, was the supply issue the
 16 dominant reason for this advice, or was it concerned
 17 about false reassurance and improper -- inappropriate or
 18 lack of training in PPE usage?
 19 **A.** I mean, it never came to a head in May. It came to a
 20 head in July, by which time the conclusion was we don't
 21 need to do this at a time when rates of Covid are so
 22 low.
 23 **Q.** Thank you.
 24 In September of 2020 there was a pilot, I think
 25 following advice from the SAGE Social Care Working
 131

1 time.
 2 **Q.** And do you know what the department did to try and
 3 correct the misapprehension that there'd been
 4 a directive in this regard?
 5 **A.** Like I said, we were very clear that it was absolutely
 6 not the policy. I noted that in the 2 April admissions
 7 guidance there's a statement in there to that effect.
 8 I suspect there may have been other statements that I
 9 haven't seen, but, because it very much was the case
 10 that we wanted to put matters right on this.
 11 **Q.** Has the department done any or did the department try
 12 and understand where the misapprehension had come from,
 13 or was it something that suppliers were doing, taking
 14 the decision themselves? Do you know where this had
 15 sprung from?
 16 **A.** I mean, I have heard speculation that it might have been
 17 wholesalers who reached that but I really don't know.
 18 **Q.** Right. And in relation to PPE and unpaid carers, we
 19 know that the initial advice to unpaid carers in
 20 April 2020 was that face masks were not recommended
 21 unless advised by a healthcare professional, and I think
 22 you said in your statement at paragraph 142 that the
 23 Deputy Chief Medical Officer and, indeed, Public Health
 24 England's advice was that unpaid carers should not use
 25 PPE while providing care. They were concerned that
 130

1 Group, to roll out free PPE for unpaid carers, and
 2 I think in January 2021 it was then rolled out
 3 nationally. Just to help you.
 4 Can we have a look, please, at the results from the
 5 pilot at INQ000110355.
 6 So this is the pilot that started in the autumn
 7 of 2020, and the outcomes of the pilot show that:
 8 "... demand [had] been low, with under 50 carers
 9 accessing PPE in each pilot location. [Local
 10 authorities] have not required a substantial amount of
 11 additional PPE to enable them to provide this group ..."
 12 Then if we just go down, you can see some of the
 13 figures there:
 14 "The highest figure we are aware of for distribution
 15 to extra-resident unpaid carers [ie those that don't
 16 live with the person they are caring for] is 256 in
 17 Birmingham in the month of July. [It] did ... rise
 18 sharply to [1,300-odd] carers in November when they
 19 extended [it] ..."
 20 On any view, these are small numbers of PPE being
 21 rolled out to 700,000-odd -- no, sorry, more,
 22 5 million-odd unpaid carers potentially.
 23 Do you know whether there was -- the low demand was
 24 because there was difficulty in identifying unpaid
 25 carers and therefore letting them know that there was
 132

1 free PPE?
 2 **A.** So I don't know why there was a low level of demand. We
 3 did this through local authorities, who would -- I mean,
 4 even if they couldn't reach all unpaid carers in their
 5 area, they would have had reach to, you know, a higher
 6 level -- higher numbers than this level of demand would
 7 suggest. So I don't know why the level of demand was
 8 low.

9 I note, though, that it was low in other nations as
 10 well, in Scotland, et cetera, but we never really got to
 11 the bottom of why it was so low.

12 **Q.** Do you think it might come back to the problems with
 13 defining who they are, therefore identifying them, and
 14 therefore notifying them and then getting PPE out to
 15 them if the unpaid carer needs it?

16 **A.** I think it could do but I -- I'm -- I think that local
 17 authorities would know more than, say, 50 carers in --
 18 any given local authority would know more than 50 carers
 19 in their area, so I think it's more than that that's
 20 going on here.

21 **Q.** Was there an issue with the amount of publicity that the
 22 rollout of free PPE to unpaid carers garnered?

23 **A.** I mean, possibly. I think we did some work on that, but
 24 possibly. As I say, it's interesting that the same
 25 issues arose in other nations who actually did this

133

1 workforce. And I think you mentioned there was
 2 a Workforce Capacity Fund that was set up -- it's not
 3 the only thing that the department did, but I'm not
 4 going to ask you about all of the steps the department
 5 took.

6 Could you go, though, please, to your paragraph 391
 7 in your statement because you say there that the
 8 department had four objectives to address workforce
 9 challenges: ensuring the sector had enough workers,
 10 supporting the workforce, protecting the workforce, and
 11 then, indeed, protecting the recipients that the
 12 workforce looked after.

13 I'd just like to look at a few of those with you.

14 **A.** Could I just interject for a minute?

15 **Q.** Certainly.

16 **A.** So I, as I said here, for the purposes of this
 17 statement, this was me creating those four categories
 18 for the purposes of the statement to try and sort of --

19 **Q.** To bring them together.

20 **A.** To make it logical because there was so much activity on
 21 workforce I felt it needed to be broken down.

22 I wouldn't want the Inquiry to get the impression that
 23 this was the -- these categories were how we approached
 24 things.

25 **Q.** No, thank you --

135

1 earlier. So I can't -- (overspeaking) --

2 **Q.** That was my final question on this topic. Do you know
 3 why it was that England didn't roll this out earlier
 4 than some of the devolved nations did?

5 **A.** Well, as I say, it was looked at in the summer. It was
 6 concluded that it wasn't necessary because rates were so
 7 low. Then it came back in the autumn. We did a pilot.
 8 It was important to pilot this to see what the level of
 9 demand was actually going to be, whether we would in
 10 fact have the stock that we would -- that was needed,
 11 and then it was rolled out in January 2021.

12 I think if you -- you can see as you look through
 13 the papers how this sort of unfolded.

14 **Q.** And what plans, if any, exist for rollout of PPE to
 15 unpaid carers in the event of a future pandemic where
 16 they need PPE? Is there any kind of plan that's ready
 17 or being formulated?

18 **A.** I mean, we're looking at PPE as a whole in terms of
 19 pandemic preparedness. I don't know explicitly on
 20 unpaid carers.

21 **Q.** Right.

22 My Lady, may I just deal with a couple of topics,
 23 perhaps, before our mid-afternoon break?

24 One of the matters that you have already referred us
 25 to, Ms Dyson, was the problems with capacity within the

134

1 **A.** -- (overspeaking) --

2 **Q.** It was your attempt to draw the strands together in an
 3 intelligible way for us.

4 **A.** Exactly.

5 **Q.** Understood. Thank you very much.

6 And bearing that in mind, clearly attempts to
 7 increase workforce capacity included a rapid induction
 8 training scheme and fast track recruitment. I'm not
 9 going to ask you about those. But the Workforce
 10 Capacity Fund was announced on 16 January 2021. And it
 11 was £120 million ring-fenced, designed to increase the
 12 use of the existing workforce, increase the size. And
 13 there was a review, as I understand it, of that fund and
 14 in total I think you say that 39,000-odd staff were
 15 recruited.

16 Can we have up on screen, please, INQ000279947_0014.
 17 And the section there, the "What do stakeholders think?"
 18 In the review:

19 "Stakeholders welcomed [the fund] being provided to
 20 mitigate the workforce capacity issues, [but said] it
 21 came late; the guidance and grant conditions being
 22 announced on 29 January ... and the first tranche of
 23 funding not being paid until February 2021.

24 Stakeholders believe that if funding had been provided
 25 as part of the winter plan in September, it would have

136

1 reduced the risk of a small number of cases of
2 [Covid-positive] staff continuing to work in care
3 homes."

4 Do you know whether any work has been done or is
5 being done to speed up the time taken to get money on
6 the ground to those that need it? I mean, on any view,
7 29 January into February is not the most inordinate
8 delay, if I can put it like that, but clearly, the
9 feedback coming back to you was that there were still --
10 nonetheless this was all a bit too late to help with the
11 pressures over that winter.

12 Can you help with that at all, Ms Dyson?

13 A. So the issue that they are complaining about, I think
14 with justification, is that this was money that would
15 run out at the end of March 2021. So they'd got very,
16 very little time to spend it. And they were asking for
17 it to come much earlier. And the reason why we didn't
18 put it out earlier -- we didn't get agreement from the
19 Treasury to do it until this point, so that when we did
20 the, I think it was called the workforce recruitment and
21 retention fund, a similar fund in the following winter,
22 that went out in October, so that was better, but I know
23 that local authorities would like to have long-term
24 funding, not these, sort of, short-term injections of
25 funding. Because it's difficult to recruit staff, and

137

1 ago where [there was] relative stability. They
2 attribute this to a number of core factors -- total
3 burn out and exhaustion from the last few months,
4 growing levels of mental health, poverty amongst the
5 workforce, triggering departures for better paid
6 work ..."

7 Presumably that's:

8 "... even [departures] from workers with a strong
9 affiliation to care and [vaccine as a condition of
10 deployment]. Everyone in the organisation is having to
11 work down -- with senior managers, local managers and
12 everyone having to turn their hand to delivery. Agency
13 staff are not available. Local authorities are calling
14 on them for help rather than being able to offer
15 help ..."

16 And essentially that provider who was reporting this
17 to Ms Rayner, who is reporting it to the Department of
18 Health, is asking for a Chatham House discussion.

19 In that email, at the top there's a reference to the
20 data, and indeed she says it at the bottom there:

21 "I ... understand the data tells a different
22 picture ..."

23 I wanted to ask about the disconnect potentially
24 between what the data was showing in September 2021, or
25 the autumn, and the very real crisis that Ms Rayner is

139

1 I think these funds were most useful in terms of
2 retaining staff or, for example, paying for childcare so
3 that someone could work for further -- an existing
4 member of staff could work or more hours.

5 It's difficult to recruit lots of people when you've
6 only got money for a short space of time.

7 Q. I think perhaps just finally before the break, one of
8 the things you said very early on in your evidence was
9 actually there was real problems with workforce capacity
10 later on into 2021, and I'd just like to look at that
11 with you.

12 Could I have up on screen, please, INQ000111776,
13 because you say in your statement the pressures were
14 acute in 2021 into 2022.

15 This is an email from 8 September. It's from
16 Vic Rayner of the National Care Forum, coming in to
17 various people in DHSC.

18 And in the body of the email, Ms Rayner says:

19 "... I would like to arrange as urgently as possible
20 a meeting with one of our members, who would be willing
21 to talk through the immediate crisis that they are
22 experiencing. They are seeing a very significant
23 deterioration in workforce over recent weeks with large
24 scale absences and departures of staff. This is ...
25 very different ... to where they were ... a few months

138

1 speaking about in this statement.

2 Do you know what the data was showing and why there
3 is potentially a disconnect?

4 A. I think this goes to a really important point that, in
5 terms of sort of recommendations. Because everyone
6 talks about data, data really matters. But some data,
7 this data, is retrospective. So workforce -- so we
8 didn't know -- from our data, we -- it appears -- and
9 I think this was right at the time -- we didn't know the
10 scale of the problem, but the way we found out about the
11 scale of the problem was through our very extensive
12 stakeholder conversations.

13 So in my view, in order to stay abreast of things
14 that are going on in this very, very large and disparate
15 sector, you need two things: you need data but you also
16 need intelligence, and those who represent the care
17 providers are a brilliant source of intelligence for the
18 department because they hear instantly when there are
19 problems on the ground.

20 So this email from Vic, it represents exactly the
21 sorts of things I was hearing in sort of September, or
22 so, at this point in time. We understood it to be, more
23 than anything about the pull of retail and hospitality
24 at that point in time, because the economy had just
25 reopened and they were paying higher wages than could be

140

1 paid for care.

2 **MS CAREY:** We, perhaps after the break, will turn to trying

3 to support the workforce and deal with burnout and

4 exhaustion.

5 Would that be a convenient moment, my Lady?

6 **LADY HALLETT:** Certainly.

7 Ms Dyson, as you've probably been told, we take

8 breaks for the benefit of everyone but particularly the

9 stenographer. So I shall return at 3.05. Thank you.

10 **(2.49 pm)**

11 **(A short break)**

12 **(3.05 pm)**

13 **LADY HALLETT:** Ms Carey.

14 **MS CAREY:** Thank you, my Lady.

15 Ms Dyson, can I ask you, please, about your

16 paragraph 477 in your part C statement, and it's on the

17 topic of Covid-19 positive working.

18 I think you set out there that in January 2021 the

19 Regional Assurance team became aware of some staff not

20 self-isolating after testing positive. Is that correct?

21 **A.** Yes.

22 **Q.** And it was happening in areas where there were acute

23 staff shortages and limited alternatives to safely staff

24 care homes, and the decision was made to work when

25 positive rather than not, to try to mitigate those staff

141

1 the minister to consider the option of police

2 involvement.

3 Can you help, Ms Dyson, with what, if anything,

4 happened in relation to police involvement in this area?

5 **A.** Our main response here was through CQC, and I remember

6 speaking extensively to Kate Terroni, who was then the

7 chief inspector of adult social care, and she was going

8 to convene all her CQC inspectors to make sure we could

9 get the message out as clearly as possible.

10 Ministers were also interested -- I mean, down the

11 line, the main thing was to get the message out as

12 quickly as possible in January and also do what we could

13 to assuage the issues on staff shortages.

14 Ministers were interested also in exploring the

15 police involvement. We looked into that. I think what

16 happened was CQC said it was not for them to refer

17 things to the police, that was not within their

18 statutory powers, but what they did do was they said

19 they would involve local authority safeguarding teams if

20 they thought that that was necessary.

21 **Q.** I think also the police in due course said that they

22 would not have the resources to be able to investigate

23 this number of staff taking this action.

24 But can I come back to sort of the fundamental

25 tension here between what was the department's position

143

1 shortages; is that it, in a nutshell?

2 **A.** Yes. I mean, it was only in a very few number of cases,

3 so it wasn't widespread, but it was -- certainly seemed

4 to be becoming more of a systemic issue than -- when we

5 first found out about it, we thought there was a one

6 rogue case, but it was clear there were a number of

7 them.

8 **Q.** Yes, in due course, you wrote an email, I think, that

9 was going to go to the minister, that you asked

10 Chris Wormald to approve or cast his eye over, and in

11 that you said there were six cases that were brought to

12 the department's attention where a Covid-positive staff

13 member had nonetheless gone on to work.

14 Do you know whether the scale was wider than that?

15 Was it just limited to those six cases? Can you help at

16 all with how widespread this problem was?

17 **A.** I believe that CQC found some more cases. The number 25

18 comes to mind but it may not be exactly that, but in

19 that sort of order.

20 **Q.** And I think in January, on the 27th, there was a joint

21 statement issued by the CQC, the Association of

22 Directors of Public Health and Public Health England, to

23 say that that should not happen, but you go on in your

24 statement to say that the department was considering how

25 best to address this issue, and advice was provided to

142

1 between providing potentially unsafe care by

2 a Covid-positive member of staff or not providing care

3 at all? Did the department have any position on which

4 of the lesser of the two evils should be adopted?

5 **A.** The department's clear position was that Covid-positive

6 staff should not be coming to work, and we were doing

7 everything we could to help with the staff shortages.

8 And indeed, I think the message that that went out was,

9 you know, if you've got staff shortages you need to be

10 flagging that locally and relying on mutual aid.

11 I mean, we were putting in the Workforce Capacity Fund,

12 as we've already discussed; we did a big recruitment

13 drive at the same time but, ultimately, providers should

14 not be having people come to work who were

15 Covid-positive. They needed to find alternative ways of

16 ensuring safe staffing.

17 **Q.** January 2021, when these six examples were brought to

18 the department's attention, it was a time when there was

19 rising rates of Covid infection, was any thought given

20 to how to prevent this reoccurring in winter of '21 into

21 2022 when, again, there were other winter pressures as

22 normally exist?

23 **A.** It was just our very clear messaging: if you are

24 Covid-positive, you must not come into a care home,

25 which is such a -- where the risk of Covid spreading is

144

1 so high. This is against the law, you mustn't do it.

2 **Q.** Just before we broke, you explained how you had

3 categorised into four, sort of, neat areas objectives

4 that the department had to try to deal with workforce

5 challenges, and one of those was supporting the adult

6 social care workforce. I think you say in your

7 statement that the Adult Social Care Taskforce

8 recommended a review of wellbeing services in one of the

9 reports that they had done, I think, in the summer of

10 2020. Do you know whether there was such a review

11 conducted?

12 **A.** So what happened with the taskforce report was it sort

13 of morphed into the winter plan and the two things were

14 published alongside each other. And the winter plan

15 talks a lot about all the sort of resources that they

16 are --

17 **Q.** I'm going to show it on screen in a moment.

18 **A.** Okay.

19 **Q.** So, with that in mind, shall we call up, please,

20 INQ000058216_0037 and 0038, and I've just pulled out the

21 support part of the winter plan, and we can see there

22 "National support" and, indeed, "Actions for local

23 authorities", but I suppose, really, the question is,

24 this is a plan that came out in, I think, September 2020

25 in preparation for the winter of 2020 to 2021. Was

145

1 of their staff.

2 **Q.** You alight on, there, perhaps a distinction between the

3 NHS workforce and the adult social care workforce, but

4 clearly the -- NHS England, for example, launched

5 a dedicated mental health hotline for NHS staff. Is

6 that something that the department could have chosen to

7 do for the adult social care workforce, notwithstanding

8 that it's for providers to help, but give the

9 overarching banner of support to adult social care?

10 **A.** I suppose it could have chosen to do that. There was

11 always an issue about how you reach all the adult social

12 care workforce. There is no register of the workforce.

13 So there are all sorts of things you can provide, but

14 will they be taken up by -- as you said at the outset,

15 there's 1.2 million people who are employed by

16 18,000 providers.

17 **Q.** We are aware that Northern Ireland, Scotland and Wales

18 have a mandatory registration for both, I think,

19 residential and domiciliary care workers. Not the

20 position in England, as we understand it.

21 Do you think a register of the care workers would

22 assist in the event of a future pandemic? And if so, in

23 what ways?

24 **A.** It would definitely assist in the event of a future

25 pandemic, because there were times when we thought

147

1 there any support put in place for the workforce prior

2 to the publication of the winter plan?

3 **A.** So I think quite a lot of these things had already been

4 put in place and I think some of them are referred to,

5 but I couldn't tell you off the top of my head which

6 they are, in the April plan published on 15 April. And

7 then the one in May, the Care Home Support Package

8 published in -- (overspeaking) --

9 **Q.** Perhaps I can help you, Ms Dyson, because certainly if

10 we look at some of the bullet points, there is an offer

11 to the workforce is brought together in the Care

12 Workforce App, that is something that was launched in

13 May of 2020, according to your statement, and there was

14 certainly some guidance issued on health and wellbeing

15 in May, as well.

16 So -- but do you know, for example, what specific

17 work the department did to try to support the wellbeing

18 and workforce, aside from the winter plan?

19 **A.** I think this was principally it. I mean, if you -- the

20 next page of this talks about the responsibilities of

21 providers, and clearly the adult social care workforce

22 is employed by, you know, sort of 18,000 providers. So

23 it's very different from a public sector sort of

24 national workforce like the NHS. And first and

25 foremost, it's for providers to look after the wellbeing

146

1 about: how can we get to the workforce? And we had no

2 route to get to the workforce other than through

3 providers, which is obviously an indirect route to the

4 workforce.

5 **Q.** Given the size of the workforce in England, which is, on

6 any view, much larger than in the devolved nations, how

7 feasible is it for there to be a mandatory registration

8 requirement?

9 **A.** I mean, it's feasible but there are plenty of people who

10 think it's not a good idea. So there are mixed views on

11 this, but it is feasible.

12 **Q.** On behalf of the department, do you have any views as to

13 who should keep such a register and maintain a register?

14 **A.** I mean, if we were to have such a register -- and this

15 goes to the question of -- I mean, you could have, sort

16 of, Skills for Care. They have the adult social care

17 workforce data. But I suppose if you were moving into

18 a world of workforce professionalisation along these

19 lines, I mean, maybe it's not the right thing to do to

20 have it sort of held at such arm's length from the

21 department. Skills for Care is an independent charity,

22 and you could set it up within the department. All

23 these things would be feasible.

24 But as I say, there are very mixed views on whether

25 this is a good idea.

148

1 Q. And what about the views --

2 LADY HALLETT: I'm sorry, Ms Carey, can I just interrupt?

3 MS CAREY: Yes.

4 LADY HALLETT: What are the opposing views to a register,
5 Ms Dyson? I don't know if Ms Carey is going to cover
6 it. I may have stopped her in her tracks.

7 MS CAREY: Not at all.

8 A. I honestly -- I can't remember the detail of this.
9 I remember Matt Hancock was very keen to do this, and
10 also I think we consulted on it in late 2021 as part of
11 some reform work. But I think there are some
12 stakeholders who think this is not a good idea, they
13 think it might put people off. But I think you -- yeah,
14 I'm afraid I can't remember the detail of why they're
15 against it.

16 LADY HALLETT: Thank you.

17 MS CAREY: One aspect of the pandemic was undoubtedly
18 emerging evidence that showed that there was
19 a disproportionate impact of Covid on black and minority
20 ethnic members of staff, and can I ask you a little bit
21 about that, please, because I think at your
22 paragraph 449 you make reference to, there, the risk
23 reduction framework. I'll just let you turn it up,
24 Ms Dyson, as I do as well.

25 But the department developed what was called the
149

1 And 52 hadn't.

2 But if we just look to the bottom of that page,
3 clearly over that two-week period, the respondees were
4 asked for their awareness and take-up of that social
5 care risk reduction framework, and it was much lower.
6 And if we go over the page, please, when asked the
7 question "Are you aware of the framework?", 88 people
8 said no. So almost two-thirds of the respondents.

9 "Have you used it?" Even worse figures: 109 of the
10 respondents had not.

11 Do you know whether the department was aware of,
12 albeit a small study but, nonetheless, an important
13 study that showed, perhaps, the risk reduction framework
14 wasn't being utilised, no doubt, as much as the
15 department would like.

16 A. I think the important -- so this is part of David
17 Pearson's overall taskforce. I think the important
18 thing here was: were people having the conversations?
19 I think it mattered less whether they were having the
20 conversations because they knew about the risk reduction
21 framework than were they having the conversations in the
22 first place, because the risk reduction framework was
23 all about supporting those conversations. It was saying
24 you should have a conversation, this is how you do it,
25 it's a very sensitive issue, these are the sorts of

151

1 adult social care risk reduction framework, to be used
2 in all social care settings or social care
3 interventions. It was to provide guidance for employers
4 on how they should support workers who were more
5 vulnerable to infection or adverse outcomes, including
6 the risks by ethnicity. And that framework came out on
7 19 June 2020.

8 Can we have a look, please, at INQ000109673.

9 And this is an extract from a report done by the
10 adult social care support taskforce, BAME Communities
11 Advisory Group. It was an advisory group that worked
12 between 31 July and 14 August 2020, so just a two-week
13 period, and they received 142 responses from the social
14 care workforce.

15 And we can see there that confidence in support, the
16 quantitative section of the group's work showed risk
17 assessments were often a successful measure for BAME
18 staff to feel more secure, higher level of confidence
19 coming around -- sorry, around support coming from
20 employers than the government or official guidance, and
21 the majority of respondents had been risk assessed
22 regarding ethnicity.

23 And you can see there, perhaps if we just zoom out
24 again, "Have you had a risk assessment based around your
25 ethnicity?" Actually, 90 of the 142 respondents had.

150

1 things you should talk about, and then this is how you
2 can mitigate.

3 If those conversations were happening without
4 reference to the risk reduction framework then I don't
5 think that that's a problem. And in fact, if we put out
6 a risk reduction framework on 19 June, bearing in mind
7 how difficult it is to get things across such a large
8 sector, I'm actually quite surprised that -- is it --
9 38% of people were aware of the Adult Social Care Risk
10 Reduction Framework.

11 Q. I follow your argument, which is as long as the risk
12 assessment is been doing (sic), whether it's the risk
13 assessment framework that provokes it, it doesn't
14 matter, it's important that the risk assessment is
15 undertaken.

16 A. Yes.

17 Q. But nonetheless, this was an area where the department
18 were concerned about the disproportionate impact and
19 arguably the framework that they put out isn't certainly
20 getting the airtime or the publicity that perhaps the
21 department wanted and you could have had more risk
22 assessments, potentially, if the framework had been
23 better publicised. There is that argument. Do you see
24 that, Ms Dyson?

25 A. Potentially. I mean, we would have used -- I don't know

152

1 if we did in this case but we would have used Skills for
 2 Care as a way of reaching the workforce.
 3 **Q.** And is the risk reduction framework still in place now
 4 or is that a pandemic-specific --
 5 **A.** Not that I'm aware of. Could I just mention one other
 6 thing that was happening at the same time as this on the
 7 question of, sort of, risk around ethnicity, which is
 8 the decision that was taken on 26 June to prioritise the
 9 adult social care workforce -- sorry, the care home
 10 workforce for regular asymptomatic testing, to
 11 prioritise them ahead of the NHS by several months. And
 12 that was taken partly because of the risks in care homes
 13 to residents, but also because of the risks to the
 14 workforce. And the evidence that went into that meeting
 15 when those decisions were taken explicitly talked about
 16 the fact that 21% of the adult social care workforce was
 17 from an ethnic minority background, rising to 60% in
 18 London, and other risk factors such as living in housing
 19 of multiple occupation, being on zero-hours contracts,
 20 et cetera.
 21 So we were doing other things alongside, at the same
 22 time, in June 2020.
 23 **Q.** No, and thank you for adding that context, but if the
 24 department is going to go to the trouble to put out
 25 a risk reduction framework but then it doesn't seem to

153

1 know, they were in priority number 1, alongside
 2 residents, because of the risks, both to residents and
 3 to them, within the care home environment.
 4 **Q.** I think, Ms Dyson, though, you're aware that, certainly
 5 particularly within some black and minority ethnic
 6 communities, there is lower take-up of the vaccine for
 7 a number of different reasons.
 8 Aside from the vaccine, I just wonder whether there
 9 was perhaps not enough attention given to trying to
 10 promote the department's concerns to protect black and
 11 minority ethnic workforce members?
 12 **A.** I mean, I'm not aware of other things that we did. You
 13 know, there was a lot of work done, but I mean,
 14 particularly, if I can come up back to the vaccine,
 15 NHS England did a huge amount of work with ethnic
 16 minority communities to encourage them to take up the
 17 vaccine, which was for their protection.
 18 **Q.** And whilst we're on this topic, can I ask you, please,
 19 to look at INQ000543049.
 20 This is an extract from a statement by Skills for
 21 Care. I'll just wait for it to come on screen. And if
 22 it doesn't, I can read it out to you, Ms Dyson, but the
 23 Social Care Workforce Race Equality Standard collects
 24 data from local authorities on nine race equality
 25 indicators, and I think you're aware that Skills for

155

1 have landed with the workforces, it's not necessarily
 2 the best advert for trying to support the workforce,
 3 particularly those who are disproportionately affected,
 4 to understand that they are being thought of, looked
 5 after, and work is being specifically done for them?
 6 Do you think perhaps there is a communications issue
 7 surrounding things like the risk reduction framework?
 8 It wasn't publicised enough?
 9 **A.** I mean, possibly but, as we discussed before, it's
 10 really hard to reach the whole of the workforce because
 11 we don't have a list of who they all are. And I do
 12 think the fact that this is, I think you said, August,
 13 so it's potentially sort of six, eight weeks on, you
 14 know, things always take a while to get through. So it
 15 would have been interesting to see, you know, if you'd
 16 done a similar survey a few months later, you know,
 17 would the numbers have improved.
 18 **Q.** That's what I was going to ask you. In addition to the
 19 prioritisation of asymptomatic testing and things like
 20 the framework, are you able to point to any other
 21 measures that the department took to try to address the
 22 disproportionate impact of Covid-19 on the adult social
 23 care workforce?
 24 **A.** I mean, the vaccine, clearly, which was prioritised for
 25 the adult social -- people working in care homes. You

154

1 Care have recommended that the Department of Health,
 2 along with the Minister of Housing, Communities and
 3 Local Government, and DfE, should mandate and fund
 4 implementation of that Workforce Race Equality Standard
 5 into all its work?
 6 Can you help with any Department of Health comment
 7 on the Skills for Care recommendation?
 8 **A.** So the department funded a pilot of 18 -- so this is for
 9 local authorities. The department funded the first
 10 18 local authorities getting this standard. The
 11 department also funded the data tool to support the
 12 rollout of the race equality standard.
 13 Since then, as I understand it, Skills for Care have
 14 been rolling it out themselves, without funding from
 15 central government. I believe they've got to around
 16 73 local authorities, so they seem to be doing a good
 17 job in getting this out to local government, building on
 18 the pilot of the first 18 that was funded by the
 19 Department of Health and Social Care.
 20 **Q.** And can you help us, in what way would the Department of
 21 Health have been assisted if perhaps this had been
 22 rolled out sooner or more local authorities were
 23 complying with it in the pandemic? I mean, obviously
 24 data is a good thing but is there any specific thing you
 25 can point to and say: well, that would have been really

156

1 beneficial if we'd that the equality standard collected
2 data?
3 **A.** So this is about local authorities, I think it is about
4 local authorities' own workforces as opposed to the care
5 workforce, so it's about social workers, et cetera.

6 I'm sure that that would have been useful, given the
7 concerns about race equality, but it's not obvious to me
8 precisely what it -- I mean, I think that's probably
9 a question for local government as to precisely what it
10 would have been useful for.

11 **Q.** I'll turn to a different topic, and that of visiting
12 restrictions, please.

13 And the Inquiry is aware, essentially, of the
14 competing arguments here: of the need for protection of
15 those who are in care homes, but equally, the real harm
16 that is done by the isolation and lack of familial
17 contact that that restriction brings.

18 I'm not going to take you through all the various
19 iterations of the visiting guidance, but at your
20 paragraph 289 you make reference to the SAGE Social Care
21 Working Group consensus, and there was essentially not
22 that much evidence, if any, to deal with the extent to
23 which visitors transmitted the virus into care homes.
24 They said evidence was weaker on the risk of
25 introduction and transmission of Covid-19 infection from

157

1 glove with the -- with Jenny Harries, with Public Health
2 England. So we were all -- they were very much part of
3 our decision making in terms of how to balance these
4 risks.

5 **Q.** I follow that PHE, or UKHSA as it now is, has a role in
6 it, but is there anything preventing the department for
7 asking such research to be done so that we understand
8 the extent to which visitors bring in infections?

9 **A.** Not that I can think of.

10 **Q.** Whilst we're on visiting restrictions, in your first
11 statement you make reference to the changes brought
12 about by Regulation 9A, which came into being I think in
13 2024, which aims to make sure that people staying in
14 a care home, or indeed a hospital, receive visits from
15 people they want to see.

16 And can you help us, please, with what was the
17 rationale behind amending the regulations to bring in or
18 codify, effectively, a right to receive visitors in care
19 homes and hospitals?

20 **A.** It was the experience of the pandemic.

21 So at every point in the pandemic we were wrestling
22 with the -- trying to square the circle as -- to balance
23 things. I mean, it is to note that when Omicron came,
24 and I don't know if the Inquiry has heard evidence on
25 this, but at the beginning, when we first got notified

159

1 visitors. Further work through the commissioning of new
2 studies was needed.

3 Was or is any work being done by Department of
4 Health to try to work out the extent to which visitors
5 bring in infections into care homes?

6 **A.** I think the point here was that there wasn't the
7 evidence that we would have ideally had. But on the
8 other hand, it was very clear that all footfall, if you
9 like, into a care home brought risk with it. So anyone
10 coming into a care home, for whatever purpose, that was
11 a risk.

12 So in answer to your question, I'm not aware that
13 we're doing any extra work in this space.

14 **Q.** It's just that a number of the Bereaved Group members in
15 particular say: well, if the evidence emerges that we're
16 not a vector of transmission or a significant vector of
17 transmission, it makes the argument for imposing
18 visiting restrictions less.

19 I suspect you can see that point, but hence why they
20 are keen to know whether there is an evidential basis
21 for the restrictions in terms of the data showing that
22 they bring in X proportion of infection.

23 **A.** I mean, I think this is a question principally for
24 Public Health England, but we -- every time we made
25 changes to the visiting restrictions we worked hand in

158

1 about Omicron, which was the end of November 2021, we
2 were incredibly fearful because we knew it was much more
3 infectious than what had gone before, and at that point
4 we didn't know whether it was more lethal.

5 And so we were fearful we were going back to the --
6 more -- equally lethal -- we were fearful we were going
7 back to the position of March 2020. But against that
8 backdrop we decided to -- not to close care homes to
9 visiting. We brought in restrictions again, but we kept
10 the essential caregiver learning from the experience of
11 what had gone before.

12 The regulation that we brought in that you mentioned
13 was really to codify that experience and make sure that
14 it would only be in the most exceptional circumstances
15 that care homes would be closed to visiting.

16 **Q.** That's what I wanted to ask you about -- because there
17 is that caveat that, clearly, if exceptional
18 circumstances apply, then the right to have a visitor
19 falls away. But wouldn't a pandemic essentially be the
20 exceptional circumstance? Wouldn't we be back in the
21 position that we were in in March, April, May of 2020?

22 **A.** I mean, the guidance that CQC has given underneath that
23 provision makes it clear that it really is -- if it
24 really, really can't -- you know, there is no way of
25 doing this safely. But we can't close the door to --

160

1 you know, it is possible that you get another pandemic
 2 where, in order to keep people safe, you do have to
 3 close visiting down again. I mean, I hope -- I hope --
 4 very much hope we don't end up in that place.

5 **Q.** I think you said in your statement the CQC have a role
 6 to play in ensuring that visitors are being -- are
 7 allowed. And I think there's a correction to make, is
 8 there not, to your paragraph 52 in your statement A,
 9 where it should be a reference to 2023 amendment
 10 regulations not to the Health and Social Care Act of
 11 2022?

12 **A.** Yeah.

13 **Q.** All right, well, we'll deal with the formalities but
 14 thank you for that.

15 Can I ask you, please, about do not attempt
 16 cardiopulmonary resuscitation notices, please. It's
 17 your paragraph 615, Ms Dyson, if it helps you, onwards.

18 One of the things you say there, I think at
 19 paragraph 613, is you say that:

20 "The Department did not receive evidence of ..."

21 Forgive me, let me just turn the paragraph up
 22 itself:

23 "... evidence of inappropriate and blanket use of
 24 DNACPRs.

25 What do you mean when you say the department didn't

161

1 taking this approach but many are, and the press are not
 2 helping. This is similar to the 'blanket DNAR' to which
 3 you reference elsewhere. We do not have any volume of
 4 statistics yet but some people in care homes showing
 5 symptoms do survive and I think we should be
 6 acknowledging this fact."

7 And they talk about:

8 "The [standard operating procedure] I mention below,
 9 also has a role in dispelling this or statements that
 10 those ... requiring NHS hospital treatment will continue
 11 to receive it. Anything you are able to say in this
 12 area will go some way towards services not feeling
 13 totally isolated and cut off, and minimising the fear
 14 that everybody in a care home will die".

15 Now, a number of issues in that section there
 16 please, but is this an example, perhaps, of some of the
 17 anecdotal evidence to which you just referred a moment
 18 ago --

19 **A.** Yes.

20 **Q.** -- with emails being sent into the department, and the
 21 like? Right.

22 From the department's perspective, was there ever
 23 a policy that promoted or enabled there to be a blanket
 24 DNACPR policy?

25 **A.** Absolutely not.

163

1 receive evidence of it? Because the department was
 2 clearly aware of concerns and I just want there to be no
 3 misunderstanding about what the department knew or had
 4 been told.

5 **A.** I mean, there were many examples, anecdotal examples, of
 6 this. And, indeed, the CQC review that was done,
 7 I think in October 2021, said that that was the case.
 8 I think that sentence maybe simply means we didn't
 9 receive, you know, sort of comprehensive sort of
 10 analysis on this, but absolutely, we were hearing about
 11 it -- (overspeaking) --

12 **Q.** I didn't want there to be any misunderstanding about the
 13 fact that this was raised as an issue with the
 14 department, and could we have a look on screen, in fact,
 15 at INQ000565710_0002.

16 This is an email sent to the department in --
 17 forgive me the date has disappeared off it, but it was
 18 sent to the department and in the middle of -- thank
 19 you -- 11 April, thank you very much -- there is
 20 reference, can you see, at point 2 there, commenting on
 21 a piece of evidence. But in the middle of that
 22 paragraph you see:

23 "There is a perception that people receiving
 24 services in a care home and with [Covid-19] symptoms are
 25 automatically palliative. Not every GP practice is

162

1 **Q.** Or any policy that elided do not attempt cardiopulmonary
 2 resuscitation with the fact that other treatment must
 3 still be continued?

4 **A.** No. I mean, the department, as soon as it heard about
 5 this, the department, through multiple routes, wrote out
 6 to the sector, and I can go through the list if it's
 7 helpful, but, you know, through the NHS, through adult
 8 social care routes, through the Chief Social Worker
 9 routes, through the Chief Nurse, everything it could do,
 10 to say this is completely wrong, do not do it.

11 **Q.** We know that in the autumn of 2020 the department
 12 commissioned the CQC to do a DNACPR report. There was
 13 an interim report and a final report with which the
 14 chair is very familiar. And in due course there was a,
 15 I think a ministerial group set up to develop universal
 16 principles for advanced care planning.

17 Can we just have a look at that please,
 18 INQ000587737, page 168 to 169.

19 It's probably easier just to put the paragraph up on
 20 screen from your statement. You say:

21 "One of the key outputs of the group was the joint
 22 publication of a set of Universal Principles for Advance
 23 Care Planning ... published in March 2022 ... as to
 24 'what good looks like' ..."

25 And we can see there six high-level principles.

164

1 Thank you:
 2 "The person is central to developing and agreeing
 3 their Advance Care Plan ...
 4 "... personalised conversations ...
 5 "The person agrees the outcomes of their Advance
 6 Care Planning conversation ..."
 7 And so on.
 8 And without wishing to disparage the work of the
 9 universal principles, is there any other work being
 10 done, though, to provide more ground-level guidance to
 11 ensure that there isn't blanket or inappropriate DNACPR
 12 policies being written or being imposed on people in
 13 care homes in the care sector? What is sort of at the
 14 level under this, if I can put it like that?
 15 **A.** This, then, became part of the single assessment
 16 framework which the Care Quality Commission uses and
 17 that, if you like, is the best way of getting to all the
 18 care providers, that's the basis on which they are
 19 inspected.
 20 **Q.** Can you help us now with where DNACPR records are kept
 21 for the adult social care sector, because we've often
 22 heard about perhaps there being a GP record, maybe
 23 a hospital record, maybe a care home record, and not
 24 necessarily the three records aligning. Do you know now
 25 if there is one central repository for DNACPR records,

165

1 multiple agencies to highlight the issue, and deal
 2 with it.
 3 **Q.** Given that there was no departmental directive saying
 4 this was acceptable or permissible, did the department
 5 do work to try and understand why, given this problem
 6 was still happening even though no one told GPs to do it
 7 or care homes to do it, to try and understand what
 8 generated?
 9 **A.** I think that was the CQC review. That was the mechanism
 10 to try and understand that.
 11 **Q.** Okay. Can I come on to deal with the issue of data,
 12 please. And this is mainly covered in your part D
 13 statement, Ms Dyson.
 14 You say at the outset of that statement that the
 15 Department of Health was not operationally responsible
 16 for adult social care data collections, but you did
 17 receive annual returns from NHS Digital, we know the CQC
 18 included data in their annual report. But is this the
 19 position, that going into the pandemic, there was no
 20 realtime data available to the department?
 21 **A.** Yes.
 22 **Q.** Right. Now, there were some changes made during the
 23 pandemic, and I'd like to ask you about some of those,
 24 please. And in particular, you say there was changes
 25 made to test and trace data, deaths of care home

167

1 as far as the adult social care sector is concerned?
 2 **A.** So I've been trying to get to the bottom of this. There
 3 is a digital care record for care providers.
 4 I understand any DNACPRs are not kept there, because
 5 they have to be signed off by the GP. So they will be
 6 held somewhere within a GP record, but I'm not sure
 7 what, in terms of the sort of central repository, I'm
 8 not sure what that would be, but we can continue to try
 9 and find out, and let the Inquiry know when we have.
 10 **Q.** Right. One of the concerns of the bereaved groups is
 11 that the CQC report that was commissioned was perhaps
 12 commissioned too late in the pandemic and there have
 13 been these concerns that had been growing from a much
 14 earlier stage in the autumn of 2020. Can you help at
 15 all about why the decision was taken in the autumn to
 16 commission the CQC report?
 17 **A.** I don't know why it was in the autumn, but I think the
 18 really important point is how much action happened
 19 during -- basically during April, you know, we could not
 20 have done more, I think, to communicate out through
 21 every channel that we have across the health and care
 22 sector to say that this was inappropriate. And in fact,
 23 that was noted in the CQC review that said there was
 24 evidence of unacceptable DNACPRs being used at the start
 25 of the pandemic but there was a quick response from

166

1 residents data, and reporting via the Capacity Tracker.
 2 Perhaps my packaging up, or yours, but I'd like to look
 3 at those three areas with you, please.
 4 Data from test and trace, you say was useful to show
 5 prevalence and outbreaks. Can you help with, and it's
 6 at your paragraphs 16 and 17 in part D, when did the
 7 test and trace data become available to the department?
 8 Because we know test and trace was launched on 28 May,
 9 and we know it was reported in sitrep data from
 10 16 October but it doesn't mean the data wasn't available
 11 to the department before then; can you help?
 12 **A.** So the -- the test and trace data -- I mean, it became
 13 most meaningful once you had regular testing. So that
 14 rolled out from July but probably didn't become -- get
 15 into its full rhythm, I would guess, until about
 16 September. We then had the dashboard that was built,
 17 the Palantir dashboard that came on stream about that
 18 point of time, so end of September, beginning of
 19 October, and that was where the test and trace data was
 20 reported and reported daily.
 21 **Q.** That brings us on to the dashboard. I think you said in
 22 your statement it was rolled out from 1 October 2020.
 23 It was interactive and local authorities had access to
 24 the dashboard and, indeed, ministers used it at meetings
 25 and various other groups. Can you help me with this:

168

1 was the dashboard in any way developed in secret or
 2 without the DHSC's knowledge?
 3 **A.** No. There were many emails. You can see all the
 4 different people who were involved, including analysts,
 5 from my team, across with Palantir, and NH -- I think
 6 the NHS held the contract maybe at that point with
 7 Palantir. Many people were involved in developing the
 8 dashboard.
 9 **Q.** Was there ever any orders that you're aware of not to
 10 share the dashboard with either ministers or any other
 11 group that wanted to see the dashboard data?
 12 **A.** No, absolutely not.
 13 **Q.** Can we have a look, please, at the actual data itself.
 14 Thank you very much. It's INQ000512951. And
 15 I wonder if we can go to page 23, which I think may be
 16 a couple of slides on. Thank you.
 17 This is an extract from 5 January 2021, and it shows
 18 here the regions across England, and a summary of the
 19 positive cases, both a staff and residents -- is this in
 20 care homes, Ms Dyson?
 21 **A.** Yes, yes.
 22 **Q.** And we can see there that, as at January 2021, there is
 23 significant increases in London, the east, and the
 24 south east, compared with the previous seven days. And
 25 so it's a useful tool to show you increase in infection

169

1 **A.** Yes.
 2 **Q.** -- sufficient supplies?
 3 You mentioned the Capacity Tracker, is that
 4 a different dataset or was it just a sort of -- it sat
 5 under the regional and, indeed, national overview?
 6 **A.** So what the dashboard did was bring all these different
 7 datasets together, so what we're looking at here is Test
 8 and Trace data. But the brilliant thing about the
 9 dashboard was it combined Test and Trace data and
 10 Capacity Tracker in a way that was very accessible for
 11 us as policymakers in the department.
 12 And we could then -- once we saw what was going on,
 13 by then we had a regional -- or we were building our
 14 Regional Assurance team, and they could get on the phone
 15 to the relevant local authority or care home to say --
 16 you know, to just ask some questions about what was
 17 going on.
 18 **Q.** Is the dashboard still in use?
 19 **A.** No.
 20 **Q.** No.
 21 **A.** But Capacity Tracker is.
 22 **Q.** Right. We'll come on to that.
 23 Is there the capability nonetheless in the
 24 department to get the dashboard back up and running
 25 again in the event that we have a future pandemic?

171

1 rates or decrease, depending on the position.
 2 Obviously that regional overview was helpful but
 3 help us with the dashboard. How, from there, did one go
 4 to working out perhaps which local authority had
 5 a problem or which care home in particular had
 6 a problem? How had it sort of trickled down?
 7 **A.** So this is the dashboard that many, many of us looked at
 8 every day, and it was vital. It gave us this rolling
 9 seven-day data. So, as you say, you could absolutely
 10 compare -- see what was going on at national level, then
 11 at regional level. Then you could click through and you
 12 could get to all the 150 -- I think it was then 152
 13 local authorities. And from there, you could click down
 14 into the all the care homes that were in that local
 15 authority, and then you could see what was going on in
 16 that care home and you could see that care home's
 17 Capacity Tracker data.
 18 So, for example, in a care home where there was an
 19 outbreak, you could have a look and see: well, what are
 20 they doing on staff movement? What are they doing on
 21 paying sick pay?
 22 **Q.** So you could actually go down to, sort of, care home
 23 level and know what their outbreaks were, how many staff
 24 absences there were. I think -- did it cover PPE and
 25 whether they had --

170

1 **A.** I'm sure we could do that, yes.
 2 **Q.** Now the tracker, I think that was already -- that was
 3 something that was adapted for use during the pandemic.
 4 It was voluntary, as I think you said earlier. But
 5 clearly, one of the things during the pandemic to try to
 6 encourage provision of data was to make access to funds,
 7 not just the Infection Control Fund, linked to whether
 8 returns were made by the Capacity Tracker?
 9 Help us with the position with the tracker today.
 10 Would it be useful still if there were a future pandemic
 11 now? Because clearly you might want to look at bed
 12 capacity outside of pandemic times, but what does the
 13 department say is its benefit in the event that we
 14 had a pandemic later this year?
 15 **A.** I mean, we still use it for all sorts of purposes: bed
 16 occupancy, we look at staff absences. So there are all
 17 sorts of purposes it's currently used for. It's very
 18 easy for us to add extra fields if we need to. I mean,
 19 there is obviously a process to be gone through, because
 20 we're conscious of imposing burdens on providers, and
 21 it's important we do -- there's proper governance around
 22 it, but it would, in principle, be easy to add in extra
 23 data collections into the Capacity Tracker.
 24 **Q.** And I think it may be something you said earlier,
 25 forgive me if I'm repeating myself, but is it now

172

1 mandatory too?

2 **A.** Yes.

3 **Q.** All right. A couple of different topics, please,

4 perhaps before we wrap up.

5 In your part E, which is your lessons learned part

6 of the statement, you make reference to the Chief

7 Medical Officer's technical report, which refers to

8 research and any investigation to increase care home

9 resilience.

10 Are you able to help with any work that is being

11 undertaken by the department now to conduct research, or

12 have the capability of standing up research in the event

13 of a future pandemic?

14 **A.** So there may well be things going on in UKHSA, but the

15 thing that I'm aware of is that the Vivaldi Study is

16 still going, albeit it's no longer looking at Covid, but

17 it is looking at care homes from, sort of, other

18 perspectives. So I think that is very useful research

19 for the future.

20 **Q.** In relation to Vivaldi, can I just ask you a few

21 questions, please.

22 I think -- was there a budget set for the project as

23 far as the department is aware?

24 **A.** So we've been trying to get to the bottom of exactly

25 what happened with Vivaldi. We've been digging round in

173

1 that comments like that were being made?

2 **A.** No.

3 **Q.** By the time you joined the department in September, were

4 comments like that being made about the need to cover

5 themselves?

6 **A.** I can't recall anyone making that sort of comment.

7 **Q.** From your researches, was there any suggestion that the

8 department did not want to uncover perhaps the scale of

9 infections in care homes?

10 **A.** Not at all. And it is worth adding another point about

11 Vivaldi. Vivaldi was a really important study, but what

12 Vivaldi uncovered, we already knew, albeit this was

13 a more robust study. So, for example, Vivaldi talks

14 about staff -- preventing staff movement. We already

15 knew that. We had already taken action in May to stop

16 staff movement. Vivaldi -- the importance of testing,

17 we already knew about that.

18 So Vivaldi is important but it's not the only study

19 that matters, and in fact most of the action that -- in

20 fact all the action that was needed, that Vivaldi points

21 to, was already underway, albeit Vivaldi was sort of

22 massively -- and very robust study.

23 **Q.** Another topic, please, is that of Care Act easements.

24 Clearly there were a number of conditions placed on

25 local authorities when they adopted an easement or

175

1 lots of emails. So from the emails that I've seen to

2 date, I've seen a lot of emails going on in May with

3 people trying to get a budget for Vivaldi involving

4 finance people, involving commercial people, this was

5 a -- sort of a procurement issue. I haven't seen where

6 that actually got to, but definitely people were doing

7 everything that I would expect them to be doing to get

8 a budget for Vivaldi.

9 **Q.** Was there -- or do you know whether -- was there anyone

10 in the Department of Health at that time that didn't

11 want the Vivaldi project to get up and running and

12 report on its findings?

13 **A.** I mean, there's nothing I've seen in all these emails

14 that would suggest that that's the case.

15 **Q.** Were you aware from your research whether the department

16 refused to share data with the Vivaldi project?

17 **A.** Again, nothing I've seen in these emails.

18 **Q.** Do you know whether Minister Whately was briefed in

19 private about Vivaldi?

20 **A.** Not that I'm aware of.

21 **Q.** The Inquiry has seen some evidence to suggest that in

22 summer of 2020 there were meetings in the Department of

23 Health where people were making comments like "Come the

24 Inquiry, we'd better cover our backs", to put it

25 ineloquently. Have you seen any paperwork that suggests

174

1 modification to the assessments that were carried out.

2 I think the department is aware of concern from user

3 groups and carer groups about potentially unmet needs

4 being prevalent or lower wellbeing, changes being made

5 at the last minute to assessments and the like.

6 You have set out in your statement that by

7 18 May 2020 there were six local authorities all in the

8 Midlands that were using easements and two other local

9 authorities that had used them but had stopped using

10 them.

11 On any view, potentially quite a low number of local

12 authorities in the scheme of things, and certainly no

13 easements have been used since June 2020.

14 There is a concern that perhaps they were being used

15 but that local authorities were not notifying the

16 Department of Health that they were being used. Did you

17 in the department get any sense of whether that was or

18 might have been happening?

19 **A.** I don't think that was the case. I think the issue is

20 whether -- because what was happening was people were

21 using Care Act flexibilities, and in fact when Omicron

22 came and we considered whether to turn Care Act

23 easements back on, the conclusion -- you know, what

24 local authorities said to us was: no, we don't need it

25 because we have the flexibility within the Care Act.

176

1 So I think the point -- there's an important study
 2 by -- a Manchester University study, I think.
 3 **Q.** Yes.
 4 **A.** And the concern there is: well, actually, is there too
 5 much flexibility in the Care Act? Which --
 6 **Q.** Can we have a look at that --
 7 **A.** Yes.
 8 **Q.** -- because it might help those following.
 9 **A.** Yeah.
 10 **Q.** Can we have up on screen, please, perhaps, your
 11 statement ending 737, at page 159. It might just take
 12 a moment to bring it up because we're flitting between
 13 statements.
 14 It's INQ000587737, page 159, and at the top of the
 15 page there a reference to the University of Manchester
 16 study in November 2020:
 17 "The project investigated the impacts of Care Act
 18 easements on older carers of people living with dementia
 19 at home to make recommendations about the operation of
 20 this legislation ..."
 21 And there's the report -- or one of the main
 22 findings:
 23 "... that carers and the family members they were
 24 supporting 'experienced significant changes from their
 25 usual care and support, which in many cases resulted in
 177

1 unfair that some of these local authorities that use the
 2 Care Act easements in exactly the right way were coming
 3 under pressure, but other people, other local
 4 authorities who did similar things, but without going
 5 through that process, didn't come under -- I mean, so
 6 I understand the point.
 7 **Q.** To go back from the other angle, though, and perhaps the
 8 significant changes being reported by carers and their
 9 family members, which resulted in lower wellbeing and
 10 unmet need, can you help with what safeguards, if any,
 11 were written into this to try and prevent such dramatic
 12 changes to people's care needs?
 13 **A.** I do think some of that is will be about lockdown more
 14 generally. So, for example, I know it was really
 15 difficult, and I should say this: the University of
 16 Manchester report makes very, very difficult reading.
 17 But some of the problems that it's alluding to were
 18 caused by lockdown so, for example, day centres closing,
 19 and indeed some, I understand, some families decided
 20 that they didn't want care because they didn't want
 21 a home carer coming into their home because they were
 22 concerned about the risk of Covid.
 23 I mean, what we did generally was there was an
 24 ethical framework which in fact the Permanent Secretary
 25 commissioned in February, which was published on
 179

1 lower wellbeing and unmet need'."
 2 And it goes on, I think, to set out the point you
 3 were just referring to, Ms Dyson, that:
 4 "Although the experiences were similar across the
 5 local authority areas in this study, easements were
 6 differentially implemented, soon revoked, and not in
 7 force for any local authority beyond July 2020. There
 8 appears to have been little consequence -- whether
 9 political, legal or regulatory -- for local authorities
 10 that did not invoke easements. However, for the local
 11 authorities that did, there was considerable pressure
 12 from lawyers, NGOs, lobby groups and adverse media
 13 attention."
 14 Was the department aware that local authorities that
 15 did invoke easements were coming under some criticism
 16 and --
 17 **A.** Yes.
 18 **Q.** And what was the department's view about it from that
 19 angle, in the first instance?
 20 **A.** The chief social workers went out to those local
 21 authorities and conducted extensive interviews to
 22 understand how they were using the Care Act easements to
 23 make sure that it was all in accordance with the
 24 guidance, which they concluded that it was. So I mean,
 25 I sort of understand the point that says it feels a bit
 178

1 19 March, it was always very important that all
 2 decisions of this kind, whether under Care Act easements
 3 or not, were taken being cognisant of that ethical
 4 framework.
 5 But the broader points that are being made here,
 6 which is about how do you have oversight of what's going
 7 on in local authorities in terms of the flexibilities
 8 that there are under the Care Act, we've now legislated
 9 so that CQC has -- inspects local authorities the way in
 10 which they exercise the Care Act, so they will be
 11 looking at these types of issues, you know, either
 12 within a pandemic, let's hope not, or in normal times as
 13 well.
 14 **Q.** Perhaps moving in to my final point, and levers, or the
 15 lack thereof. We've looked at the financial incentives
 16 that perhaps can be levied to try and ensure data
 17 returns are being met. You've spoken there of, I think,
 18 changes to ensure that the CQC inspects to ensure that
 19 Care Act responsibilities are being applied, but from
 20 the department's perspective, is there any
 21 recommendation that the department has got as to how to
 22 ensure it has the levers it needs, aside from those
 23 discrete areas that we've spoken about already this
 24 afternoon?
 25 **A.** I think this goes to the Baroness Casey review, because
 180

1 there are big questions here about whether adult social
 2 care is set up in the right way.

3 **Q.** I understand that, but that review may be many months,
 4 if not years, away. If we had a pandemic more
 5 immediately than that, do you have any recommendations
 6 or suggestions for how the government could gain the
 7 levers it might need to be able to support the care
 8 sector and, indeed, impose things on the care sector?

9 **A.** I think we're in a much, much better place than we were
 10 in 2020 through the legislation we've already talked
 11 about, through data, through CQC inspections, through
 12 the visiting regulations, and then there's one we
 13 haven't talked about, which is the power the government
 14 now has but hasn't yet used to be able to give money
 15 direct to providers. So all the money that went to
 16 providers during the Covid pandemic had to go through
 17 local authorities instructing them to pass it on. We
 18 now have the power to fund providers directly.

19 **MS CAREY:** Ms Dyson, thank you very much.
 20 My Lady, that's all the questions I ask but there
 21 are some Core Participant questions.

22 **LADY HALLETT:** There are. Thank you, Ms Carey.
 23 Ms Dyson, just few more questions for you but
 24 I promise you you are going to finish by the time we
 25 finish this evening.

181

1 say, if there were 94, then I don't know where all of
 2 those were.

3 **Q.** In your draft note back in January to the Minister you
 4 say that it appears that in some cases the action has
 5 been signed off at a local level on the grounds that
 6 there is a risk to safe staffing levels without
 7 Covid-positive staff continuing to work. So I wanted to
 8 ask you, do you agree that the prevalence of
 9 Covid-positive staff continuing to work during the
 10 pandemic was illustrative of the failure of the
 11 UK Government to grip the workforce issues and shortages
 12 that had been known before the onset of the pandemic?

13 **A.** I mean, we are talking about 94 staff out of
 14 1.2 million, so I do think we need to think about it in
 15 the -- get some sort of perspective on that. I mean, as
 16 we have discovered, there were problems in the
 17 workforce. There were problems particularly at this
 18 time, but equally, there were times during the pandemic
 19 when things, as regards the workforce, were relatively
 20 stable. We saw an email on that, making that point just
 21 before the break.

22 So I think this was a particular issue.
 23 I should just add that that draft note became an
 24 actual note about two hours later, and went to the
 25 Secretary of State and then there was a note to the

183

1 Ms Morris should be just to your right.

2 **Questions from MS MORRIS KC**

3 **MS MORRIS:** Thank you.

4 Good afternoon, Ms Dyson. I ask questions on behalf
 5 of the Covid Bereaved Families for Justice UK. My first
 6 topic is returning back to the issue of Covid-positive
 7 staff within care homes. Now, Ms Carey King's Counsel
 8 has touched on that with you already. I wanted to
 9 expand a little bit in terms of the detail, please, and
 10 the scale and some of the underlying issues.

11 We've already mentioned your note or draft note to
 12 the Minister from January in 2021 in which you
 13 highlighted six cases the department was aware about and
 14 I think following this -- that draft note, the number of
 15 reports that the Inquiry has evidence of increased by 50
 16 in February and 94 in April. You said you thought it
 17 was about 25. I just wanted to draw your attention to
 18 that. So by 13 April 2021 there were 94 reports, within
 19 the department's knowledge.

20 I wanted to ask you if you could help with whether
 21 there were cases of staff continuing to work in both
 22 residential and in community settings. Was it in both
 23 or just in one?

24 **A.** I don't recall but I mean, all the cases that were
 25 brought to my attention were in care homes, but as you

182

1 Prime Minister on it over that weekend.

2 **Q.** Thank you.

3 You've touched on some of the money delivered
 4 through the Infection Control Fund, but given the
 5 reports that were received by the department, do you
 6 accept that that money had proven insufficient to tackle
 7 the problem of preventing Covid-positive staff coming in
 8 to work?

9 **A.** That's why we were doing the Workforce Capacity Fund
 10 that actually had already been announced by the time of
 11 this note, so that was -- had been announced a couple of
 12 weeks earlier. This was the end of January, I think the
 13 Workforce Capacity Fund of 120 million had been
 14 announced in mid -- I think in mid-January.

15 **Q.** My next topic, the March 2020 hospital discharge policy.
 16 I wanted to ask you a little bit more about that,
 17 please.

18 So there was a national steering group meeting on
 19 11 March 2020. Ros Roughton, the then Director of Adult
 20 Social Care, emailed NHSE with her concerns that DHSC
 21 was lacking the ability to tell local authorities what
 22 she referred to as "the scary narrative" on what the
 23 pressure will be like in the acute sector so that they
 24 can really understand why the NHS may need to act the
 25 way that it does.

184

1 After the hospital discharge requirements had been
2 issued on 19 March, PHE officials noted that NHSE had
3 "major concerns" with the guidance for infection
4 prevention and control in care homes and would lead the
5 sector to being "too risk averse" describing what they
6 described as being blocks in the system.

7 I wanted your help, please, with, first of all, why
8 weren't DHSC officials able to tell local authorities
9 this scary narrative on what pressure was anticipated to
10 be like just days from this meeting?

11 **A.** I haven't seen that email, I don't know about that, but
12 I -- I mean, it's clearly part of the narrative around
13 the hospital discharge. It was being made -- and
14 remember, I think you said that that -- the Ros Roughton
15 email, was that, did you say, 13 March?

16 **Q.** 11 March.

17 **A.** 11 March.

18 **Q.** After 11 March.

19 **A.** Yes, so things changed a lot between 11 March and
20 19 March, so I'm sure that by the time of the hospital
21 discharge guidance on 19 March, I'm sure that there were
22 conversations happening about the need for it, you know,
23 we needed local authorities to be helping with the
24 hospital discharge policy.

25 **Q.** Yes. As you say, is it fair to say that the DHSC and
185

1 Covid-19-positive cases that didn't require treatment in
2 hospital.

3 What consideration, if any, was given to that as an
4 option before the March 2020 hospital discharge policy
5 was put into place?

6 **A.** Sorry, again, I haven't seen that. What was the date of
7 that, the hot ...?

8 **Q.** So 20 April, this is when the hot, the hot --

9 **A.** Oh, I see.

10 **Q.** Hot care homes came as suggestion. But why wasn't that
11 considered before March 2020?

12 **A.** I mean, the issue about hospital discharge is that we
13 didn't know about -- we didn't have the testing to know
14 who was Covid-positive, it just didn't exist at the
15 time, and we didn't about asymptomatic transmission.

16 By 20 April we did know about all of those things
17 and the guidance had changed on 15 April to say that you
18 must isolate people when they go into care -- when they
19 come from hospital into care homes.

20 So I think it was just a case of what we didn't know
21 at the point of the discharge guidance, but we did know
22 by 20 April.

23 **Q.** My third topic and my final topic is around PPE and
24 guidance for unpaid carers.

25 So in the 13 March 2020 guidance for home care, the
187

1 NHSE needed care homes to be willing to accept untested
2 patients from hospital if that policy was in fact going
3 to be effective?

4 **A.** Yes.

5 **Q.** So if there's an unwillingness to, or lacking the
6 ability to deliver the scary narrative, was the ASC
7 sector deliberately kept in the dark so that when the
8 time came, care home managers would not be too risk
9 averse in accepting urgent hospital discharges?

10 **A.** I think we're missing the -- between 11 March and, sort
11 of, 19 March. I just don't know -- I wasn't there at
12 the time, I don't know what happened in that period, but
13 clearly we were getting closer and closer. Lockdown was
14 on 23 March. You know, things changed very rapidly in
15 that period. I'm sure we were communicating with the
16 sector about what was going on. I mean, there was more
17 guidance issued on 13 March, you know, things were
18 moving extremely rapidly, so I don't think we should
19 read into an email on 11 March to say that there was no
20 communication with the sector after that.

21 **Q.** You've recognised in your evidence already this
22 afternoon that there was later the development of
23 designated settings. On 20 April 2020, PHE suggested
24 that consideration be given to the question of what they
25 call "hot" care homes as a place to cohort and manage
186

1 authors noted that the provision of care and support
2 within people's home is a high priority service and --
3 in that most care and support cannot be deferred to
4 another day without putting risks -- individuals at risk
5 of harm, and therefore it is vital that these services
6 are prioritised with this guidance and support. And
7 this particular guidance advised the use of PPE
8 including face masks for those performing domiciliary
9 care when in up close and personal contact with those
10 they were caring for.

11 But in relation to face masks, by contrast, on
12 8 April, guidance to unpaid carers said: we do not
13 recommend use of face masks as an effective means of
14 preventing the spread of infection unless you're told by
15 a healthcare professional.

16 As far as DHSC was concerned, was the care and
17 support provided by an unpaid carer to a person in
18 a home a high-priority service in the same way as
19 a domiciliary carer?

20 **A.** Absolutely. You know, the value that we put on unpaid
21 carers was just huge. They did an amazing job during
22 the pandemic, in really, really difficult circumstances.
23 We've already talked about the advice that Public Health
24 England gave us about why PPE for unpaid carers at this
25 point in time was not appropriate. Obviously things
188

1 changed later in the year.

2 **Q.** Can you see why that distinction in guidance seemed
3 illogical to many of the bereaved families in the UK and
4 Northern Ireland, amongst those -- amongst the -- many
5 of those who are unpaid carers. Can you see the --

6 **A.** I think it's important to probably distinguish between
7 the extra-resident unpaid carers and those living in the
8 same household. So PPE was never recommended for people
9 living in the same household except where Covid was
10 actually in the household.

11 Where we moved to was in treating the extra-resident
12 carers in the same way as domiciliary carers, but later
13 in the year.

14 **MS MORRIS:** Thank you very much.

15 My Lady, my remaining questions have been covered by
16 Ms Carey, thank you.

17 Thank you very much.

18 **LADY HALLETT:** Very grateful, Ms Morris.

19 Thank you very much, it's now Ms Jones. If you look
20 across the hearing room, Ms Dyson, you might see her.

21 **MS JONES:** My Lady, Ms Carey actually asked the topic I was
22 going to ask about, so I've got no further questions for
23 Ms Dyson.

24 **LADY HALLETT:** I'm very grateful, Ms Jones, thank you.
25 Ms Beattie, who is probably behind her.

189

1 [As read] "There is a gap in our knowledge
2 concerning local authorities who are not operating under
3 easements but whose actions mean they should be."

4 In order to fill that knowledge gap, the department
5 needed to know about local authorities that had not
6 formally declared easements but who were taking action
7 such as reducing the care provided to people with care
8 plans, leaving them with unmet needs, didn't it?

9 **A.** As far as I know, people were using the existing
10 flexibilities in the Care Act. So I think you can
11 say -- or the Care Act -- you can make the contention
12 that the Care Act is too flexible, and there have
13 been -- you know, people have talked about concerns
14 about unmet need for many years. But I don't think you
15 can say that they -- or I don't have the evidence to say
16 that they should -- they ought to have been using
17 Care Act easements. I just don't know.

18 **Q.** Is that precisely the thing that the department needed
19 to look into, whether the local authorities were
20 applying flexibilities, or really were in the territory
21 of easements?

22 **A.** Yeah, I think it's just very difficult to get --
23 you know, you've got a whole country, and we do have
24 to -- local authorities have the statutory duties here.
25 They know their populations really well. They are real

191

Questions from MS BEATTIE

1 **MS BEATTIE:** Thank you, my Lady.

2 Ms Dyson, I ask questions on behalf of Disabled
3 People's Organisations and the questions concern
4 Care Act easements which you have covered in your
5 statements and which continued to be in force after you
6 came into post.

7 The Minister for Social Care, Helen Whately, was
8 provided with a submission on 19 May 2020 on the impact
9 of Care Act easements, and that submission said that
10 chief social workers had spoken to or corresponded with
11 principal social workers from the seven local
12 authorities then operating easements. It might have
13 been six at that point but there had been a total of
14 seven. And that was out of a total of 153 local
15 authorities in England; is that right?

16 **A.** Yes.

17 **Q.** The chief social workers had not contacted or reviewed
18 what was happening in the other 146 local authorities,
19 but only the seven that had formally notified their use
20 of easements. That's correct, isn't it?

21 **A.** Yes.

22 **Q.** The submission, the same submission of 19 May, had said
23 in terms -- and for the record, this at page 3,
24 paragraph 6 of that submission:

190

1 experts in adult social care. And although I had Chief
2 Social Worker -- I had two job-sharing chief social
3 workers, you know, the idea that they could get across
4 the whole country and do what they were doing in those,
5 sort of, seven local authorities across the whole
6 country, I don't think that they could.

7 As I said before, I think we are now in a different
8 place, given that we have the CQC inspection powers
9 which could be used for exactly this type of thing, and
10 CQC have the expert -- you know, they have employed the
11 experts to do -- in the right numbers to do this work.

12 **Q.** The next submission to the minister, on 25 June 2020,
13 stated that monitoring of the overall system should
14 remain light touch, since chief social workers have good
15 oversight of the only local authority still operating
16 under easements.

17 So that light touch monitoring would again, as
18 I think you're accepting, still not tell you anything
19 about the local authorities that had not formally
20 notified the easements, would it?

21 **A.** No, I mean, that's right.

22 But as I say, I think we're at risk of sort of
23 almost cutting out the expertise of local authorities
24 here, who both had the expertise and the statutory
25 duties to comply with the Care Act here. But yes, if

192

1 your question is "Was the department sort of all knowing
2 as to what was going on across the 153 local authorities
3 in this space?", no, we didn't have that information.

4 **Q.** Right, so from the point of view of central government,
5 there wasn't any effective monitoring of how the
6 easements were operating and whether local authorities
7 were using the easements or the flexibilities?

8 **A.** So there was effective monitoring of those who were
9 using easements, but we didn't know what was going on
10 for those who were not using easements.

11 **Q.** And equally, from the point of view of central
12 government, there wasn't any effective monitoring of
13 whether local authorities were failing to meet care
14 users' needs during the pandemic, for example by cutting
15 their care packages, was there?

16 **A.** I mean, I have not seen any evidence that that was the
17 case. The evidence that I've seen of the sort of
18 flexibilities that were being used were things like
19 delaying financial assessments, that sort of thing. But
20 I'm not all knowing, so it's possible. But in terms of
21 the evidence that has come to me.

22 **Q.** I'm not sure if you were following the Inquiry this
23 morning, but the Inquiry heard from Age UK today that
24 local authorities had reduced care packages for people
25 living in their own homes. Were you aware of that?

193

1 told them to, might that also bring into question
2 whether the guidance itself was being properly
3 understood, or perhaps not complied with, because these
4 things were happening and yet there was such a small
5 number of reports?

6 **A.** I think the question it brings into play is -- is the
7 Care Act flexibilities. And whether -- if it really was
8 the case that someone was having a package of care taken
9 down from three times a day to one, you know, once
10 a day, I mean, it would be interesting to know what
11 other circumstances there were. Because, I mean, other
12 things I've heard from directors of adult social
13 services is that there were -- family members were more
14 around. So, you know, I think you can't judge too much
15 without really understanding all the circumstances of
16 the case.

17 But I do think that this brings up a question about
18 the flexibilities within the Care Act. You know, is the
19 width of the discretion there -- is it too wide? And
20 I think we need to look at that. And again, I would
21 expect, one, that would be looked at by the CQC when
22 they're inspecting how local authorities operate their
23 Care Act duties; and, two, I would expect Baroness Casey
24 to look at that as part of her review.

25 **Q.** And after you came into post in October 2020, the Think

195

1 **A.** I mean, what I've heard from -- just anecdotally from
2 directors of adult social services is that people asked
3 to have their care packages reduced because they were
4 worried about people, say, who hadn't been vaccinated
5 going into their homes.

6 But look, if Age UK have got evidence of that, then,
7 you know, I accept that.

8 **Q.** So, similarly, if there is evidence, as there is, of
9 daily care provision of someone who is, for example,
10 used to receiving care three times a day and that being
11 reduced down to once a day, so that, for example, they
12 didn't get dressed for a prolonged period of time,
13 because of the inability to meet their eligible needs,
14 would that be something above and beyond the examples
15 you've given of day services closing or people of their
16 own volition declining services?

17 **A.** Yes.

18 **Q.** And again, would that be a matter of concern and
19 a matter of interest to the department, having brought
20 in the easement provisions, to know whether that was
21 happening across the country?

22 **A.** Yes.

23 **Q.** And if that was happening, but only a very small number
24 of local authorities had formally invoked the easements
25 in the way that the guidance and the legislation had

194

1 Local, Act Personal partnership that had been engaged by
2 the department on an ongoing basis in relation to
3 easements had provided a review which described a very
4 grey line between Care Act easement implementation and
5 other local authority responses to Covid-19.

6 That raised precisely this problem, didn't it, of
7 whether -- of which was happening, and whether care
8 needs were being appropriately met?

9 **A.** Well, it comes back to the point I've just made which is
10 the degree of flexibility within the Care Act.

11 **Q.** And a further submission to the minister in
12 November 2020 suggested and referred to ADASS that the
13 national guidance was unclear, open to interpretation,
14 and that this was limiting the use of easements by local
15 authorities. Did that trigger any change or review of
16 the guidance while you were in post?

17 **A.** We stopped using easements, and when we consulted about
18 turning them back on again, as I said, for the purposes
19 of Omicron, the universal view was that they were not
20 needed.

21 **Q.** Right, but they remained in post, though, for ten months
22 of your --

23 **A.** Yes, but they were not being used.

24 **Q.** According to the information you had; is that right?

25 **A.** Yes.

196

1 **MS BEATTIE:** Thank you, my Lady.
2 **LADY HALLETT:** Thank you very much, Ms Beattie.
3 That completes the questions we have for you,
4 Ms Dyson. You mentioned the burden on providers. I am
5 acutely conscious of the burden the Inquiry places on
6 material providers and on our witnesses. You may want
7 to take the I'm sure glad news back to the department
8 that the burden that the Inquiry has placed on the
9 department for which you currently work is coming to
10 an end. We haven't finished with the department yet but
11 it is coming to an end. But also, I'm sure it was
12 a great burden on you to have to catch up on what had
13 happened in such fast-moving times when you weren't in
14 post. So thank you very much indeed for all that you
15 did to get yourself up to speed, and for helping the
16 Inquiry to the extent that you have.
17 **THE WITNESS:** Thank you.
18 **LADY HALLETT:** Thank you.
19 Very well, I shall return at 10.00 tomorrow.
20 **MS CAREY:** Thank you, my Lady.
21 **(4.20 pm)**
22 **(The hearing adjourned until 10.00 am the following day)**
23
24
25

197

1	I N D E X	
2		PAGE
3	MS CAROLINE ABRAHAMS (sworn)	1
4	Questions from COUNSEL TO THE INQUIRY	1
5	Questions from MS MORRIS KC	37
6	Questions from MR FOLEY	41
7		
8	MS EMILY HOLZHAUSEN (sworn)	43
9	Questions from COUNSEL TO THE INQUIRY	43
10	Questions from MS JONES	78
11		
12	MS MICHELLE DYSON (sworn)	86
13	Questions from LEAD COUNSEL TO THE	86
14	INQUIRY FOR MODULE 6	
15	Questions from MS MORRIS KC	182
16	Questions from MS BEATTIE	190
17		
18		
19		
20		
21		
22		
23		
24		
25		

198

LADY HALLETT: [31] 1/3 1/7 1/9 31/19 32/22 37/15 41/21 42/18 43/3 43/8 43/11 43/16 54/9 54/12 54/17 77/23 77/25 85/17 86/5 86/17 86/21 141/6 141/13 149/2 149/4 149/16 181/22 189/18 189/24 197/2 197/18 MR FOLEY: [2] 41/24 42/15 MS BEATTIE: [2] 190/2 197/1 MS CAREY: [10] 86/16 86/18 86/24 141/2 141/14 149/3 149/7 149/17 181/19 197/20 MS HANDS: [5] 1/4 1/12 32/23 37/12 43/6 MS JONES: [3] 78/4 85/16 189/21 MS JUNG: [9] 43/10 43/14 43/23 54/10 54/16 54/18 77/18 77/24 86/12 MS MORRIS: [4] 37/18 41/19 182/3 189/14 THE WITNESS: [7] 1/8 1/10 43/2 43/20 86/4 86/23 197/17 '21 [1] 144/20 '21 into [1] 144/20 'blanket [1] 163/2 'experienced [1] 177/24 'what [1] 164/24 - -- and [1] 19/7 -- it [1] 47/8 0 0002 [2] 103/23 162/15 0014 [1] 136/16 0023 [1] 124/19 0032 [1] 114/11 0037 [1] 145/20 0038 [1] 145/20 1 1 October 2020 [1] 168/22 1,084 daily [1] 126/13 1,300-odd [1] 132/18	1.2 million [3] 91/15 147/15 183/14 1.35 [2] 86/10 86/15 10 [1] 7/18 10 March 2020 [1] 7/9 10,000 [1] 91/15 10.00 [3] 1/2 197/19 197/22 100 [1] 69/6 109 [1] 151/9 11 [3] 99/2 162/19 185/19 11 March [5] 185/16 185/17 185/18 186/10 186/19 11 March 2020 [2] 72/12 184/19 11.18 [1] 54/13 11.35 [2] 54/12 54/15 111 [3] 72/19 73/3 74/3 112,000 [1] 91/16 12 [1] 59/9 12 February 2020 [1] 100/2 12 June 2020 [1] 40/6 12,000 [1] 46/11 12.20 [1] 86/13 120 million [3] 117/23 136/11 184/13 120,000 [1] 98/23 121 [1] 127/12 12th [1] 103/25 13 [2] 78/9 182/18 13 March [4] 65/7 125/3 185/15 186/17 13 March 2020 [2] 124/10 187/25 13 million [2] 47/5 47/23 14 August 2020 [1] 150/12 142 [3] 130/22 150/13 150/25 146 [1] 190/19 15 [2] 108/7 146/6 15 April [1] 187/17 15 minutes' [1] 86/8 15,525 [1] 91/11 150 [1] 170/12 152 [1] 170/12 153 [1] 190/15 153 local [1] 193/2 159 [3] 110/24 177/11 177/14 16 [3] 8/15 104/5 168/6 16 January [1] 136/10 16 July 2025 [1] 1/1 16 March [2] 125/17 126/4	16 October [1] 168/10 168 [1] 164/18 169 [1] 164/18 17 [1] 168/6 17 September 2020 [1] 87/14 175,000 [1] 48/25 176,000 staff [1] 99/2 18 [2] 156/8 156/18 18 local [1] 156/10 18 May 2020 [1] 176/7 18,000 [1] 104/24 18,000 providers [2] 146/22 147/16 19 [17] 9/5 22/11 38/1 40/7 40/10 42/1 103/25 104/4 121/14 141/17 152/6 154/22 157/25 162/24 185/21 186/11 196/5 19 June 2020 [1] 150/7 19 March [4] 106/20 180/1 185/2 185/20 19 May [1] 190/23 19 May 2020 [1] 190/9 19,000 [1] 40/6 2 2 December [1] 68/6 2,169 [1] 110/25 2.49 [1] 141/10 20 [4] 104/7 104/9 186/23 187/16 20 April [2] 187/8 187/22 20 July [1] 116/19 2005 [1] 91/1 2010 [2] 46/9 98/3 2015 [2] 98/3 98/5 2017 [2] 93/13 93/16 2018 [1] 95/22 2020 [61] 7/9 8/15 9/6 9/6 19/12 30/11 33/11 40/4 40/6 40/23 46/10 55/3 72/12 74/9 87/14 87/19 88/14 97/25 100/2 101/19 106/9 108/7 114/13 122/6 124/5 124/10 125/2 126/15 127/25 129/7 130/20 131/24 132/7 145/10 145/24 145/25 146/13 150/7 150/12 153/22 160/7 160/21 164/11 166/14 168/22 174/22 176/7 176/13 177/16 178/7 181/10 184/15 184/19 186/23 187/4 187/11 187/25 190/9 192/12	195/25 196/12 2021 [30] 30/7 30/9 60/7 87/16 91/18 93/8 99/17 99/18 99/21 111/1 117/23 118/15 132/2 134/11 136/10 136/23 137/15 138/10 138/14 139/24 141/18 144/17 145/25 149/10 160/1 162/7 169/17 169/22 182/12 182/18 2022 [6] 46/9 108/3 138/14 144/21 161/11 164/23 2023 [1] 161/9 2024 [2] 71/22 159/13 2025 [2] 1/1 93/4 203 [1] 109/3 21 [1] 153/16 222,000 [1] 47/17 23 [1] 169/15 23 March [1] 186/14 24 hours [2] 45/19 50/14 249 [1] 110/23 25 [3] 122/11 142/17 182/17 25 February [1] 105/3 25 June 2020 [1] 192/12 256 [1] 132/16 26 June [1] 153/8 27th [1] 142/20 28 May [1] 168/8 289 [1] 157/20 29 [1] 136/22 29 January [1] 137/7 29 May [1] 116/17 2:1 [1] 54/25 3 3.05 [2] 141/9 141/12 300 [2] 91/7 125/12 300 face [1] 125/4 300 masks [1] 125/10 31 December [1] 68/8 31 July [1] 150/12 310 [1] 91/2 311,000 [1] 47/17 319-odd [1] 90/22 37 [2] 111/2 111/2 38 [1] 152/9 39,000-odd [1] 136/14 391 [1] 135/6 4 4 million [1] 46/13 4.20 [1] 197/21 4.3 million [1] 46/10	4.7 million [2] 47/14 91/19 449 [1] 149/22 450,000-odd [1] 91/13 461 [1] 114/1 477 [1] 141/16 4:1 [1] 54/25 5 5 January [1] 169/17 5 March [1] 102/5 5 million-odd [1] 132/22 5.8 million [3] 45/11 47/3 47/11 50 [3] 107/12 132/8 182/15 50 carers [2] 133/17 133/18 50 staff [1] 125/10 50,000 [1] 44/11 50,000 unpaid [1] 44/7 500 [1] 76/18 52 [2] 151/1 161/8 586 million [1] 122/17 6 6 April [1] 126/12 6 March [1] 105/9 60 [1] 153/17 600 million [2] 108/7 121/13 613 [1] 161/19 615 [1] 161/17 627,700 [1] 47/18 63 [1] 11/4 65 years [1] 4/12 66 [1] 59/10 68 [1] 117/15 7 700,000-odd [1] 132/21 73 local [1] 156/16 737 [1] 177/11 75 [4] 108/8 122/7 122/10 122/25 78 [1] 116/17 8 8 April [1] 188/12 8 September [1] 138/15 80 [3] 57/18 104/17 122/18 81 [1] 57/3 84 [1] 62/5 85 [1] 91/14 88 [1] 151/7
---	---	--	---	--

9 900,000 [1] 92/19 92 [2] 48/15 116/20 94 [4] 182/16 182/18 183/1 183/13 98 [1] 108/11 9A [1] 159/12	accepting [2] 186/9 192/18 access [25] 11/21 17/15 17/20 17/22 19/14 20/3 24/2 32/13 34/17 34/23 38/21 41/15 50/11 50/12 58/18 58/20 59/17 59/20 62/9 64/7 69/23 71/3 75/11 168/23 172/6 accessible [1] 171/10 accessing [2] 38/19 132/9 accommodation [2] 110/22 123/8 accordance [1] 178/23 according [3] 47/18 146/13 196/24 account [2] 32/11 84/25 accountable [1] 101/2 accreditation [1] 33/19 accredited [1] 34/1 achieve [5] 27/2 51/3 51/3 51/4 93/20 achieved [1] 54/2 achieving [1] 112/14 acknowledged [2] 15/23 97/23 acknowledging [1] 163/6 across [28] 12/21 22/20 23/8 24/7 26/25 41/22 44/7 44/10 46/10 57/19 58/7 64/13 66/10 78/1 93/22 97/22 102/9 113/7 152/7 166/21 169/5 169/18 178/4 189/20 192/3 192/5 193/2 194/21 across-government [1] 97/22 act [30] 15/18 96/4 110/12 161/10 175/23 176/21 176/22 176/25 177/5 177/17 178/22 179/2 180/2 180/8 180/10 180/19 184/24 190/5 190/10 191/10 191/11 191/12 191/17 192/25 195/7 195/18 195/23 196/1 196/4 196/10 action [10] 7/22 16/1 106/5 143/23 166/18 175/15 175/19 175/20 183/4 191/6 actions [5] 85/13	95/12 95/19 145/22 191/3 active [1] 58/3 actively [1] 114/20 activities [3] 3/13 58/2 58/6 activity [2] 3/16 135/20 actual [3] 124/20 169/13 183/24 actually [36] 4/24 16/7 16/11 17/3 20/9 22/21 22/25 24/9 26/9 27/13 34/6 62/25 70/16 72/4 79/6 82/14 98/4 98/10 99/12 102/16 103/16 106/17 115/19 115/23 116/9 133/25 134/9 138/9 150/25 152/8 170/22 174/6 177/4 184/10 189/10 189/21 acute [3] 138/14 141/22 184/23 acutely [1] 197/5 adapted [1] 172/3 ADASS [3] 96/8 100/25 196/12 add [3] 172/18 172/22 183/23 adding [2] 153/23 175/10 addition [1] 154/18 additional [11] 51/1 52/5 76/11 76/24 77/4 77/15 110/2 110/2 114/19 131/3 132/11 address [11] 40/15 42/11 77/7 93/11 97/22 117/21 120/16 121/5 135/8 142/25 154/21 addressed [2] 36/16 39/5 addressing [1] 37/5 adequate [4] 61/13 63/3 94/18 102/24 adequately [1] 19/2 adjourned [1] 197/22 Adjournment [1] 86/14 administration [1] 2/10 administrations [2] 2/6 44/17 administrative [1] 56/4 admissions [3] 41/5 114/12 130/6 admitted [2] 7/2 23/12 adopt [1] 80/17 adopted [3] 61/2 144/4 175/25	adult [66] 1/17 2/14 2/16 3/18 3/23 8/16 9/14 48/12 48/16 66/21 67/15 82/10 87/12 88/12 89/11 90/4 90/6 90/8 90/14 90/18 90/21 91/10 93/20 94/5 94/15 94/19 95/4 95/13 96/9 96/21 97/3 97/9 98/4 98/21 105/8 105/20 109/16 119/6 126/15 126/18 129/24 143/7 145/5 145/7 146/21 147/3 147/7 147/9 147/11 148/16 150/1 150/10 152/9 153/9 153/16 154/22 154/25 164/7 165/21 166/1 167/16 181/1 184/19 192/1 194/2 195/12 adults [3] 48/11 48/19 48/20 advance [9] 14/1 20/13 26/9 26/24 27/16 39/6 164/22 165/3 165/5 advanced [2] 27/11 164/16 advantage [2] 16/10 41/13 advent [1] 5/20 adverse [3] 6/22 150/5 178/12 advert [1] 154/2 advice [20] 2/22 3/1 8/11 13/2 14/5 29/23 30/2 31/7 51/10 83/13 85/7 100/10 107/3 112/2 130/19 130/24 131/16 131/25 142/25 188/23 advise [2] 7/11 81/12 advised [3] 64/20 130/21 188/7 advisory [3] 67/21 150/11 150/11 advocacy [1] 86/2 advocate [1] 38/21 Affairs [1] 44/4 affect [1] 76/15 affected [1] 154/3 affectionate [1] 28/17 affects [2] 46/20 46/21 affiliate [1] 44/8 affiliation [1] 139/9 afford [1] 38/20 afraid [1] 149/14 after [17] 8/15 12/17 13/3 42/5 43/18 79/13 125/18 135/12 141/2 141/20 146/25 154/5	185/1 185/18 186/20 190/6 195/25 afternoon [5] 86/16 134/23 180/24 182/4 186/22 afterthought [2] 6/14 123/15 afterwards [2] 19/19 21/21 again [30] 1/16 20/14 23/18 26/17 28/4 42/7 82/16 82/18 82/19 85/15 94/23 96/10 105/22 111/6 112/5 113/16 113/23 118/22 131/8 144/21 150/24 160/9 161/3 171/25 174/17 187/6 192/17 194/18 195/20 196/18 against [8] 26/6 31/3 71/25 115/3 117/10 145/1 149/15 160/7 age [44] 1/14 1/21 1/21 1/23 2/5 2/14 2/16 2/18 3/3 3/12 6/8 6/12 7/9 8/1 9/4 10/22 12/2 13/20 14/5 14/14 15/3 16/20 17/15 19/12 22/18 24/7 24/16 25/22 27/10 30/7 30/9 30/12 30/15 30/19 33/7 33/11 33/15 35/12 40/22 42/8 42/14 70/17 193/23 194/6 Age Cymru [3] 14/14 42/8 42/14 Age UK [28] 1/14 1/21 1/21 2/5 2/18 6/8 6/12 7/9 9/4 10/22 13/20 15/3 16/20 19/12 22/18 24/7 24/16 25/22 27/10 30/7 30/15 30/19 33/11 33/15 35/12 40/22 193/23 194/6 Age UK's [3] 8/1 14/5 17/15 Age UKs [2] 3/3 3/12 aged [1] 4/12 agencies [2] 91/15 167/1 agency [2] 114/18 139/12 agenda [1] 128/1 ages [1] 24/3 agitated [1] 57/25 ago [2] 139/1 163/18 agree [8] 23/4 33/3 40/16 55/12 55/13 78/13 120/7 183/8 agreed [1] 101/8 agreeing [1] 165/2 agreement [2]
--	--	--	--	--

A	74/23 79/20 79/24 161/7	amazing [2] 118/19 188/21	173/8 173/10 174/25 175/7 176/11 176/17 178/7 179/10 180/20 181/5 187/3 193/5 193/12 193/16 196/15	April 2017 [1] 93/13 April 2020 [4] 8/15 40/4 130/20 186/23 April 2021 [1] 182/18 aprons [1] 58/25 are [190] 1/22 4/5 4/6 4/12 4/20 9/6 10/1 17/12 20/17 20/17 20/20 22/13 26/7 26/23 27/7 27/10 28/16 28/16 33/17 33/25 34/8 35/10 37/8 37/14 37/15 38/12 39/1 39/5 40/13 40/25 41/19 42/23 43/4 44/12 45/2 45/6 45/8 45/8 45/11 45/12 45/13 45/22 46/2 46/23 47/3 47/7 47/13 47/14 48/11 48/15 48/19 48/20 48/20 49/4 49/6 49/6 49/7 49/12 49/17 49/20 49/22 50/4 50/4 50/10 50/17 52/11 52/14 52/14 54/6 62/6 62/16 63/3 63/19 64/2 69/3 69/25 71/4 75/3 75/11 75/19 75/19 77/24 78/23 78/24 79/4 79/5 79/5 79/7 79/10 84/1 84/25 85/5 85/16 85/18 86/7 87/12 87/23 88/20 88/24 90/20 91/1 92/19 93/10 94/17 98/8 98/19 99/6 100/14 100/20 100/24 101/2 101/5 101/10 102/24 104/11 108/10 109/16 110/9 112/16 113/1 114/19 114/22 116/12 118/8 119/12 121/25 128/8 128/15 129/13 129/13 131/21 132/14 132/16 132/20 133/13 137/13 138/21 138/22 139/13 139/13 140/14 140/17 140/18 144/23 145/16 146/4 146/6 147/13 147/15 147/17 148/9 148/10 148/24 149/4 149/11 151/7 151/25 154/3 154/4 154/11 154/20 157/15 158/20 161/6 161/6 162/24 163/1 163/1 163/11 165/18 165/20 166/4 170/19 170/20 172/16 173/10 180/5 180/8 180/17 180/19 181/1 181/21 181/22 181/24 183/13 188/6 189/5 191/2 191/25
agreement... [2] 118/12 137/18 agrees [1] 165/5 ahead [3] 43/4 117/14 153/11 Ahmed [1] 129/8 AI [1] 5/20 aid [1] 144/10 aim [2] 127/11 127/14 aimed [1] 94/13 aims [1] 159/13 airborne [1] 32/14 airtime [1] 152/20 alarm [1] 7/21 albeit [4] 151/12 173/16 175/12 175/21 alight [1] 147/2 alighted [1] 125/12 aligning [1] 165/24 all [116] 3/12 5/8 6/8 10/5 10/21 12/12 15/13 18/15 19/2 20/5 20/16 21/18 22/8 24/3 24/5 25/7 26/1 26/8 26/16 30/19 32/21 34/19 36/9 36/14 37/8 37/13 39/1 39/13 43/20 44/13 46/16 48/20 56/22 58/12 58/19 62/8 69/3 71/8 73/8 73/12 73/18 77/24 81/9 81/22 82/14 84/2 85/4 85/16 85/18 86/1 87/6 87/8 88/11 89/23 91/13 95/19 96/9 98/1 99/21 101/10 107/19 109/14 110/2 113/22 118/22 120/11 121/20 125/7 125/13 125/19 127/21 133/4 135/4 137/10 137/12 142/16 143/8 144/3 145/15 147/11 147/13 148/22 149/7 150/2 151/23 154/11 156/5 157/18 158/8 159/2 161/13 165/17 166/15 169/3 170/12 170/14 171/6 172/15 172/16 173/3 174/13 175/10 175/20 176/7 178/23 180/1 181/15 181/20 182/24 183/1 185/7 187/16 193/1 193/20 195/15 197/14 allocation [1] 121/21 allow [5] 32/17 40/18 117/17 119/15 119/16 Allowance [5] 69/22 71/8 77/3 92/19 92/20 allowed [5] 73/15	26/23 79/20 79/24 161/7 alluded [1] 71/20 alluding [1] 179/17 almost [7] 35/16 41/17 85/20 107/10 119/19 151/8 192/23 alone [2] 34/20 64/22 along [6] 5/9 16/1 84/9 86/21 148/18 156/2 alongside [8] 24/3 31/10 98/11 103/7 116/11 145/14 153/21 155/1 already [28] 1/13 2/23 6/20 20/20 25/18 35/11 52/4 97/6 106/5 107/12 107/13 114/3 134/24 144/12 146/3 172/2 175/12 175/14 175/15 175/17 175/21 180/23 181/10 182/8 182/11 184/10 186/21 188/23 also [70] 1/25 3/8 3/12 4/11 5/9 5/22 6/6 6/11 9/4 9/9 10/11 10/17 10/25 12/22 14/1 14/14 14/25 17/1 17/7 18/5 20/23 25/24 27/3 27/8 28/20 29/12 29/16 30/16 42/23 46/13 48/13 49/10 51/25 53/18 56/2 57/2 57/21 58/13 59/24 61/8 61/22 66/21 67/11 68/17 73/3 74/10 80/13 80/17 82/5 89/13 106/5 107/1 109/17 111/9 116/11 120/6 127/7 127/16 131/14 140/15 143/10 143/12 143/14 143/21 149/10 153/13 156/11 163/9 195/1 197/11 alternative [1] 144/15 alternatively [1] 20/7 alternatives [1] 141/23 although [11] 10/9 12/10 39/16 44/19 52/9 80/9 90/1 96/2 129/16 178/4 192/1 always [14] 4/5 10/9 30/6 36/11 41/16 46/5 67/13 74/18 95/8 111/9 123/13 147/11 154/14 180/1 am [8] 1/2 41/24 54/13 54/15 56/15 88/10 197/4 197/22	ameliorate [1] 115/6 amending [1] 159/17 amendment [1] 161/9 America [1] 6/20 amongst [6] 26/13 26/19 53/13 139/4 189/4 189/4 amount [7] 3/5 4/3 4/7 6/24 132/10 133/21 155/15 amounts [1] 63/11 analysis [1] 162/10 analysts [1] 169/4 anecdotal [4] 16/3 129/25 162/5 163/17 anecdotaly [1] 194/1 angle [2] 178/19 179/7 annex [1] 114/12 announced [6] 115/2 136/10 136/22 184/10 184/11 184/14 announcements [2] 12/18 13/4 annual [2] 167/17 167/18 another [15] 13/10 18/8 25/10 63/1 69/19 82/18 83/4 85/15 99/1 101/8 120/21 161/1 175/10 175/23 188/4 answer [14] 8/18 16/15 33/5 33/8 42/3 42/13 96/18 97/14 98/19 102/14 104/22 115/13 125/15 158/12 answered [2] 8/17 70/1 anti [1] 31/7 anticipated [1] 185/9 anxiety [2] 36/24 56/24 anxious [1] 18/10 any [70] 12/17 14/17 16/20 20/17 33/6 34/20 35/1 35/10 36/14 42/8 42/9 64/4 75/3 76/9 84/24 91/3 91/5 92/10 93/3 102/22 107/25 108/14 112/23 113/10 115/3 119/4 121/5 122/3 125/22 130/11 132/20 133/18 134/14 134/16 137/4 137/6 144/3 144/19 146/1 148/6 148/12 154/20 156/6 156/24 157/22 158/3 158/13 162/12 163/3 164/1 165/9 166/4 169/1 169/9 169/10	approach [5] 22/17 80/18 84/2 84/4 163/1 approached [1] 135/23 approaches [1] 121/24 approaching [1] 20/24 appropriate [4] 72/24 73/8 93/20 188/25 appropriated [2] 52/17 55/23 appropriately [2] 75/23 196/8 approve [1] 142/10 approved [2] 110/19 110/24 approximately [1] 91/18 April [30] 7/18 7/25 8/15 40/4 60/8 65/10 88/1 88/2 89/6 93/13 106/25 107/16 108/5 126/12 127/17 130/6 130/20 146/6 146/6 160/21 162/19 166/19 182/16 182/18 186/23 187/8 187/16 187/17 187/22 188/12	

<p>A</p> <p>are... [1] 192/7</p> <p>area [8] 27/13 28/4 38/23 133/5 133/19 143/4 152/17 163/12</p> <p>areas [11] 9/13 16/3 50/23 53/8 70/15 72/5 141/22 145/3 168/3 178/5 180/23</p> <p>aren't [3] 44/23 50/2 83/17</p> <p>arguably [3] 26/3 28/13 152/19</p> <p>argument [3] 152/11 152/23 158/17</p> <p>arguments [1] 157/14</p> <p>arising [3] 17/18 51/24 82/2</p> <p>arm's [1] 148/20</p> <p>arm's length [1] 148/20</p> <p>arose [5] 12/6 44/24 58/14 95/1 133/25</p> <p>around [29] 11/5 17/15 18/19 25/23 29/11 30/9 33/25 37/22 38/9 39/15 45/9 53/6 59/14 62/17 65/17 74/16 90/20 91/24 92/13 97/13 150/19 150/19 150/24 153/7 156/15 172/21 185/12 187/23 195/14</p> <p>arrange [2] 87/3 138/19</p> <p>arrived [2] 87/25 127/24</p> <p>as [280]</p> <p>as well [1] 53/24</p> <p>ASC [2] 90/25 186/6</p> <p>aside [6] 44/22 52/3 107/8 146/18 155/8 180/22</p> <p>ask [64] 2/1 12/5 21/23 24/14 25/21 26/23 32/24 37/19 38/2 40/16 41/25 42/7 43/23 44/1 48/9 51/18 54/21 70/2 72/20 73/3 75/18 76/4 78/6 82/2 83/7 87/18 90/3 91/22 96/17 97/14 99/23 101/5 103/20 104/10 104/19 104/20 106/16 113/24 118/25 121/13 123/12 124/2 124/18 124/25 125/7 135/4 136/9 139/23 141/15 149/20 154/18 155/18 160/16 161/15 167/23 171/16 173/20 181/20 182/4 182/20 183/8</p>	<p>184/16 189/22 190/3</p> <p>asked [13] 6/1 7/22 26/20 67/18 101/15 105/1 119/11 121/20 142/9 151/4 151/6 189/21 194/2</p> <p>asking [11] 13/3 19/17 45/6 68/25 77/21 87/8 102/13 124/16 137/16 139/18 159/7</p> <p>aspect [1] 149/17</p> <p>assemblies [1] 44/17</p> <p>assessed [1] 150/21</p> <p>assessment [7] 50/18 50/22 150/24 152/12 152/13 152/14 165/15</p> <p>assessments [10] 15/20 51/16 69/13 69/13 69/14 150/17 152/22 176/1 176/5 193/19</p> <p>asset [1] 72/15</p> <p>assist [3] 44/24 147/22 147/24</p> <p>assistance [2] 44/21 93/12</p> <p>assisted [3] 27/9 27/12 156/21</p> <p>associate [2] 46/5 52/9</p> <p>Association [6] 78/8 96/8 105/20 129/8 129/13 142/21</p> <p>assuage [1] 143/13</p> <p>assumed [1] 95/8</p> <p>assuming [1] 119/19</p> <p>assumptions [1] 11/22</p> <p>assurance [8] 101/1 101/3 101/24 104/2 109/25 117/1 141/19 171/14</p> <p>assure [2] 100/23 113/21</p> <p>assured [1] 83/15</p> <p>asymptomatic [5] 40/3 123/21 153/10 154/19 187/15</p> <p>at [262]</p> <p>at page 3 [1] 190/24</p> <p>attack [1] 56/15</p> <p>attempt [3] 136/2 161/15 164/1</p> <p>attempts [2] 101/19 136/6</p> <p>attending [2] 1/15 23/14</p> <p>attention [13] 22/6 23/21 35/12 36/6 72/7 129/18 129/23 142/12 144/18 155/9 178/13 182/17 182/25</p>	<p>attracting [1] 34/2</p> <p>attributable [1] 40/7</p> <p>attribute [2] 82/3 139/2</p> <p>audience [1] 13/15</p> <p>August [4] 114/13 116/9 150/12 154/12</p> <p>August 2020 [1] 114/13</p> <p>authorities [71] 15/19 15/25 59/20 59/22 60/5 60/25 64/18 65/1 69/12 70/14 72/25 73/2 74/15 75/16 96/18 100/4 101/2 102/9 111/6 121/23 122/9 122/12 132/10 133/3 133/17 137/23 139/13 145/23 155/24 156/9 156/10 156/16 156/22 157/3 168/23 170/13 175/25 176/7 176/9 176/12 176/15 176/24 178/9 178/11 178/14 178/21 179/1 179/4 180/7 180/9 181/17 184/21 185/8 185/23 190/13 190/16 190/19 191/2 191/5 191/19 191/24 192/5 192/19 192/23 193/2 193/6 193/13 193/24 194/24 195/22 196/15</p> <p>authorities' [1] 157/4</p> <p>authority [30] 50/19 72/1 92/20 100/15 100/21 101/16 101/22 102/12 102/23 103/11 103/15 103/17 103/21 104/1 109/15 109/24 110/10 110/12 110/21 113/19 121/20 133/18 143/19 170/4 170/15 171/15 178/5 178/7 192/15 196/5</p> <p>authors [1] 188/1</p> <p>automatically [1] 162/25</p> <p>autumn [11] 99/18 117/2 122/16 131/12 132/6 134/7 139/25 164/11 166/14 166/15 166/17</p> <p>available [15] 9/20 13/1 50/7 60/18 71/24 71/25 111/22 112/17 113/11 119/15 126/12 139/13 167/20 168/7 168/10</p> <p>averse [2] 185/5 186/9</p> <p>avoid [1] 109/5</p> <p>aware [33] 17/1</p>	<p>40/25 87/23 95/18 101/14 107/9 109/20 114/24 126/11 128/25 129/13 132/14 141/19 147/17 151/7 151/11 152/9 153/5 155/4 155/12 155/25 157/13 158/12 162/2 169/9 173/15 173/23 174/15 174/20 176/2 178/14 182/13 193/25</p> <p>awareness [2] 56/3 151/4</p> <p>away [3] 21/22 160/19 181/4</p> <p>awful [3] 3/15 21/11 115/18</p> <p>awry [1] 129/11</p> <p>B</p> <p>back [43] 1/7 11/1 20/7 31/18 47/22 56/21 60/1 65/20 67/8 67/10 77/19 79/18 84/6 89/2 99/21 102/21 103/10 109/24 111/12 112/8 117/25 118/8 118/15 119/10 119/11 119/19 127/3 133/12 134/7 137/9 143/24 155/14 160/5 160/7 160/20 171/24 176/23 179/7 182/6 183/3 196/9 196/18 197/7</p> <p>backdrop [1] 160/8</p> <p>background [1] 153/17</p> <p>backs [1] 174/24</p> <p>bad [1] 41/17</p> <p>balance [2] 159/3 159/22</p> <p>BAME [2] 150/10 150/17</p> <p>bandwagon [1] 32/19</p> <p>banging [1] 31/3</p> <p>banner [1] 147/9</p> <p>Baroness [4] 98/20 119/8 180/25 195/23</p> <p>based [4] 39/22 93/24 94/5 150/24</p> <p>basic [1] 75/17</p> <p>basically [2] 76/14 166/19</p> <p>basis [9] 87/14 108/9 108/20 122/11 122/20 123/1 158/20 165/18 196/2</p> <p>battering [1] 4/18</p> <p>battle [1] 56/17</p> <p>be [276]</p> <p>be worn [1] 124/17</p> <p>bearing [2] 136/6</p>	<p>152/6</p> <p>Beattie [4] 189/25 190/1 197/2 198/16</p> <p>became [19] 6/17 11/13 17/23 18/9 19/7 19/7 23/6 24/21 46/10 90/16 96/3 99/16 105/16 117/21 127/22 141/19 165/15 168/12 183/23</p> <p>because [115] 2/17 2/23 4/3 5/3 6/15 6/17 7/20 8/7 9/12 11/15 13/6 14/6 26/6 30/18 31/6 35/23 37/1 45/18 46/20 48/5 51/24 55/14 56/19 57/4 57/5 58/1 59/4 61/5 61/10 61/13 61/20 63/8 68/10 68/11 76/12 76/18 77/6 77/15 78/22 79/19 79/22 81/12 83/24 84/20 85/21 86/8 88/22 89/8 90/3 91/22 91/25 92/7 92/14 92/17 94/4 94/16 96/4 96/5 99/23 102/16 106/6 106/21 112/11 112/24 113/5 113/12 117/18 118/6 118/17 118/20 118/25 120/22 120/24 120/24 127/19 128/12 128/15 130/9 132/24 134/6 135/7 135/20 137/25 138/13 140/5 140/18 140/24 146/9 147/25 149/21 151/20 151/22 153/12 153/13 154/10 155/2 160/2 160/16 162/1 165/21 166/4 168/8 172/11 172/19 176/20 176/25 177/8 177/12 179/20 179/21 180/25 194/3 194/13 195/3 195/11</p> <p>become [9] 27/14 46/18 49/21 56/16 78/12 111/21 126/7 168/7 168/14</p> <p>becomes [1] 115/16</p> <p>becoming [4] 26/14 46/12 57/10 142/4</p> <p>bed [7] 3/7 3/9 41/8 122/19 123/1 172/11 172/15</p> <p>beds [6] 91/13 95/15 108/9 110/25 111/20 122/11</p> <p>been [120] 3/21 7/17 8/18 9/14 9/19 9/20 10/5 10/8 12/19 16/21 18/8 18/25 21/18 23/14 25/14 25/18</p>
---	---	---	---	--

<p>B</p> <p>been... [104] 26/5 28/25 31/13 33/1 33/2 33/3 34/24 34/24 37/10 38/16 41/5 41/14 47/20 52/8 55/7 55/23 56/20 60/20 60/22 61/1 61/15 63/8 63/9 69/6 69/14 70/5 70/20 70/21 71/21 73/12 73/12 73/22 74/23 75/25 76/2 78/13 78/14 80/20 80/25 81/10 81/11 81/22 81/24 90/5 90/8 90/12 92/4 94/2 94/3 98/3 101/11 102/13 102/17 102/22 106/5 106/20 106/25 109/6 109/20 110/19 115/18 122/16 123/14 128/2 130/3 130/8 130/16 132/8 136/24 137/4 141/7 146/3 150/21 152/12 152/22 154/15 156/14 156/21 156/21 156/25 157/6 157/10 162/4 166/2 166/13 166/13 173/24 173/25 176/13 176/18 178/8 183/5 183/12 184/10 184/11 184/13 185/1 189/15 190/14 190/14 191/13 191/16 194/4 196/1</p> <p>before [35] 1/20 2/13 3/19 8/19 10/4 12/1 17/14 33/10 39/2 40/22 43/3 43/13 54/19 61/18 64/24 87/10 88/5 105/15 115/17 119/11 123/4 128/22 134/23 138/7 145/2 154/9 160/3 160/11 168/11 173/4 183/12 183/21 187/4 187/11 192/7</p> <p>beforehand [1] 27/20 beginning [11] 19/11 24/19 51/22 56/11 70/10 83/21 90/24 107/16 108/4 159/25 168/18</p> <p>behalf [12] 1/13 35/12 37/20 41/25 42/13 78/6 86/2 87/4 120/15 148/12 182/4 190/3</p> <p>behaviour [2] 35/18 58/1</p> <p>behind [8] 78/2 84/19 85/13 85/20 102/4 127/10 159/17 189/25</p>	<p>behind it [1] 127/10 being [93] 6/21 8/6 23/2 24/1 24/6 28/1 28/25 29/12 30/21 31/12 31/25 32/14 35/7 35/8 35/15 38/20 42/2 51/25 52/17 53/12 55/3 58/6 58/19 58/22 62/2 62/3 65/11 65/21 70/15 73/2 74/21 77/4 80/15 82/5 82/8 88/1 88/18 92/10 96/17 97/4 100/4 107/11 108/15 111/21 112/12 112/19 113/10 114/25 118/6 119/5 128/5 128/16 128/24 132/20 134/17 136/19 136/21 136/23 137/5 139/14 151/14 153/19 154/4 154/5 158/3 159/12 161/6 163/20 165/9 165/12 165/12 165/22 166/24 173/10 175/1 175/4 176/4 176/4 176/14 176/16 179/8 180/3 180/5 180/17 180/19 185/5 185/6 185/13 193/18 194/10 195/2 196/8 196/23</p> <p>believe [9] 37/13 38/3 41/3 92/15 94/3 108/10 136/24 142/17 156/15</p> <p>below [1] 163/8 beneficial [1] 157/1 benefit [7] 10/11 20/18 30/3 69/22 87/7 141/8 172/13</p> <p>benefits [9] 27/16 50/3 50/4 59/8 71/9 76/16 76/19 77/2 77/10</p> <p>bereaved [6] 37/20 42/1 158/14 166/10 182/5 189/3</p> <p>bespoke [1] 35/4 best [10] 32/8 71/11 72/16 85/20 101/12 115/15 119/13 142/25 154/2 165/17</p> <p>better [27] 9/15 13/16 13/17 19/8 19/21 20/8 30/5 32/15 38/14 41/11 65/4 72/5 76/17 78/11 78/14 81/1 84/8 92/3 92/4 111/11 111/13 112/7 137/22 139/5 152/23 174/24 181/9</p> <p>between [26] 12/11 26/21 35/22 40/5 47/5 56/3 57/14 60/24</p>	<p>70/14 71/15 72/4 98/3 101/18 113/25 114/19 118/4 139/24 143/25 144/1 147/2 150/12 177/12 185/19 186/10 189/6 196/4</p> <p>beyond [2] 178/7 194/14</p> <p>big [17] 2/19 10/9 11/17 16/25 31/13 31/18 96/11 97/12 99/16 102/17 105/12 115/13 115/20 118/18 128/2 144/12 181/1</p> <p>bigger [2] 90/17 119/22</p> <p>biggest [1] 126/17</p> <p>Birmingham [1] 132/17</p> <p>bit [10] 44/2 48/2 52/20 57/16 87/10 137/10 149/20 178/25 182/9 184/16</p> <p>black [3] 149/19 155/5 155/10</p> <p>blanket [3] 161/23 163/23 165/11</p> <p>blocking [1] 75/10</p> <p>blocks [1] 185/6</p> <p>blown [1] 102/4</p> <p>blue [1] 26/4</p> <p>body [4] 25/20 35/7 35/8 138/18</p> <p>bond [1] 28/17</p> <p>book [1] 42/20</p> <p>booklet [1] 88/18</p> <p>both [10] 9/5 122/19 122/21 123/10 147/18 155/2 169/19 182/21 182/22 192/24</p> <p>bottom [8] 63/16 85/3 100/12 133/11 139/20 151/2 166/2 173/24</p> <p>box [3] 93/18 100/3 100/16</p> <p>branches [1] 1/22</p> <p>breached [1] 40/9</p> <p>break [12] 3/15 43/3 43/13 43/18 54/9 54/14 54/19 134/23 138/7 141/2 141/11 183/21</p> <p>breaking [1] 25/10</p> <p>breaks [5] 50/15 50/25 61/25 68/20 141/8</p> <p>breathing [1] 22/14</p> <p>Brexit [1] 105/13</p> <p>brick [1] 31/4</p> <p>brief [2] 2/13 46/22</p> <p>briefed [1] 174/18</p> <p>briefly [5] 1/20 4/1 24/14 54/21 78/17</p>	<p>brilliant [3] 70/12 140/17 171/8</p> <p>bring [12] 11/1 23/21 33/11 94/14 135/19 158/5 158/22 159/8 159/17 171/6 177/12 195/1</p> <p>bringing [5] 43/12 106/2 113/3 115/3 129/18</p> <p>brings [6] 68/23 90/2 157/17 168/21 195/6 195/17</p> <p>broad [2] 45/22 114/8</p> <p>broader [2] 26/2 180/5</p> <p>broadly [1] 57/18</p> <p>broke [1] 145/2</p> <p>broken [1] 135/21</p> <p>brothers [1] 46/3</p> <p>brought [11] 4/19 129/22 142/11 144/17 146/11 158/9 159/11 160/9 160/12 182/25 194/19</p> <p>bubbles [2] 68/17 81/23</p> <p>budget [3] 173/22 174/3 174/8</p> <p>building [3] 72/6 156/17 171/13</p> <p>buildings [1] 41/12</p> <p>builds [1] 74/5</p> <p>built [3] 75/13 117/2 168/16</p> <p>bulk [1] 128/13</p> <p>bullet [3] 72/13 114/13 146/10</p> <p>Bullion [1] 105/19</p> <p>bundle [1] 72/9</p> <p>burden [6] 55/10 61/24 197/4 197/5 197/8 197/12</p> <p>burdens [1] 172/20</p> <p>burn [1] 139/3</p> <p>burn out [1] 139/3</p> <p>burnout [1] 141/3</p> <p>burnt [1] 62/3</p> <p>business [2] 33/16 82/22</p> <p>but [341]</p> <p>buy [4] 51/6 59/7 59/11 126/19</p> <p>buying [1] 38/19</p>	<p>calls [3] 26/4 60/10 117/2</p> <p>calmer [1] 90/1</p> <p>came [27] 5/9 12/20 18/23 53/15 65/10 66/4 68/16 68/18 107/10 111/2 113/18 120/4 126/14 131/19 131/19 134/7 136/21 145/24 150/6 159/12 159/23 168/17 176/22 186/8 187/10 190/7 195/25</p> <p>Campaign [1] 78/7</p> <p>can [162] 1/18 2/13 5/14 7/11 15/14 21/7 25/15 26/21 27/2 27/3 27/3 28/7 30/3 31/19 34/6 34/7 35/7 38/13 42/6 42/21 43/7 44/20 44/21 45/6 45/14 45/18 45/19 46/17 46/22 46/24 48/9 48/17 49/2 49/5 51/1 53/20 54/6 54/20 57/15 62/9 65/5 69/18 72/13 73/8 73/9 73/19 75/18 76/4 79/6 82/2 83/7 83/9 84/22 86/16 86/17 87/2 87/18 89/2 90/25 91/22 93/11 93/18 94/1 94/7 94/16 95/1 96/17 97/14 98/8 99/22 100/2 100/10 100/14 100/23 101/4 101/6 101/18 103/20 103/23 104/3 104/10 104/14 106/8 106/16 107/6 112/3 114/10 114/13 116/8 117/4 117/21 118/10 118/25 119/4 119/10 121/13 122/3 124/2 124/18 124/25 125/7 127/4 129/5 129/9 129/21 132/4 132/12 134/12 136/16 137/8 137/12 141/15 142/15 143/3 143/24 145/21 146/9 147/13 148/1 149/2 149/20 150/8 150/15 150/23 152/2 155/14 155/18 155/22 156/6 156/20 156/25 158/19 159/9 159/16 161/15 162/20 164/6 164/17 164/25 165/14 165/20 166/8 166/14 167/11 168/5 168/11 168/25 169/3 169/13 169/15 169/22 173/20 177/6 177/10 179/10 180/16 184/24 189/2 189/5 191/10 191/11 191/15</p>
--	--	---	--	---

C	44/13 44/19 45/7 45/8 45/11 45/23 46/1 46/2 46/10 46/12 46/18 46/21 47/3 47/7 48/12 48/20 48/24 49/4 50/17 51/12 51/17 51/20 51/21 51/23 52/1 52/2 52/7 52/10 52/14 52/16 52/18 52/23 52/23 53/3 53/4 53/19 53/23 54/20 54/23 54/24 55/3 55/6 55/18 55/22 56/5 56/9 56/20 57/3 57/14 57/14 58/19 59/6 59/7 59/16 59/23 60/12 60/24 61/19 61/22 61/24 62/20 63/7 63/9 63/23 63/25 63/25 64/6 64/13 64/13 64/20 65/9 65/12 66/4 66/7 66/11 67/2 67/17 67/19 67/21 68/4 68/21 69/2 69/4 69/10 69/13 69/22 70/19 71/1 71/8 71/16 72/12 73/18 74/2 74/14 74/18 74/22 75/1 75/8 75/11 75/14 76/7 76/17 76/18 76/24 77/1 77/15 78/10 79/9 79/14 79/23 80/1 80/12 80/15 80/17 82/11 83/24 84/20 86/3 88/14 91/19 91/22 91/24 92/2 92/11 92/14 92/18 92/21 92/21 93/1 93/2 93/5 119/2 119/2 119/6 130/18 130/19 130/24 131/1 131/5 132/1 132/8 132/15 132/18 132/22 132/25 133/4 133/17 133/18 133/22 134/15 134/20 177/18 177/23 179/8 187/24 188/12 188/21 188/24 189/5 189/7 189/12 189/12	81/21 82/19 84/19 85/8 85/13 85/19 132/16 188/10 Caroline [3] 1/5 1/6 198/3 carried [2] 46/8 176/1 case [19] 18/25 26/16 28/25 42/15 57/21 65/3 89/9 89/13 95/25 130/9 142/6 153/1 162/7 174/14 176/19 187/20 193/17 195/8 195/16 cases [15] 18/3 28/23 88/22 137/1 142/2 142/11 142/15 142/17 169/19 177/25 182/13 182/21 182/24 183/4 187/1 Casey [5] 98/21 118/23 119/8 180/25 195/23 cast [1] 142/10 catch [1] 197/12 catching [1] 7/3 categories [2] 135/17 135/23 categorised [1] 145/3 caught [1] 83/17 cause [1] 31/13 caused [6] 18/3 21/20 26/18 30/21 80/17 179/18 causing [1] 8/4 caveat [1] 160/17 ceasing [1] 22/1 census [4] 47/9 47/12 47/20 91/18 censuses [1] 47/19 central [8] 60/10 110/14 156/15 165/2 165/25 166/7 193/4 193/11 centre [1] 100/11 centred [1] 78/16 centres [2] 3/13 179/18 certain [1] 49/16 certainly [21] 8/25 19/9 19/10 19/22 23/5 34/10 49/21 53/17 87/23 91/18 111/21 120/3 129/20 135/15 141/6 142/3 146/9 146/14 152/19 155/4 176/12 cetera [6] 89/17 89/20 118/22 133/10 153/20 157/5 chair [1] 164/14 chaired [3] 67/16 67/22 105/18	challenge [2] 62/18 63/13 challenges [7] 67/1 73/22 96/23 96/24 109/1 135/9 145/5 challenging [3] 58/1 62/22 109/5 change [6] 4/22 25/2 52/1 89/14 105/23 196/15 changed [6] 25/12 25/16 185/19 186/14 187/17 189/1 changes [13] 15/18 16/24 24/16 27/9 158/25 159/11 167/22 167/24 176/4 177/24 179/8 179/12 180/18 changing [2] 10/25 13/12 channel [2] 127/6 166/21 chaos [2] 88/1 88/3 chaotic [2] 89/4 89/24 characteristic [1] 19/20 characteristics [1] 78/18 charitable [1] 44/6 charities [1] 30/20 charity [2] 1/14 148/21 Chatham [1] 139/18 check [3] 18/2 43/6 86/9 check-ups [1] 18/2 Checker [1] 108/10 checking [2] 101/5 102/11 checklist [1] 101/4 chief [12] 121/20 130/23 143/7 164/8 164/9 173/6 178/20 190/11 190/18 192/1 192/2 192/14 childcare [1] 138/2 children [6] 31/15 46/24 46/25 48/10 48/14 48/14 choice [1] 49/11 choose [1] 102/25 chose [1] 123/8 chosen [3] 16/13 147/6 147/10 Chris [1] 142/10 Chris Wormald [1] 142/10 churn [1] 38/25 circle [2] 36/22 159/22 circled [1] 8/8 circumstance [1] 160/20	circumstances [7] 39/13 92/9 160/14 160/18 188/22 195/11 195/15 Civil [1] 13/13 claimants [1] 69/21 Clap [1] 52/18 clarification [1] 12/23 clarify [1] 53/10 clarity [5] 42/24 54/2 55/22 80/24 85/7 cleaning [1] 3/9 clear [20] 12/19 52/6 52/12 52/18 52/24 52/24 53/4 53/8 53/22 81/4 81/17 82/20 90/17 105/16 130/5 142/6 144/5 144/23 158/8 160/23 clearer [4] 10/22 59/14 81/25 82/17 clearly [30] 80/6 81/2 84/14 94/19 99/4 100/21 101/19 113/12 118/14 120/12 121/15 124/1 124/10 125/8 128/2 129/16 136/6 137/8 143/9 146/21 147/4 151/3 154/24 160/17 162/2 172/5 172/11 175/24 185/12 186/13 click [2] 170/11 170/13 clinical [2] 26/14 112/2 clinically [1] 100/7 clinician [1] 23/9 Clipper [1] 127/8 close [8] 28/1 29/4 99/6 120/4 160/8 160/25 161/3 188/9 closed [5] 57/8 84/19 85/13 85/20 160/15 closely [1] 82/22 closer [2] 186/13 186/13 closest [1] 28/18 closing [2] 179/18 194/15 closure [1] 61/22 clubs [2] 3/13 58/2 co [3] 67/22 107/5 107/5 co-chaired [1] 67/22 co-produced [1] 107/5 co-published [1] 107/5 codes [3] 69/5 69/6 69/8 codify [2] 159/18 160/13
----------	--	---	--	---

C			
coffers [1] 76/15	commented [1] 125/9	115/6 117/14	confidence [7] 26/22
cognisant [1] 180/3	commenting [2] 62/18 162/20	competing [1] 157/14	34/12 48/17 63/18
cognition [1] 17/10	comments [8] 8/9	complaining [1] 137/13	81/13 150/15 150/18
cognitive [1] 58/5	42/2 67/6 89/1 100/25	complete [3] 85/21	confident [2] 85/8
cohesive [1] 94/14	174/23 175/1 175/4	88/1 121/15	101/7
cohort [2] 70/21	commercial [1] 174/4	completed [1] 47/12	confidentiality [1] 36/25
186/25	commission [2] 165/16 166/16	completely [4] 26/5	confines [1] 81/2
cohorting [2] 114/18	commissioned [6] 96/8 131/11 164/12	31/9 62/25 164/10	confirm [1] 43/23
123/6	166/11 166/12 179/25	completes [2] 42/19	confirmation [1] 40/19
coin [1] 31/23	commissioner [1] 37/6	197/3	confirmed [1] 104/4
Cold [1] 33/12	commissioners [1] 24/8	complex [2] 45/20	conflate [1] 100/17
collaboratively [1] 106/13	commissioning [2] 109/1 158/1	49/23	confusing [2] 52/13
collating [1] 110/14	committed [1] 33/18	compliance [1] 108/11	53/18
colleagues [2] 42/14	committee [1] 101/9	complicated [3] 2/24	confusion [7] 43/8
82/21	committees [1] 7/5	13/18 27/14	43/17 51/24 53/6
collect [1] 69/2	common [3] 12/6	complied [1] 195/3	53/10 53/13 65/14
collected [2] 73/2	28/6 55/17	comply [1] 192/25	connected [1] 75/15
157/1	commonsense [2] 84/2 84/4	complying [1] 156/23	conscious [5] 42/2
collecting [4] 35/2	communicate [5] 5/18 14/2 14/7 22/22	comprehensive [5] 47/18 72/2 72/3 75/20	77/19 93/15 172/20
72/20 73/4 75/17	166/20	162/9	197/5
collection [2] 75/5	communicated [1] 81/5	concentrating [1] 45/1	consensus [2] 123/25 157/21
75/7	communicating [4] 34/21 63/3 106/21	concern [12] 16/24	consequence [1] 178/8
collections [2] 167/16 172/23	186/15	23/25 23/25 28/6 97/8	consequences [2] 19/6 35/18
collectively [1] 1/23	communication [7] 8/25 13/23 25/23 26/1	99/4 99/9 176/2	consider [7] 20/10
collects [1] 155/23	73/19 73/20 186/20	176/14 177/4 190/4	30/15 40/2 46/1 63/2
column [2] 93/23	communications [10] 13/17 14/10 52/12	194/18	66/7 143/1
94/16	53/17 53/22 80/25	concerned [12] 59/1	considerable [1] 178/11
combination [4] 5/3	81/6 82/25 96/14	61/14 116/25 121/25	considerably [1] 18/24
18/15 18/22 82/15	154/6	124/12 129/21 130/25	consideration [5] 19/8 67/20 74/21
combined [1] 171/9	communicators [1] 13/13	131/16 152/18 166/1	186/24 187/3
come [38] 9/10 11/25	communities [9] 37/25 38/10 38/17	179/22 188/16	considerations [1] 71/14
15/2 21/3 32/7 44/3	71/2 116/2 150/10	concerning [1] 191/2	considered [10] 6/15
46/7 47/22 55/15 59/5	155/6 155/16 156/2	concerns [21] 8/1	19/2 20/13 111/25
60/1 64/17 65/20	community [13] 17/16 24/18 72/24	16/20 17/4 17/15	112/1 112/5 114/25
75/22 79/18 80/5	74/11 81/9 93/24 94/5	17/18 19/9 23/15 24/7	120/10 176/22 187/11
81/20 84/6 99/14	94/25 115/20 116/5	24/16 58/14 102/6	consistently [2] 30/24
99/21 103/10 115/10	119/23 119/23 182/22	112/15 129/22 155/10	73/11
116/5 117/25 130/12	community-based [2] 93/24 94/5	157/7 162/2 166/10	construct [1] 47/8
133/12 137/17 143/24	companies [2] 5/17	166/13 184/20 185/3	consultant [1] 18/1
144/14 144/24 155/14	5/21	191/13	consultation [4] 19/12 20/21 115/2
155/21 167/11 171/22	compare [1] 170/10	concluded [2] 134/6	117/16
174/23 179/5 187/19	compared [2] 17/13	178/24	consultations [1] 19/25
193/21	169/24	conclusion [2] 131/20 176/23	consulted [5] 8/18
comes [7] 3/5 55/21	compassion [1] 12/12	concrete [1] 83/2	40/22 79/5 149/10
65/4 74/14 118/8	compensation [2]	condensed [1] 69/7	196/17
142/18 196/9		condition [3] 45/17	contact [8] 22/8
coming [28] 4/22		78/12 139/9	28/14 30/23 32/17
11/10 11/11 18/15		conditions [15] 4/21	78/23 84/11 157/17
19/23 28/20 33/10		17/25 18/3 18/10	188/9
58/24 63/19 67/8		20/25 21/7 33/22	
67/10 85/9 85/10		48/14 49/21 49/24	
86/21 89/12 119/23		55/9 58/8 74/17	
137/9 138/16 144/6		136/21 175/24	
150/19 150/19 158/10		conduct [1] 173/11	
178/15 179/2 179/21		conducted [4] 17/11	
184/7 197/9 197/11		71/21 145/11 178/21	
commencing [1] 126/12		conference [2] 12/18	
comment [4] 14/19		13/7	
89/6 156/6 175/6			

<p>C</p> <p>correct... [10] 46/17 61/8 107/22 126/8 129/1 129/4 129/16 130/3 141/20 190/21</p> <p>correction [1] 161/7</p> <p>correctly [1] 81/12</p> <p>corresponded [1] 190/11</p> <p>cost [2] 55/16 59/9</p> <p>costs [3] 77/5 77/6 77/16</p> <p>cottage [1] 5/22</p> <p>could [112] 3/14 6/18 8/12 9/12 13/9 13/16 13/25 15/20 17/13 20/6 23/13 25/13 29/18 32/2 32/20 35/4 35/16 37/9 42/5 43/23 44/1 51/18 56/6 58/17 60/20 60/22 61/1 63/14 64/10 65/1 68/25 69/9 70/22 70/23 71/5 71/12 72/8 72/15 73/20 74/1 75/14 78/16 80/25 81/13 81/22 81/24 88/5 92/4 92/22 93/14 94/12 96/23 97/12 101/12 102/8 104/6 104/25 105/9 107/25 110/22 111/11 111/12 111/17 112/7 112/10 113/4 113/6 113/16 113/22 115/8 115/25 116/24 117/1 119/18 126/6 126/11 131/2 133/16 135/6 135/14 138/3 138/4 138/12 140/25 143/8 143/12 144/7 147/6 147/10 148/15 148/22 152/21 153/5 162/14 164/9 166/19 170/9 170/11 170/12 170/13 170/15 170/16 170/19 170/22 171/12 171/14 172/1 181/6 182/20 192/3 192/6 192/9</p> <p>couldn't [5] 58/1 58/2 58/20 133/4 146/5</p> <p>council [2] 69/17 69/18</p> <p>councils [2] 4/4 16/7</p> <p>counsel [9] 1/11 43/22 86/6 86/9 86/20 182/7 198/4 198/9 198/13</p> <p>count [1] 48/24</p> <p>countries [4] 2/21 6/19 6/21 47/19</p> <p>country [8] 4/2 6/23 27/8 45/11 191/23</p>	<p>192/4 192/6 194/21</p> <p>couple [7] 5/14 12/5 105/7 134/22 169/16 173/3 184/11</p> <p>course [38] 1/12 5/19 14/10 16/25 17/21 18/16 19/20 20/3 20/6 21/6 24/24 26/12 26/19 28/19 28/25 31/9 38/15 42/11 45/5 51/23 69/12 69/20 77/10 80/17 83/24 85/22 88/7 90/15 101/15 105/21 111/19 115/10 117/10 121/9 126/22 142/8 143/21 164/14</p> <p>cover [9] 50/7 50/13 80/8 104/8 120/18 149/5 170/24 174/24 175/4</p> <p>covered [5] 50/2 104/6 167/12 189/15 190/5</p> <p>covers [1] 44/9</p> <p>Covid [42] 9/5 22/11 37/20 38/1 40/7 40/10 42/1 61/14 67/10 105/8 105/10 105/15 105/21 121/2 121/14 131/9 131/21 137/2 141/17 142/12 144/2 144/5 144/15 144/19 144/24 144/25 149/19 154/22 157/25 162/24 173/16 179/22 181/16 182/5 182/6 183/7 183/9 184/7 187/1 187/14 189/9 196/5</p> <p>Covid-19 [12] 9/5 22/11 38/1 40/7 40/10 42/1 121/14 141/17 154/22 157/25 162/24 196/5</p> <p>Covid-19-positive [1] 187/1</p> <p>Covid-positive [9] 137/2 144/5 144/15 144/24 182/6 183/7 183/9 184/7 187/14</p> <p>CQC [36] 103/19 104/14 104/16 104/18 104/19 105/1 109/12 109/21 109/22 109/23 110/11 110/19 111/6 113/21 124/23 125/4 142/17 142/21 143/5 143/8 143/16 160/22 161/5 162/6 164/12 166/11 166/16 166/23 167/9 167/17 180/9 180/18 181/11 192/8 192/10 195/21</p> <p>CQC-registered [2]</p>	<p>124/23 125/4</p> <p>create [3] 89/16 106/14 131/2</p> <p>creating [2] 118/13 135/17</p> <p>credit [2] 23/1 76/25</p> <p>crisis [5] 7/6 8/8 36/21 138/21 139/25</p> <p>critical [6] 63/17 64/3 65/17 73/7 83/12 128/15</p> <p>critically [4] 53/21 64/10 75/11 85/2</p> <p>criticism [2] 10/5 178/15</p> <p>cross [2] 37/7 93/13</p> <p>Cross-government [1] 93/13</p> <p>current [1] 35/5</p> <p>currently [2] 172/17 197/9</p> <p>cut [1] 163/13</p> <p>cutting [3] 37/7 192/23 193/14</p> <p>CV [1] 100/6</p> <p>Cymru [5] 14/14 14/15 42/1 42/8 42/14</p> <p>D</p> <p>Dad [1] 81/22</p> <p>daily [5] 59/8 126/13 126/13 168/20 194/9</p> <p>damage [2] 25/18 31/11</p> <p>dare [1] 97/16</p> <p>dark [1] 186/7</p> <p>dashboard [15] 111/19 168/16 168/17 168/21 168/24 169/1 169/8 169/10 169/11 170/3 170/7 171/6 171/9 171/18 171/24</p> <p>data [83] 35/2 60/18 60/18 64/12 64/16 64/24 68/24 69/2 69/3 69/23 69/24 70/4 70/8 70/13 71/5 71/7 71/14 71/19 71/24 71/25 72/15 72/20 73/2 73/4 73/7 73/9 73/12 74/5 74/16 75/4 75/4 75/7 76/2 93/7 93/8 108/1 108/19 110/14 111/19 111/21 112/21 112/24 113/5 126/12 139/20 139/21 139/24 140/2 140/6 140/6 140/6 140/7 140/8 140/15 148/17 155/24 156/11 156/24 157/2 158/21 167/11 167/16 167/18 167/20 167/25 168/1 168/4 168/7 168/9 168/10 168/12 168/19</p>	<p>169/11 169/13 170/9 170/17 171/8 171/9 172/6 172/23 174/16 180/16 181/11</p> <p>dataset [2] 71/11 171/4</p> <p>datasets [3] 70/20 71/11 171/7</p> <p>date [5] 104/5 108/16 162/17 174/2 187/6</p> <p>daughters [1] 81/20</p> <p>David [6] 9/10 10/8 67/16 92/25 106/2 151/16</p> <p>day [22] 3/13 3/15 6/9 6/9 45/19 46/12 50/14 57/9 61/23 68/19 110/18 120/14 170/8 170/9 179/18 188/4 194/10 194/11 194/15 195/9 195/10 197/22</p> <p>days [7] 8/15 45/19 50/14 57/8 105/16 169/24 185/10</p> <p>days' [2] 126/3 127/4</p> <p>DCLG [1] 94/8</p> <p>DCMO [1] 131/13</p> <p>deal [13] 39/16 41/4 45/4 64/24 102/17 105/12 134/22 141/3 145/4 157/22 161/13 167/1 167/11</p> <p>dealing [3] 1/20 15/7 100/20</p> <p>deals [1] 93/18</p> <p>dealt [3] 65/25 119/11 129/19</p> <p>deaths [3] 8/2 40/6 167/25</p> <p>December [3] 30/11 68/6 68/8</p> <p>December 2020 [1] 30/11</p> <p>decent [1] 91/6</p> <p>decided [4] 52/1 122/25 160/8 179/19</p> <p>decision [15] 23/22 32/8 53/13 56/4 56/7 66/8 66/25 82/9 89/20 128/18 130/14 141/24 153/8 159/3 166/15</p> <p>decision-making [1] 89/20</p> <p>decisions [10] 7/7 16/4 25/23 26/7 26/7 26/9 74/20 79/5 153/15 180/2</p> <p>declared [1] 191/6</p> <p>decline [2] 58/5 58/5</p> <p>declined [1] 58/7</p> <p>declines [1] 17/20</p> <p>declining [1] 194/16</p> <p>deconditioning [2]</p>	<p>17/9 18/20</p> <p>decrease [2] 3/23 170/1</p> <p>dedicated [1] 147/5</p> <p>deep [1] 29/8</p> <p>deeply [1] 79/7</p> <p>deferred [1] 188/3</p> <p>define [2] 53/3 92/11</p> <p>defined [5] 52/15 53/1 79/22 80/7 83/24</p> <p>defining [1] 133/13</p> <p>definitely [10] 10/14 18/8 18/10 29/4 33/4 36/15 73/17 83/2 147/24 174/6</p> <p>definition [12] 3/6 51/20 54/20 65/19 65/24 79/19 81/25 82/20 82/21 82/23 83/15 91/17</p> <p>definitional [1] 91/25</p> <p>definitions [3] 81/4 81/10 83/11</p> <p>degree [5] 2/8 3/3 24/20 48/17 196/10</p> <p>delay [3] 43/12 65/11 137/8</p> <p>delaying [1] 193/19</p> <p>delays [1] 66/13</p> <p>deliberate [1] 128/18</p> <p>deliberately [3] 122/25 128/9 186/7</p> <p>deliver [1] 186/6</p> <p>deliverables [1] 94/17</p> <p>delivered [1] 184/3</p> <p>deliverers [1] 79/3</p> <p>delivery [2] 64/1 139/12</p> <p>demand [11] 12/14 12/16 28/2 124/10 126/7 132/8 132/23 133/2 133/6 133/7 134/9</p> <p>demanding [1] 33/18</p> <p>dementia [5] 3/14 28/11 28/15 58/8 177/18</p> <p>demographic [1] 75/18</p> <p>demonstration [1] 63/7</p> <p>denial [1] 26/17</p> <p>denotes [1] 76/14</p> <p>denying [1] 80/18</p> <p>department [138] 10/2 11/2 19/15 55/2 66/11 66/12 69/21 82/22 87/4 87/18 87/22 87/25 89/3 89/5 89/10 89/15 91/6 92/1 93/5 93/16 94/8 94/21 95/6 95/9 95/21 96/1 96/7 96/7 96/24 97/10</p>
--	--	---	--	---

D	Deputy [1] 130/23	65/11 67/16 67/17	differentially [1] 178/6	39/15 39/17
department... [108]	describe [4] 28/5	68/20 72/5 76/18 77/7	differently [2] 50/1	disconnect [2]
97/21 101/24 103/2	37/24 89/24 103/14	80/9 80/11 83/9 84/8	73/21	139/23 140/3
104/12 106/13 106/17	described [9] 14/14	87/21 92/13 92/17	difficult [21] 8/10	discount [1] 69/18
106/20 106/24 107/5	17/7 23/15 30/12 55/3	96/10 96/10 96/22	14/2 17/23 24/22 27/6	discovered [1]
107/7 107/25 109/7	87/24 121/17 185/6	104/8 105/2 106/17	31/6 32/6 33/18 39/13	183/16
110/3 110/7 111/4	196/3	107/7 108/21 111/21	41/14 73/24 92/7	discrete [1] 180/23
111/24 112/3 112/16	describing [1] 185/5	116/8 120/18 120/22	106/7 128/12 137/25	discretion [1] 195/19
112/21 112/24 115/1	description [3] 55/12	121/5 124/7 124/16	138/5 152/7 179/15	discuss [2] 49/3
120/15 121/5 121/20	55/13 85/14	130/2 130/11 132/17	179/16 188/22 191/22	62/10
123/17 124/21 126/10	deserve [1] 33/21	133/3 133/23 133/25	difficulties [1] 115/7	discussed [8] 35/11
127/24 128/18 128/23	deserves [2] 23/1	134/4 134/7 135/3	difficulty [2] 87/3	53/12 54/19 62/9 66/3
128/24 129/9 129/12	33/20	137/19 143/18 144/3	132/24	102/1 144/12 154/9
129/18 129/20 130/2	designated [17]	144/12 146/17 153/1	digest [1] 13/8	discussing [1] 47/14
130/11 130/11 135/3	110/17 110/22 110/24	155/12 155/15 161/20	digging [1] 173/25	discussion [3] 17/5
135/4 135/8 139/17	111/5 111/8 111/14	167/4 167/16 168/6	digital [2] 166/3	32/20 139/18
140/18 142/24 144/3	111/15 111/20 111/23	170/3 170/24 171/6	167/17	disorganisation [1]
145/4 146/17 147/6	112/15 112/22 112/25	175/8 176/16 178/10	digitally [1] 75/15	24/20
148/12 148/21 148/22	113/9 113/11 113/13	178/11 178/15 179/4	dignified [1] 25/4	disparage [1] 165/8
149/25 151/11 151/15	113/15 186/23	179/23 185/15 187/16	dip [2] 104/23 104/25	disparate [2] 69/3
152/17 152/21 153/24	designed [2] 114/4	187/21 188/21 196/15	direct [6] 3/4 51/5	140/14
154/21 156/1 156/6	136/11	197/15	124/23 127/6 131/2	dispatched [1] 127/1
156/8 156/9 156/11	desire [1] 26/16	didn't [63] 13/6 16/18	181/15	dispelling [1] 163/9
156/19 156/20 158/3	despair [1] 12/24	21/14 31/24 32/1	directed [2] 94/3	disproportionate [5]
159/6 161/20 161/25	detail [6] 3/18 14/19	34/19 35/23 36/13	94/4	31/17 38/4 149/19
162/1 162/3 162/14	58/12 149/8 149/14	36/14 36/25 53/15	direction [3] 62/22	152/18 154/22
162/16 162/18 163/20	182/9	59/16 61/10 61/13	82/17 108/2	disproportionately
164/4 164/5 164/11	detailed [1] 95/20	61/16 61/25 64/22	directive [4] 129/15	[1] 154/3
167/4 167/15 167/20	details [1] 119/4	68/19 74/14 76/20	129/20 130/4 167/3	Disruption [1] 126/5
168/7 168/11 171/11	deteriorating [1]	76/23 77/3 79/12	directly [7] 33/8	dissimilar [1] 89/25
171/24 172/13 173/11	28/23	80/12 80/14 80/18	34/17 34/21 42/3	distances [1] 60/2
173/23 174/10 174/15	deterioration [1]	82/9 82/24 82/25	44/16 56/1 181/18	distinction [3] 53/16
174/22 175/3 175/8	138/23	83/20 89/18 102/16	director [10] 1/14	147/2 189/2
176/2 176/16 176/17	devastating [2] 39/20	112/9 115/10 117/14	9/14 44/4 87/12 90/4	distinguish [3] 49/15
178/14 180/21 182/13	88/14	120/5 120/7 121/3	90/6 90/7 90/9 90/14	52/3 189/6
184/5 191/4 191/18	develop [3] 14/15	134/3 137/17 137/18	184/19	distressed [1] 57/25
193/1 194/19 196/2	92/22 164/15	140/8 140/9 160/4	directorate [1] 90/21	distressing [2] 57/23
197/7 197/9 197/10	developed [3] 6/16	161/25 162/8 162/12	directors [5] 96/8	60/11
department's [15]	149/25 169/1	168/14 174/10 179/5	105/20 142/22 194/2	distributed [1] 65/6
92/25 102/23 115/15	developing [4]	179/20 179/20 187/1	195/12	distribution [5] 60/14
119/13 129/22 131/15	102/19 127/5 165/2	187/13 187/13 187/14	disabilities [1] 88/16	63/24 64/5 127/6
142/12 143/25 144/5	169/7	187/15 187/20 191/8	disability [2] 45/17	132/14
144/18 155/10 163/22	development [1]	193/3 193/9 194/12	58/9	district [1] 21/2
178/18 180/20 182/19	186/22	196/6	disabled [7] 46/25	divergences [1] 45/2
departmental [1]	devised [1] 59/22	die [1] 163/14	48/13 51/1 51/13	diverted [2] 128/24
167/3	devolved [8] 2/6	died [1] 88/17	57/24 74/16 190/3	129/3
departments [2]	44/15 44/22 44/25	differed [1] 12/11	disappeared [1]	DNACPR [7] 25/21
89/13 94/13	57/19 76/6 134/4	difference [3] 9/12	162/17	25/23 163/24 164/12
departures [3]	148/6	10/10 57/14	discharge [25] 39/25	165/11 165/20 165/25
138/24 139/5 139/8	DfE [1] 156/3	differences [1] 2/9	40/10 40/12 40/15	DNACPRs [3] 161/24
depend [1] 92/8	DH [2] 94/7 94/8	different [42] 12/14	40/18 79/9 79/15	166/4 166/24
dependent [1]	DHSC [8] 87/18	32/4 32/5 48/3 49/19	95/23 106/9 106/11	DNAR' [1] 163/2
107/23	100/23 108/16 138/17	50/23 51/10 51/11	106/19 106/22 107/15	do [179] 2/20 2/25
depending [5] 9/25	184/20 185/8 185/25	51/12 51/19 54/4 58/8	110/4 111/9 112/6	3/12 4/23 6/1 6/1 6/16
12/24 50/18 91/17	188/16	60/18 64/13 69/6	113/18 184/15 185/1	8/7 9/9 9/22 10/11
170/1	DHSC's [1] 169/2	69/24 74/18 76/13	185/13 185/21 185/24	11/11 12/1 14/11 15/9
depends [2] 45/10	did [91] 4/15 11/5	78/19 78/20 78/25	187/4 187/12 187/21	15/24 16/8 16/13
47/8	12/20 12/25 14/24	82/4 91/24 94/13	discharged [7] 109/8	17/17 21/1 23/3 27/2
deployed [1] 14/12	16/1 16/11 16/15	100/6 100/17 103/8	111/5 111/7 111/12	27/3 27/6 27/12 27/15
deployment [1]	16/18 16/20 17/4 17/5	105/24 119/25 120/13	111/18 112/8 112/19	27/19 29/17 33/21
139/10	19/17 23/21 23/24	120/13 121/24 138/25	discharges [3] 66/23	34/3 34/4 34/14 35/1
depressed [1] 18/9	24/16 38/3 38/6 41/6	139/21 146/23 155/7	110/8 186/9	35/8 35/9 35/25 38/6
deprived [1] 38/23	41/7 45/24 57/23	157/11 169/4 171/4	discharging [2]	38/13 38/14 40/16
	59/19 62/10 62/13	171/6 173/3 192/7		40/21 41/11 45/12

D	168/10	draft [5] 62/12 182/11 182/14 183/3 183/23 drafted [1] 66/14 drafters [1] 63/2 drafting [2] 19/3 53/14 dramatic [1] 179/11 draw [6] 9/17 22/6 35/12 36/6 136/2 182/17 drawn [2] 74/11 74/23 dream [1] 42/23 dressed [1] 194/12 dried [1] 21/4 drinking [1] 28/21 drive [1] 144/13 driven [1] 107/3 drugs [2] 20/4 25/9 due [10] 45/5 67/19 99/3 101/14 105/21 111/19 115/10 142/8 143/21 164/14 during [51] 5/11 6/12 6/13 9/1 12/15 14/1 17/11 17/22 18/11 22/18 23/16 24/18 24/25 25/3 25/17 26/2 26/20 27/4 35/17 37/1 37/11 38/22 51/23 53/11 54/2 55/6 57/17 57/22 58/14 59/18 59/20 60/20 61/19 76/4 84/18 85/22 88/11 90/15 93/21 98/17 110/23 166/19 166/19 167/22 172/3 172/5 181/16 183/9 183/18 188/21 193/14 duties [5] 15/19 110/12 191/24 192/25 195/23 duty [1] 109/17 DWP [2] 71/7 92/18 dying [6] 6/6 21/16 25/4 27/9 27/12 28/24 dynamic [2] 46/15 48/6 Dyson [40] 86/18 86/19 86/21 86/24 86/25 88/24 92/6 93/15 97/16 101/14 105/9 109/2 112/3 114/2 123/12 127/11 128/25 134/25 137/12 141/7 141/15 143/3 146/9 149/5 149/24 152/24 155/4 155/22 161/17 167/13 169/20 178/3 181/19 181/23 182/4 189/20 189/23 190/3 197/4 198/12	doing [24] 3/9 6/7 17/6 29/25 34/11 81/8 92/9 95/6 97/10 98/19 117/4 130/13 144/6 152/12 153/21 156/16 158/13 160/25 170/20 170/20 174/6 174/7 184/9 192/4 domiciliary [11] 39/17 39/21 64/21 120/12 121/6 121/10 125/23 147/19 188/8 188/19 189/12 dominant [1] 131/16 don't [63] 8/20 11/12 14/12 18/19 25/15 39/2 42/14 46/1 46/5 49/20 49/22 50/1 50/10 50/12 52/9 63/6 67/13 75/8 75/24 75/25 84/2 84/6 84/23 97/1 98/14 98/15 100/17 103/16 104/22 106/11 109/10 111/15 112/13 116/14 118/7 125/10 125/25 128/8 130/17 131/20 132/15 133/2 133/7 134/19 149/5 152/4 152/25 154/11 159/24 161/4 166/17 176/19 176/24 182/24 183/1 185/11 186/11 186/12 186/18 191/14 191/15 191/17 192/6 done [43] 7/3 13/14 13/16 18/4 25/19 37/9 54/1 70/12 73/5 73/12 81/7 81/22 82/12 84/22 92/10 95/20 96/17 97/22 97/22 101/18 102/11 102/22 104/20 108/2 108/15 109/24 113/10 119/5 120/16 130/11 137/4 137/5 145/9 150/9 154/5 154/16 155/13 157/16 158/3 159/7 162/6 165/10 166/20 door [1] 160/25 Doors [3] 84/19 85/13 85/20 doubled [1] 76/12 doubt [5] 5/24 11/25 32/4 98/22 151/14 down [22] 10/2 16/7 22/22 34/5 35/22 47/24 55/21 83/1 88/21 100/12 105/10 127/4 132/12 135/21 139/11 143/10 161/3 170/6 170/13 170/22 194/11 195/9	E e-portal [2] 127/7 127/19 each [15] 1/22 2/9 12/11 14/22 15/2 15/14 15/15 44/15 47/19 51/19 68/16 103/8 113/19 132/9 145/14 earlier [23] 7/22 33/1 33/2 42/2 47/2 63/25 68/2 70/20 71/5 71/17 74/23 81/23 81/24 116/10 128/22 134/1 134/3 137/17 137/18 166/14 172/4 172/24 184/12 early [21] 6/14 6/18 7/16 8/22 11/3 11/6 19/2 20/14 24/19 27/17 27/25 38/4 57/8 74/20 75/1 79/20 90/16 102/1 105/16 128/3 138/8 earn [1] 34/2 ease [1] 24/22 easement [3] 175/25 194/20 196/4 easements [34] 15/21 16/21 51/15 61/21 96/5 175/23 176/8 176/13 176/23 177/18 178/5 178/10 178/15 178/22 179/2 180/2 190/5 190/10 190/13 190/21 191/3 191/6 191/17 191/21 192/16 192/20 193/6 193/7 193/9 193/10 194/24 196/3 196/14 196/17 easier [4] 14/6 34/25 70/21 164/19 easily [3] 37/9 93/6 121/4 east [3] 98/25 169/23 169/24 easy [3] 73/23 172/18 172/22 eating [2] 28/20 58/7 echo [1] 1/15 economy [1] 140/24 Education [2] 87/22 89/15 effect [2] 51/15 130/7 effective [5] 186/3 188/13 193/5 193/8 193/12 effectively [6] 51/6 61/25 92/9 107/2 110/11 159/18 efficiency [1] 86/6 effort [1] 67/5	efforts [1] 102/22 eight [1] 154/13 eighties [1] 62/7 either [13] 19/2 25/10 30/3 35/12 36/15 56/16 56/17 60/10 72/21 129/1 131/13 169/10 180/11 elected [1] 44/17 elided [1] 164/1 eligible [5] 4/8 50/17 50/21 121/16 194/13 else [6] 10/4 24/3 61/15 70/3 87/21 88/21 elsewhere [2] 22/19 163/3 email [13] 129/6 129/12 129/15 138/15 138/18 139/19 140/20 142/8 162/16 183/20 185/11 185/15 186/19 emailed [2] 129/9 184/20 emails [7] 163/20 169/3 174/1 174/1 174/2 174/13 174/17 emergency [6] 76/6 125/16 126/1 126/6 127/2 127/3 emerges [1] 158/15 emerging [1] 149/18 Emily [4] 43/14 43/15 43/25 198/8 emotional [1] 45/15 emphasis [2] 31/12 31/16 empirical [1] 30/24 employed [3] 146/22 147/15 192/10 employers [2] 150/3 150/20 employment [5] 49/8 49/14 50/1 50/7 53/1 enable [2] 23/10 132/11 enabled [1] 163/23 enabling [1] 27/17 encourage [2] 155/16 172/6 end [17] 17/13 24/14 24/22 28/10 29/2 60/8 87/25 107/16 118/15 124/16 137/15 160/1 161/4 168/18 184/12 197/10 197/11 endeavour [1] 10/12 ending [1] 177/11 ends [1] 20/25 energy [1] 67/5 engage [1] 27/11 engaged [1] 196/1 engagement [1] 84/7 England [36] 1/22
----------	--------	---	--	--	---

E	79/21 80/4 80/9 160/10	38/11 43/18 44/3 44/20 47/3 51/14	93/23 136/12 138/3 191/9	132/15 189/7 189/11
England... [35] 2/5 9/2 14/21 15/4 30/8 30/16 45/2 47/15 47/16 51/21 59/22 60/6 60/19 66/10 76/8 76/23 91/12 93/21 94/4 106/12 106/14 113/8 113/18 131/14 134/3 142/22 147/4 147/20 148/5 155/15 158/24 159/2 169/18 188/24 190/16	essentially [11] 4/2 7/13 21/12 94/12 96/19 102/11 107/17 139/16 157/13 157/21 160/19	73/23 82/4 85/21 91/8 91/23 93/18 129/25 138/8 149/18 153/14 157/22 157/24 158/7 158/15 159/24 161/20 161/23 162/1 162/21 163/17 166/24 174/21 182/15 186/21 191/15 193/16 193/17 193/21 194/6 194/8	expand [2] 37/21 182/9 expanded [2] 48/1 82/24 expansion [1] 91/4 expect [5] 45/21 118/23 174/7 195/21 195/23	extract [4] 55/1 150/9 155/20 169/17 extremely [5] 42/22 57/25 59/1 60/11 186/18 extremis [1] 27/1 eye [1] 142/10
England's [1] 130/24	et [6] 89/17 89/20 118/22 133/10 153/20 157/5	evidential [1] 158/20	expectations [1] 33/25	F
enhance [1] 31/8	et cetera [6] 89/17 89/20 118/22 133/10 153/20 157/5	evils [1] 144/4	expecting [1] 16/9	face [12] 28/14 28/14 30/22 30/22 77/15 115/7 125/1 125/4 130/20 188/8 188/11 188/13
enough [23] 4/19 4/24 4/24 6/23 37/3 38/3 38/6 41/15 41/15 64/22 95/13 95/15 95/15 95/16 99/11 101/20 102/12 102/24 102/24 118/7 135/9 154/8 155/9	ethical [2] 179/24 180/3	exacerbated [1] 118/2	experience [12] 5/11 6/4 19/1 20/11 21/19 29/21 30/2 30/18 89/9 159/20 160/10 160/13	facilities [4] 40/11 41/6 109/4 110/20
ensure [19] 26/22 27/4 39/4 40/13 64/6 72/16 77/14 78/15 80/2 84/23 102/23 108/15 113/11 114/6 165/11 180/16 180/18 180/18 180/22	ethnic [8] 37/23 37/25 70/24 149/20 153/17 155/5 155/11 155/15	exactly [12] 28/12 48/6 53/8 97/2 103/6 108/5 136/4 140/20 142/18 173/24 179/2 192/9	experience/advice [1] 30/2	facing [1] 2/4
ensuring [5] 114/16 123/6 135/9 144/16 161/6	ethnicity [4] 150/6 150/22 150/25 153/7	example [47] 6/19 7/5 10/17 14/8 16/4 18/8 19/25 20/21 34/21 36/8 38/17 39/8 41/6 47/9 50/4 50/23 57/12 57/24 58/23 61/11 67/7 67/7 68/5 68/18 69/18 71/2 73/16 74/24 78/25 79/9 82/18 83/22 109/21 116/16 123/6 124/7 138/2 146/16 147/4 163/16 170/18 175/13 179/14 179/18 193/14 194/9 194/11	experienced [4] 2/5 22/18 29/9 37/25	fact [30] 7/23 11/9 16/21 61/25 63/11 66/3 68/13 77/20 80/19 82/5 82/8 83/16 106/10 120/6 126/6 129/19 134/10 152/5 153/16 154/12 162/13 162/14 163/6 164/2 166/22 175/19 175/20 176/21 179/24 186/2
enter [1] 117/25	even [21] 7/16 15/10 15/15 17/23 23/3 23/22 26/3 34/19 41/13 53/22 59/25 79/15 80/16 80/19 99/17 115/25 116/16 133/4 139/8 151/9 167/6	examples [13] 5/14 8/24 9/1 9/7 12/2 28/7 62/16 64/2 81/4 144/17 162/5 162/5 194/14	expert [2] 106/2 192/10	factor [2] 65/21 79/10
entering [1] 55/8	evening [1] 181/25	Excellence [1] 108/25	expertise [4] 13/17 78/13 192/23 192/24	factored [1] 63/25
entirely [3] 12/19 43/19 53/8	event [18] 92/11 95/14 95/25 96/13 96/14 99/12 102/2 104/16 112/1 113/13 115/14 119/14 134/15 147/22 147/24 171/25 172/13 173/12	excellent [2] 30/4 86/2	experts [5] 49/21 78/12 109/16 192/1 192/11	factors [3] 65/18 139/2 153/18
entitled [1] 84/19	events [2] 102/2 102/10	except [2] 55/13 189/9	explain [5] 48/1 56/7 76/10 78/10 84/17	facts [1] 6/17
entitlements [1] 79/12	ever [2] 163/22 169/9	exception [1] 117/17	explained [3] 59/18 83/25 145/2	fail [1] 97/12
environment [2] 89/22 155/3	every [15] 41/17 46/11 46/14 46/18 110/20 113/5 113/7 117/17 120/14 125/3 158/24 159/21 162/25 166/21 170/8	examples [13] 5/14 8/24 9/1 9/7 12/2 28/7 62/16 64/2 81/4 144/17 162/5 162/5 194/14	explaining [2] 13/17 56/10	failed [1] 40/2
equal [2] 66/24 67/18	everybody [7] 4/25 9/12 19/7 24/3 59/24 75/15 163/14	excellent [2] 30/4 86/2	explains [1] 102/21 explicitly [4] 91/5 121/9 134/19 153/15	failing [1] 193/13
equalities [1] 75/22	everyday [2] 58/6 83/19	exceptional [3] 160/14 160/17 160/20	exploring [1] 143/14	failings [1] 6/12
equality [7] 71/4 155/23 155/24 156/4 156/12 157/1 157/7	everyone [10] 64/1 88/10 88/21 106/6 127/23 128/20 139/10 139/12 140/5 141/8	except [2] 55/13 189/9	exposed [1] 14/25	fails [1] 29/15
equally [6] 113/8 118/5 157/15 160/6 183/18 193/11	everything [3] 144/7 164/9 174/7	exception [1] 117/17	express [1] 104/15	failure [5] 40/17 82/3 97/11 105/14 183/10
equates [1] 46/11	everywhere [1] 20/2	exceptions [1] 80/3	expressed [2] 84/12 84/13	failures [1] 17/9
equipped [2] 11/23 41/4	evidence [48] 1/13 12/1 20/15 23/8 23/18 25/20 26/20 28/5 30/21 30/25 31/1 31/2	executives [1] 121/20	extant [1] 124/5	fair [8] 7/21 13/5 14/20 19/5 32/18 41/10 118/12 185/25
equivalent [1] 54/23		exercise [1] 180/10	extend [1] 104/8	fairly [3] 4/21 66/14 114/8
eradicated [1] 115/25		exhausted [2] 62/1 62/4	extended [1] 132/19	faith [1] 13/11
eradicating [1] 117/9		exhaustion [2] 139/3 141/4	extending [1] 114/17	fallback [1] 111/16
especially [3] 24/19 57/7 73/19		exhibited [2] 58/12 65/1	extensive [2] 140/11 178/21	falls [1] 160/19
essential [14] 5/2 22/9 65/19 65/19 65/24 65/25 77/20 79/3 79/17 79/19		exist [3] 134/14 144/22 187/14	externally [1] 30/20	false [2] 131/3 131/17
		existence [1] 100/1	extra [8] 77/16 86/8 132/15 158/13 172/18 172/22 189/7 189/11	familial [1] 157/16
		existing [5] 9/25	extra-resident [3]	familiar [3] 20/20 124/4 164/14

F	142/2 154/16 173/20 181/23 fewer [1] 121/2 fields [1] 172/18 fiercely [1] 4/3 fifth [1] 22/10 figure [3] 47/11 48/3 132/14 figures [9] 47/10 47/13 47/21 47/23 48/9 48/21 48/25 132/13 151/9 file [1] 26/5 fill [5] 107/18 107/22 108/14 108/18 191/4 filled [1] 108/15 filling [2] 107/24 108/10 final [6] 33/10 115/22 134/2 164/13 180/14 187/23 finally [5] 11/3 36/17 76/4 83/7 138/7 finance [1] 174/4 financial [5] 77/5 108/13 115/7 180/15 193/19 financially [1] 11/14 find [7] 82/24 82/25 83/9 93/6 102/7 144/15 166/9 findings [2] 174/12 177/22 fine [1] 43/20 fined [1] 80/16 finish [2] 181/24 181/25 finished [1] 197/10 first [34] 2/20 2/25 6/19 20/22 37/16 37/22 39/19 56/22 58/19 58/21 68/10 73/8 73/18 75/7 85/1 88/8 95/19 97/16 98/1 99/15 99/19 108/3 126/24 136/22 142/5 146/24 151/22 156/9 156/18 159/10 159/25 178/19 182/5 185/7 first 18 [1] 156/18 Firstly [1] 22/17 fit [3] 18/24 26/10 101/5 five [4] 87/5 87/9 103/7 103/8 flag [1] 73/7 flagged [3] 97/4 109/21 109/22 flagging [3] 98/9 107/14 144/10 flashing [1] 128/1 flex [1] 91/6 flexibilities [8] 176/21 180/7 191/10	191/20 193/7 193/18 195/7 195/18 flexibility [3] 176/25 177/5 196/10 flexible [2] 51/5 191/12 flimsy [1] 58/25 flitting [1] 177/12 floors [1] 123/6 flows [1] 85/25 flu [6] 68/14 69/10 70/18 93/13 100/5 104/4 flux [1] 4/22 focus [5] 7/14 57/15 90/15 115/19 117/21 focused [3] 66/23 95/12 105/17 Foley [4] 41/22 41/23 42/18 198/6 follow [4] 62/25 116/5 152/11 159/5 followed [1] 67/6 following [9] 1/18 87/7 103/25 131/25 137/21 177/8 182/14 193/22 197/22 food [3] 11/15 59/11 73/21 footfall [1] 158/8 footing [1] 127/15 fora [1] 95/9 force [4] 9/5 14/4 178/7 190/6 forefront [1] 15/7 forego [1] 16/13 foremost [2] 85/1 146/25 forgive [4] 129/9 161/21 162/17 172/25 forgotten [2] 7/17 37/11 form [1] 12/12 formal [4] 3/6 4/13 49/13 55/8 formalised [2] 49/6 49/13 formalities [1] 161/13 formally [5] 22/23 190/20 191/6 192/19 194/24 format [1] 12/14 former [2] 29/22 94/11 formulated [1] 134/17 forum [4] 101/6 121/25 129/6 138/16 forums [2] 64/18 66/25 forward [3] 39/4 67/14 87/1 forwards [1] 131/12	found [7] 1/19 14/6 17/12 74/1 140/10 142/5 142/17 Foundation [2] 70/12 71/20 four [5] 17/12 69/7 135/8 135/17 145/3 fragile [3] 4/17 5/22 118/1 fragility [3] 97/5 97/15 98/19 fragmented [1] 5/1 frail [1] 20/24 frailty [1] 22/15 framework [21] 149/23 150/1 150/6 151/5 151/7 151/13 151/21 151/22 152/4 152/6 152/10 152/13 152/19 152/22 153/3 153/25 154/7 154/20 165/16 179/24 180/4 free [4] 25/5 132/1 133/1 133/22 frequently [1] 12/20 friend [1] 88/15 friends [4] 45/9 46/4 49/20 112/20 frightened [1] 18/17 front [1] 88/8 frustrated [1] 79/7 frustrating [1] 30/18 frustration [1] 32/21 full [8] 15/13 43/24 58/25 86/24 92/10 102/4 126/24 168/15 fully [2] 56/7 96/21 function [2] 75/13 90/17 functions [1] 89/16 fund [28] 4/4 4/24 76/6 76/7 108/6 114/3 115/11 116/12 117/23 119/15 120/8 121/12 122/4 122/6 122/15 135/2 136/10 136/13 136/19 137/21 137/21 144/11 156/3 172/7 181/18 184/4 184/9 184/13 fundamental [6] 40/17 55/4 63/21 63/21 77/10 143/24 fundamentally [2] 110/6 110/10 fundamentals [1] 64/15 funded [7] 38/24 97/9 103/17 156/8 156/9 156/11 156/18 funding [15] 12/8 76/4 97/8 98/2 107/23 113/17 113/18 115/12 121/16 122/24 136/23	136/24 137/24 137/25 156/14 funds [3] 121/21 138/1 172/6 furlough [2] 82/18 82/19 further [11] 7/18 35/10 37/14 85/4 92/22 104/15 119/19 138/3 158/1 189/22 196/11 future [39] 9/24 14/1 15/11 19/18 26/23 27/19 29/18 34/15 35/14 35/25 39/6 40/12 53/3 63/14 63/16 64/5 64/15 65/3 72/6 75/13 76/9 83/3 84/24 92/12 112/1 113/14 115/14 115/16 116/8 119/14 120/1 120/2 134/15 147/22 147/24 171/25 172/10 173/13 173/19
G				
gain [3] 9/18 59/19 181/6 gap [6] 10/3 11/17 21/12 35/22 191/1 191/4 gaps [1] 70/4 gardens [1] 32/16 garnered [1] 133/22 gave [5] 91/23 116/23 116/23 170/8 188/24 general [8] 11/20 47/25 53/23 65/16 87/12 90/4 90/6 90/9 generally [15] 2/4 6/25 13/5 13/14 19/21 24/17 29/19 32/19 35/13 35/22 38/10 105/5 111/23 179/14 179/23 generals [1] 90/7 generated [1] 167/8 genuine [1] 36/1 geographically [1] 112/19 get [68] 4/6 13/7 17/19 18/3 21/22 22/11 24/22 26/16 32/19 42/14 47/11 48/3 56/18 58/22 59/12 60/13 62/5 64/20 68/7 68/19 69/18 70/22 72/16 74/2 75/14 75/20 76/20 82/1 82/17 84/8 86/8 88/5 93/1 98/1 98/16 105/1 112/11 113/4 113/20 115/17				

G	99/9 103/2 103/4 104/18 104/19 104/20 106/7 111/13 113/6 116/25 118/2 118/4 118/9 129/23 133/20 134/9 135/4 136/9 140/14 142/9 143/7 145/17 149/5 153/24 154/18 157/18 160/5 160/6 167/19 170/10 170/15 171/12 171/17 173/14 173/16 174/2 179/4 180/6 181/24 186/2 186/16 189/22 193/2 193/9 194/5	14/6 governmental [1] 82/6 governments [2] 2/9 23/22 gowns [1] 124/7 GP [14] 21/24 57/12 68/21 69/4 69/9 70/14 70/16 71/25 75/10 92/17 162/25 165/22 166/5 166/6 GP records [1] 71/25 GPs [5] 68/22 69/9 73/2 92/17 167/6 grant [1] 136/21 grants [2] 51/5 51/9 granular [1] 9/15 grateful [3] 1/15 189/18 189/24 grave [1] 17/2 great [6] 14/11 17/19 21/21 36/10 52/10 197/12 greater [3] 5/17 32/12 123/19 greatest [2] 38/13 123/25 grew [1] 90/21 grey [1] 196/4 grip [1] 183/11 ground [4] 63/5 137/6 140/19 165/10 ground-level [1] 165/10 grounds [1] 183/5 group [32] 10/15 15/6 28/22 30/8 30/16 46/15 49/13 49/25 53/11 67/21 68/5 88/13 92/15 100/1 103/24 105/6 105/8 105/10 105/12 105/17 105/17 105/21 132/1 132/11 150/11 150/11 157/21 158/14 164/15 164/21 169/11 184/18 group 6 [1] 92/15 group's [1] 150/16 groups [17] 9/23 10/11 28/12 30/5 32/25 33/6 33/7 51/11 66/20 66/22 77/8 93/11 166/10 168/25 176/3 176/3 178/12 growing [4] 98/8 98/14 139/4 166/13 guess [2] 102/17 168/15 guidance [72] 12/20 13/8 13/12 13/14 14/5 14/13 19/4 29/17 29/20 30/14 39/24 46/6 53/7 53/12 53/14 53/15 59/5 62/10	62/11 62/12 62/14 62/15 62/18 63/2 63/4 65/7 65/10 65/11 65/16 66/4 66/8 66/13 79/11 79/14 82/5 82/8 83/14 83/22 96/16 104/16 105/3 106/19 106/25 107/8 114/12 116/14 116/23 124/16 130/7 136/21 146/14 150/3 150/20 157/19 160/22 165/10 178/24 185/3 185/21 186/17 187/17 187/21 187/24 187/25 188/6 188/7 188/12 189/2 194/25 195/2 196/13 196/16 Gypsy [1] 71/1 H had [165] 7/17 7/20 7/22 8/18 9/14 9/15 9/16 9/20 10/5 10/6 10/7 13/11 16/7 16/12 16/21 19/22 19/23 23/9 23/9 23/13 25/8 25/18 26/5 27/20 29/20 30/16 31/15 33/2 34/18 34/23 36/11 38/18 41/5 42/8 43/13 55/23 57/5 57/6 57/7 57/8 58/24 58/25 60/7 60/18 61/12 63/3 66/24 67/10 67/11 70/20 71/11 73/12 73/12 73/14 73/22 74/22 75/13 77/5 77/6 79/13 80/24 81/7 81/10 84/14 88/13 88/16 89/10 89/14 89/16 89/20 93/16 98/3 98/4 98/16 100/25 102/14 104/5 104/7 104/20 105/13 106/4 107/14 109/6 109/22 110/19 111/19 113/18 116/1 120/18 121/15 121/23 122/7 122/9 122/17 122/20 124/13 126/2 126/7 128/2 128/4 130/12 130/14 132/8 133/5 135/8 135/9 136/24 140/24 142/13 145/2 145/4 145/9 146/3 148/1 150/21 150/24 150/25 151/10 152/21 152/22 156/21 158/7 160/3 160/11 162/3 166/13 168/13 168/16 168/23 170/4 170/5 170/6 170/25 171/13 172/14 175/15 176/9 176/9 181/4 181/16	183/12 184/6 184/10 184/11 184/13 185/1 185/2 187/17 190/11 190/14 190/18 190/20 190/23 191/5 192/1 192/2 192/19 192/24 193/24 194/24 194/25 196/1 196/3 196/24 197/12 hadn't [5] 90/8 90/11 109/20 151/1 194/4 half [1] 126/25 Hancock [3] 91/23 121/17 149/9 hand [3] 139/12 158/8 158/25 handfoam [1] 129/14 handgel [1] 129/14 hands [3] 1/3 30/2 31/19 hands-on [1] 30/2 happen [10] 22/24 24/23 35/23 40/13 71/17 74/14 95/18 102/16 123/3 142/23 happened [23] 4/10 11/18 14/19 14/21 17/22 20/5 25/3 26/17 30/19 74/18 88/11 96/6 101/21 125/1 125/3 125/18 143/4 143/16 145/12 166/18 173/25 186/12 197/13 happening [15] 48/6 65/15 95/7 141/22 152/3 153/6 167/6 176/18 176/20 185/22 190/19 194/21 194/23 195/4 196/7 hard [5] 5/25 52/8 65/15 83/1 154/10 harder [1] 38/16 hardest [1] 28/13 harm [2] 157/15 188/5 Harries [1] 159/1 has [52] 2/18 2/23 3/21 4/6 4/8 4/10 7/10 15/18 25/20 27/8 27/13 28/4 34/7 42/8 44/8 45/16 47/20 51/14 52/8 59/24 72/22 74/20 75/25 76/2 84/14 87/24 97/21 97/21 97/22 98/20 109/15 110/4 125/9 129/9 129/10 130/11 137/4 159/5 159/24 160/22 162/17 163/9 174/21 180/9 180/21 180/22 181/14 182/8 182/15 183/4 193/21 197/8 hasn't [1] 181/14
----------	--	---	---	---

H	164/4 165/22 193/23 194/1 195/12	86/9 100/20 104/2 116/8 125/5 125/17 133/20 135/16 143/5 143/25 151/18 157/14 158/6 169/18 171/7 180/5 181/1 191/24 192/24 192/25	122/12 123/7 123/9 123/11 123/13 123/18 144/24 146/7 153/9 155/3 158/9 158/10 159/14 162/24 163/14 165/23 167/25 170/5 170/16 170/18 170/22 171/15 173/8 177/19 179/21 179/21 186/8 187/25 188/2 188/18	186/2 186/9 187/2 187/4 187/12 187/19 hospitality [2] 118/16 140/23 hospitals [3] 84/11 109/8 159/19 hot [5] 186/25 187/7 187/8 187/8 187/10 hotline [7] 126/5 126/8 126/11 126/14 126/25 127/3 147/5	
have [305]		here's [1] 108/7	home's [1] 170/16	hour [1] 92/8	
haven't [8] 35/11	hearing [9] 8/2 8/13 41/22 78/2 88/14 140/21 162/10 189/20 197/22	high [6] 12/14 78/15 145/1 164/25 188/2 188/18	home-based [1] 39/22	hours [8] 45/19 50/8 50/14 62/17 89/23 138/4 153/19 183/24	
77/19 130/9 174/5	heart [1] 13/12	high-level [1] 164/25	homecare [9] 65/9	House [1] 139/18	
181/13 185/11 187/6	heating [2] 59/11 77/6	high-quality [1] 78/15	91/15 95/15 120/17	household [3] 189/8 189/9 189/10	
197/10	heavily [2] 8/22 31/1	higher [7] 37/25 47/22 98/24 133/5 133/6 140/25 150/18	120/19 120/21 120/21 122/21 123/23	houses [1] 120/13	
having [27] 7/3 18/2	held [7] 6/24 9/22 94/1 94/2 148/20 166/6 169/6	highest [1] 132/14	homes [97] 4/23 8/3	housing [2] 153/18 156/2	
21/12 27/22 30/3	Helen [4] 10/18 101/15 102/1 190/8	highlight [1] 167/1	10/17 11/5 11/10 15/5	how [83] 2/9 2/22 4/15 7/11 9/7 11/22 14/14 16/25 17/1 17/2 26/21 27/2 27/3 27/19 27/25 28/5 29/14 29/18 34/14 34/17 37/24 38/13 46/14 46/20 47/6 47/8 54/1 56/10 62/20 63/4 63/5 63/14 64/4 80/24 81/6 81/18 81/19 81/20 83/9 83/23 85/14 88/10 93/5 95/23 96/12 96/13 96/15 98/13 104/6 104/16 104/25 109/7 111/4 111/7 115/15 118/8 119/13 119/22 121/24 134/13 135/23 142/16 142/24 144/20 145/2 147/11 148/1 148/6 150/4 151/24 152/1 152/7 159/3 166/18 170/3 170/6 170/23 178/22 180/6 180/21 181/6 193/5 195/22	
31/11 34/1 38/21	hello [2] 1/8 28/20	highlighted [2] 109/3 182/13	16/5 19/24 19/25 20/11 20/12 21/10 22/23 24/17 25/4 28/4 30/22 32/15 35/20 35/21 36/9 39/16 39/20 40/1 41/4 41/10 42/12 55/11 66/23 78/25 84/11 91/11 91/12 98/8 99/6 99/8 107/15 109/5 109/8 109/12 110/4 110/9 110/19 113/8 113/25 114/20 115/8 115/20 116/3 116/6 116/18 117/3 118/6 119/24 120/22 121/1 121/22 122/11 122/21 123/1 123/5 123/10 123/11 123/14 123/19 123/20 123/22 124/11 124/24 125/1 125/21 137/3 141/24 153/12 154/25 157/15 157/23 158/5 159/19 160/8 160/15 163/4 165/13 167/7 169/20 170/14 173/17 175/9 182/7 182/25 185/4 186/1 186/25 187/10 187/19 193/25 194/5	however [3] 112/15 118/2 178/10	
41/15 43/5 59/18	help [75] 1/9 3/7 3/9 3/10 4/13 5/19 7/6 9/18 15/14 20/17 21/3 23/13 27/19 32/2 34/1 34/8 34/10 34/14 36/25 42/6 48/11 66/25 80/21 86/1 86/21 89/13 90/25 91/8 91/20 92/11 94/1 94/14 95/1 96/23 101/4 101/18 101/24 105/9 106/16 106/17 107/7 112/3 115/24 118/10 118/17 118/22 122/3 127/5 127/11 128/19 132/3 137/10 137/12 139/14 139/15 142/15 143/3 144/7 146/9 147/8 156/6 156/20 159/16 165/20 166/14 168/5 168/11 168/25 170/3 172/9 173/10 177/8 179/10 182/20 185/7	him [1] 9/13		hubs [1] 60/15	
60/12 62/7 73/7 90/5	helped [3] 5/7 10/22 121/10	himself [1] 9/14	home [108] 3/15 4/13 4/23 6/6 8/4 11/11 11/13 11/16 11/23 14/15 14/16 14/25 15/10 15/12 18/16 21/17 21/24 23/6 24/4 24/5 28/13 29/22 30/7 30/11 30/13 31/14 31/24 32/6 32/7 35/15 36/12 38/19 38/22 38/23 38/24 39/22 40/3 40/7 40/10 41/17 57/6 58/4 58/24 60/1 63/20 67/9 67/10 67/12 77/7 79/2 85/9 85/10 88/17 88/21 95/15 97/12 111/10 111/10 111/13 112/8 112/9 113/2 113/3 113/5 113/7 114/7 114/17 115/23 120/20 121/1 121/7 121/7 121/7 121/7 121/8 121/8 122/1 122/4	homecare [9] 65/9	huge [7] 2/17 9/11 12/16 56/24 124/10 155/15 188/21
110/19 118/6 119/15	he [13] 9/12 9/13 9/14 9/15 9/16 9/22 10/9 23/13 58/1 58/23 58/25 67/16 87/24	hit [6] 28/12 36/5 36/21 38/16 39/10 99/18	honestly [1] 149/8	hugely [4] 30/18 33/17 49/17 52/7	
127/20 139/10 139/12	head [4] 31/3 131/19 131/20 146/5	hitting [1] 6/18	hope [9] 8/11 30/17 82/17 83/3 114/9 161/3 161/3 161/4 180/12	human [1] 24/2	
144/14 151/18 151/19	heading [1] 52/22	HMT [1] 115/9	hospital [33] 22/13 23/6 23/10 23/12 24/5 35/21 39/16 40/14 40/18 66/23 67/8 79/8 79/15 95/23 106/9 106/22 107/15 112/11 112/12 159/14 163/10 165/23 184/15 185/1 185/13 185/20 185/24		
151/21 194/19 195/8	headline [1] 100/4	hobby [1] 51/8			
havoc [1] 8/4	heads [1] 122/19	hold [4] 24/22 65/2 112/21 112/24			
he [13] 9/12 9/13	health [64] 17/16 17/20 17/24 18/10 19/16 20/23 21/12 31/6 39/5 42/9 42/10 45/20 50/2 50/24 52/19 54/24 55/2 55/4 55/7 57/1 57/13 57/14 66/11 68/12 69/11 70/12 70/22 71/3 71/20 73/25 74/4 78/11 85/10 87/4 87/25 94/8 94/21 104/12 106/14 129/9 129/12 129/20 130/23 131/13 139/4 139/18 142/22 142/22 146/14 147/5 156/1 156/6 156/19 156/21 158/4 158/24 159/1 161/10 166/21 167/15 174/10 174/23 176/16 188/23	holding [1] 35/2			
9/14 9/15 9/16 9/22	helpful [9] 5/23 9/18 9/24 33/1 33/3 42/22 58/11 164/7 170/2	Holzhausen [8] 43/14 43/15 43/16 43/25 54/19 78/5 85/19 198/8			
10/9 23/13 58/1 58/23	helping [5] 14/12 28/20 163/2 185/23 197/15	home [108] 3/15 4/13 4/23 6/6 8/4 11/11 11/13 11/16 11/23 14/15 14/16 14/25 15/10 15/12 18/16 21/17 21/24 23/6 24/4 24/5 28/13 29/22 30/7 30/11 30/13 31/14 31/24 32/6 32/7 35/15 36/12 38/19 38/22 38/23 38/24 39/22 40/3 40/7 40/10 41/17 57/6 58/4 58/24 60/1 63/20 67/9 67/10 67/12 77/7 79/2 85/9 85/10 88/17 88/21 95/15 97/12 111/10 111/10 111/13 112/8 112/9 113/2 113/3 113/5 113/7 114/7 114/17 115/23 120/20 121/1 121/7 121/7 121/7 121/7 121/8 121/8 122/1 122/4			
58/25 67/16 87/24	helped [3] 5/7 10/22 121/10	holder [1] 71/7			
147/5 156/1 156/6	helpful [9] 5/23 9/18 9/24 33/1 33/3 42/22 58/11 164/7 170/2	holding [1] 35/2			
156/19 156/21 158/4	helpline [1] 3/1	Holzhausen [8] 43/14 43/15 43/16 43/25 54/19 78/5 85/19 198/8			
158/24 159/1 161/10	helplines [2] 12/7 28/7	home [108] 3/15 4/13 4/23 6/6 8/4 11/11 11/13 11/16 11/23 14/15 14/16 14/25 15/10 15/12 18/16 21/17 21/24 23/6 24/4 24/5 28/13 29/22 30/7 30/11 30/13 31/14 31/24 32/6 32/7 35/15 36/12 38/19 38/22 38/23 38/24 39/22 40/3 40/7 40/10 41/17 57/6 58/4 58/24 60/1 63/20 67/9 67/10 67/12 77/7 79/2 85/9 85/10 88/17 88/21 95/15 97/12 111/10 111/10 111/13 112/8 112/9 113/2 113/3 113/5 113/7 114/7 114/17 115/23 120/20 121/1 121/7 121/7 121/7 121/7 121/8 121/8 122/1 122/4			
166/21 167/15 174/10	helps [5] 51/2 109/2 114/1 127/12 161/17	hit [6] 28/12 36/5 36/21 38/16 39/10 99/18			
174/23 176/16 188/23	hence [4] 90/22 105/17 123/20 158/19	hit [6] 28/12 36/5 36/21 38/16 39/10 99/18			
Health Foundation	her [14] 56/17 56/18 81/15 82/24 101/16 102/6 118/25 143/8 149/6 149/6 184/20 189/20 189/25 195/24	hit [6] 28/12 36/5 36/21 38/16 39/10 99/18			
[1] 70/12	Her Majesty's [1] 82/24	hit [6] 28/12 36/5 36/21 38/16 39/10 99/18			
healthcare [12]	here [26] 44/12 60/20 60/22 61/1 61/2 68/1	hit [6] 28/12 36/5 36/21 38/16 39/10 99/18			
17/21 17/23 19/14		hit [6] 28/12 36/5 36/21 38/16 39/10 99/18			
20/12 20/19 24/3		hit [6] 28/12 36/5 36/21 38/16 39/10 99/18			
26/21 26/23 93/24		hit [6] 28/12 36/5 36/21 38/16 39/10 99/18			
94/5 130/21 188/15		hit [6] 28/12 36/5 36/21 38/16 39/10 99/18			
hear [5] 16/15 36/18		hit [6] 28/12 36/5 36/21 38/16 39/10 99/18			
36/19 86/16 140/18		hit [6] 28/12 36/5 36/21 38/16 39/10 99/18			
heard [29] 2/23 4/20		hit [6] 28/12 36/5 36/21 38/16 39/10 99/18			
15/18 16/3 21/11		hit [6] 28/12 36/5 36/21 38/16 39/10 99/18			
22/18 22/20 23/7		hit [6] 28/12 36/5 36/21 38/16 39/10 99/18			
24/11 25/20 25/22		hit [6] 28/12 36/5 36/21 38/16 39/10 99/18			
28/6 31/23 32/4 34/19		hit [6] 28/12 36/5 36/21 38/16 39/10 99/18			
51/14 52/18 74/20		hit [6] 28/12 36/5 36/21 38/16 39/10 99/18			
82/3 89/24 107/22		hit [6] 28/12 36/5 36/21 38/16 39/10 99/18			
119/1 130/16 159/24		hit [6] 28/12 36/5 36/21 38/16 39/10 99/18			

I	135/14 149/2 153/5 155/8 162/2 182/17 191/17	158/19	idea [7] 41/18 113/1 129/21 148/10 148/25 149/12 192/3	160/17 160/23 161/17 164/6 165/14 165/17 165/25 169/15 172/10 172/18 172/25 179/10 181/4 181/4 182/20 183/1 186/2 186/5 187/3 189/19 192/25 193/22 194/6 194/8 194/23 195/7
I ask... [21] 41/25 42/7 43/23 44/1 51/18 76/4 78/6 83/7 87/18 97/14 118/25 121/13 123/12 124/18 125/7 141/15 149/20 155/18 181/20 182/4 190/3	I know [7] 15/3 103/6 106/16 115/18 126/17 137/22 179/14	I thank [1] 42/15	ideally [2] 26/10 158/7	ill [1] 56/18
I believe [2] 37/13 142/17	I look [1] 68/3	I think [215]	identical [2] 2/10 116/10	illness [3] 45/16 58/9 99/3
I call [1] 86/18	I may [8] 1/4 2/1 12/6 21/23 25/21 55/1 57/15 149/6	I totally [1] 31/20	identification [8] 54/20 64/13 68/21 68/24 69/4 72/17 75/8 85/6	illogical [1] 189/3
I can [8] 86/17 137/8 146/9 155/14 155/22 159/9 164/6 165/14	I mean [68] 8/8 35/8 62/16 63/16 64/20 67/3 89/6 89/14 90/12 97/1 98/1 98/2 99/13 103/14 104/22 105/2 106/25 107/10 109/10 111/8 113/4 117/6 118/18 119/18 119/19 120/18 126/17 126/24 127/24 130/16 131/19 133/3 134/18 137/6 143/10 144/11 148/9 148/14 148/15 148/19 152/25 154/9 154/24 155/12 155/13 156/23 158/23 159/23 160/22 162/5 164/4 168/12 172/15 172/18 174/13 178/24 179/5 179/23 182/24 183/13 183/15 185/12 186/16 192/21 193/16 194/1 195/10 195/11	I understand [8] 110/2 117/6 122/21 156/13 166/4 179/6 179/19 181/3	identified [4] 6/11 33/13 70/21 96/23	illustrative [1] 183/10
I can't [8] 14/19 25/17 33/8 42/13 104/25 117/8 134/1 175/6	I might [1] 56/18	I was [11] 6/5 6/9 32/24 43/3 70/1 87/22 89/16 90/3 140/21 154/18 189/21	identify [12] 15/15 34/11 38/13 40/5 46/20 69/9 70/17 70/25 73/24 75/14 92/16 113/19	imagination [1] 93/4
I certainly [1] 120/3	I misheard [1] 108/23	I wasn't [2] 102/13 186/11	identifying [4] 92/2 92/4 132/24 133/13	imagine [2] 35/7 125/15
I come [2] 47/22 143/24	I note [1] 133/9	I will [4] 22/5 43/6 56/16 56/19	ie [2] 72/22 132/15	immediate [2] 11/12 138/21
I comment [1] 89/6	I noted [1] 130/6	I wonder [1] 169/15	ie those [1] 132/15	immediately [1] 181/5
I completely [1] 31/9	I promise [1] 181/24	I would [14] 21/23 36/6 65/20 82/16 84/9 88/10 100/19 104/22 113/4 118/23 119/18 168/15 195/20 195/23	if [159] 1/4 9/19 10/5 11/13 12/5 14/2 16/21 18/19 18/23 21/23 22/2 22/13 23/6 25/15 25/21 27/20 28/13 29/18 33/1 34/4 38/19 38/22 39/10 41/11 42/5 42/6 43/17 47/22 48/11 49/17 50/3 50/24 51/2 55/1 56/10 56/12 56/12 57/15 59/25 60/17 65/21 68/3 68/11 69/18 72/13 72/22 74/22 75/5 75/13 75/19 76/14 78/24 79/2 81/10 82/18 83/5 91/3 92/3 92/22 93/4 99/21 100/2 100/12 100/14 101/12 101/20 102/22 103/17 104/6 108/9 109/2 110/4 111/10 111/12 111/16 112/7 112/8 112/9 112/24 113/11 114/1 114/13 114/18 115/7 115/16 115/25 117/3 117/25 118/3 119/16 120/1 122/3 123/2 123/3 124/12 124/13 125/10 127/12 129/17 132/12 133/4 133/15 134/12 134/14 136/24 137/8 143/3 143/19 144/9 144/23 146/9 146/19 147/22 148/14 148/17 149/5 150/23 151/2 151/6 152/3 152/5 152/22 153/1 153/23 154/15 155/14 155/21 156/21 157/1 157/22 158/8 158/15 159/24	immense [1] 56/23
I could [1] 42/5	I recall [1] 40/24	I wouldn't [4] 89/24 103/14 120/1 135/22		impact [27] 4/16 16/25 17/2 17/7 21/9 28/8 30/16 31/21 37/23 38/4 38/7 51/16 55/15 56/6 56/7 58/17 61/4 61/21 65/11 73/13 80/23 84/14 88/19 149/19 152/18 154/22 190/9
I couldn't [1] 146/5	I remember [6] 17/6 88/13 88/15 88/18 143/5 149/9	I'd [8] 12/5 24/14 93/9 113/24 135/13 138/10 167/23 168/2		impacted [1] 6/21
I dare [1] 97/16	I represent [2] 78/6 83/8	I'll [7] 42/15 45/1 55/1 56/16 149/23 155/21 157/11		impacts [5] 57/2 58/13 61/19 66/16 177/17
I do [8] 38/6 40/21 67/15 149/24 154/11 179/13 183/14 195/17	I saw [1] 62/12	I'm [52] 2/23 8/20 11/16 14/11 29/22 34/18 37/10 42/2 42/13 43/17 46/6 48/16 55/15 77/19 78/5 90/1 93/2 93/15 95/18 99/14 103/6 109/2 113/16 113/22 114/1 123/16 133/16 135/3 136/8 145/17 149/2 149/14 152/8 153/5 155/12 157/6 157/18 158/12 166/6 166/7 172/1 172/25 173/15 174/20 185/20 185/21 186/15 189/24 193/20 193/22 197/7 197/11		implemented [7] 16/21 63/4 67/24 68/3 68/19 74/13 178/6
I don't [30] 8/20 14/12 39/2 42/14 63/6 67/13 75/25 84/6 97/1 98/14 100/17 104/22 111/15 125/25 133/2 133/7 134/19 149/5 152/4 152/25 159/24 166/17 176/19 183/1 185/11 186/12 186/18 191/14 191/15 192/6	I shall [4] 54/12 86/10 141/9 197/19	I'm sure [1] 197/7		imply [1] 7/21
I echo [1] 1/15	I should [3] 27/7 179/15 183/23	I've [21] 48/10 56/20 81/6 83/25 85/22 89/23 95/21 96/10 102/13 116/16 145/20 166/2 174/1 174/2 174/13 174/17 189/22 193/17 194/1 195/12 196/9		importance [7] 31/9 34/22 38/7 56/5 56/8 116/22 175/16
I feel [2] 67/5 75/25	I sort [1] 178/25	ICF [2] 121/16 122/3		important [47] 25/25 28/21 29/5 34/2 34/3 36/18 42/25 45/2 46/6 46/20 48/5 49/15 49/17 49/25 52/3 52/5 53/21 63/6 63/7 64/10 65/20 68/10 72/22 75/11 75/16 85/2 85/5 85/24 90/13 95/3 109/15 112/6 118/11 127/17 134/8 140/4 151/12 151/16 151/17 152/14 166/18 172/21 175/11 175/18 177/1 180/1 189/6
I felt [2] 92/13 135/21	I start [2] 45/6 68/25			impose [1] 181/8
I follow [2] 152/11 159/5	I suggested [1] 43/12			
I get [2] 88/5 115/17	I suppose [2] 90/11 115/13			
I guess [1] 102/17	I suspect [2] 130/8			
I had [3] 88/13 192/1 192/2				
I have [12] 6/4 30/17 31/23 36/20 44/5 89/8 93/11 93/14 129/5 130/16 138/12 193/16				
I haven't [3] 174/5 185/11 187/6				
I hope [4] 30/17 114/9 161/3 161/3				
I imagine [1] 125/15				
I just [25] 31/19 42/4 48/9 52/24 54/21 56/10 56/10 56/12 72/8 79/18 88/5 89/2 91/9 91/20 98/15 104/10 106/16 134/22				

I	46/24 61/1 77/25 97/18 100/22 102/7 106/14 110/17 112/19 115/1 129/2 130/23 135/11 139/20 144/8 145/22 159/14 162/6 168/24 171/5 179/19 181/8 197/14	initially [3] 52/9 74/24 87/13 injections [1] 137/24 innovation [1] 122/8 innovations [2] 5/12 5/15 innovative [1] 92/24 inordinate [1] 137/7 inpatient [1] 93/25 inpatients [1] 94/25 input [3] 30/13 30/15 62/13 INQ [1] 87/6 INQ000022748 [1] 93/14 INQ000058216 [1] 145/20 INQ000109673 [1] 150/8 INQ000110355 [1] 132/5 INQ000111776 [1] 138/12 INQ000239455 [1] 72/9 INQ000279947 [1] 136/16 INQ000325286 [1] 114/11 INQ000509808 [1] 1/19 INQ000512951 [1] 169/14 INQ000543049 [1] 155/19 INQ000565710 [1] 162/15 INQ000587737 [3] 124/19 164/18 177/14 INQ000591762 [1] 22/2 INQ000595342 [1] 103/23 INQ000595344 [1] 99/24 INQ000608140 [1] 129/5 INQUIRY [35] 1/11 1/13 2/23 15/18 25/20 28/4 42/25 43/22 51/14 74/20 82/4 85/22 86/2 86/7 86/20 87/24 88/8 114/2 114/24 124/4 135/22 157/13 159/24 166/9 174/21 174/24 182/15 193/22 193/23 197/5 197/8 197/16 198/4 198/9 198/14 inside [1] 37/2 insight [3] 29/23 78/24 79/1 insights [1] 2/12 insofar [1] 114/6	inspected [1] 165/19 inspecting [1] 195/22 inspection [2] 110/12 192/8 inspections [1] 181/11 inspector [1] 143/7 inspectors [1] 143/8 inspects [2] 180/9 180/18 instance [1] 178/19 instances [2] 63/8 80/15 instantly [1] 140/18 instead [2] 16/14 20/20 Institute [1] 108/25 instructing [1] 181/17 instructions [1] 62/19 insufficient [1] 184/6 integrated [2] 78/15 79/4 integrity [1] 21/1 intelligence [4] 11/1 72/15 140/16 140/17 intelligible [1] 136/3 intending [1] 23/3 intense [1] 45/14 intention [1] 102/15 interacted [1] 10/18 interaction [1] 42/8 interactive [1] 168/23 interest [2] 104/15 194/19 interested [2] 143/10 143/14 interesting [3] 133/24 154/15 195/10 interim [2] 87/13 164/13 interject [1] 135/14 internally [1] 98/12 interpretation [3] 79/25 83/15 196/13 interrogate [1] 74/16 interrupt [2] 31/19 149/2 intervene [1] 23/10 intervened [1] 23/13 interventions [1] 150/3 interviews [1] 178/21 into [83] 8/4 9/10 10/3 11/1 13/8 27/22 30/15 32/11 39/16 39/17 40/1 40/10 40/19 49/22 58/24 62/6 62/14 63/19 63/25 64/23 67/8 67/10 69/7 78/15 79/1 85/9 85/10 88/5 90/22	96/21 97/8 98/4 98/21 99/9 102/4 105/1 107/10 111/7 111/9 111/13 113/3 115/17 115/20 115/23 116/2 119/23 120/20 121/7 121/8 123/8 137/7 138/10 138/14 143/15 144/20 144/24 145/3 145/13 148/17 153/14 156/5 157/23 158/5 158/9 158/10 159/12 163/20 167/19 168/15 170/14 172/23 179/11 179/21 186/19 187/5 187/18 187/19 190/7 191/19 194/5 195/1 195/6 195/25 introduced [3] 31/25 110/11 121/9 introduction [1] 157/25 invaluable [1] 55/7 investigate [1] 143/22 investigated [1] 177/17 investigation [1] 173/8 invisible [6] 55/14 55/18 81/7 84/21 84/24 85/14 invited [3] 30/7 30/10 33/2 invoke [2] 178/10 178/15 invoked [1] 194/24 involve [1] 143/19 involved [5] 8/22 79/5 91/9 169/4 169/7 involvement [4] 62/10 143/2 143/4 143/15 involving [3] 83/10 174/3 174/4 inwards [1] 36/22 Ireland [6] 24/8 33/7 47/17 76/21 147/17 189/4 is [373] is coming [1] 197/9 isn't [10] 15/16 22/4 27/13 27/17 61/20 70/24 113/2 152/19 165/11 190/21 isolate [5] 41/6 56/19 72/22 107/4 187/18 isolated [7] 15/1 56/17 57/10 60/4 73/22 113/1 163/13 isolating [2] 114/6 141/20 isolation [5] 18/11 110/18 110/20 119/16
----------	---	--	---	---

I	138/15 141/16 146/23 146/25 147/8 148/9 148/10 148/19 151/25 152/12 152/14 154/1 154/9 154/13 157/5 157/7 158/14 161/16 164/6 164/19 168/5 169/14 169/25 172/17 172/17 172/21 173/16 175/18 177/14 179/17 185/12 189/6 189/19 191/22 193/20 it's -- it [1] 94/11 Italy [1] 6/19 items [1] 127/1 iterations [3] 107/8 124/15 157/19 its [15] 1/14 4/16 17/2 30/4 30/15 37/15 40/22 41/21 47/12 90/9 109/24 156/5 168/15 172/13 174/12 itself [4] 58/4 161/22 169/13 195/2	July [10] 1/1 93/4 116/19 123/22 131/8 131/20 132/17 150/12 168/14 178/7 July 2020 [1] 178/7 July 2025 [1] 93/4 jump [1] 89/2 June [9] 40/6 108/11 127/17 150/7 152/6 153/8 153/22 176/13 192/12 June 2020 [2] 153/22 176/13 Jung [6] 43/9 54/9 54/17 77/25 78/2 86/11 just [139] 4/1 11/19 12/5 12/13 12/23 14/7 14/8 16/24 18/21 21/17 21/21 24/14 27/1 28/3 28/19 29/12 31/19 37/16 37/21 39/7 42/4 43/6 44/1 47/13 48/9 48/10 51/23 52/24 53/1 53/10 54/21 55/1 56/10 56/10 56/12 57/11 57/15 57/16 58/25 59/9 59/15 61/4 61/18 62/9 62/16 63/13 65/17 70/2 70/2 72/8 76/10 79/18 82/2 85/12 87/2 87/10 88/5 89/2 90/11 91/9 91/14 91/14 91/20 91/22 92/6 95/1 95/3 96/19 96/23 97/14 98/1 98/15 99/10 100/12 100/14 103/17 104/10 104/22 105/4 105/6 106/16 111/16 114/10 115/17 115/19 119/5 119/10 119/25 123/24 127/3 127/14 129/7 132/3 132/12 134/22 135/13 135/14 138/7 138/10 140/24 142/15 144/23 145/2 145/20 149/2 149/23 150/12 150/23 151/2 153/5 155/8 155/21 158/14 161/21 162/2 163/17 164/17 164/19 171/4 171/16 172/7 173/20 177/11 178/3 181/23 182/1 182/17 182/23 183/20 183/23 185/10 186/11 187/14 187/20 188/21 191/17 191/22 194/1 196/9 Justice [3] 37/20 42/1 182/5 Justice UK [2] 37/20 182/5	justification [1] 137/14 K Kate [1] 143/6 Kate Terroni [1] 143/6 KC [4] 37/17 182/2 198/5 198/15 Keegan [1] 92/1 keen [2] 149/9 158/20 keep [10] 13/12 44/1 53/2 56/17 56/18 69/12 69/16 81/8 148/13 161/2 keeping [3] 31/16 56/23 57/5 kept [5] 108/16 160/9 165/20 166/4 186/7 key [11] 8/1 19/16 33/13 58/13 58/21 59/3 61/18 63/9 65/21 106/12 164/21 kind [12] 32/17 50/5 51/8 71/5 73/6 82/11 105/13 105/25 108/13 110/6 134/16 180/2 kinds [4] 22/20 39/13 50/20 83/10 King's [1] 182/7 knee [1] 26/15 knew [10] 9/12 106/6 127/20 128/14 151/20 160/2 162/3 175/12 175/15 175/17 know [178] 10/24 15/3 15/6 16/23 21/20 27/10 31/12 46/2 52/13 52/15 55/22 57/6 58/20 58/24 59/9 59/10 59/13 60/15 60/17 61/15 61/16 62/7 64/16 65/7 66/16 67/9 67/11 67/11 68/1 68/2 68/9 68/21 71/15 73/4 74/8 74/17 75/13 77/5 78/10 78/18 78/19 81/15 81/22 82/15 82/15 83/3 85/12 90/8 90/13 90/17 91/7 98/9 98/16 99/11 101/12 102/3 102/3 102/16 102/19 103/4 103/6 104/22 104/24 106/3 106/16 107/24 109/7 109/19 110/3 110/8 110/16 111/4 111/7 111/12 112/11 112/23 113/2 113/6 113/10 115/9 115/18 116/3 116/21 117/3 117/4 118/13 122/24 124/5 125/2	125/12 125/21 125/25 126/17 127/15 128/4 128/20 130/2 130/14 130/17 130/19 131/4 132/23 132/25 133/2 133/5 133/7 133/17 133/18 134/2 134/19 137/4 137/22 140/2 140/8 140/9 142/14 144/9 145/10 146/16 146/22 149/5 151/11 152/25 154/14 154/15 154/16 155/1 155/13 158/20 159/24 160/4 160/24 161/1 162/9 164/7 164/11 165/24 166/9 166/17 166/19 167/17 168/8 168/9 170/23 171/16 174/9 174/18 176/23 179/14 180/11 183/1 185/11 185/22 186/11 186/12 186/14 186/17 187/13 187/13 187/16 187/20 187/21 188/20 191/5 191/9 191/13 191/17 191/23 191/25 192/3 192/10 193/9 194/7 194/20 195/9 195/10 195/14 195/18 knowing [3] 78/21 193/1 193/20 knowledge [11] 6/24 10/6 33/6 42/7 66/9 82/6 93/7 169/2 182/19 191/1 191/4 known [5] 1/23 15/21 96/3 127/7 183/12
isolation... [1] 157/16 issue [46] 2/17 23/5 24/12 26/1 64/12 71/14 92/14 97/3 98/2 99/13 99/15 99/16 105/4 105/14 110/7 110/11 115/21 116/1 116/1 117/13 117/14 119/8 119/20 119/21 119/22 120/2 121/3 127/25 128/2 131/11 131/15 133/21 137/13 142/4 142/25 147/11 151/25 154/6 162/13 167/1 167/11 174/5 176/19 182/6 183/22 187/12 issued [11] 7/10 8/17 65/7 65/11 76/7 76/7 79/11 142/21 146/14 185/2 186/17 issues [37] 2/1 2/4 2/10 6/8 10/16 11/25 15/8 18/22 19/1 23/21 25/22 38/9 42/3 44/24 58/18 58/21 67/13 71/2 75/22 91/25 97/23 98/22 99/13 99/19 105/12 107/1 109/20 110/6 120/1 131/14 133/25 136/20 143/13 163/15 180/11 182/10 183/11 issuing [2] 107/8 124/25 it [509] it in [1] 99/2 it's [119] 2/23 5/5 6/4 13/15 25/25 27/6 27/12 28/20 29/21 33/18 46/5 47/4 49/14 49/17 49/18 49/25 51/7 51/9 52/5 52/8 52/12 53/4 53/21 59/12 60/3 60/11 60/11 61/20 63/6 63/6 64/2 69/10 70/2 72/9 72/9 73/6 74/8 75/11 75/17 77/3 77/20 78/1 78/21 79/3 79/15 79/16 79/17 80/6 82/14 83/2 83/18 84/2 85/12 85/13 90/13 91/2 92/7 93/3 94/11 95/3 96/4 97/23 98/9 98/14 103/20 107/21 108/18 109/10 111/8 115/13 118/1 120/11 123/14 124/20 124/20 125/15 126/24 127/12 129/7 133/19 133/24 135/2 137/25 138/5	J jab [1] 34/22 James [1] 105/19 January [19] 97/25 99/17 111/1 117/23 132/2 134/11 136/10 136/22 137/7 141/18 142/20 143/12 144/17 169/17 169/22 182/12 183/3 184/12 184/14 January 2020 [1] 97/25 January 2021 [7] 99/17 111/1 117/23 132/2 134/11 141/18 169/22 Jenny [1] 159/1 jerk [1] 26/15 job [9] 6/7 13/16 13/19 14/11 14/13 92/10 156/17 188/21 192/2 job-sharing [1] 192/2 jobs [2] 89/14 120/9 John's [1] 78/7 join [4] 30/7 30/10 33/2 87/21 joined [3] 90/5 128/22 175/3 joining [2] 89/2 89/12 joint [4] 10/12 69/13 142/20 164/21 jointly [2] 72/11 105/18 Jones [6] 78/1 78/3 85/17 189/19 189/24 198/10 journey [1] 66/17 judge [1] 195/14	justification [1] 137/14 K Kate [1] 143/6 Kate Terroni [1] 143/6 KC [4] 37/17 182/2 198/5 198/15 Keegan [1] 92/1 keen [2] 149/9 158/20 keep [10] 13/12 44/1 53/2 56/17 56/18 69/12 69/16 81/8 148/13 161/2 keeping [3] 31/16 56/23 57/5 kept [5] 108/16 160/9 165/20 166/4 186/7 key [11] 8/1 19/16 33/13 58/13 58/21 59/3 61/18 63/9 65/21 106/12 164/21 kind [12] 32/17 50/5 51/8 71/5 73/6 82/11 105/13 105/25 108/13 110/6 134/16 180/2 kinds [4] 22/20 39/13 50/20 83/10 King's [1] 182/7 knee [1] 26/15 knew [10] 9/12 106/6 127/20 128/14 151/20 160/2 162/3 175/12 175/15 175/17 know [178] 10/24 15/3 15/6 16/23 21/20 27/10 31/12 46/2 52/13 52/15 55/22 57/6 58/20 58/24 59/9 59/10 59/13 60/15 60/17 61/15 61/16 62/7 64/16 65/7 66/16 67/9 67/11 67/11 68/1 68/2 68/9 68/21 71/15 73/4 74/8 74/17 75/13 77/5 78/10 78/18 78/19 81/15 81/22 82/15 82/15 83/3 85/12 90/8 90/13 90/17 91/7 98/9 98/16 99/11 101/12 102/3 102/3 102/16 102/19 103/4 103/6 104/22 104/24 106/3 106/16 107/24 109/7 109/19 110/3 110/8 110/16 111/4 111/7 111/12 112/11 112/23 113/2 113/6 113/10 115/9 115/18 116/3 116/21 117/3 117/4 118/13 122/24 124/5 125/2	125/12 125/21 125/25 126/17 127/15 128/4 128/20 130/2 130/14 130/17 130/19 131/4 132/23 132/25 133/2 133/5 133/7 133/17 133/18 134/2 134/19 137/4 137/22 140/2 140/8 140/9 142/14 144/9 145/10 146/16 146/22 149/5 151/11 152/25 154/14 154/15 154/16 155/1 155/13 158/20 159/24 160/4 160/24 161/1 162/9 164/7 164/11 165/24 166/9 166/17 166/19 167/17 168/8 168/9 170/23 171/16 174/9 174/18 176/23 179/14 180/11 183/1 185/11 185/22 186/11 186/12 186/14 186/17 187/13 187/13 187/16 187/20 187/21 188/20 191/5 191/9 191/13 191/17 191/23 191/25 192/3 192/10 193/9 194/7 194/20 195/9 195/10 195/14 195/18 knowing [3] 78/21 193/1 193/20 knowledge [11] 6/24 10/6 33/6 42/7 66/9 82/6 93/7 169/2 182/19 191/1 191/4 known [5] 1/23 15/21 96/3 127/7 183/12	
L				
Lab [1] 70/13 lack [16] 11/16 11/20 11/20 14/8 24/1 24/20 30/22 57/8 68/15 72/4 80/24 82/6 88/19 131/18 157/16 180/15 lacking [2] 184/21 186/5 Lady [24] 1/4 1/15 32/23 37/13 41/20 41/24 42/17 43/6 43/10 43/14 54/11 54/16 77/19 78/4 86/16 134/22 141/5 141/14 181/20 189/15 189/21 190/2 197/1 197/20 Ladyship [1] 118/25 landed [1] 154/1 language [3] 13/9 58/7 83/19 laptop [1] 51/7 large [10] 12/21 21/4 48/17 59/8 62/2 99/5				

L	116/16 117/7 117/15 117/20 118/11 119/17 119/18 120/3 177/20 181/10 194/25 legislative [3] 16/10 108/18 114/25 length [1] 148/20 lens [1] 39/8 less [20] 6/15 8/9 8/23 17/12 18/24 18/24 31/12 37/9 38/20 38/21 38/24 70/25 74/2 90/23 112/18 121/2 123/18 126/2 151/19 158/18 lesser [1] 144/4 lessons [4] 19/13 19/17 42/11 173/5 let [5] 34/20 64/22 149/23 161/21 166/9 let's [1] 180/12 lethal [2] 160/4 160/6 letter [2] 21/23 22/17 letting [1] 132/25 level [25] 3/8 56/24 66/10 69/2 69/4 72/23 95/11 96/13 96/14 103/22 104/11 110/15 133/2 133/6 133/6 133/7 134/8 150/18 164/25 165/10 165/14 170/10 170/11 170/23 183/5 levels [4] 57/17 117/19 139/4 183/6 lever [1] 121/17 levers [3] 180/14 180/22 181/7 levied [1] 180/16 LGA [2] 100/25 128/15 lies [2] 32/21 96/19 life [7] 6/9 18/19 24/14 24/22 28/10 29/2 32/6 light [3] 100/5 192/14 192/17 like [83] 2/18 3/13 5/5 5/5 5/23 8/10 9/13 9/17 9/19 10/8 12/5 13/20 14/24 15/5 21/1 21/3 21/23 22/5 24/14 28/19 28/21 29/21 31/3 32/16 32/20 34/23 35/7 35/11 36/1 36/13 45/8 49/7 53/2 54/9 56/21 58/6 61/23 65/18 65/20 72/19 73/3 74/3 77/9 80/6 80/13 81/11 81/23 83/4 83/8 85/9 88/10 89/19 93/9 95/22 95/23 104/18 104/23 104/25 113/24 128/17	130/5 135/13 137/8 137/23 138/10 138/19 146/24 151/15 154/7 154/19 158/9 163/21 165/14 165/17 167/23 168/2 174/23 175/1 175/4 176/5 184/23 185/10 193/18 like' [1] 164/24 likely [10] 18/6 37/10 38/18 38/23 39/10 70/17 70/25 74/2 74/3 75/20 limited [5] 7/1 109/4 112/17 141/23 142/15 limiting [2] 114/18 196/14 line [4] 63/16 83/16 143/11 196/4 lines [2] 16/1 148/19 linkages [2] 64/16 71/19 linked [7] 69/25 70/18 70/20 71/5 71/9 73/13 172/7 links [1] 30/4 list [18] 34/19 68/6 74/10 74/22 85/4 85/4 92/22 93/1 93/2 115/21 115/22 116/9 116/10 116/11 123/4 125/16 154/11 164/6 listen [2] 13/7 36/23 listened [2] 83/23 84/10 lists [6] 70/8 70/14 70/16 70/24 71/15 74/19 little [14] 29/21 34/17 44/2 48/1 57/16 66/15 81/18 87/1 87/10 137/16 149/20 178/8 182/9 184/16 live [2] 84/2 132/16 lived [1] 29/7 lives [8] 6/15 18/14 20/25 29/8 46/23 59/24 79/1 88/22 living [15] 11/11 16/5 18/16 24/4 28/13 30/22 65/8 120/24 121/1 123/20 153/18 177/18 189/7 189/9 193/25 lobby [1] 178/12 local [137] 3/3 3/12 9/13 15/19 15/25 23/22 44/8 50/19 53/19 59/20 59/22 60/5 60/14 60/25 64/17 64/18 64/21 65/1 69/2 69/4 69/12 69/15 69/17 70/14 70/15 71/16 72/1 73/2	74/11 74/15 75/16 92/20 94/12 95/9 95/10 95/24 96/11 96/13 96/14 96/17 100/4 100/5 100/15 100/20 100/24 101/2 101/6 101/10 101/16 101/21 101/24 102/9 102/12 102/23 103/11 103/15 103/17 103/21 104/1 106/21 106/23 109/15 109/24 110/10 110/12 110/20 111/6 113/19 121/20 121/23 122/8 122/12 132/9 133/3 133/16 133/18 137/23 139/11 139/13 143/19 145/22 155/24 156/3 156/9 156/10 156/16 156/17 156/22 157/3 157/4 157/9 168/23 170/4 170/13 170/14 171/15 175/25 176/7 176/8 176/11 176/15 176/24 178/5 178/7 178/9 178/10 178/14 178/20 179/1 179/3 180/7 180/9 181/17 183/5 184/21 185/8 185/23 190/12 190/15 190/19 191/2 191/5 191/19 191/24 192/5 192/15 192/19 192/23 193/2 193/6 193/13 193/24 194/24 195/22 196/1 196/5 196/14 locally [5] 53/18 69/23 95/4 95/7 144/10 location [1] 132/9 lockdown [4] 80/9 179/13 179/18 186/13 lockdowns [1] 19/6 locked [1] 88/21 logical [1] 135/20 logistical [1] 127/9 London [3] 98/24 153/18 169/23 loneliness [1] 18/12 lonely [1] 15/1 long [17] 17/1 17/25 31/7 32/20 45/17 46/24 48/14 67/25 79/13 84/11 111/17 116/15 116/21 117/8 117/20 137/23 152/11 long-term [3] 45/17 48/14 137/23 longer [2] 77/7 173/16 look [52] 31/18 35/7 36/22 39/1 39/7 45/10 49/2 50/25 57/11 59/5	59/7 68/3 70/8 72/13 75/19 80/5 83/22 93/4 93/17 98/22 101/19 107/20 114/10 115/21 118/23 123/4 124/18 125/19 129/5 131/11 132/4 134/12 135/13 138/10 146/10 146/25 150/8 151/2 155/19 162/14 164/17 168/2 169/13 170/19 172/11 172/16 177/6 189/19 191/19 194/6 195/20 195/24 looked [20] 16/23 27/25 57/3 70/13 71/24 96/12 99/10 104/1 104/12 105/7 105/13 110/13 131/8 134/5 135/12 143/15 154/4 170/7 180/15 195/21 looking [15] 39/4 48/16 64/9 72/6 92/17 97/11 104/3 105/14 105/15 123/4 134/18 171/7 173/16 173/17 180/11 looks [9] 16/12 50/22 95/22 95/23 95/23 104/17 104/23 104/24 164/24 lose [2] 18/20 120/8 loss [1] 17/10 lost [3] 76/2 88/22 118/15 lot [41] 2/25 3/8 3/16 3/18 4/21 4/22 7/3 7/14 16/9 21/15 23/7 25/8 26/18 27/15 28/4 35/23 36/24 47/10 48/8 53/19 62/2 62/15 65/14 67/4 68/7 68/18 89/12 89/17 96/19 97/10 98/4 107/2 115/18 116/14 118/15 129/25 145/15 146/3 155/13 174/2 185/19 lots [9] 15/7 30/20 30/20 41/12 58/8 91/5 103/15 138/5 174/1 loud [1] 128/1 Louise [3] 98/20 118/23 119/8 loved [12] 28/3 28/8 28/15 29/3 29/4 30/23 31/16 31/22 31/23 36/12 36/14 56/23 low [10] 131/9 131/22 132/8 132/23 133/2 133/8 133/9 133/11 134/7 176/11 lower [9] 3/8 38/18 110/9 123/13 151/5
----------	--	--	--	---

<p>L</p> <p>lower... [4] 155/6 176/4 178/1 179/9</p> <p>lower-level [1] 3/8</p> <p>lowest [1] 50/5</p> <p>lunch [2] 3/13 86/8</p> <p>M</p> <p>made [35] 4/17 7/18 7/19 8/10 9/11 10/9 11/13 13/4 13/22 16/24 18/6 18/11 19/8 32/6 37/9 67/6 67/22 68/17 71/19 72/11 74/21 76/16 79/5 87/5 141/24 158/24 167/22 167/25 172/8 175/1 175/4 176/4 180/5 185/13 196/9</p> <p>main [8] 69/22 79/2 87/7 96/24 100/4 143/5 143/11 177/21</p> <p>mainly [1] 167/12</p> <p>maintain [2] 63/17 148/13</p> <p>Majesty's [1] 82/24</p> <p>major [3] 97/11 105/14 185/3</p> <p>majority [4] 38/1 48/18 91/12 150/21</p> <p>make [26] 7/6 41/9 53/15 53/21 67/16 71/6 75/3 107/25 109/25 113/17 115/17 117/2 117/16 135/20 143/8 149/22 157/20 159/11 159/13 160/13 161/7 172/6 173/6 177/19 178/23 191/11</p> <p>makers [6] 23/22 53/13 56/4 56/7 66/25 82/9</p> <p>makes [4] 52/13 158/17 160/23 179/16</p> <p>making [10] 3/9 31/21 49/12 66/8 89/20 109/4 159/3 174/23 175/6 183/20</p> <p>manage [3] 104/6 109/18 186/25</p> <p>managed [2] 19/21 126/18</p> <p>managers [8] 14/16 14/25 15/10 15/13 32/7 139/11 139/11 186/8</p> <p>managing [1] 12/25</p> <p>Manchester [3] 177/2 177/15 179/16</p> <p>mandate [1] 156/3</p> <p>mandatory [6] 107/22 108/1 108/5 147/18 148/7 173/1</p>	<p>manifested [1] 58/4</p> <p>manner [1] 64/7</p> <p>many [37] 2/17 4/20 5/1 5/24 8/2 9/17 11/10 12/2 14/10 17/8 17/10 18/14 18/16 18/22 21/17 24/12 25/19 29/9 44/9 47/6 93/5 99/13 109/7 111/4 111/7 162/5 163/1 169/3 169/7 170/7 170/7 170/23 177/25 181/3 189/3 189/4 191/14</p> <p>March [45] 7/9 7/9 30/9 40/5 40/23 65/7 72/12 74/9 91/10 102/1 102/5 105/9 106/9 106/20 107/16 124/10 125/2 125/3 125/17 126/4 126/15 129/7 137/15 160/7 160/21 164/23 180/1 184/15 184/19 185/2 185/15 185/16 185/17 185/18 185/19 185/20 185/21 186/10 186/11 186/14 186/17 186/19 187/4 187/11 187/25</p> <p>March 2020 [8] 40/23 74/9 106/9 129/7 160/7 184/15 187/4 187/11</p> <p>March 2021 [2] 30/9 137/15</p> <p>March 2022 [1] 164/23</p> <p>market [2] 59/7 109/18</p> <p>masks [8] 125/1 125/4 125/10 125/20 130/20 188/8 188/11 188/13</p> <p>mass [1] 18/20</p> <p>massively [3] 89/10 117/9 175/22</p> <p>match [1] 64/14</p> <p>material [1] 197/6</p> <p>materialise [1] 11/5</p> <p>materialised [1] 7/23</p> <p>Matt [1] 149/9</p> <p>matter [8] 13/6 49/3 49/19 62/16 63/1 152/14 194/18 194/19</p> <p>mattered [1] 151/19</p> <p>matters [9] 44/22 45/5 50/8 119/12 120/10 130/10 134/24 140/6 175/19</p> <p>maximum [1] 54/25</p> <p>may [56] 1/4 2/1 2/5 12/6 12/19 16/15 18/6 20/25 21/23 22/2 25/21 28/15 32/1 33/2</p>	<p>33/5 42/7 50/19 55/1 57/15 86/18 87/16 99/21 101/25 103/10 108/7 108/7 110/8 110/13 112/17 112/19 115/7 116/17 122/6 123/12 127/17 130/8 131/19 134/22 142/18 146/7 146/13 146/15 149/6 160/21 168/8 169/15 172/24 173/14 174/2 175/15 176/7 181/3 184/24 190/9 190/23 197/6</p> <p>May 15 [1] 108/7</p> <p>May 2020 [1] 122/6</p> <p>May 2021 [1] 87/16</p> <p>May of [1] 146/13</p> <p>maybe [11] 21/2 89/11 94/4 96/2 117/5 120/12 148/19 162/8 165/22 165/23 169/6</p> <p>me [19] 32/2 35/25 53/15 67/18 86/16 88/16 90/2 95/1 128/17 129/7 129/9 135/17 157/7 161/21 161/21 162/17 168/25 172/25 193/21</p> <p>meals [1] 3/7</p> <p>mean [89] 8/8 14/24 16/2 27/21 35/8 53/20 62/16 63/16 64/20 67/3 69/8 89/6 89/9 89/14 90/12 93/7 97/1 98/1 98/2 98/8 98/20 99/13 102/10 103/14 104/22 105/2 106/25 107/10 109/10 111/8 113/4 117/6 118/14 118/18 119/18 119/19 120/18 125/15 126/17 126/24 127/24 130/16 131/19 133/3 133/23 134/18 137/6 142/2 143/10 144/11 146/19 148/9 148/14 148/15 148/19 152/25 154/9 154/24 155/12 155/13 156/23 157/8 158/23 159/23 160/22 161/3 161/25 162/5 164/4 168/10 168/12 172/15 172/18 174/13 178/24 179/5 179/23 182/24 183/13 183/15 185/12 186/16 187/12 191/3 192/21 193/16 194/1 195/10 195/11</p> <p>meaningful [1] 168/13</p> <p>meaningfully [1] 62/13</p> <p>means [10] 18/21</p>	<p>20/1 33/24 73/8 76/15 76/19 94/18 109/18 162/8 188/13</p> <p>means-tested [2] 76/15 76/19</p> <p>meant [10] 5/6 11/12 15/19 18/22 24/21 31/1 48/2 82/12 122/4 127/2</p> <p>measure [5] 48/6 94/18 98/10 98/13 150/17</p> <p>measured [1] 98/12</p> <p>measures [5] 40/13 42/5 57/12 69/11 154/21</p> <p>mechanism [1] 167/9</p> <p>mechanisms [2] 63/24 85/8</p> <p>media [2] 6/20 178/12</p> <p>medical [5] 11/24 27/25 31/2 130/23 173/7</p> <p>medically [1] 25/6</p> <p>medication [3] 18/7 20/4 20/4</p> <p>medications [3] 24/15 24/17 24/22</p> <p>meet [5] 10/15 124/21 126/11 193/13 194/13</p> <p>meeting [8] 10/12 102/1 102/5 103/24 138/20 153/14 184/18 185/10</p> <p>meetings [2] 168/24 174/22</p> <p>member [5] 101/8 125/9 138/4 142/13 144/2</p> <p>members [18] 25/24 32/2 52/15 58/19 84/13 101/3 101/4 114/7 114/16 123/7 125/11 138/20 149/20 155/11 158/14 177/23 179/9 195/13</p> <p>members/population [1] 101/3</p> <p>membership [1] 44/12</p> <p>mental [6] 18/10 45/16 57/1 58/9 139/4 147/5</p> <p>mention [2] 153/5 163/8</p> <p>mentioned [12] 93/8 97/6 98/23 104/14 105/15 114/4 121/12 135/1 160/12 171/3 182/11 197/4</p> <p>message [3] 143/9 143/11 144/8</p>	<p>messages [4] 52/13 70/22 73/20 85/6</p> <p>messaging [3] 55/15 55/21 144/23</p> <p>met [4] 2/11 26/23 180/17 196/8</p> <p>methods [1] 20/8</p> <p>MHCLG [2] 101/23 102/15</p> <p>Michelle [4] 86/18 86/19 86/25 198/12</p> <p>microphone [1] 87/2</p> <p>mid [5] 40/4 125/2 134/23 184/14 184/14</p> <p>mid-afternoon [1] 134/23</p> <p>mid-January [1] 184/14</p> <p>mid-March [1] 125/2</p> <p>middle [5] 7/25 93/23 104/2 162/18 162/21</p> <p>Midlands [1] 176/8</p> <p>might [48] 11/23 16/18 20/18 31/7 34/1 35/7 45/15 45/21 51/8 56/18 59/6 60/1 61/15 62/19 64/16 70/18 72/23 80/5 90/22 91/20 92/8 99/2 99/5 99/6 99/8 107/20 109/19 109/21 109/23 109/23 109/24 111/11 112/5 119/25 119/25 122/16 123/15 130/16 133/12 149/13 172/11 176/18 177/8 177/11 181/7 189/20 190/13 195/1</p> <p>miles [1] 81/13</p> <p>million [20] 45/11 46/10 46/13 47/3 47/5 47/11 47/14 47/23 91/15 91/19 108/7 117/23 121/13 122/17 126/25 132/22 136/11 147/15 183/14 184/13</p> <p>millions [2] 44/9 44/13</p> <p>mind [5] 87/1 136/6 142/18 145/19 152/6</p> <p>mine [2] 8/10 88/15</p> <p>minimise [1] 22/8</p> <p>minimising [1] 163/13</p> <p>minimum [2] 54/25 118/13</p> <p>minister [14] 10/18 37/6 101/15 102/6 142/9 143/1 156/2 174/18 182/12 183/3 184/1 190/8 192/12 196/11</p> <p>ministerial [1] 164/15</p>
---	---	---	--	--

M	month [5] 7/18 7/22 65/10 108/19 132/17	118/18 123/8	189/25 190/1 197/2 198/16	195/14 197/2 197/14
ministers [5] 31/5 143/10 143/14 168/24 169/10	months [14] 25/3 30/19 32/12 90/16 99/15 99/20 105/23 113/12 138/25 139/3 153/11 154/16 181/3 196/21	moved [4] 71/9 120/19 120/20 189/11	Ms Carey [8] 86/17 141/13 149/2 149/5 181/22 182/7 189/16 189/21	multiple [3] 153/19 164/5 167/1
Ministry [1] 94/11	minorities [2] 37/23 70/25	movement [28] 89/18 113/25 114/19 115/4 115/16 115/19 115/25 116/7 116/15 116/16 116/19 116/20 116/23 117/1 117/4 117/17 118/5 119/10 119/14 119/20 119/21 120/2 120/11 120/17 121/6 170/20 175/14 175/16	Ms Caroline Abrahams [1] 1/5	mum [5] 6/6 34/8 56/16 81/14 81/21
minoritised [3] 37/25 38/10 38/17	morbidity [1] 112/23	more [97] 4/5 7/11 8/22 10/16 15/9 15/12 15/13 16/10 16/16 17/23 18/4 18/6 19/8 19/20 19/24 20/6 22/23 25/1 26/25 27/14 29/19 30/2 32/13 32/13 33/18 33/24 33/25 34/2 34/3 34/10 35/13 35/22 36/1 36/2 36/7 36/18 36/23 37/7 38/10 38/18 38/23 38/24 39/7 39/12 40/6 45/14 46/12 48/2 51/12 53/22 57/3 67/11 68/12 70/17 70/25 73/15 73/17 74/3 75/20 81/1 83/2 85/7 90/23 95/6 99/17 105/5 106/8 119/4 119/16 122/22 124/16 128/12 128/14 132/21 133/17 133/18 133/19 138/4 140/22 142/4 142/17 150/4 150/18 152/21 156/22 160/2 160/4 160/6 165/10 166/20 175/13 179/13 181/4 181/23 184/16 186/16 195/13	Ms Dyson [36] 86/21 86/24 88/24 92/6 93/15 97/16 101/14 105/9 109/2 112/3 114/2 123/12 127/11 128/25 134/25 137/12 141/7 141/15 143/3 146/9 149/5 149/24 152/24 155/4 155/22 161/17 167/13 169/20 178/3 181/19 181/23 182/4 189/20 189/23 190/3 197/4	must [6] 21/18 108/8 128/4 144/24 164/2 187/18
minority [6] 32/9 149/19 153/17 155/5 155/11 155/16	more [97] 4/5 7/11 8/22 10/16 15/9 15/12 15/13 16/10 16/16 17/23 18/4 18/6 19/8 19/20 19/24 20/6 22/23 25/1 26/25 27/14 29/19 30/2 32/13 32/13 33/18 33/24 33/25 34/2 34/3 34/10 35/13 35/22 36/1 36/2 36/7 36/18 36/23 37/7 38/10 38/18 38/23 38/24 39/7 39/12 40/6 45/14 46/12 48/2 51/12 53/22 57/3 67/11 68/12 70/17 70/25 73/15 73/17 74/3 75/20 81/1 83/2 85/7 90/23 95/6 99/17 105/5 106/8 119/4 119/16 122/22 124/16 128/12 128/14 132/21 133/17 133/18 133/19 138/4 140/22 142/4 142/17 150/4 150/18 152/21 156/22 160/2 160/4 160/6 165/10 166/20 175/13 179/13 181/4 181/23 184/16 186/16 195/13	moving [11] 20/10 46/15 89/22 89/25 90/23 115/19 116/2 148/17 180/14 186/18 197/13	muscle [1] 18/20	
minute [2] 135/14 176/5	misapprehension [2] 130/3 130/12	Mr [7] 9/19 41/22 41/23 42/18 91/23 121/17 198/6	Ms Emily [2] 43/14 43/25	mustn't [1] 145/1
minutes [3] 99/25 105/6 105/7	misheard [1] 108/23	Mr Foley [4] 41/22 41/23 42/18 198/6	Ms Hands [2] 1/3 31/19	mutual [1] 144/10
minutes' [1] 86/8	misinterpretation [1] 75/10	Mr Hancock [2] 91/23 121/17	Ms Holzhausen [4] 43/16 54/19 78/5 85/19	my [61] 1/4 1/15 6/5 6/6 6/7 30/17 32/21 32/23 34/8 37/13 37/13 39/15 41/19 41/20 41/24 42/13 42/17 42/20 43/6 43/10 43/11 43/14 43/18 43/25 54/11 54/16 77/19 77/24 78/4 85/16 86/9 86/16 88/8 93/7 102/15 103/20 105/19 109/11 128/1 129/10 134/2 134/22 140/13 141/5 141/14 146/5 168/2 169/5 180/14 181/20 182/5 182/25 184/15 187/23 187/23 189/15 189/15 189/21 190/2 197/1 197/20
misleading [1] 49/5	missed [1] 75/25	Mr Pearson [1] 9/19	Ms Jones [6] 78/1 78/3 85/17 189/19 189/24 198/10	my Lady [21] 1/4 1/15 32/23 37/13 41/20 41/24 42/17 43/6 43/10 54/11 77/19 78/4 86/16 134/22 141/5 141/14 181/20 189/15 189/21 190/2 197/1
missing [3] 11/8 92/23 186/10	mistake [1] 31/18	Ms [97] 1/3 1/5 1/6 1/7 1/12 31/19 31/20 35/10 37/12 37/15 37/16 37/17 37/19 41/19 41/21 41/25 42/19 43/9 43/14 43/15 43/16 43/25 54/9 54/17 54/19 77/25 78/1 78/2 78/3 78/5 85/17 85/19 86/11 86/17 86/19 86/21 86/24 88/24 92/1 92/6 93/15 97/16 101/14 105/9 109/2 112/3 114/2 123/12 127/11 128/25 134/25 137/12 138/18 139/17 139/25 141/7 141/13 141/15 143/3 146/9 149/2 149/5 149/5 149/24 152/24 155/4 155/4 155/22 161/17 167/13 167/13 169/20 178/3 181/19 181/22 181/23 182/1 182/2 182/4 182/7 189/16 189/18 189/19 189/20 189/21 189/23 189/24 189/25 190/1 190/3 197/2 197/4 198/3 198/5 198/8 198/10 198/12 198/15 198/16	Ms Jung [6] 43/9 54/9 54/17 77/25 78/2 86/11	myself [1] 172/25
misunderstand [1] 128/8	misunderstanding [2] 162/3 162/12	Ms [97] 1/3 1/5 1/6 1/7 1/12 31/19 31/20 35/10 37/12 37/15 37/16 37/17 37/19 41/19 41/21 41/25 42/19 43/9 43/14 43/15 43/16 43/25 54/9 54/17 54/19 77/25 78/1 78/2 78/3 78/5 85/17 85/19 86/11 86/17 86/19 86/21 86/24 88/24 92/1 92/6 93/15 97/16 101/14 105/9 109/2 112/3 114/2 123/12 127/11 128/25 134/25 137/12 138/18 139/17 139/25 141/7 141/13 141/15 143/3 146/9 149/2 149/5 149/5 149/24 152/24 155/4 155/22 161/17 167/13 169/20 178/3 181/19 181/22 181/23 182/1 182/2 182/4 182/7 189/16 189/18 189/19 189/20 189/21 189/23 189/24 189/25 190/1 190/3 197/2 197/4 198/3 198/5 198/8 198/10 198/12 198/15 198/16	Ms Keegan [1] 92/1	N
misunderstanding [2] 162/3 162/12	mitigate [3] 136/20 141/25 152/2	Ms [97] 1/3 1/5 1/6 1/7 1/12 31/19 31/20 35/10 37/12 37/15 37/16 37/17 37/19 41/19 41/21 41/25 42/19 43/9 43/14 43/15 43/16 43/25 54/9 54/17 54/19 77/25 78/1 78/2 78/3 78/5 85/17 85/19 86/11 86/17 86/19 86/21 86/24 88/24 92/1 92/6 93/15 97/16 101/14 105/9 109/2 112/3 114/2 123/12 127/11 128/25 134/25 137/12 138/18 139/17 139/25 141/7 141/13 141/15 143/3 146/9 149/2 149/5 149/5 149/24 152/24 155/4 155/22 161/17 167/13 169/20 178/3 181/19 181/22 181/23 182/1 182/2 182/4 182/7 189/16 189/18 189/19 189/20 189/21 189/23 189/24 189/25 190/1 190/3 197/2 197/4 198/3 198/5 198/8 198/10 198/12 198/15 198/16	Ms Morris [8] 37/15 37/17 41/21 182/1 182/2 189/18 198/5 198/15	NACAS [2] 125/8 125/9
mix [1] 56/3	Mm [3] 3/20 11/7 66/6	Ms [97] 1/3 1/5 1/6 1/7 1/12 31/19 31/20 35/10 37/12 37/15 37/16 37/17 37/19 41/19 41/21 41/25 42/19 43/9 43/14 43/15 43/16 43/25 54/9 54/17 54/19 77/25 78/1 78/2 78/3 78/5 85/17 85/19 86/11 86/17 86/19 86/21 86/24 88/24 92/1 92/6 93/15 97/16 101/14 105/9 109/2 112/3 114/2 123/12 127/11 128/25 134/25 137/12 138/18 139/17 139/25 141/7 141/13 141/15 143/3 146/9 149/2 149/5 149/5 149/24 152/24 155/4 155/22 161/17 167/13 169/20 178/3 181/19 181/22 181/23 182/1 182/2 182/4 182/7 189/16 189/18 189/19 189/20 189/21 189/23 189/24 189/25 190/1 190/3 197/2 197/4 198/3 198/5 198/8 198/10 198/12 198/15 198/16	Ms Morray [3] 138/18 139/17 139/25	Nadra [1] 129/8
models [2] 64/8 64/10	modest [1] 51/13	Ms [97] 1/3 1/5 1/6 1/7 1/12 31/19 31/20 35/10 37/12 37/15 37/16 37/17 37/19 41/19 41/21 41/25 42/19 43/9 43/14 43/15 43/16 43/25 54/9 54/17 54/19 77/25 78/1 78/2 78/3 78/5 85/17 85/19 86/11 86/17 86/19 86/21 86/24 88/24 92/1 92/6 93/15 97/16 101/14 105/9 109/2 112/3 114/2 123/12 127/11 128/25 134/25 137/12 138/18 139/17 139/25 141/7 141/13 141/15 143/3 146/9 149/2 149/5 149/5 149/24 152/24 155/4 155/22 161/17 167/13 169/20 178/3 181/19 181/22 181/23 182/1 182/2 182/4 182/7 189/16 189/18 189/19 189/20 189/21 189/23 189/24 189/25 190/1 190/3 197/2 197/4 198/3 198/5 198/8 198/10 198/12 198/15 198/16	much [75] 4/23 8/22 8/22 9/15 10/24 14/6 17/23 19/9 21/4 23/20 23/24 25/1 28/15 31/15 32/15 33/18 34/24 36/1 36/7 36/23 39/12 42/18 42/23 42/25 43/1 47/1 47/6 48/23 61/2 70/25 70/25 77/18 77/25 81/18 81/19 81/23 81/24 85/16 85/17 85/19 86/1 86/11 95/10 95/12 98/13 99/9 100/14 102/4 107/1 119/9 130/9 135/20 136/5 137/17 148/6 151/5 151/14 157/22 159/2 160/2 161/4 162/19 166/13 166/18 169/14 177/5 181/9 181/9 181/19 189/14 189/17 189/19	naive [1] 11/22
modification [1] 176/1	module [5] 1/18 1/25 26/20 86/20 198/14	Ms [97] 1/3 1/5 1/6 1/7 1/12 31/19 31/20 35/10 37/12 37/15 37/16 37/17 37/19 41/19 41/21 41/25 42/19 43/9 43/14 43/15 43/16 43/25 54/9 54/17 54/19 77/25 78/1 78/2 78/3 78/5 85/17 85/19 86/11 86/17 86/19 86/21 86/24 88/24 92/1 92/6 93/15 97/16 101/14 105/9 109/2 112/3 114/2 123/12 127/11 128/25 134/25 137/12 138/18 139/17 139/25 141/7 141/13 141/15 143/3 146/9 149/2 149/5 149/5 149/24 152/24 155/4 155/22 161/17 167/13 169/20 178/3 181/19 181/22 181/23 182/1 182/2 182/4 182/7 189/16 189/18 189/19 189/20 189/21 189/23 189/24 189/25 190/1 190/3 197/2 197/4 198/3 198/5 198/8 198/10 198/12 198/15 198/16	Ms Morray [3] 138/18 139/17 139/25	name [4] 43/24 43/25 52/1 86/24
Module 3 [1] 26/20	Module 6 [1] 1/18	Ms [97] 1/3 1/5 1/6 1/7 1/12 31/19 31/20 35/10 37/12 37/15 37/16 37/17 37/19 41/19 41/21 41/25 42/19 43/9 43/14 43/15 43/16 43/25 54/9 54/17 54/19 77/25 78/1 78/2 78/3 78/5 85/17 85/19 86/11 86/17 86/19 86/21 86/24 88/24 92/1 92/6 93/15 97/16 101/14 105/9 109/2 112/3 114/2 123/12 127/11 128/25 134/25 137/12 138/18 139/17 139/25 141/7 141/13 141/15 143/3 146/9 149/2 149/5 149/5 149/24 152/24 155/4 155/22 161/17 167/13 169/20 178/3 181/19 181/22 181/23 182/1 182/2 182/4 182/7 189/16 189/18 189/19 189/20 189/21 189/23 189/24 189/25 190/1 190/3 197/2 197/4 198/3 198/5 198/8 198/10 198/12 198/15 198/16	Ms Morray [3] 138/18 139/17 139/25	narrative [4] 184/22 185/9 185/12 186/6
Module 6 [1] 1/18	modules [1] 1/14	Ms [97] 1/3 1/5 1/6 1/7 1/12 31/19 31/20 35/10 37/12 37/15 37/16 37/17 37/19 41/19 41/21 41/25 42/19 43/9 43/14 43/15 43/16 43/25 54/9 54/17 54/19 77/25 78/1 78/2 78/3 78/5 85/17 85/19 86/11 86/17 86/19 86/21 86/24 88/24 92/1 92/6 93/15 97/16 101/14 105/9 109/2 112/3 114/2 123/12 127/11 128/25 134/25 137/12 138/18 139/17 139/25 141/7 141/13 141/15 143/3 146/9 149/2 149/5 149/5 149/24 152/24 155/4 155/22 161/17 167/13 169/20 178/3 181/19 181/22 181/23 182/1 182/2 182/4 182/7 189/16 189/18 189/19 189/20 189/21 189/23 189/24 189/25 190/1 190/3 197/2 197/4 198/3 198/5 198/8 198/10 198/12 198/15 198/16	Ms Morray [3] 138/18 139/17 139/25	nation [2] 1/22 12/11
moment [9] 54/10 87/2 103/10 118/12 129/7 141/5 145/17 163/17 177/12	money [18] 4/4 4/24 11/20 34/2 98/4 99/2 116/13 116/24 121/24 122/8 122/22 137/5 137/14 138/6 181/14 181/15 184/3 184/6	Ms [97] 1/3 1/5 1/6 1/7 1/12 31/19 31/20 35/10 37/12 37/15 37/16 37/17 37/19 41/19 41/21 41/25 42/19 43/9 43/14 43/15 43/16 43/25 54/9 54/17 54/19 77/25 78/1 78/2 78/3 78/5 85/17 85/19 86/11 86/17 86/19 86/21 86/24 88/24 92/1 92/6 93/15 97/16 101/14 105/9 109/2 112/3 114/2 123/12 127/11 128/25 134/25 137/12 138/18 139/17 139/25 141/7 141/13 141/15 143/3 146/9 149/2 149/5 149/5 149/24 152/24 155/4 155/22 161/17 167/13 169/20 178/3 181/19 181/22 181/23 182/1 182/2 182/4 182/7 189/16 189/18 189/19 189/20 189/21 189/23 189/24 189/25 190/1 190/3 197/2 197/4 198/3 198/5 198/8 198/10 198/12 198/15 198/16	Ms Morray [3] 138/18 139/17 139/25	national [22] 23/22 35/6 36/1 36/2 55/14 55/21 71/7 99/25 105/6 105/8 121/25 126/4 129/6 129/8 129/13 138/16 145/22 146/24 170/10 171/5 184/18 196/13
monitor [4] 34/7 94/18 108/16 109/18	monitoring [5] 192/13 192/17 193/5 193/8 193/12	Ms [97] 1/3 1/5 1/6 1/7 1/12 31/19 31/20 35/10 37/12 37/15 37/16 37/17 37/19 41/19 41/21 41/25 42/19 43/9 43/14 43/15 43/16 43/25 54/9 54/17 54/19 77/25 78/1 78/2 78/3 78/5 85/17 85/19 86/11 86/17 86/19 86/21 86/24 88/24 92/1 92/6 93/15 97/16 101/14 105/9 109/2 112/3 114/2 123/12 127/11 128/25 134/25 137/12 138/18 139/17 139/25 141/7 141/13 141/15 143/3 146/9 149/2 149/5 149/5 149/24 152/24 155/4 155/22 161/17 167/13 169/20 178/3 181/19 181/22 181/23 182/1 182/2 182/4 182/7 189/16 189/18 189/19 189/20 189/21 189/23 189/24 189/25 190/1 190/3 197/2 197/4 198/3 198/5 198/8 198/10 198/12 198/15 198/16	Ms Morray [3] 138/18 139/17 139/25	nationally [5] 2/20 53/18 69/20 70/2 132/3
		Ms [97] 1/3 1/5 1/6 1/7 1/12 31/19 31/20 35/10 37/12 37/15 37/16 37/17 37/19 41/19 41/21 41/25 42/19 43/9 43/14 43/15 43/16 43/25 54/9 54/17 54/19 77/25 78/1 78/2 78/3 78/5 85/17 85/19 86/11 86/17 86/19 86/21 86/24 88/24 92/1 92/6 93/15 97/16 101/14 105/9 109/2 112/3 114/2 123/12 127/11 128/25 134/25 137/12 138/18 139/17 139/25 141/7 141/13 141/15 143/3 146/9 149/2 149/5 149/5 149/24 152/24 155/4 155/22 161/17 167/13 169/20 178/3 181/19 181/22 181/23 182/1 182/2 182/4 182/7 189/16 189/18 189/19 189/20 189/21 189/23 189/24 189/25 190/1 190/3 197/2 197/4 198/3 198/5 198/8 198/10 198/12 198/15 198/16	Ms Morray [3] 138/18 139/17 139/25	nations [13] 3/4 44/15 44/18 44/22

<p>N</p> <p>nations... [9] 44/25 45/3 51/19 57/19 76/6 133/9 133/25 134/4 148/6</p> <p>nature [2] 11/9 35/18</p> <p>near [1] 112/20</p> <p>nearer [2] 19/10 21/5</p> <p>nearly [2] 44/7 61/2</p> <p>neat [1] 145/3</p> <p>necessarily [12] 23/3 29/25 49/20 62/21 64/1 64/14 79/6 94/7 98/10 103/14 154/1 165/24</p> <p>necessary [7] 41/9 80/19 115/16 131/7 131/10 134/6 143/20</p> <p>need [66] 4/7 11/15 14/2 17/20 22/8 27/14 27/21 34/4 35/3 35/25 36/2 36/3 36/3 36/7 45/3 45/17 46/21 52/12 53/3 57/17 59/6 59/13 63/23 63/24 64/1 64/15 64/16 65/5 71/19 72/17 73/10 73/24 77/14 80/2 83/2 83/14 84/23 85/3 85/4 85/11 86/10 90/12 106/11 112/13 113/1 119/2 120/15 122/2 131/21 134/16 137/6 140/15 140/15 140/16 144/9 157/14 172/18 175/4 176/24 179/10 181/7 183/14 184/24 185/22 191/14 195/20</p> <p>need' [1] 178/1</p> <p>needed [40] 10/9 19/14 21/22 25/8 39/4 48/5 59/23 60/23 64/9 67/9 80/21 83/11 84/8 90/17 91/4 92/16 94/18 105/16 107/4 109/12 109/22 113/12 113/17 113/17 113/19 113/20 113/21 114/19 123/3 124/13 134/10 135/21 144/15 158/2 175/20 185/23 186/1 191/5 191/18 196/20</p> <p>needing [2] 26/9 51/2</p> <p>needs [31] 4/25 7/1 9/16 11/24 11/24 20/23 20/23 26/23 26/25 35/20 36/15 39/7 57/21 71/16 72/7 72/17 78/20 83/5 84/24 85/1 112/18 120/14 124/22 133/15 176/3 179/12 180/22 191/8 193/14 194/13</p>	<p>196/8</p> <p>negative [3] 40/20 79/6 80/23</p> <p>neglect [1] 127/15</p> <p>neighbours [4] 45/9 46/4 79/25 80/13</p> <p>neither [4] 45/13 72/1 72/3 101/1</p> <p>nephew [1] 88/16</p> <p>nephews [1] 46/4</p> <p>network [5] 1/23 2/14 12/2 35/13 44/8</p> <p>Networked [1] 70/13</p> <p>never [3] 131/19 133/10 189/8</p> <p>new [15] 12/19 13/7 14/23 16/10 35/5 41/5 41/12 89/16 89/20 90/4 100/5 105/17 118/13 127/6 158/1</p> <p>news [2] 18/12 197/7</p> <p>next [19] 35/6 43/4 43/5 43/7 43/12 43/13 43/14 54/2 64/24 65/10 70/2 75/5 80/3 86/8 109/11 122/15 146/20 184/15 192/12</p> <p>NGOs [1] 178/12</p> <p>NH [1] 169/5</p> <p>NHS [28] 7/15 54/23 55/10 58/21 58/24 66/10 75/12 94/4 106/12 106/22 113/18 123/22 124/11 128/24 129/2 129/14 129/23 146/24 147/3 147/4 147/5 153/11 155/15 163/10 164/7 167/17 169/6 184/24</p> <p>NHS Digital [1] 167/17</p> <p>NHS England [5] 66/10 94/4 106/12 113/18 155/15</p> <p>NHSE [4] 106/14 184/20 185/2 186/1</p> <p>niche [1] 15/6</p> <p>nieces [1] 46/3</p> <p>night [1] 31/14</p> <p>nights [1] 62/5</p> <p>nine [1] 155/24</p> <p>no [52] 5/6 5/24 8/5 8/22 11/25 20/1 20/4 20/15 23/14 30/24 30/25 32/4 32/20 36/9 37/1 38/11 50/9 87/3 87/20 92/2 97/20 98/22 104/13 109/10 124/13 129/1 129/19 132/21 135/25 147/12 148/1 151/8 151/14 153/23 160/24 162/2 164/4 167/3 167/6 167/19 169/3 169/12</p>	<p>171/19 171/20 173/16 175/2 176/12 176/24 186/19 189/22 192/21 193/3</p> <p>nodded [1] 58/16</p> <p>non [3] 10/13 23/16 57/14</p> <p>non-carers [1] 57/14</p> <p>non-conveyancing [1] 23/16</p> <p>non-pandemic [1] 10/13</p> <p>none [2] 62/6 69/25</p> <p>nonetheless [5] 137/10 142/13 151/12 152/17 171/23</p> <p>normal [4] 20/5 27/2 111/10 180/12</p> <p>normally [4] 59/17 62/5 89/19 144/22</p> <p>Northern [6] 24/8 33/7 47/17 76/21 147/17 189/4</p> <p>not [219]</p> <p>note [10] 133/9 159/23 182/11 182/11 182/14 183/3 183/23 183/24 183/25 184/11</p> <p>noted [4] 130/6 166/23 185/2 188/1</p> <p>nothing [5] 50/9 50/12 70/3 174/13 174/17</p> <p>noticed [1] 34/16</p> <p>notices [2] 25/21 161/16</p> <p>notified [3] 159/25 190/20 192/20</p> <p>notifying [2] 133/14 176/15</p> <p>noting [1] 111/8</p> <p>notwithstanding [1] 147/7</p> <p>November [8] 19/12 33/11 55/3 123/23 132/18 160/1 177/16 196/12</p> <p>November 2020 [4] 33/11 55/3 177/16 196/12</p> <p>November 2021 [1] 160/1</p> <p>now [54] 22/4 24/14 27/7 27/8 27/10 31/12 31/18 39/2 47/11 47/11 52/1 52/23 54/9 68/1 69/7 71/14 76/2 76/25 82/15 82/16 82/23 87/12 90/25 91/22 93/2 94/12 98/10 102/21 103/11 104/10 105/21 107/2 107/20 108/2 108/14 108/17 110/11 118/8</p>	<p>153/3 159/5 163/15 165/20 165/24 167/22 172/2 172/11 172/25 173/11 180/8 181/14 181/18 182/7 189/19 192/7</p> <p>nowhere [1] 112/20</p> <p>NSDR [1] 126/5</p> <p>NSG [2] 105/10 105/12</p> <p>number [37] 3/23 35/8 63/8 67/22 70/19 85/25 93/6 93/10 94/13 94/13 97/20 101/15 111/20 112/17 113/12 114/14 115/8 115/11 120/13 123/9 124/25 126/14 137/1 139/2 142/2 142/6 142/17 143/23 155/1 155/7 158/14 163/15 175/24 176/11 182/14 194/23 195/5</p> <p>number 1 [1] 155/1</p> <p>number 25 [1] 142/17</p> <p>numbers [9] 12/22 74/22 91/4 91/9 126/21 132/20 133/6 154/17 192/11</p> <p>numerous [1] 84/1</p> <p>nurse [4] 21/2 22/12 45/21 164/9</p> <p>nurses [2] 15/5 25/6</p> <p>nursing [1] 91/12</p> <p>nutshell [1] 142/1</p> <p>O</p> <p>objective [1] 93/19</p> <p>objectives [2] 135/8 145/3</p> <p>obligatory [1] 107/18</p> <p>observed [3] 24/6 25/23 28/9</p> <p>obtain [2] 126/6 128/12</p> <p>obvious [5] 39/1 40/25 41/2 116/1 157/7</p> <p>obviously [14] 80/24 88/1 92/7 93/15 105/2 106/19 106/23 107/5 109/16 148/3 156/23 170/2 172/19 188/25</p> <p>occupancy [2] 91/14 172/16</p> <p>occupation [1] 153/19</p> <p>occupied [1] 91/13</p> <p>occurred [1] 9/6</p> <p>October [7] 126/15 137/22 162/7 168/10 168/19 168/22 195/25</p> <p>October 2020 [2]</p>	<p>126/15 195/25</p> <p>October 2021 [1] 162/7</p> <p>odd [6] 90/22 91/13 132/18 132/21 132/22 136/14</p> <p>off [14] 66/15 76/6 76/17 81/15 113/22 124/23 125/20 125/23 146/5 149/13 162/17 163/13 166/5 183/5</p> <p>offer [2] 139/14 146/10</p> <p>offered [2] 12/11 14/16</p> <p>offers [2] 5/3 13/22</p> <p>Officer [1] 130/23</p> <p>Officer's [1] 173/7</p> <p>offices [1] 44/14</p> <p>official [2] 79/14 150/20</p> <p>officials [8] 13/11 17/5 29/24 29/25 31/5 37/8 185/2 185/8</p> <p>often [29] 4/23 10/16 12/21 13/6 13/15 15/1 17/20 18/1 18/18 19/22 21/8 22/23 25/6 26/1 28/19 29/5 29/20 32/5 37/11 49/10 49/21 55/14 78/10 78/19 79/9 83/13 83/25 150/17 165/21</p> <p>Oh [3] 77/23 108/17 187/9</p> <p>okay [5] 42/15 56/13 111/17 145/18 167/11</p> <p>old [3] 4/12 77/1 99/2</p> <p>older [60] 2/4 2/16 3/4 3/10 3/14 3/22 4/11 6/14 6/16 7/1 7/7 8/13 10/23 12/4 12/13 12/22 17/8 17/10 17/16 17/19 18/13 18/23 19/7 19/10 19/15 19/23 20/18 20/22 20/24 21/16 21/16 23/5 23/11 23/25 26/18 26/19 26/22 27/10 28/8 31/11 35/14 36/8 36/19 37/1 37/2 37/6 37/10 37/24 38/2 38/8 38/12 39/9 40/9 42/12 45/18 51/13 61/11 70/19 74/16 177/18</p> <p>Omicron [4] 159/23 160/1 176/21 196/19</p> <p>on [323]</p> <p>on this [1] 121/11</p> <p>once [8] 8/4 21/18 36/13 108/19 168/13 171/12 194/11 195/9</p> <p>one [80] 4/11 14/4</p>
---	---	--	---	---

<p>O</p> <p>one... [78] 17/11 17/12 17/21 21/17 22/18 25/9 32/11 34/5 34/16 35/9 36/14 37/2 42/4 42/20 45/25 46/18 46/19 47/12 58/13 58/22 60/10 62/4 64/15 64/25 70/7 71/21 72/8 76/6 77/20 77/21 81/17 84/1 87/8 87/23 90/2 92/8 97/21 102/8 104/20 104/21 113/1 114/7 114/9 114/16 115/17 120/5 120/9 120/10 120/20 123/7 124/1 124/23 125/8 125/20 125/23 127/9 129/7 134/24 138/7 138/20 142/5 145/5 145/8 146/7 149/17 153/5 161/18 164/21 165/25 166/10 167/6 170/3 172/5 177/21 181/12 182/23 195/9 195/21</p> <p>one-off [1] 125/20</p> <p>one-third [2] 46/18 46/19</p> <p>ones [13] 17/25 28/3 28/8 28/15 29/4 29/4 30/23 31/16 31/22 31/24 56/23 68/3 127/20</p> <p>ones' [1] 36/12</p> <p>ongoing [1] 196/2</p> <p>online [6] 2/11 12/13 14/22 20/7 57/9 131/6</p> <p>only [25] 29/15 40/13 42/21 76/19 76/23 78/18 104/17 108/9 112/17 114/7 114/16 123/5 123/7 123/9 123/22 125/21 129/14 135/3 138/6 142/2 160/14 175/18 190/20 192/15 194/23</p> <p>ONS [1] 93/7</p> <p>onset [2] 4/18 183/12</p> <p>onto [2] 127/22 128/16</p> <p>onwards [7] 98/5 107/17 122/23 123/22 127/18 128/2 161/17</p> <p>open [3] 8/9 59/7 196/13</p> <p>operate [2] 82/16 195/22</p> <p>operated [1] 63/5</p> <p>operates [1] 11/10</p> <p>operating [5] 163/8 190/13 191/2 192/15 193/6</p>	<p>operation [2] 126/25 177/19</p> <p>operationally [1] 167/15</p> <p>opportunities [1] 16/11</p> <p>opportunity [1] 76/1</p> <p>opposed [2] 94/5 157/4</p> <p>opposing [1] 149/4</p> <p>optimal [1] 79/6</p> <p>option [2] 143/1 187/4</p> <p>options [3] 94/22 94/24 109/4</p> <p>or [183] 2/17 3/13 4/13 9/20 11/6 12/18 12/19 13/7 13/24 14/18 15/9 15/11 15/20 17/23 17/24 18/9 19/2 19/3 20/6 20/7 20/7 20/13 20/16 20/21 21/2 21/3 21/14 22/17 22/19 22/24 23/22 23/22 24/4 24/5 25/16 25/22 28/10 28/10 30/4 33/6 33/7 34/5 34/23 35/2 35/3 35/12 39/21 40/3 41/7 41/8 42/9 42/10 43/18 45/17 45/17 46/1 46/24 48/12 49/5 49/13 51/5 51/10 51/13 52/14 53/12 54/5 55/9 56/5 56/16 56/17 59/25 62/21 62/23 62/25 63/20 67/10 69/7 69/13 72/21 75/4 76/23 77/2 78/24 80/4 81/8 83/4 83/15 83/18 84/7 87/19 91/3 92/20 94/1 94/14 97/22 97/24 98/14 99/2 103/4 104/2 104/19 104/20 107/5 109/12 109/24 110/6 111/5 111/6 112/20 112/22 112/24 114/18 114/20 121/7 123/6 124/14 125/9 127/7 129/2 130/11 130/13 131/3 131/13 131/16 131/17 134/17 137/4 138/2 138/4 139/24 140/21 142/10 144/2 150/2 150/5 150/20 152/20 153/4 156/22 158/3 158/16 159/5 159/14 159/17 162/3 163/9 163/23 164/1 165/11 165/12 167/4 167/7 168/2 169/1 169/10 170/1 170/5 171/4 171/13</p>	<p>171/15 173/11 174/9 175/25 176/4 176/17 177/21 178/9 180/3 180/12 180/14 181/6 182/11 182/23 186/5 190/11 190/18 191/11 191/15 191/20 193/7 194/15 195/3 196/15 order [5] 13/2 140/13 142/19 161/2 191/4</p> <p>orders [1] 169/9</p> <p>ordinarily [3] 93/25 94/24 104/12</p> <p>ordinary [3] 13/9 58/19 104/10</p> <p>organisation [11] 8/18 28/9 35/3 35/4 35/5 42/10 44/6 84/18 104/6 112/24 139/10</p> <p>organisations [14] 8/10 13/20 16/22 44/9 60/25 69/16 71/16 81/11 83/8 83/12 84/3 84/10 94/14 190/4</p> <p>organised [1] 5/5</p> <p>organising [1] 49/18</p> <p>organograms [1] 89/19</p> <p>original [2] 84/6 122/6</p> <p>other [60] 1/14 2/21 3/3 6/18 11/19 14/22 15/2 15/14 15/15 16/22 31/23 42/9 46/22 48/15 51/4 53/8 54/6 54/7 65/17 66/5 67/11 69/15 71/6 75/3 80/13 85/23 85/25 89/13 96/1 107/20 109/14 114/22 119/12 125/17 127/15 130/8 133/9 133/25 144/21 145/14 148/2 153/5 153/18 153/21 154/20 155/12 158/8 164/2 165/9 168/25 169/10 173/17 176/8 179/3 179/3 179/7 190/19 195/11 195/11 196/5</p> <p>others [10] 5/23 9/17 14/15 19/22 24/12 32/15 41/11 72/5 79/25 89/8</p> <p>otherwise [6] 18/4 28/24 44/23 50/6 98/14 117/18</p> <p>ought [2] 125/22 191/16</p> <p>our [39] 3/1 3/1 3/3 4/2 6/8 6/23 9/18 22/12 23/8 24/7 27/8 29/3 33/12 33/15 33/19 35/12 44/11 60/10 66/16 68/1 68/4</p>	<p>82/21 83/12 83/15 84/3 86/7 103/1 117/21 134/23 138/20 140/8 140/11 143/5 144/23 159/3 171/13 174/24 191/1 197/6</p> <p>ours [1] 81/11</p> <p>ourselves [1] 26/8</p> <p>out [94] 3/7 3/17 4/22 8/12 11/11 12/20 13/19 18/18 18/23 19/13 20/9 22/5 24/25 26/4 31/16 35/16 46/8 46/16 49/22 53/17 57/5 58/4 58/12 60/1 62/3 63/9 66/14 67/8 68/6 70/22 73/20 83/13 83/18 87/6 88/21 94/17 102/6 105/3 106/5 106/20 108/6 112/11 113/15 114/14 114/22 116/13 117/22 120/1 120/3 123/21 125/21 128/9 131/4 132/1 132/2 132/21 133/14 134/3 134/11 137/15 137/18 137/22 139/3 140/10 141/18 142/5 143/9 143/11 144/8 145/20 145/24 150/6 150/23 152/5 152/19 153/24 155/22 156/14 156/17 156/22 158/4 164/5 166/9 166/20 168/14 168/22 170/4 176/1 176/6 178/2 178/20 183/13 190/15 192/23</p> <p>outbreak [1] 170/19</p> <p>outbreaks [2] 168/5 170/23</p> <p>outcome [2] 50/18 51/7</p> <p>outcomes [5] 39/20 51/3 132/7 150/5 165/5</p> <p>outline [1] 93/19</p> <p>outlined [1] 121/21</p> <p>outlying [1] 95/2</p> <p>outnumber [1] 54/24</p> <p>outputs [1] 164/21</p> <p>outrageous [1] 129/17</p> <p>outset [4] 25/25 40/17 147/14 167/14</p> <p>outside [8] 8/9 30/5 36/24 41/2 77/2 77/12 106/2 172/12</p> <p>over [23] 4/6 4/12 10/14 25/12 30/19 35/6 46/9 47/23 52/8 56/20 69/6 78/12 94/16 121/17 126/13 126/25 129/23 137/11</p>	<p>138/23 142/10 151/3 151/6 184/1</p> <p>overall [2] 151/17 192/13</p> <p>overarching [5] 88/6 94/22 98/15 115/17 147/9</p> <p>overlap [3] 70/13 70/15 72/4</p> <p>overnight [1] 89/14</p> <p>oversight [3] 75/6 180/6 192/15</p> <p>overspeaking [6] 50/11 77/12 134/1 136/1 146/8 162/11</p> <p>overtaken [1] 102/2</p> <p>overtook [1] 102/10</p> <p>overview [2] 170/2 171/5</p> <p>overwhelmed [6] 21/11 26/14 28/1 60/9 62/2 62/3</p> <p>overwhelmingly [1] 115/2</p> <p>own [16] 11/15 12/24 16/5 35/20 55/11 74/3 76/14 109/24 111/13 112/8 121/1 123/20 126/19 157/4 193/25 194/16</p> <hr/> <p>P</p> <p>pace [1] 13/14</p> <p>package [3] 6/7 146/7 195/8</p> <p>packages [4] 16/5 193/15 193/24 194/3</p> <p>packaging [1] 168/2</p> <p>page [15] 72/10 100/13 100/17 129/6 129/10 146/20 151/2 151/6 164/18 169/15 177/11 177/14 177/15 190/24 198/2</p> <p>page 159 [2] 177/11 177/14</p> <p>page 168 [1] 164/18</p> <p>page 2 [1] 72/10</p> <p>page 23 [1] 169/15</p> <p>page 4 [1] 129/6</p> <p>paging [1] 129/10</p> <p>paid [12] 45/12 49/6 49/7 49/15 51/25 52/14 53/16 54/4 54/5 136/23 139/5 141/1</p> <p>pain [2] 25/5 30/21</p> <p>painful [1] 29/1</p> <p>pairs [1] 59/10</p> <p>Palantir [3] 168/17 169/5 169/7</p> <p>palliative [2] 28/10 162/25</p> <p>pan [1] 104/4</p> <p>pandemic [183] 2/11</p>
---	---	---	---	---

P	para [1] 78/5 paragraph [24] 11/4 22/3 22/6 22/10 78/9 97/1 109/3 109/11 110/23 114/1 126/1 127/12 130/22 135/6 141/16 149/22 157/20 161/8 161/17 161/19 161/21 162/22 164/19 190/25 paragraph 121 [1] 127/12 paragraph 13 [1] 78/9 paragraph 142 [1] 130/22 paragraph 203 [1] 109/3 paragraph 249 [1] 110/23 paragraph 289 [1] 157/20 paragraph 391 [1] 135/6 paragraph 449 [1] 149/22 paragraph 461 [1] 114/1 paragraph 477 [1] 141/16 paragraph 52 [1] 161/8 paragraph 6 [1] 190/25 paragraph 613 [1] 161/19 paragraph 615 [1] 161/17 paragraph 63 [1] 11/4 paragraphs [2] 127/16 168/6 paragraphs 16 [1] 168/6 parcels [1] 73/21 parents [2] 46/24 48/13 parliaments [1] 44/17 part [40] 9/4 15/3 22/5 27/17 33/23 34/13 35/19 62/17 70/13 72/18 74/19 79/4 84/8 85/24 87/8 96/5 97/9 103/18 106/10 114/1 114/4 119/21 122/3 122/7 124/25 127/13 128/3 136/25 141/16 145/21 149/10 151/16 159/2 165/15 167/12 168/6 173/5 173/5 185/12 195/24 Participant [1]	181/21 Participants [1] 77/21 particular [21] 4/19 8/3 11/23 12/17 14/9 20/18 21/2 28/9 65/16 66/24 89/11 90/12 98/25 107/6 120/6 125/9 158/15 167/24 170/5 183/22 188/7 particularly [24] 6/13 6/19 12/17 20/24 21/5 22/4 27/25 36/6 36/8 37/2 38/9 39/20 57/9 74/11 90/16 98/3 105/4 118/14 120/23 141/8 154/3 155/5 155/14 183/17 partly [3] 11/9 94/20 153/12 partnered [1] 14/14 partners [2] 36/12 46/3 partnership [1] 196/1 parts [1] 21/5 party [1] 66/19 pass [1] 181/17 passing [1] 118/11 passported [5] 108/8 122/9 122/10 122/18 122/20 patchy [2] 19/19 24/11 patient [6] 22/8 25/24 40/14 57/12 69/9 75/9 patients [13] 22/11 22/12 22/23 39/15 40/1 40/10 40/18 78/7 93/25 94/24 109/5 112/25 186/2 patterns [1] 82/11 pausing [1] 47/13 pay [8] 11/16 50/8 51/6 59/11 118/12 118/17 119/16 170/21 paying [5] 114/5 118/12 138/2 140/25 170/21 payment [3] 76/11 76/11 76/24 payments [1] 51/5 Pearson [5] 9/10 9/19 67/16 92/25 106/3 Pearson's [1] 151/17 peer [3] 14/16 14/16 49/13 pejorative [1] 123/15 Pensions [2] 66/13 69/21 people [239] people's [14] 18/14 19/24 24/23 26/18 38/8 40/9 46/22 50/23	57/1 58/4 58/5 179/12 188/2 190/4 per [7] 19/10 108/9 122/11 122/19 122/19 122/19 123/1 per se [1] 19/10 perceived [2] 27/21 31/8 percentage [1] 122/17 perception [6] 6/13 6/16 15/25 16/2 123/12 162/23 perfect [2] 42/21 93/3 performing [1] 188/8 perhaps [50] 8/17 10/8 13/3 13/25 15/10 20/20 25/13 27/23 28/9 29/12 34/11 67/7 80/4 81/18 85/20 90/23 90/23 91/8 100/13 101/4 102/8 103/20 107/23 109/3 110/6 129/10 134/23 138/7 141/2 146/9 147/2 150/23 151/13 152/20 154/6 155/9 156/21 163/16 165/22 166/11 168/2 170/4 173/4 175/8 176/14 177/10 179/7 180/14 180/16 195/3 period [7] 11/3 46/9 150/13 151/3 186/12 186/15 194/12 periods [1] 18/1 Permanent [1] 179/24 permanently [1] 87/16 permissible [1] 167/4 permissive [1] 81/4 permit [1] 80/9 permitted [1] 81/2 person [29] 3/14 10/5 20/10 20/12 20/19 23/5 23/11 23/14 25/10 29/12 34/9 51/2 51/2 59/25 78/10 78/16 78/18 78/22 78/24 80/20 84/1 110/1 111/11 112/10 112/18 132/16 165/2 165/5 188/17 person-centred [1] 78/16 personal [5] 3/6 6/4 26/7 188/9 196/1 personalised [2] 69/23 165/4 personally [1] 23/10 personnel [1] 90/22	perspective [6] 89/4 102/23 131/15 163/22 180/20 183/15 perspectives [1] 173/18 persuade [1] 8/6 pervasive [1] 88/4 PHE [4] 107/3 159/5 185/2 186/23 phone [3] 26/4 117/2 171/14 phrase [1] 91/25 phraseology [1] 103/21 phrases [1] 123/16 physical [3] 17/9 57/2 58/5 physio [1] 21/3 pick [4] 6/23 87/2 88/24 102/24 picked [1] 103/1 picking [1] 29/11 picture [4] 72/16 74/5 75/21 139/22 piece [3] 13/7 106/4 162/21 pieces [1] 82/4 pilot [9] 131/24 132/5 132/6 132/7 132/9 134/7 134/8 156/8 156/18 pin [1] 83/1 place [39] 5/7 7/4 7/5 10/12 15/14 20/6 24/24 25/13 26/16 32/1 34/5 34/24 35/16 36/19 40/13 41/9 41/16 69/1 75/24 76/23 81/24 83/5 85/9 91/3 109/23 109/25 112/12 113/14 113/19 113/21 146/1 146/4 151/22 153/3 161/4 181/9 186/25 187/5 192/8 placed [5] 31/12 31/16 41/11 175/24 197/8 placement [1] 112/17 places [8] 4/20 16/3 19/21 20/1 39/21 74/2 74/18 197/5 placing [1] 109/5 plan [25] 7/11 22/12 91/3 93/19 94/14 94/23 95/2 100/21 101/13 101/23 103/9 103/15 104/5 110/17 113/14 134/16 136/25 145/13 145/14 145/21 145/24 146/2 146/6 146/18 165/3 planned [3] 20/13 20/16 25/14
----------	--	---	--	---

P	154/20 156/25 158/6 158/19 159/21 160/3 162/20 166/18 168/18 169/6 175/10 177/1 178/2 178/25 179/6 180/14 183/20 187/21 188/25 190/14 193/4 193/11 196/9	possibility [1] 23/14 possible [14] 27/18 65/22 72/16 111/9 112/9 114/6 114/17 114/24 120/11 138/19 143/9 143/12 161/1 193/20 possibly [5] 71/11 105/1 133/23 133/24 154/9 post [11] 9/20 10/6 88/2 90/5 90/9 90/12 190/7 195/25 196/16 196/21 197/14 posts [1] 91/15 potential [2] 75/12 97/11 potentially [11] 94/23 110/8 132/22 139/23 140/3 144/1 152/22 152/25 154/13 176/3 176/11 pounds [1] 76/17 poverty [3] 77/7 77/15 139/4 power [2] 181/13 181/18 powers [3] 76/22 143/18 192/8 PPE [78] 11/21 32/13 32/13 34/23 38/19 41/8 41/15 53/7 57/8 58/15 58/18 58/20 58/22 58/25 59/6 59/14 59/17 59/20 60/5 60/12 60/14 61/6 61/10 61/13 62/9 62/10 62/12 62/20 63/17 64/1 64/7 64/9 65/2 65/17 67/7 73/20 74/21 85/9 89/17 107/4 124/2 124/11 124/12 124/13 124/16 124/22 126/2 126/3 126/19 127/1 127/7 127/7 127/11 127/14 127/23 127/25 128/5 128/12 128/24 130/18 130/25 131/1 131/18 132/1 132/9 132/11 132/20 133/1 133/14 133/22 134/14 134/16 134/18 170/24 187/23 188/7 188/24 189/8 practical [7] 12/12 29/21 50/20 63/12 67/1 94/22 94/23 practically [1] 64/5 practice [14] 5/13 5/15 11/6 20/9 21/24 22/1 22/21 23/1 26/6 63/4 70/9 101/12 117/9 162/25 practices [4] 23/16	23/23 70/14 75/10 pre [5] 55/18 59/16 69/1 90/19 93/10 pre-pandemic [5] 55/18 59/16 69/1 90/19 93/10 precisely [6] 81/2 97/1 157/8 157/9 191/18 196/6 predecessor [1] 105/19 predictions [1] 99/1 predominantly [2] 5/4 32/14 prefaced [1] 5/10 preference [1] 129/24 preparation [2] 93/17 145/25 prepare [2] 104/16 106/6 prepared [2] 5/25 115/23 preparedness [6] 93/10 103/2 104/5 105/4 124/6 134/19 prescriptions [1] 24/17 present [2] 29/6 104/17 press [3] 12/18 13/7 163/1 pressure [8] 21/1 67/4 68/12 77/5 178/11 179/3 184/23 185/9 pressures [3] 137/11 138/13 144/21 presumably [2] 94/8 139/7 pretty [1] 21/4 prevalence [2] 168/5 183/8 prevalent [1] 176/4 prevent [6] 114/4 114/15 118/5 119/22 144/20 179/11 preventable [1] 55/9 preventing [6] 55/8 124/1 159/6 175/14 184/7 188/14 prevention [2] 113/20 185/4 previous [2] 8/17 169/24 previously [1] 90/5 primarily [2] 46/2 66/22 primary [3] 79/16 83/25 90/6 Prime [1] 184/1 Prime Minister [1] 184/1 principal [1] 190/12	principally [3] 81/21 146/19 158/23 principle [2] 63/22 172/22 principles [4] 164/16 164/22 164/25 165/9 prior [4] 4/13 51/22 90/9 146/1 prioritisation [1] 154/19 prioritise [4] 95/24 128/10 153/8 153/11 prioritised [4] 66/7 92/14 154/24 188/6 priority [8] 67/17 68/5 106/12 123/13 123/18 155/1 188/2 188/18 prisms [1] 39/10 private [2] 5/3 174/19 privately [1] 103/17 probably [17] 5/22 9/25 18/24 29/7 33/24 34/4 34/9 37/6 38/20 41/22 43/11 141/7 157/8 164/19 168/14 189/6 189/25 problem [18] 18/9 23/11 33/9 35/19 76/19 97/19 97/23 98/10 98/15 140/10 140/11 142/16 152/5 167/5 170/5 170/6 184/7 196/6 problems [14] 11/19 15/15 20/3 21/1 38/19 98/17 127/21 133/12 134/25 138/9 140/19 179/17 183/16 183/17 procedure [2] 71/14 163/8 process [4] 2/24 24/21 172/19 179/5 processes [1] 5/7 procurement [1] 174/5 produced [8] 19/12 33/11 82/5 82/8 84/18 96/11 96/16 107/5 production [2] 62/11 66/8 products [1] 96/12 professional [5] 13/13 20/19 30/2 130/21 188/15 professionalisation [1] 148/18 professionalise [1] 118/18 professionalised [1] 33/21 professionalising [2] 33/23 34/13 professionalism [1]
----------	---	---	--	--

P	provider-level [1] 104/11	put [32] 5/25 11/15 13/8 15/14 18/17 20/6 20/7 23/8 25/5 26/5 31/5 36/18 81/24 99/2 105/3 106/5 116/13 117/22 130/10 137/8 137/18 146/1 146/4 149/13 152/5 152/19 153/24 164/19 165/14 174/24 187/5 188/20	55/14 62/22 67/4 67/25 68/3 70/16 78/17 79/9 83/21 83/25 84/11 92/24 95/20 98/4 102/3 102/5 102/17 105/24 125/18 146/3 152/8 176/11	19/7 20/1 21/21 26/17 29/19 31/6 36/9 36/15 39/8 42/25 42/25 44/12 46/15 47/8 59/23 60/5 60/6 60/23 63/10 64/9 65/17 67/6 68/19 69/3 74/14 79/22 80/2 80/6 80/21 82/1 85/11 88/23 92/24 95/19 99/18 105/24 106/3 109/16 109/19 115/20 115/24 125/18 128/3 130/17 131/9 133/10 140/4 140/6 145/23 154/10 156/25 160/13 160/23 160/24 160/24 166/18 175/11 179/14 184/24 188/22 188/22 191/20 191/25 195/7 195/15
professionalism... [1] 118/20	providers [43] 61/9 83/12 99/5 103/12 103/16 104/4 104/7 104/15 104/24 107/13 108/8 108/9 109/19 121/15 122/10 122/22 126/6 126/18 126/20 127/9 127/19 127/21 128/4 128/10 128/16 128/19 128/20 140/17 144/13 146/21 146/22 146/25 147/8 147/16 148/3 165/18 166/3 172/20 181/15 181/16 181/18 197/4 197/6	puts [1] 68/12	quote [1] 47/10	realtime [1] 167/20
professionals [12] 8/14 13/15 19/23 20/10 21/13 21/21 25/5 26/14 27/22 29/22 30/5 78/11	provides [2] 28/18 69/16	putting [4] 33/24 83/18 144/11 188/4	quoted [2] 38/9 48/10	reason [10] 16/6 47/22 59/3 68/9 68/9 78/22 110/5 120/22 131/16 137/17
profit [1] 5/4	providing [14] 33/16 34/18 55/10 55/16 57/3 63/11 81/9 83/10 93/24 110/25 123/7 130/25 144/1 144/2	Q	R	reasons [5] 17/17 20/18 52/4 120/4 155/7
progressive [1] 5/21	provision [6] 4/2 20/12 160/23 172/6 188/1 194/9	qualifications [2] 21/14 118/21	race [5] 155/23 155/24 156/4 156/12 157/7	reassurance [3] 12/23 28/18 131/17
project [4] 173/22 174/11 174/16 177/17	provisions [1] 194/20	qualified [1] 25/7	raise [3] 17/4 23/24 42/4	rebuilding [1] 27/7
prolonged [1] 194/12	provokes [1] 152/13	quality [5] 22/4 36/3 78/15 101/13 165/16	raised [3] 2/1 162/13 196/6	rebuilt [1] 26/21
promise [1] 181/24	public [29] 5/2 13/15 14/7 24/24 31/6 34/6 34/12 42/9 42/10 44/4 47/25 53/14 53/23 58/20 65/16 69/11 70/22 80/25 81/5 84/13 106/14 130/23 131/13 142/22 142/22 146/23 158/24 159/1 188/23	quantitative [1] 150/16	randomised [1] 30/25	recall [6] 25/15 25/17 40/24 97/1 175/6 182/24
promises [1] 11/4	publicised [2] 152/23 154/8	quarantine [1] 41/7	range [5] 45/14 50/23 51/11 69/24 94/22	receipt [2] 4/12 17/8
promote [1] 155/10	publicity [2] 133/21 152/20	quarter [1] 99/18	rapid [1] 136/7	receive [9] 50/19 93/25 159/14 159/18 161/20 162/1 162/9 163/11 167/17
promoted [1] 163/23	publicly [1] 97/9	quarterly [3] 108/20 108/21 108/22	rapidly [2] 186/14 186/18	received [7] 12/7 23/19 28/4 101/16 128/23 150/13 184/5
prompting [1] 45/15	publish [3] 103/3 103/7 108/19	question [21] 48/1 70/1 72/21 75/17 84/6 99/22 115/13 119/11 134/2 145/23 148/15 151/7 153/7 157/9 158/12 158/23 186/24 193/1 195/1 195/6 195/17	rate [3] 98/5 98/11 111/3	receiving [8] 3/24 26/4 28/10 39/21 51/16 57/21 162/23 194/10
proper [2] 67/19 172/21	published [9] 24/9 87/9 103/4 107/5 145/14 146/6 146/8 164/23 179/25	questions [45] 1/11 37/13 37/14 37/17 37/19 41/19 41/23 41/25 42/19 43/22 77/22 77/24 78/3 78/6 85/16 85/18 86/20 87/8 93/9 101/5 102/14 106/8 113/24 171/16 173/21 181/1 181/20 181/21 181/23 182/2 182/4 189/15 189/22 190/1 190/3 190/4 197/3 198/4 198/5 198/6 198/9 198/10 198/13 198/15 198/16	rated [2] 109/6 110/4	recent [1] 138/23
properly [3] 84/25 131/1 195/2	pull [4] 71/10 71/10 73/9 140/23	quick [3] 6/23 62/15 166/25	rates [7] 112/22 113/7 131/9 131/21 134/6 144/19 170/1	recently [1] 71/21
proportion [4] 48/12 59/8 62/3 158/22	pulled [1] 145/20	quickly [15] 7/3 10/25 13/3 18/4 25/18 28/24 65/6 66/14 68/3 76/12 76/16 83/6 113/15 125/18 143/12	rather [10] 14/5 16/9 16/13 77/2 89/4 89/24 110/14 115/13 139/14 141/25	receptive [1] 83/9
proposals [1] 120/18	pulling [1] 70/8	quite [43] 2/24 3/18 6/18 7/15 10/25 13/17 14/23 15/5 17/25 17/25 23/7 23/18 25/18 28/1 32/18 45/20 46/17 46/20 47/10 49/21 51/9	really [71] 5/1 6/1 6/24 9/18 11/20 18/21	recipient [2] 21/25 29/16
proposed [1] 115/5	purpose [2] 101/6 158/10			recipients [2] 31/22 135/11
protect [4] 24/24 38/14 81/8 155/10	purposes [7] 108/4 131/11 135/16 135/18 172/15 172/17 196/18			recognise [10] 33/20 38/3 38/6 52/21 68/14 81/7 118/19 118/21 119/5 119/9
protected [2] 49/7 61/16	push [1] 73/19			recognised [6] 68/7 73/18 78/14 112/16 119/3 186/21
protecting [2] 135/10 135/11				recognising [2] 56/8 70/23
protection [5] 6/2 71/14 131/3 155/17 157/14				recognition [6] 36/7
protections [3] 49/14 49/16 50/6				
protective [1] 11/5				
prove [1] 21/7				
proven [1] 184/6				
provide [36] 2/13 2/21 2/25 3/4 3/13 5/14 9/1 12/2 12/3 13/2 28/7 32/16 44/20 44/21 45/14 51/1 62/7 65/18 72/22 79/21 80/4 80/16 80/18 81/15 81/19 81/20 82/3 84/23 92/8 93/20 99/5 121/21 132/11 147/13 150/3 165/10				
provided [20] 1/13 1/21 1/25 12/2 12/12 42/24 60/5 61/22 78/16 80/12 80/22 81/10 82/11 136/19 136/24 142/25 188/17 190/9 191/7 196/3				
provider [11] 64/21 97/11 97/12 103/22 104/11 105/14 106/24 107/24 125/4 126/2 139/16				

R				
recognition... [5] 54/21 68/15 85/23 85/25 118/25	referring [1] 178/3 refers [2] 44/11 173/7	reliance [2] 19/24 82/10	108/18 148/8	restricting [7] 113/25 116/18 116/20 116/22 117/5 118/4 119/10
recollection [1] 30/17	reflected [1] 2/6 reflection [1] 35/15 reflections [1] 92/6 reflects [1] 99/10	reluctant [1] 27/11 rely [1] 119/15 relying [1] 144/10 remain [2] 113/11 192/14	requiring [1] 163/10 requisite [1] 110/20 research [9] 46/8 47/9 74/1 159/7 173/8 173/11 173/12 173/18 174/15	restriction [1] 157/17 restrictions [9] 31/21 114/17 114/25 157/12 158/18 158/21 158/25 159/10 160/9
recommend [5] 65/3 74/10 76/8 77/9 188/13	reform [1] 149/11 refreshed [1] 101/11 refuse [1] 59/3 refused [2] 57/5 174/16	remained [1] 196/21 remaining [3] 122/11 126/3 189/15 remains [1] 52/25 remember [14] 8/20 17/6 56/21 88/13 88/15 88/18 90/13 95/4 109/14 143/5 149/8 149/9 149/14 185/14	researches [1] 175/7 resident [6] 21/24 124/13 124/14 132/15 189/7 189/11	result [6] 26/15 28/2 35/17 76/1 95/1 95/18 resulted [2] 177/25 179/9
recommendation [5] 68/1 68/4 68/17 156/7 180/21	regard [4] 19/14 22/10 42/12 130/4 regarding [3] 25/21 42/5 150/22 Regardless [1] 24/4 regards [2] 42/3 183/19	remit [1] 1/20 remote [1] 20/21 reoccurring [1] 144/20 reopened [1] 140/25 repeating [1] 172/25 replaced [2] 20/7 105/8	residential [3] 65/8 147/19 182/22 residents [9] 40/3 40/7 41/7 88/19 153/13 155/2 155/2 168/1 169/19	resulting [1] 61/24 results [1] 132/4 resuscitation [2] 161/16 164/2
recommended [4] 130/20 145/8 156/1 189/8	regional [7] 117/1 141/19 170/2 170/11 171/5 171/13 171/14 regions [1] 169/18 register [10] 34/5 34/14 34/24 128/17 147/12 147/21 148/13 148/13 148/14 149/4	report [18] 33/11 33/13 67/23 108/25 109/3 116/17 145/12 150/9 164/12 164/13 164/13 166/11 166/16 167/18 173/7 174/12 177/21 179/16	resilience [5] 64/18 95/9 101/6 118/9 173/9	retail [2] 118/16 140/23
recommending [1] 72/14	registered [4] 104/24 124/23 125/4 127/22 registering [1] 127/19 registration [2] 147/18 148/7 regret [1] 29/8 regular [4] 18/2 123/21 153/10 168/13	replicate [1] 102/8 report [18] 33/11 33/13 67/23 108/25 109/3 116/17 145/12 150/9 164/12 164/13 164/13 166/11 166/16 167/18 173/7 174/12 177/21 179/16	resilient [2] 4/17 7/12 resort [1] 111/16 resources [5] 41/8 65/5 131/6 143/22 145/15	retain [2] 3/10 28/17 retaining [1] 138/2 retention [2] 97/18 137/21
record [10] 69/19 75/9 92/17 92/18 165/22 165/23 165/23 166/3 166/6 190/24	records [10] 69/12 69/15 69/16 71/25 72/1 92/18 92/21 165/20 165/24 165/25 recruit [3] 96/15 137/25 138/5 recruited [1] 136/15 recruitment [4] 114/20 136/8 137/20 144/12	reported [6] 5/11 80/15 168/9 168/20 168/20 179/8 reporting [3] 139/16 139/17 168/1 reports [11] 17/11 58/11 72/21 84/18 128/23 128/25 145/9 182/15 182/18 184/5 195/5	respiratory [2] 23/11 103/9 respite [2] 61/23 62/5 respond [2] 4/16 75/22 responded [2] 2/9 117/15	retrospective [1] 140/7 return [6] 54/12 86/10 99/22 121/21 141/9 197/19
red [1] 128/1 reduce [1] 16/4 reduced [4] 137/1 193/24 194/3 194/11 reducing [5] 55/9 116/15 117/8 117/9 191/7	regulation [2] 159/12 160/12 Regulation 9A [1] 159/12 regulations [4] 115/3 159/17 161/10 181/12 regulatory [1] 178/9 rejected [1] 115/9 related [2] 96/2 96/4 relating [1] 44/22 relation [11] 15/19 49/8 58/18 84/10 88/12 111/23 130/18 143/4 173/20 188/11 196/2	repository [2] 165/25 166/7 represent [5] 36/20 44/13 78/6 83/8 140/16 representation [1] 33/6 representative [1] 9/23 represented [1] 119/1 represents [2] 44/7 140/20 requests [2] 126/11 126/14	respect [1] 24/1 respects [1] 107/21 respiratory [2] 23/11 103/9 respite [2] 61/23 62/5 respond [2] 4/16 75/22 responded [2] 2/9 117/15	returning [3] 41/7 68/20 182/6 returns [4] 108/1 167/17 172/8 180/17 review [15] 77/10 98/21 104/19 136/13 136/18 145/8 145/10 162/6 166/23 167/9 180/25 181/3 195/24 196/3 196/15
refer [5] 48/18 52/2 52/23 108/24 143/16 reference [15] 93/22 100/3 100/13 102/7 129/11 139/19 149/22 152/4 157/20 159/11 161/9 162/20 163/3 173/6 177/15	relationship [2] 9/7 103/16 relationships [1] 9/16 relative [2] 122/1 139/1 relatively [4] 3/5 46/22 122/1 183/19 relatives [3] 29/1 49/19 81/19 relevant [2] 40/2 171/15 reliable [1] 35/4	reports [11] 17/11 58/11 72/21 84/18 128/23 128/25 145/9 182/15 182/18 184/5 195/5 repository [2] 165/25 166/7 represent [5] 36/20 44/13 78/6 83/8 140/16 representation [1] 33/6 representative [1] 9/23 represented [1] 119/1 represents [2] 44/7 140/20 requests [2] 126/11 126/14	respiratory [2] 23/11 103/9 respite [2] 61/23 62/5 respond [2] 4/16 75/22 responded [2] 2/9 117/15 respondee [1] 151/3 respondents [4] 150/21 150/25 151/8 151/10 response [22] 7/12 7/13 8/5 13/24 19/13 24/10 26/24 65/13 70/6 72/25 73/14 73/25 90/24 93/13 94/20 95/10 125/16 126/2 126/5 127/2 143/5 166/25 responses [4] 73/9 82/7 150/13 196/5 responsibilities [4] 49/9 77/17 146/20 180/19 responsibility [4] 21/15 37/7 56/22 94/20 responsible [3] 35/1 83/1 167/15 rest [2] 29/8 93/7 restrict [7] 114/19 115/3 115/15 116/7 116/21 119/13 120/11 restricted [1] 115/8	reviewed [1] 190/18 reviewing [3] 93/23 101/21 105/1 reviews [2] 15/20 20/4 revise [2] 100/5 100/22 revoked [1] 178/6 rhythm [1] 168/15 right [81] 2/4 3/21 4/14 7/16 10/7 12/21 22/20 23/7 24/5 24/6 27/10 32/8 34/9 34/22 37/16 41/4 44/3 44/10 44/14 44/21 45/18 46/8 46/12 46/16 47/2 47/20 48/13 50/17 51/18 51/21 57/18 58/13 61/7 61/11 61/20 62/1 71/22 71/23 72/1 76/5 77/23 78/1 87/14 87/23 91/3 93/9 99/21 100/20 102/5 103/12 106/1 113/21 122/14 125/5 125/7 125/19 126/1 126/16 126/17 130/10

R	rooms [1] 41/12	143/21 147/14 151/8	says [4] 129/15	116/8 116/24 132/12
right... [21] 130/18	Ros [3] 105/18	154/12 157/24 161/5	138/18 139/20 178/25	134/8 134/12 145/21
134/21 140/9 148/19	184/19 185/14	162/7 166/23 168/21	scale [10] 89/10 99/7	150/15 150/23 152/23
159/18 160/18 161/13	rota [1] 5/19	172/4 172/24 176/24	105/2 129/21 138/24	154/15 158/19 159/15
163/21 166/10 167/22	rota-ing [1] 5/19	182/16 185/14 190/10	140/10 140/11 142/14	162/20 162/22 164/25
171/22 173/3 179/2	roughly [2] 103/5	190/23 192/7 196/18	175/8 182/10	169/3 169/11 169/22
181/2 182/1 190/16	121/25	said: [1] 188/12	scar [1] 29/7	170/10 170/15 170/16
192/11 192/21 193/4	Roughton [3] 105/18	said: we [1] 188/12	scary [3] 184/22	170/19 187/9 189/2
196/21 196/24	184/19 185/14	same [19] 24/5 30/16	185/9 186/6	189/5 189/20
rights [11] 24/2	round [3] 11/20	30/23 50/3 52/25	scenario [1] 95/25	seeing [5] 6/8 18/1
26/18 36/7 36/9 36/15	122/24 173/25	64/11 80/1 89/15	scene [1] 55/18	74/8 88/17 138/22
40/9 50/2 52/7 78/7	route [4] 16/7 16/13	100/15 123/24 133/24	scheme [3] 115/6	seem [2] 153/25
79/12 88/18	148/2 148/3	144/13 153/6 153/21	136/8 176/12	156/16
ring [4] 11/5 120/8	routes [5] 16/17	188/18 189/8 189/9	school [1] 31/15	seemed [5] 8/3 16/12
121/14 136/11	103/8 164/5 164/8	189/12 190/23	scientific [1] 123/25	117/3 142/3 189/2
ring-fenced [3] 120/8	164/9	sample [2] 104/23	scope [1] 77/12	seemingly [1] 31/10
121/14 136/11	routine [2] 17/22	104/25	Scotland [15] 21/25	seems [1] 85/23
rise [1] 132/17	23/11	Sarah [1] 86/25	22/19 30/9 30/12	seen [20] 57/13
rising [3] 57/17	routinely [1] 24/23	sat [2] 90/21 171/4	47/12 47/18 47/20	70/10 72/2 73/17
144/19 153/17	row [1] 93/22	saw [13] 12/21 20/15	60/7 60/14 60/19	73/23 95/21 96/10
risk [42] 5/25 11/13	rule [2] 120/1 120/3	57/11 62/12 70/7	76/10 76/13 76/17	102/7 130/9 174/1
17/10 38/13 40/2 59/1	rules [8] 24/24 25/11	70/15 74/12 77/4	133/10 147/17	174/2 174/5 174/13
68/10 74/5 74/12	25/12 25/16 59/14	79/14 96/24 116/3	Scottish [1] 30/10	174/17 174/21 174/25
131/3 137/1 144/25	80/4 80/6 80/9	171/12 183/20	screen [13] 22/2	185/11 187/6 193/16
149/22 150/1 150/16	run [4] 95/4 95/8	say [102] 3/14 4/11	93/14 99/23 103/23	193/17
150/21 150/24 151/5	118/6 137/15	5/15 13/5 14/20 15/24	124/19 129/5 136/16	self [5] 56/19 72/22
151/13 151/20 151/22	running [3] 128/6	16/19 19/5 20/22	138/12 145/17 155/21	80/18 119/16 141/20
152/4 152/6 152/9	171/24 174/11	25/25 27/8 30/17	162/14 164/20 177/10	self-isolate [2] 56/19
152/11 152/12 152/14	rush [1] 27/22	32/18 40/8 40/11	scroll [1] 100/12	72/22
152/21 153/3 153/7	S	41/10 45/25 47/4 49/3	se [1] 19/10	self-isolating [1]
153/18 153/25 154/7	sadly [2] 22/13 25/2	49/5 49/10 52/5 53/10	second [9] 9/1 22/3	141/20
157/24 158/9 158/11	sadness [3] 29/9	53/12 54/1 54/4 54/22	22/6 36/6 39/15 68/11	self-isolation [1]
179/22 183/6 185/5	36/10 88/25	55/17 56/2 59/15	78/22 93/18 110/24	119/16
186/8 188/4 192/22	safe [12] 32/16 41/9	60/17 61/8 66/19	secondly [1] 73/9	sending [1] 112/25
risks [10] 41/1	56/18 56/23 57/6	66/22 67/15 70/4 75/5	secret [1] 169/1	senior [2] 23/9
120/16 123/19 123/25	63/19 81/9 113/1	83/21 84/9 88/5 88/10	Secretary [3] 115/1	139/11
150/6 153/12 153/13	117/18 144/16 161/2	90/19 91/10 96/22	179/24 183/25	sense [8] 7/20 88/3
155/2 159/4 188/4	183/6	97/16 102/10 104/23	section [3] 136/17	99/7 102/16 123/16
robust [7] 92/2	safeguarding [3]	106/10 108/5 108/17	150/16 163/15	123/17 131/3 176/17
100/24 101/20 102/12	17/8 39/8 143/19	108/21 110/22 111/16	sector [39] 1/17 2/15	sensibly [1] 107/25
102/24 175/13 175/22	safeguards [1]	111/24 112/7 112/21	3/19 4/15 5/4 5/4 7/11	sensitive [1] 151/25
robustness [1] 104/2	179/10	115/5 117/3 117/8	8/16 9/5 21/20 49/5	sent [5] 21/24 88/18
rogue [1] 142/6	safely [5] 111/18	121/23 126/4 126/10	55/7 67/3 74/25 82/7	162/16 162/18 163/20
role [17] 2/19 9/22	112/7 112/10 141/23	127/20 127/24 128/15	86/3 106/3 107/12	sentence [1] 162/8
15/9 29/15 46/13	160/25	133/17 133/24 134/5	118/10 119/6 121/18	separate [2] 41/12
46/14 56/4 56/8 71/7	safety [3] 40/14	135/7 136/14 138/13	124/22 126/16 135/9	90/12
83/8 87/13 101/3	40/14 50/2	142/23 142/24 145/6	140/15 146/23 152/8	Separately [1] 96/7
109/15 121/12 159/5	SAGE [3] 131/10	148/24 156/25 161/18	164/6 165/13 165/21	September [16]
161/5 163/9	131/25 157/20	161/19 161/25 163/11	166/1 166/22 181/8	87/14 88/3 89/3 89/25
roles [2] 2/14 46/16	said [62] 7/10 7/19	164/10 164/20 166/22	181/8 184/23 185/5	127/21 127/25 128/21
roll [3] 113/15 132/1	11/4 12/18 26/24	167/14 167/24 168/4	186/7 186/16 186/20	131/24 136/25 138/15
134/3	29/11 29/14 36/20	170/9 171/15 172/13	sectors [3] 6/21	139/24 140/21 145/24
rolled [9] 123/21	39/18 39/23 47/2 50/1	179/15 183/1 183/4	85/23 118/16	168/16 168/18 175/3
128/9 131/4 132/2	53/1 53/25 57/18	185/15 185/25 185/25	secure [1] 150/18	September 2020 [2]
132/21 134/11 156/22	58/23 59/24 61/5 81/6	186/19 187/17 191/11	see [58] 6/18 8/12	127/25 145/24
168/14 168/22	86/1 92/1 94/17 96/19	191/15 191/15 192/22	42/6 47/9 49/25 50/13	September 2021 [1]
rolling [2] 156/14	96/20 97/14 97/21	194/4	53/7 53/20 57/23	139/24
170/8	107/17 107/17 108/7	say: [1] 158/15	59/13 70/9 72/14 74/1	serious [2] 17/25
rollout [3] 133/22	112/15 116/11 117/16	say: well [1] 158/15	75/21 77/9 79/9 81/19	21/7
134/14 156/12	119/20 121/14 121/19	saying [14] 5/10 7/13	85/3 86/17 92/22	seriously [1] 26/25
Roma [1] 71/2	123/14 130/5 130/22	24/9 28/20 109/10	93/18 94/7 95/12	servants [1] 29/24
room [4] 15/12 41/22	135/16 136/20 138/8	116/14 116/18 116/20	98/13 100/2 101/20	service [10] 5/2
78/2 189/20	142/11 143/16 143/18	123/3 125/16 126/24	104/3 104/14 104/25	12/10 13/13 15/10
		128/8 151/23 167/3	113/5 113/6 114/13	21/4 35/7 36/2 69/17

S	143/7 184/22	137/21 154/16 163/2	11/9 16/23 18/5 19/16	87/11 88/22 88/24
service... [2] 188/2	she'd [1] 102/7	178/4 179/4	33/16 33/23 34/13	88/25 90/23 91/9
188/18	sheer [1] 18/5	similarly [1] 194/8	34/18 35/9 35/22 36/5	92/13 95/19 96/9
services [36] 9/14	shifted [1] 47/21	simple [1] 13/18	37/3 54/5 54/6 55/2	96/16 96/22 99/4
12/15 12/25 17/16	shopping [1] 3/10	simply [5] 35/17	55/5 55/7 58/21 58/22	99/25 106/8 107/23
19/22 26/14 28/1	short [5] 54/14 86/14	46/17 82/9 125/13	66/12 66/21 67/3	108/19 108/25 109/3
53/19 57/4 57/5 57/8	137/24 138/6 141/11	162/8	67/15 68/13 82/10	110/6 113/24 115/6
57/9 59/3 60/9 61/7	short-term [1]	since [5] 42/7 88/8	87/5 87/12 88/12	118/11 119/12 123/5
61/9 61/23 61/23	137/24	156/13 176/13 192/14	89/11 90/4 90/6 90/9	123/10 123/15 124/20
61/23 64/14 68/13	shortage [1] 124/8	single [3] 32/5	90/14 90/18 90/21	125/19 132/12 133/23
68/20 71/3 73/3 73/7	shortages [13] 95/22	120/14 165/15	91/10 93/21 94/6	134/4 140/6 141/19
95/24 96/9 105/20	117/11 117/22 117/24	Sir [2] 9/10 10/8	94/15 94/19 95/4	142/17 146/4 146/10
145/8 162/24 163/12	118/1 120/5 124/4	Sir David [2] 9/10	95/13 96/9 96/21 97/3	146/14 149/11 149/11
188/5 194/2 194/15	141/23 142/1 143/13	10/8	97/9 98/5 98/21 105/8	155/5 163/4 163/12
194/16 195/13	144/7 144/9 183/11	sister [1] 81/15	105/10 105/20 105/21	163/16 167/22 167/23
set [36] 3/17 9/23	shorthand [1] 100/7	sisters [1] 46/3	108/24 109/1 109/17	171/16 174/21 178/15
18/21 32/25 35/8 35/8	should [57] 5/13 5/15	sit [1] 95/10	119/6 126/15 126/18	179/1 179/13 179/17
58/12 60/6 60/7 63/24	26/8 27/7 35/1 40/12	site [1] 11/11	127/21 129/24 131/25	179/19 179/19 181/21
64/8 66/20 67/18 72/2	54/1 54/2 60/12 62/23	sitrep [1] 168/9	143/7 145/6 145/7	182/10 183/4 183/15
72/3 89/20 93/11	62/24 63/10 64/5	sits [1] 101/3	146/21 147/3 147/7	184/3
94/17 102/6 102/17	65/14 68/4 70/10	sitting [3] 87/1	147/9 147/11 148/16	somebody [9] 9/19
105/17 105/22 105/23	72/19 72/24 73/3 75/6	103/11 103/15	150/1 150/2 150/2	10/6 21/3 45/15 45/16
113/13 114/14 114/22	78/1 78/5 78/13 78/14	situation [8] 19/18	150/10 150/13 151/4	45/19 65/4 67/10
126/5 135/2 141/18	83/3 83/22 94/2 94/3	25/16 26/12 35/13	152/9 153/9 153/16	75/18
148/22 164/15 164/22	98/1 107/3 110/3	48/7 52/11 83/4	154/22 154/25 155/23	someone [11] 10/4
173/22 176/6 178/2	110/7 110/13 116/7	120/19	156/19 157/5 157/20	10/8 35/3 72/20 72/23
181/2	116/13 122/22 127/24	situations [2] 12/24	161/10 164/8 164/8	100/25 111/9 120/19
sets [1] 125/20	129/2 130/24 142/23	49/22	165/21 166/1 167/16	138/3 194/9 195/8
setting [12] 19/13	144/4 144/6 144/13	six [8] 142/11 142/15	178/20 181/1 184/20	someone's [1] 67/9
37/7 63/20 110/21	148/13 150/4 151/24	144/17 154/13 164/25	190/8 190/11 190/12	something [35]
111/14 112/25 120/12	152/1 156/3 161/9	176/7 182/13 190/14	190/18 192/1 192/2	12/18 13/25 16/13
120/17 120/19 120/21	163/5 179/15 182/1	size [6] 90/25 91/7	192/2 192/14 194/2	16/22 23/7 23/12 27/1
120/21 121/4	183/23 186/18 191/3	98/11 98/13 136/12	195/12	27/12 29/6 29/11 34/5
settings [22] 34/20	191/16 192/13	148/5	society [2] 27/1	36/1 55/19 60/20
40/12 40/19 65/8 65/9	shouldering [1]	skill [2] 13/13 14/8	27/15	61/15 62/17 65/2 72/7
66/5 110/17 110/24	77/16	skilled [1] 33/17	solution [4] 65/5	74/12 76/8 77/3 77/8
111/5 111/8 111/15	shoulders [1] 58/10	skills [11] 21/14 34/8	97/24 111/12 119/17	79/19 80/2 83/2 94/19
111/20 111/24 112/16	shouldn't [3] 6/1	98/12 101/1 148/16	solutions [1] 109/1	97/14 104/11 111/5
112/22 113/9 113/11	34/11 127/15	148/21 153/1 155/20	solve [1] 97/24	130/13 146/12 147/6
113/13 113/15 150/2	show [5] 46/14 132/7	155/25 156/7 156/13	some [143] 1/16 2/1	172/3 172/24 194/14
182/22 186/23	145/17 168/4 169/25	skin [1] 21/1	2/8 2/20 3/5 3/12 5/10	sometimes [19] 6/15
seven [8] 45/19	showed [5] 46/9	slides [1] 169/16	5/12 5/17 5/21 5/23	10/16 11/21 12/24
50/14 169/24 170/9	126/12 149/18 150/16	slight [1] 2/8	8/24 11/11 11/22	21/16 25/6 26/15 51/9
190/12 190/15 190/20	151/13	slightly [12] 12/11	11/25 12/7 15/3 15/25	57/25 60/4 61/9 64/20
192/5	showing [4] 139/24	47/11 47/21 47/25	16/9 16/12 16/23	67/6 67/11 69/14
seven days [1] 50/14	140/2 158/21 163/4	51/19 54/4 70/17	17/17 18/3 18/7 19/1	71/16 75/10 79/24
seven-day [1] 170/9	shows [1] 169/17	76/13 78/2 90/1	19/16 19/21 19/25	123/14
several [2] 80/5	shut [1] 99/8	128/15 129/11	21/19 21/20 23/1	somewhere [2] 87/21
153/11	sic [1] 152/12	slow [1] 32/19	24/10 25/22 27/10	166/6
severe [1] 93/21	sick [3] 11/16 50/8	small [14] 3/5 51/9	28/7 28/23 31/23	son [1] 57/24
shall [7] 43/4 54/12	170/21	70/16 104/23 104/25	32/15 32/17 33/12	sons [1] 46/3
86/10 89/6 141/9	side [3] 31/23 106/23	126/20 127/6 127/18	35/7 36/18 36/25	soon [4] 10/3 116/4
145/19 197/19	106/24	127/18 132/20 137/1	37/14 41/10 42/3 45/2	164/4 178/6
shape [1] 82/9	sign [3] 61/14 61/15	151/12 194/23 195/4	45/4 45/20 46/21	sooner [3] 9/20 9/20
shaped [1] 30/13	113/22	smaller [4] 48/24	46/23 49/23 51/24	156/22
share [5] 25/9 81/14	signed [3] 66/15	74/25 128/10 128/19	52/20 53/6 53/7 53/8	sores [1] 21/1
101/12 169/10 174/16	166/5 183/5	sniff [1] 125/8	53/15 56/12 56/20	sorry [19] 9/6 31/19
shared [2] 2/11 24/7	significant [12] 20/23	so [330]	57/6 58/2 59/22 60/5	42/13 43/5 43/8 43/11
sharing [3] 60/2	63/11 70/19 97/7	social [128] 1/17	62/6 64/2 65/17 65/21	43/17 45/24 47/13
71/15 192/2	98/16 98/18 106/4	2/14 2/16 2/22 3/6	66/19 67/25 68/2	65/23 78/5 88/10
sharply [1] 132/18	138/22 158/16 169/23	3/16 3/18 3/23 4/2 4/4	68/18 69/11 70/9	104/19 122/19 132/21
shattering [1] 21/19	177/24 179/8	4/5 4/8 4/25 5/2 5/8	70/12 71/4 71/8 71/15	149/2 150/19 153/9
she [4] 92/3 139/20	similar [10] 14/20	6/25 7/8 7/16 8/16 9/5	72/5 74/15 76/5 80/17	187/6
	16/1 16/14 57/18 61/2	9/11 9/14 9/16 10/2	83/20 83/20 84/9	sort [68] 4/18 8/8

S	spoke [3] 58/23 97/15 119/2	standing [3] 105/12 127/3 173/12	135/4	190/10 190/23 190/23 190/25 192/12 196/11
sort... [66] 13/8 21/4 52/21 52/21 53/6 59/13 60/3 61/1 66/9 68/15 83/19 88/3 88/5 92/22 97/6 97/21 97/23 98/3 99/17 103/19 104/23 106/4 106/22 107/10 110/14 117/8 120/7 121/4 127/14 127/17 127/25 134/13 135/18 137/24 140/5 140/21 142/19 143/24 145/3 145/12 145/15 146/22 146/23 148/15 148/20 153/7 154/13 162/9 162/9 165/13 166/7 170/6 170/22 171/4 173/17 174/5 175/6 175/21 178/25 183/15 186/10 192/5 192/22 193/1 193/17 193/19	spoken [6] 80/23 97/20 100/16 180/17 180/23 190/11	start [20] 1/20 2/13 4/16 7/2 7/9 10/7 21/5 34/16 45/6 49/22 56/10 68/25 70/5 72/19 73/4 87/10 87/19 93/9 119/19 166/24	sticking [1] 61/4 stiffen [1] 18/19 still [26] 32/17 52/25 52/25 62/7 63/23 65/18 70/18 75/7 75/24 88/3 89/4 90/13 90/15 116/1 117/3 118/3 137/9 153/3 164/3 167/6 171/18 172/10 172/15 173/16 192/15 192/18	Subsequently [1] 8/21 substantial [2] 25/20 132/10 success [2] 111/25 112/4 successful [1] 150/17
sorts [13] 3/8 14/20 19/9 51/4 66/25 116/12 121/17 123/2 140/21 147/13 151/25 172/15 172/17	spread [6] 114/14 114/15 118/5 121/14 124/1 188/14	started [5] 70/7 70/9 108/3 127/18 132/6	stock [3] 124/24 125/13 134/10	such [23] 10/16 23/21 34/14 50/8 62/18 67/3 76/7 85/24 126/7 128/9 129/2 144/25 145/10 148/13 148/14 148/20 152/7 153/18 159/7 179/11 191/7 195/4 197/13
sounds [2] 126/17 128/17	sprung [1] 130/15	state [8] 3/18 4/8 4/15 10/18 38/24 49/7 115/1 183/25	stockpile [4] 65/2 124/6 124/7 124/24	suffering [4] 24/23 28/10 30/21 56/15
source [5] 29/8 36/10 62/21 75/16 140/17	square [1] 159/22	stated [1] 192/13	stood [3] 105/10 105/11 125/17	sufficient [6] 6/2 41/6 41/8 62/13 97/10 171/2
sources [5] 6/9 69/3 69/24 73/12 75/17	stability [1] 139/1	statement [73] 1/18 1/21 3/17 4/11 5/10 6/5 6/11 7/10 7/18 7/19 8/15 8/24 11/4 13/21 15/24 17/7 24/9 28/5 29/14 30/12 37/24 40/8 44/23 47/4 49/3 54/22 55/17 56/2 58/12 59/16 61/8 66/19 72/11 78/9 80/8 84/17 90/19 91/11 96/20 106/10 108/24 109/11 110/23 114/2 115/5 121/19 121/23 124/20 126/4 126/10 130/7 130/22 135/7 135/17 135/18 138/13 140/1 141/16 142/21 142/24 145/7 146/13 155/20 159/11 161/5 161/8 164/20 167/13 167/14 168/22 173/6 176/6 177/11	stood up [1] 105/11	suggest [7] 20/15 43/3 48/15 65/1 133/7 174/14 174/21
south [2] 98/25 169/24	stable [1] 183/20	statements [8] 1/25 2/2 12/1 87/5 130/8 163/9 177/13 190/6	stop [4] 11/14 15/13 46/19 175/15	suggested [4] 43/12 59/5 186/23 196/12
south east [1] 169/24	staff [103] 4/19 4/20 5/18 11/10 21/9 21/11 29/16 30/4 32/7 40/3 41/8 41/16 54/6 58/24 58/25 64/22 85/10 90/20 95/16 99/2 104/7 104/8 104/17 113/25 114/5 114/7 114/16 114/18 114/18 114/19 114/21 115/3 115/7 115/15 115/19 115/19 115/22 115/25 116/2 116/7 116/14 116/15 116/18 116/20 116/22 117/1 117/4 117/10 117/17 117/24 118/1 118/4 118/7 119/10 119/13 119/20 119/21 119/24 120/2 120/5 120/11 120/17 121/6 123/7 123/8 123/22 123/23 125/10 136/14 137/2 137/25 138/2 138/4 138/24 139/13 141/19 141/23 141/23 141/25 142/12 143/13 143/23 144/2 144/6 144/7 144/9 147/1 147/5 149/20 150/18 169/19 170/20 170/23 172/16 175/14 175/14 175/16 182/7 182/21 183/7 183/9 183/13 184/7	stopped [8] 17/24 18/7 19/23 19/23 58/6 149/6 176/9 196/17	stories [5] 6/20 16/3 16/16 21/11 88/19	suggesting [4] 53/25 73/1 83/17 93/3
space [4] 41/12 138/6 158/13 193/3	staffed [1] 38/24	states [2] 22/7 22/11	straight [1] 43/7	suggestion [2] 175/7 187/10
speak [5] 1/16 2/1 2/6 86/10 88/2	staffing [3] 117/18 144/16 183/6	statistics [4] 48/17 75/18 96/12 163/4	strain [1] 55/9	suggestions [1] 181/6
speaking [4] 13/5 56/20 140/1 143/6	stage [4] 24/19 38/5 131/5 166/14	statutory [5] 50/8 109/17 143/18 191/24 192/24	strands [1] 136/2	suggests [1] 174/25
specific [11] 10/16 44/24 66/4 67/18 69/5 90/8 110/18 112/18 146/16 153/4 156/24	stages [4] 6/14 11/6 19/3 20/14	stay [2] 18/17 140/13	strategic [1] 39/7	suitable [1] 109/25
specifically [4] 17/9 58/17 65/12 154/5	stakeholder [2] 30/8 140/12	stayed [1] 10/7	strategically [1] 38/12	suite [1] 96/11
spectrum [1] 45/22	stakeholders [5] 9/24 136/17 136/19 136/24 149/12	staying [1] 159/13	strategy [3] 8/16 70/6 103/2	summarise [1] 91/9
speculation [1] 130/16	standard [6] 155/23 156/4 156/10 156/12 157/1 163/8	steering [4] 99/25 103/24 105/6 184/18	stream [1] 168/17	summary [4] 2/13 3/21 114/8 169/18
Speech [1] 58/7	standards [1] 36/3	stems [1] 108/2	stressed [1] 62/4	summer [3] 134/5 145/9 174/22
speed [3] 82/5 137/5 197/15		stenographer [1] 141/9	stretch [1] 93/3	sums [1] 85/21
spend [3] 3/14 76/14 137/16		stenographer's [1] 42/23	strong [2] 28/17 139/8	supervision [1] 131/2
spending [1] 116/13		step [1] 7/11	stronger [1] 36/4	suppliers [2] 129/13 130/13
spent [2] 121/22 122/4		stepped [2] 10/2 12/3	strongly [1] 52/16	supplies [3] 129/2 129/23 171/2
spiked [1] 12/16		steps [5] 114/22 121/5 124/21 125/18	struck [1] 36/13	supply [10] 64/9 124/4 124/23 125/13 125/20 125/23 126/4 126/6 131/14 131/15
split [1] 90/7			structural [4] 37/22 38/7 38/15 39/5	supplying [1] 129/14
			structured [1] 90/24	support [68] 3/4 3/9 5/8 9/5 9/11 12/3 12/12 13/2 13/23 14/16 14/17 15/2 15/9 15/11 15/12 15/14 22/14 27/15 28/22 36/3 38/22 45/14 45/15 45/17 46/21 49/13 50/16 50/19 50/20 51/4 51/11
			structures [6] 7/4 9/25 33/24 36/18 75/24 89/21	
			struggling [3] 59/11 128/14 128/19	
			studies [2] 48/15 158/2	
			study [14] 45/10 71/20 71/21 151/12 151/13 173/15 175/11 175/13 175/18 175/22 177/1 177/2 177/16 178/5	
			subgroup [2] 30/10 67/18	
			subject [3] 38/15 38/25 112/1	
			submission [7] 190/9	

S	124/14	talks [4] 140/6 145/15 146/20 175/13	Terroni [1] 143/6	that I [5] 22/5 77/19 105/14 119/11 130/8
support... [37] 51/12 51/17 54/22 55/10 55/25 61/17 61/21 61/22 66/17 70/23 73/25 76/11 81/21 95/16 107/15 109/12 117/23 120/8 141/3 145/21 145/22 146/1 146/7 146/17 147/9 150/4 150/10 150/15 150/19 154/2 156/11 177/25 181/7 188/1 188/3 188/6 188/17	symptoms [4] 72/21 124/13 162/24 163/5	target [1] 73/8	test [9] 40/20 167/25 168/4 168/7 168/8 168/12 168/19 171/7 171/9	that it [1] 52/19
supported [5] 36/4 63/23 65/8 81/25 92/5	system [20] 24/21 36/5 55/5 60/19 60/22 60/25 61/2 69/9 77/1 77/2 82/10 92/2 92/3 95/4 97/5 97/15 98/5 127/8 185/6 192/13	targeted [5] 59/14 60/8 73/15 73/17 74/24	tested [3] 41/5 76/15 76/19	that's [66] 4/3 4/10 4/14 5/19 10/4 14/7 18/20 26/2 33/9 37/13 43/20 44/11 44/16 45/1 46/4 46/19 47/10 47/20 48/2 48/13 50/13 56/12 59/3 59/13 61/11 63/21 65/15 65/22 65/25 67/21 68/10 69/11 69/19 71/21 71/23 73/10 77/12 78/17 83/14 83/23 84/20 91/7 96/1 96/6 96/8 99/18 103/18 110/5 114/8 115/21 129/4 129/16 129/17 133/19 134/16 139/7 152/5 154/18 157/8 160/16 165/18 174/14 181/20 184/9 190/21 192/21
supporting [9] 2/19 29/16 29/16 95/10 107/19 135/10 145/5 151/23 177/24	systematic [3] 68/21 69/11 75/8	task [3] 9/5 33/17 33/18	testing [11] 67/7 89/17 107/4 121/9 123/21 141/20 153/10 154/19 168/13 175/16 187/13	their [119] 3/11 3/15 5/18 6/2 6/15 8/13 10/23 11/15 12/10 12/22 12/24 15/1 16/5 17/19 18/1 18/2 18/7 20/25 22/15 24/2 24/2 26/5 26/19 26/23 27/25 28/8 28/14 29/1 29/8 30/12 30/13 30/23 31/14 31/15 31/22 32/7 35/20 36/12 36/14 46/13 46/14 46/23 49/8 50/3 50/4 50/5 51/7 52/17 55/11 55/23 56/23 59/8 61/7 61/16 62/7 63/20 64/21 64/22 66/17 67/10 70/13 74/3 74/16 75/8 76/14 76/15 76/15 76/22 78/13 78/18 78/19 79/1 79/23 81/9 84/12 84/13 84/15 84/20 84/21 84/24 88/14 88/22 89/8 99/6 104/4 109/18 109/19 112/8 112/20 116/2 118/19 120/9 121/1 123/20 126/19 127/23 133/4 133/19 139/12 143/17 147/1 151/4 155/17 165/3 165/5 167/18 170/23 177/24 179/8 179/21 190/20 191/25 193/15 193/25 194/3 194/5 194/13 194/15 195/22
supports [1] 51/7	systems [10] 5/7 33/19 33/24 59/23 60/6 60/7 64/17 69/1 72/19 73/10	tax [2] 69/17 69/18	than [41] 4/5 14/5 16/11 18/4 18/24 19/21 28/24 32/15 33/19 38/2 40/6 41/11 46/12 51/13 54/7 66/5 72/5 78/11 110/14 111/13 123/13 123/19 126/2 133/6 133/17 133/18 133/19 134/4 139/14 140/23 140/25 141/25 142/4 142/14 148/2 148/6 150/20 151/21 160/3 181/5 181/9	them [80] 6/1 6/9 8/6 9/11 13/1 15/14 22/13 25/9 26/4 26/10 27/17
suppose [10] 32/11 35/15 85/24 90/11 115/13 118/8 123/2 145/23 147/10 148/17	systemic [2] 6/12 142/4	taxis [1] 119/16	thank [115] 1/9 1/10 3/17 16/20 32/22 32/23 33/9 37/12 37/18 39/4 39/14 41/19 41/20 41/21 41/24 42/15 42/17 42/18 42/23 43/1 43/2 43/8 43/20 44/1 44/2 44/14 44/19 45/4 45/5 45/24 46/8 47/1 48/4 48/9 48/23 49/1 51/14 53/25 54/8 54/10 54/12 54/16 54/18 55/24 56/2 56/14 57/15 59/15 61/4 61/18 66/2 66/3 67/21 68/23 70/1 71/13 71/18 72/8 74/7 74/10 76/3 77/18 77/24 77/25 78/4 80/8 84/16 85/16 85/17 85/19 86/1 86/4 86/5 86/11 86/12 86/17 86/21 86/23 88/24 89/1 90/2 100/9 100/14 108/23 108/23 129/10 131/23 135/25 136/5 141/9 141/14 149/16 153/23 161/14 162/18 162/19 165/1 169/14 169/16 181/19 181/22 182/3 184/2 189/14 189/16 189/17 189/19 189/24 190/2 197/1 197/2 197/14 197/17 197/18 197/20	
supposed [2] 50/25 103/13	T	team [7] 43/5 79/4 90/25 117/1 141/19 169/5 171/14	telephone [3] 12/7 20/8 20/21	
sure [33] 2/23 11/17 14/11 16/19 25/17 29/23 34/18 37/10 46/7 53/21 55/15 67/17 90/1 92/23 99/14 103/6 109/25 113/16 113/22 143/8 157/6 159/13 160/13 166/6 166/8 172/1 178/23 185/20 185/21 186/15 193/22 197/7 197/11	tab [1] 72/9	teams [2] 78/15 143/19	tell [6] 58/17 78/5 146/5 184/21 185/8 192/18	
surging [1] 28/2	tab 4 [1] 72/9	technical [1] 173/7	telling [2] 26/4 88/15	
surmise [1] 16/18	table [1] 120/18	techniques [1] 14/24	tells [2] 35/25 139/21	
surprise [1] 36/11	tables [1] 11/15	technology [2] 5/18 14/22	temperature [2] 61/12 61/14	
surprised [1] 152/8	tackle [2] 121/14 184/6	ten [2] 4/11 196/21	tend [4] 33/19 38/18 51/9 52/23	
surprising [1] 72/4	tailored [1] 112/18	tended [2] 70/16 126/19	tendency [1] 36/21	
surrounding [1] 154/7	take [26] 16/10 21/15 26/8 26/9 27/17 32/1 32/11 48/17 52/10 81/20 84/4 87/2 103/17 111/11 119/10 119/15 121/5 124/8 141/7 151/4 154/14 155/6 155/16 157/18 177/11 197/7	tens [1] 81/13	tends [1] 51/12	
survey [3] 57/12 96/11 154/16	take-up [2] 151/4 155/6	tension [3] 36/24 118/4 143/25	tens [1] 81/13	
survive [2] 22/16 163/5	taken [21] 7/22 13/24 23/6 26/25 34/1 39/11 67/13 84/25 109/23 116/17 121/23 131/12 137/5 147/14 153/8 153/12 153/15 166/15 175/15 180/3 195/8	term [10] 29/14 45/17 46/5 48/14 52/8 52/17 53/19 54/4 137/23 137/24	term [10] 29/14 45/17 46/5 48/14 52/8 52/17 53/19 54/4 137/23 137/24	
survived [1] 18/23	takes [1] 112/4	terminology [3] 49/2 52/6 53/7	terms [29] 4/21 11/6 33/21 44/20 50/6 50/16 54/6 56/6 61/18 62/9 68/19 75/4 77/11 83/18 106/5 113/7 116/7 118/21 124/22 134/18 138/1 140/5 158/21 159/3 166/7 180/7 182/9 190/24 193/20	
suspect [2] 130/8 158/19	taking [12] 10/12 16/4 18/7 18/14 51/8 62/23 62/24 87/13 130/13 143/23 163/1 191/6	terrified [1] 56/15	territory [1] 191/20	
suspended [1] 15/20	talk [11] 2/25 9/12 14/22 62/2 65/20 85/1 99/14 109/11 138/21 152/1 163/7			
sustainability [1] 55/4	talked [6] 89/8 153/15 181/10 181/13 188/23 191/13			
sustainable [1] 127/14	talking [21] 23/9 49/18 49/19 52/11 52/14 52/14 53/9 53/23 55/22 57/24 60/23 62/4 65/15 77/4 78/25 79/2 81/23 95/5 104/3 125/5 183/13			
swiftly [1] 102/3				
sworn [6] 1/6 43/15 86/19 198/3 198/8 198/12				
symptomatic [1]				

T	there [363]	38/20 39/1 50/10 63/5	140/16 141/25 142/15	39/24 41/3 43/4 46/16
them... [69] 28/18	there'd [1] 130/3	66/14 81/17 82/14	145/5 151/23 152/3	46/24 62/13 67/5
31/25 33/2 36/20	there's [47] 4/21 5/24	82/15 83/18 83/20	153/15 154/3 157/15	67/25 68/16 69/5
38/13 38/14 39/1	10/11 15/12 20/15	85/5 85/12 85/25	163/10 167/23 168/3	78/12 82/13 84/12
41/13 41/14 49/15	32/4 36/21 36/24	88/11 89/18 90/2	177/8 178/20 180/22	86/10 88/2 88/4 88/8
50/13 52/2 52/19	36/25 43/11 45/9 47/8	95/18 95/22 95/23	183/2 187/16 188/8	88/23 89/5 89/16
52/20 55/16 57/6	47/14 50/9 50/12 51/4	100/15 113/16 116/12	188/9 189/4 189/5	89/18 92/10 95/7 96/2
63/20 64/20 65/12	51/11 51/19 61/11	123/2 123/5 123/9	189/7 192/4 193/8	97/4 97/25 98/6 98/18
67/25 68/7 69/25 72/5	64/12 65/14 67/9	135/24 138/8 140/13	193/10	100/1 102/13 102/20
75/23 81/12 84/14	75/12 81/18 87/3 91/5	140/15 140/21 143/17	though [21] 7/16	107/11 111/1 115/9
85/3 86/10 87/6 92/4	94/16 95/19 100/13	145/13 146/3 147/13	23/3 67/15 79/15	120/6 125/14 128/6
92/16 95/17 96/20	104/2 106/19 106/22	148/23 152/1 152/7	80/19 96/18 99/22	130/1 131/7 131/20
96/25 100/22 101/1	106/23 115/18 118/3	153/21 154/7 154/14	103/12 107/2 108/13	131/21 137/5 137/16
103/14 104/20 107/6	118/18 123/12 130/7	154/19 155/12 159/23	109/10 111/23 125/20	138/6 140/9 140/22
107/7 112/11 116/23	139/19 147/15 161/7	161/18 172/5 173/14	128/23 133/9 135/6	140/24 144/13 144/18
116/23 118/7 119/15	172/21 174/13 177/1	176/12 179/4 181/8	155/4 165/10 167/6	153/6 153/22 158/24
123/10 127/19 128/12	177/21 181/12 186/5	183/19 185/19 186/14	179/7 196/21	168/18 174/10 175/3
132/11 132/25 133/13	there's nothing [1]	186/17 187/16 188/25	thought [17] 20/16	181/24 183/18 184/10
133/14 133/15 135/19	50/9	193/18 195/4 195/12	35/19 36/11 39/2	185/20 186/8 186/12
139/14 142/7 143/16	thereafter [3] 24/12	think [286]	91/20 92/3 93/5	187/15 188/25 194/12
146/4 153/11 154/5	101/22 124/15	thinking [6] 37/2 37/3	100/19 113/4 117/6	timely [1] 64/7
155/3 155/16 174/7	therefore [5] 49/14	38/11 39/11 39/12	125/22 142/5 143/20	times [14] 10/13
176/9 176/10 181/17	132/25 133/13 133/14	95/5	144/19 147/25 154/4	13/22 26/1 27/3 49/4
191/8 195/1 196/18	188/5	thinks [1] 62/24	182/16	56/21 104/10 147/25
theme [1] 12/6	therein [1] 32/21	third [5] 46/18 46/19	thoughts [2] 115/15	172/12 180/12 183/18
themes [2] 33/13	thereof [1] 180/15	72/13 94/16 187/23	119/13	194/10 195/9 197/13
58/14	these [43] 6/8 15/8	thirdly [1] 36/17	thousands [1] 76/17	today [10] 1/16 2/2
themselves [21] 5/25	22/20 22/24 26/7	thirds [1] 151/8	threat [1] 39/9	35/11 44/13 45/12
6/2 7/2 29/24 38/21	27/22 37/8 39/1 48/16	this [240]	three [10] 69/7 104/7	45/23 87/5 91/1 172/9
46/1 48/20 52/22 58/7	51/6 62/6 66/22 70/20	those [140] 1/18 2/2	104/15 105/23 126/3	193/23
59/6 59/19 61/9 62/8	71/8 77/16 81/23	2/21 3/8 3/10 5/14	127/4 165/24 168/3	together [12] 15/2
71/1 75/14 79/7 80/12	95/12 95/19 98/22	6/21 6/23 9/6 9/7	194/10 195/9	18/15 18/22 70/8
103/12 130/14 156/14	100/10 107/1 108/4	10/11 10/21 11/25	three days' [2] 126/3	73/13 80/5 84/2 94/14
175/5	116/12 125/17 127/15	12/5 12/15 12/25 13/3	127/4	135/19 136/2 146/11
then [89] 10/3 11/14	132/20 135/23 137/24	14/24 15/3 16/6 16/16	threshold [1] 4/7	171/7
12/20 13/8 14/1 22/10	138/1 144/17 146/3	16/16 17/4 17/18 18/3	through [51] 3/1 3/1	told [13] 14/4 18/16
27/3 29/2 33/15 34/1	148/18 148/23 151/25	19/1 19/9 19/16 20/1	15/8 28/6 29/7 37/5	30/24 43/5 48/8 57/16
36/17 50/18 51/2	159/3 166/13 171/6	20/6 20/14 20/24 21/6	40/9 50/19 55/20	60/12 91/23 141/7
52/20 53/16 56/6	174/13 174/17 179/1	21/6 21/9 24/7 25/2	59/20 60/14 64/17	162/4 167/6 188/14
66/16 67/6 69/12	180/11 188/5 195/3	25/9 25/12 25/12	64/18 64/21 66/17	195/1
69/20 70/4 72/24	they [299]	25/16 27/20 28/9	74/2 82/21 89/1 91/8	toll [1] 56/25
75/22 81/11 81/15	they'd [1] 137/15	28/12 32/9 32/10	91/21 116/5 119/24	tomorrow [1] 197/19
84/17 85/3 88/20 89/2	they're [15] 29/13	36/19 38/20 39/10	122/9 122/10 122/18	too [21] 2/7 2/21 4/23
89/9 90/1 90/7 92/4	45/12 45/16 45/18	41/5 41/19 44/18 45/4	122/20 133/3 134/12	6/4 8/14 14/21 15/5
92/21 93/19 94/9	47/22 49/23 50/25	47/10 47/19 47/21	138/21 140/11 143/5	25/24 32/4 36/25
94/23 96/6 96/16 98/9	60/3 69/9 79/2 79/4	48/21 50/10 50/12	148/2 154/14 157/18	37/11 85/13 137/10
101/21 102/8 102/18	95/12 129/18 149/14	52/13 55/11 60/9	158/1 164/5 164/6	166/12 173/1 177/4
102/21 103/7 103/20	195/22	63/24 64/10 64/17	164/7 164/7 164/8	185/5 186/8 191/12
105/15 106/20 106/25	they've [3] 69/6	66/25 67/13 67/23	164/9 166/20 170/11	195/14 195/19
108/5 112/10 113/21	104/1 156/15	68/25 70/24 71/10	172/19 179/5 181/10	took [17] 15/3 15/25
114/22 116/5 116/13	thing [25] 2/20 13/10	71/10 71/19 72/16	181/11 181/11 181/11	16/16 22/22 25/2
119/11 122/11 124/15	20/22 27/6 32/11 51/8	73/7 74/19 76/2 77/8	181/16 184/4	29/23 32/5 56/25
131/8 131/10 131/12	63/12 73/6 75/7 96/1	77/24 80/3 81/10	throughout [7] 2/11	66/15 67/4 67/25 68/7
132/2 132/12 133/14	109/14 117/7 117/10	82/14 83/8 83/10	6/5 24/13 46/23 56/25	88/2 113/12 124/21
134/7 134/11 135/11	135/3 143/11 148/19	83/10 83/20 83/20	106/12 116/3	135/5 154/21
143/6 146/7 152/1	151/18 153/6 156/24	84/22 85/5 85/12	thrown [1] 49/22	tool [3] 107/11
152/4 153/25 156/13	156/24 171/8 173/15	85/16 85/18 87/7	tied [1] 108/6	156/11 169/25
160/18 165/15 168/11	191/18 192/9 193/19	88/25 90/16 91/4 94/1	tighter [1] 64/9	top [6] 59/12 100/3
168/16 170/10 170/11	things [77] 3/8 3/10	97/23 99/19 104/5	time [86] 4/6 4/24 7/6	100/16 139/19 146/5
170/12 170/15 171/12	6/1 8/7 13/18 14/21	104/15 107/2 108/9	7/25 8/7 10/14 10/18	177/14
171/13 181/12 183/1	17/21 18/15 19/21	110/2 114/17 117/24	13/1 14/9 15/13 17/1	topic [18] 28/3 33/10
183/25 184/19 190/13	20/5 21/6 22/20 22/24	123/9 123/16 125/19	17/5 18/1 25/2 25/12	39/15 42/4 57/15
194/6	25/13 28/21 32/16	128/25 132/15 135/13	29/2 29/5 30/23 31/7	64/25 68/23 83/7
	34/16 34/23 37/8	135/17 136/9 137/6	32/20 33/11 34/23	134/2 141/17 155/18

<p>T</p> <p>topic... [7] 157/11 175/23 182/6 184/15 187/23 187/23 189/21</p> <p>topics [5] 37/21 77/20 87/11 134/22 173/3</p> <p>total [4] 136/14 139/2 190/14 190/15</p> <p>totally [3] 31/20 60/4 163/13</p> <p>touch [2] 192/14 192/17</p> <p>touched [2] 182/8 184/3</p> <p>towards [4] 56/23 94/4 118/15 163/12</p> <p>trace [8] 167/25 168/4 168/7 168/8 168/12 168/19 171/8 171/9</p> <p>track [1] 136/8</p> <p>tracker [23] 9/2 107/10 107/18 107/20 107/21 107/24 108/1 108/4 108/12 108/14 108/15 116/19 116/24 121/16 168/1 170/17 171/3 171/10 171/21 172/2 172/8 172/9 172/23</p> <p>tracks [1] 149/6</p> <p>Trade [1] 82/22</p> <p>tragedies [1] 88/25</p> <p>trained [2] 41/15 45/21</p> <p>training [7] 33/25 34/7 41/9 131/2 131/4 131/18 136/8</p> <p>tranche [1] 136/22</p> <p>tranches [1] 115/11</p> <p>transfer [1] 22/13</p> <p>transformation [1] 90/20</p> <p>translate [1] 83/14</p> <p>transmissibility [1] 31/2</p> <p>transmission [13] 31/8 31/13 40/4 59/2 59/4 61/6 103/9 114/5 116/4 157/25 158/16 158/17 187/15</p> <p>transmitted [2] 120/25 157/23</p> <p>transmitting [1] 121/4</p> <p>transparency [1] 36/4</p> <p>transparent [1] 34/10</p> <p>travel [5] 65/18 79/21 80/3 81/13 81/19</p> <p>Traveller [1] 71/1</p> <p>travelling [1] 60/2</p>	<p>Treasury [3] 82/24 120/7 137/19</p> <p>treated [3] 24/1 73/20 94/24</p> <p>treating [1] 189/11</p> <p>treatment [4] 74/4 163/10 164/2 187/1</p> <p>trend [2] 4/6 5/19</p> <p>triage [3] 60/22 64/17 70/23</p> <p>triaged [2] 60/9 60/17</p> <p>triaging [1] 59/23</p> <p>trial [1] 30/25</p> <p>trickled [1] 170/6</p> <p>trigger [1] 196/15</p> <p>triggering [1] 139/5</p> <p>trouble [2] 22/22 153/24</p> <p>true [3] 15/5 60/3 129/17</p> <p>trust [3] 26/21 27/7 72/12</p> <p>try [29] 5/18 21/12 23/21 23/24 92/10 93/1 96/15 97/22 115/6 118/3 120/16 121/5 124/21 128/18 130/2 130/11 135/18 141/25 145/4 146/17 154/21 158/4 166/8 167/5 167/7 167/10 172/5 179/11 180/16</p> <p>trying [18] 4/23 8/6 8/20 13/6 32/7 71/2 74/15 97/24 102/7 114/6 114/14 141/2 154/2 155/9 159/22 166/2 173/24 174/3</p> <p>turn [10] 62/17 68/24 106/8 106/11 139/12 141/2 149/23 157/11 161/21 176/22</p> <p>turnaround [1] 62/15</p> <p>turned [5] 7/20 13/19 24/25 35/16 77/19</p> <p>turning [1] 196/18</p> <p>turns [1] 81/20</p> <p>two [20] 9/7 37/21 39/10 78/21 90/7 100/17 101/16 102/6 104/14 120/4 140/15 144/4 145/13 150/12 151/3 151/8 176/8 183/24 192/2 195/23</p> <p>two hours [1] 183/24</p> <p>two-thirds [1] 151/8</p> <p>two-way [1] 9/7</p> <p>two-week [1] 151/3</p> <p>type [3] 22/17 32/25 192/9</p> <p>types [4] 37/8 45/13 100/17 180/11</p>	<p>U</p> <p>UK [52] 1/14 1/21 1/21 1/23 2/5 2/18 6/8 6/12 7/9 9/4 9/4 10/22 12/21 13/20 15/3 16/20 19/12 22/18 22/19 22/20 23/8 24/7 24/16 25/22 27/10 30/7 30/15 30/19 33/11 33/15 35/12 37/20 40/22 44/4 44/6 44/7 44/8 44/10 44/13 44/19 44/20 46/10 47/4 51/19 78/7 92/21 93/1 182/5 183/11 189/3 193/23 194/6</p> <p>UK Government [2] 9/4 183/11</p> <p>UK wide [1] 44/20</p> <p>UK's [3] 8/1 14/5 17/15</p> <p>UKHSA [2] 159/5 173/14</p> <p>UKs [2] 3/3 3/12</p> <p>ultimately [3] 30/6 31/17 144/13</p> <p>unable [5] 11/14 28/14 50/4 68/12 77/5</p> <p>unacceptable [1] 166/24</p> <p>uncertainty [1] 47/6</p> <p>unclear [2] 50/7 196/13</p> <p>uncover [1] 175/8</p> <p>uncovered [1] 175/12</p> <p>under [23] 3/5 27/24 49/14 49/16 50/7 51/20 52/22 67/3 77/4 91/14 91/15 103/11 103/15 132/8 165/14 171/5 178/15 179/3 179/5 180/2 180/8 191/2 192/16</p> <p>underestimate [1] 98/14</p> <p>underfunded [1] 122/1</p> <p>Underfunding [1] 97/17</p> <p>underlying [2] 97/3 182/10</p> <p>underneath [1] 160/22</p> <p>understand [34] 13/9 31/9 31/20 58/1 66/25 80/13 80/14 82/9 84/3 90/3 91/17 97/19 107/21 110/2 117/6 122/21 123/16 130/12 136/13 139/21 147/20 154/4 156/13 159/7 166/4 167/5 167/7</p>	<p>167/10 178/22 178/25 179/6 179/19 181/3 184/24</p> <p>understand it [3] 91/17 97/19 147/20</p> <p>understandable [2] 27/23 36/21</p> <p>understandably [3] 7/15 66/22 67/4</p> <p>understanding [13] 2/24 9/15 10/7 27/15 28/16 30/1 32/14 56/4 56/8 63/3 81/18 84/7 195/15</p> <p>understands [1] 114/2</p> <p>understands it [1] 114/2</p> <p>understood [7] 9/13 29/17 81/1 116/22 136/5 140/22 195/3</p> <p>undertaken [5] 33/17 69/14 81/1 152/15 173/11</p> <p>undertaking [1] 29/13</p> <p>undervalued [1] 55/19</p> <p>underway [1] 175/21</p> <p>undoubtedly [2] 32/10 149/17</p> <p>unease [1] 7/20</p> <p>unfair [1] 179/1</p> <p>unfolded [1] 134/13</p> <p>unfortunate [2] 10/1 18/21</p> <p>unfortunately [2] 11/17 29/10</p> <p>unhelpful [1] 24/25</p> <p>unintended [2] 19/6 35/17</p> <p>unintentionally [1] 21/13</p> <p>unit [1] 37/7</p> <p>universal [5] 76/25 164/15 164/22 165/9 196/19</p> <p>University [3] 177/2 177/15 179/15</p> <p>unless [4] 22/9 65/4 130/21 188/14</p> <p>unlikely [1] 22/15</p> <p>unmet [5] 176/3 178/1 179/10 191/8 191/14</p> <p>unofficially [1] 16/14</p> <p>unpaid [85] 44/7 44/9 45/6 45/8 45/11 45/23 46/2 47/3 47/6 48/2 49/4 49/8 51/21 52/2 52/16 52/23 53/4 53/20 53/23 54/20 54/23 54/24 55/3 55/6 55/18 56/5 56/9 59/16</p>	<p>61/19 64/6 65/9 65/12 66/4 66/7 67/1 67/19 69/2 71/1 74/21 74/25 75/19 75/21 76/7 78/10 79/7 80/12 80/15 82/10 85/2 86/3 88/14 91/19 91/22 91/24 92/2 92/7 92/11 92/14 92/18 93/2 93/5 119/1 119/2 119/6 130/18 130/19 130/24 131/1 131/5 132/1 132/15 132/22 132/24 133/4 133/15 133/22 134/15 134/20 187/24 188/12 188/17 188/20 188/24 189/5 189/7</p> <p>unprecedented [1] 48/7</p> <p>unsafe [2] 40/9 144/1</p> <p>unsure [1] 79/23</p> <p>untested [2] 40/1 186/1</p> <p>until [8] 40/4 60/7 74/14 105/22 136/23 137/19 168/15 197/22</p> <p>untrained [1] 49/20</p> <p>unusual [2] 21/17 22/21</p> <p>unwell [4] 11/14 21/15 22/14 23/7</p> <p>unwillingness [1] 186/5</p> <p>up [86] 4/9 6/23 7/3 7/11 9/23 13/24 18/19 21/4 29/11 32/25 35/8 35/8 37/7 44/2 45/18 51/8 60/7 60/8 63/24 64/8 64/14 65/4 66/20 67/6 67/18 74/5 74/11 74/23 75/22 77/6 77/6 85/4 85/21 87/2 87/13 88/2 88/24 89/10 89/20 93/11 98/3 102/18 103/1 103/23 104/5 105/11 105/18 105/22 105/23 106/11 108/11 108/16 113/13 117/2 124/16 125/17 126/5 128/6 135/2 136/16 137/5 138/12 145/19 147/14 148/22 149/23 151/4 155/6 155/14 155/16 161/4 161/21 164/15 164/19 168/2 171/24 173/4 173/12 174/11 177/10 177/12 181/2 188/9 195/17 197/12 197/15</p> <p>updated [1] 47/11</p> <p>upfront [1] 23/2</p> <p>uplift [1] 77/1</p> <p>upon [3] 82/25 107/23 125/12</p>
--	--	--	--	---

<p>U</p> <p>ups [1] 18/2</p> <p>upset [1] 26/18</p> <p>uptake [1] 14/17</p> <p>urgency [2] 25/1 82/7</p> <p>urgent [1] 186/9</p> <p>urgently [1] 138/19</p> <p>us [43] 9/17 9/17 10/22 14/4 16/12 16/12 17/6 20/17 26/8 29/3 29/4 42/6 43/1 48/8 48/11 57/16 58/17 68/23 81/25 86/22 91/23 96/24 99/7 102/10 106/6 117/10 119/4 127/11 129/21 134/24 136/3 156/20 159/16 165/20 168/21 170/3 170/7 170/8 171/11 172/9 172/18 176/24 188/24</p> <p>usage [1] 131/18</p> <p>use [29] 2/17 2/18 5/17 12/6 14/22 14/23 32/12 53/19 62/20 62/21 91/18 91/25 101/23 102/15 117/1 122/12 124/2 130/24 131/1 136/12 161/23 171/18 172/3 172/15 179/1 188/7 188/13 190/20 196/14</p> <p>used [28] 15/23 27/1 53/16 54/7 69/6 69/10 71/5 76/1 107/12 107/13 114/4 121/24 150/1 151/9 152/25 153/1 166/24 168/24 172/17 176/9 176/13 176/14 176/16 181/14 192/9 193/18 194/10 196/23</p> <p>useful [13] 9/19 10/21 14/18 15/17 30/13 70/5 138/1 157/6 157/10 168/4 169/25 172/10 173/18</p> <p>user [2] 122/19 176/2</p> <p>users' [1] 193/14</p> <p>uses [1] 165/16</p> <p>using [18] 5/9 14/5 16/5 35/21 54/4 108/3 123/16 124/24 176/8 176/9 176/21 178/22 191/9 191/16 193/7 193/9 193/10 196/17</p> <p>usual [2] 33/19 177/25</p> <p>usually [2] 29/22 69/10</p> <p>utilised [3] 110/22 111/21 151/14</p> <p>utterly [1] 52/12</p>	<p>V</p> <p>vacancies [8] 91/16 97/7 97/18 98/9 98/23 98/24 107/14 111/17</p> <p>vacancy [3] 98/5 98/11 111/2</p> <p>vaccinated [2] 83/23 194/4</p> <p>vaccination [6] 68/5 69/10 70/8 70/18 71/12 83/22</p> <p>vaccinations [1] 68/15</p> <p>vaccine [7] 123/24 139/9 154/24 155/6 155/8 155/14 155/17</p> <p>vaccines [2] 92/14 92/15</p> <p>value [3] 52/10 54/22 188/20</p> <p>variable [1] 20/9</p> <p>various [8] 13/22 107/8 114/22 124/15 131/6 138/17 157/18 168/25</p> <p>vast [2] 74/22 74/22</p> <p>vector [2] 158/16 158/16</p> <p>ventilator [1] 22/15</p> <p>version [2] 22/5 122/15</p> <p>very [175] 1/15 4/17 5/1 5/1 6/22 7/1 7/3 7/9 8/10 10/3 10/15 10/21 10/24 12/20 13/6 14/25 14/25 15/16 18/9 18/18 18/21 19/9 20/9 21/7 21/15 23/9 23/11 23/20 23/24 24/21 24/25 25/6 26/2 27/6 28/21 28/24 28/25 29/9 29/20 30/13 32/6 34/3 41/14 41/14 41/17 42/18 42/22 42/22 42/23 43/1 44/16 45/22 46/6 46/24 47/1 48/5 48/6 48/7 48/23 49/10 49/18 49/23 49/25 49/25 51/5 52/13 52/13 52/16 52/18 52/24 55/25 57/7 57/10 57/23 58/3 58/11 58/22 58/23 59/14 60/8 60/11 62/15 62/15 64/12 64/15 65/15 65/20 66/9 66/9 66/10 67/20 71/9 71/10 73/24 75/16 76/12 76/16 77/18 77/25 78/19 81/17 83/1 83/23</p>	<p>84/13 85/14 85/16 85/17 86/1 86/11 89/22 89/22 89/24 92/13 95/10 95/12 98/16 99/9 99/16 100/14 102/4 102/19 102/19 105/17 107/1 119/9 120/4 125/10 127/16 127/16 128/2 130/5 130/9 131/9 136/5 137/15 137/16 138/8 138/22 138/25 139/25 140/11 140/14 140/14 142/2 144/23 146/23 148/24 149/9 151/25 158/8 159/2 161/4 162/19 164/14 169/14 171/10 172/17 173/18 175/22 179/16 179/16 180/1 181/19 186/14 189/14 189/17 189/18 189/19 189/24 191/22 194/23 196/3 197/2 197/14 197/19</p> <p>via [1] 168/1</p> <p>Vic [2] 138/16 140/20</p> <p>Vic Rayner [1] 138/16</p> <p>view [19] 4/15 11/8 33/15 40/8 41/4 80/25 84/21 92/25 101/17 112/4 132/20 137/6 140/13 148/6 176/11 178/18 193/4 193/11 196/19</p> <p>viewed [2] 14/13 24/1</p> <p>views [9] 32/5 35/1 84/12 84/13 148/10 148/12 148/24 149/1 149/4</p> <p>virtual [1] 19/24</p> <p>virus [13] 8/3 18/18 31/3 31/8 31/25 32/15 35/18 114/15 119/23 120/23 120/25 121/3 157/23</p> <p>visibility [1] 84/22</p> <p>visible [1] 57/2</p> <p>visit [1] 20/19</p> <p>visiting [23] 10/17 19/22 21/13 28/3 28/19 29/14 30/8 30/11 30/14 31/21 31/24 32/17 88/20 120/13 157/11 157/19 158/18 158/25 159/10 160/9 160/15 161/3 181/12</p> <p>visitor [1] 160/18</p> <p>visitors [8] 29/12 31/11 157/23 158/1 158/4 159/8 159/18 161/6</p>	<p>visits [4] 20/10 22/1 32/1 159/14</p> <p>vital [5] 50/15 78/21 85/23 170/8 188/5</p> <p>Vivaldi [16] 173/15 173/20 173/25 174/3 174/8 174/11 174/16 174/19 175/11 175/11 175/12 175/13 175/16 175/18 175/20 175/21</p> <p>voice [4] 44/2 66/24 67/18 87/2</p> <p>voice up [1] 44/2</p> <p>voices [3] 32/10 36/19 84/9</p> <p>volition [1] 194/16</p> <p>volume [2] 127/6 163/3</p> <p>voluntary [1] 172/4</p> <p>volunteer [1] 53/2</p> <p>volunteers [3] 45/13 89/12 96/15</p> <p>voted [1] 27/8</p> <p>vulnerable [9] 40/12 67/12 72/23 74/12 74/25 100/7 120/23 121/2 150/5</p> <hr/> <p>W</p> <p>wage [1] 118/13</p> <p>wages [2] 114/5 140/25</p> <p>wagons [2] 8/8 36/22</p> <p>wait [1] 155/21</p> <p>Wales [9] 14/19 24/9 33/7 42/4 42/9 42/10 47/17 76/18 147/17</p> <p>walk [1] 17/12</p> <p>wall [1] 31/4</p> <p>want [30] 4/5 29/3 31/24 32/1 42/14 52/5 52/24 56/10 67/15 76/24 78/17 91/9 98/15 100/17 106/16 111/15 118/2 118/23 125/8 128/8 135/22 159/15 162/2 162/12 172/11 174/11 175/8 179/20 179/20 197/6</p> <p>wanted [20] 10/24 38/2 40/16 45/25 52/21 71/6 76/21 79/18 93/4 130/10 139/23 152/21 160/16 169/11 182/8 182/17 182/20 183/7 184/16 185/7</p> <p>was [621]</p> <p>was -- it [2] 116/10 117/13</p> <p>was broadly [1] 57/18</p> <p>was set [1] 135/2</p> <p>was: [1] 176/24</p>	<p>was: no [1] 176/24</p> <p>wasn't [32] 4/19 12/13 26/12 27/21 29/19 31/10 41/2 60/6 68/14 73/6 76/7 76/21 79/22 82/12 86/9 89/25 102/11 102/13 108/5 131/4 131/7 131/10 134/6 142/3 151/14 154/8 158/6 168/10 186/11 187/10 193/5 193/12</p> <p>watching [1] 18/12</p> <p>wave [5] 9/1 19/13 19/15 39/19 110/24</p> <p>waves [1] 19/18</p> <p>way [48] 6/22 9/7 13/18 14/23 20/8 23/25 25/4 25/5 31/16 34/20 40/19 49/22 50/3 50/13 64/11 68/20 82/16 83/2 85/20 95/3 107/12 107/14 107/18 107/25 112/14 116/15 116/21 117/8 117/20 120/25 127/22 128/9 136/3 140/10 153/2 156/20 160/24 163/12 165/17 169/1 171/10 179/2 180/9 181/2 184/25 188/18 189/12 194/25</p> <p>ways [8] 5/2 8/25 12/3 78/21 114/14 124/1 144/15 147/23</p> <p>we [443]</p> <p>we'd [4] 27/20 118/15 157/1 174/24</p> <p>we'll [7] 46/7 64/24 99/14 99/21 125/19 161/13 171/22</p> <p>we're [33] 1/15 11/25 26/10 34/4 49/19 53/8 53/9 55/22 72/6 75/20 78/24 79/2 81/23 83/12 103/6 104/3 107/9 112/25 113/3 118/11 119/19 125/5 134/18 155/18 158/13 158/15 159/10 171/7 172/20 177/12 181/9 186/10 192/22</p> <p>we've [18] 57/13 60/1 66/3 69/24 82/3 105/6 107/22 110/11 144/12 165/21 173/24 173/25 180/8 180/15 180/23 181/10 182/11 188/23</p> <p>weaker [1] 157/24</p> <p>website [1] 3/2</p> <p>Wednesday [1] 1/1</p> <p>week [10] 45/19 50/14 56/21 91/23 103/25 117/17 126/12</p>
--	--	---	--	--

W	24/11 24/16 25/22	53/17 53/22 57/2	7/10 8/8 8/25 9/18	88/16 88/20 92/1 92/7
week... [3] 126/25	27/16 27/16 29/21	57/11 59/4 59/7 59/9	10/24 10/24 12/3 12/7	93/25 94/1 94/24
150/12 151/3	30/18 31/10 31/12	60/12 60/17 62/16	12/20 14/13 15/19	97/24 105/18 107/3
weekend [1] 184/1	32/8 33/12 34/7 34/19	62/22 63/10 63/19	15/23 21/7 21/25	112/13 114/5 115/22
weekly [1] 2/11	35/6 35/23 35/25	64/9 65/15 65/16 67/8	24/21 26/5 27/12	117/15 119/1 119/2
weeks [3] 138/23	38/13 39/4 42/24 48/2	70/7 72/6 74/14 74/20	27/23 29/3 30/25	120/8 120/24 121/1
154/13 184/12	48/6 50/20 56/7 56/21	75/17 76/1 79/4 80/5	31/13 32/6 34/1 34/2	123/8 126/23 127/20
weeks' [1] 105/7	58/17 59/19 60/23	83/21 83/23 87/24	44/9 45/3 45/10 53/11	130/17 133/3 133/13
weighed [2] 31/1	62/10 65/11 65/14	88/21 95/5 99/18	57/12 59/5 68/18	133/25 138/20 139/16
31/10	67/1 67/23 68/1 69/1	101/5 101/19 102/10	68/19 69/22 76/13	139/17 140/16 143/6
Welcome [1] 1/7	69/8 70/4 70/7 71/24	103/4 106/21 108/3	79/20 80/14 82/7	144/14 147/15 148/9
welcomed [1] 136/19	71/25 72/3 73/10	111/1 115/21 118/15	91/12 91/17 94/19	148/13 149/12 150/4
well [79] 3/4 6/7 6/10	73/13 78/17 81/2 81/7	120/12 125/3 126/2	95/22 97/4 97/4 98/12	154/3 154/11 157/15
9/23 10/13 11/19	82/2 82/12 82/15 83/7	131/8 131/21 132/18	101/16 105/18 106/25	169/4 179/4 187/14
11/23 11/24 12/14	83/16 84/20 89/8	137/19 138/5 140/18	108/6 108/8 109/18	189/5 189/25 191/2
14/2 15/4 18/24 20/1	89/23 93/12 94/17	141/24 142/4 144/17	112/16 114/3 115/18	191/6 192/24 193/8
20/22 20/25 24/19	95/1 95/6 95/7 96/3	144/18 144/21 147/25	120/25 121/10 121/16	193/10 194/4 194/9
26/9 26/10 27/5 27/9	96/6 96/10 96/24 97/2	151/6 153/15 159/23	121/21 122/9 122/15	whoever [2] 31/25
28/12 28/25 29/17	97/21 98/19 101/18	159/25 161/25 166/9	122/16 124/16 126/20	69/16
35/15 38/24 39/17	101/21 102/21 102/22	168/6 175/25 176/21	127/16 131/20 144/3	whole [13] 26/6
44/18 45/21 45/25	105/2 106/4 106/17	183/19 186/7 187/8	144/25 146/5 148/3	27/13 32/9 50/23
48/10 50/15 50/22	107/4 107/14 110/11	187/18 187/18 188/9	148/5 152/11 153/7	51/11 79/18 102/18
52/22 53/14 53/20	113/6 113/6 116/3	195/21 196/17 197/13	154/24 155/17 157/23	126/18 134/18 154/10
53/24 55/25 57/19	116/8 116/25 117/21	where [59] 6/20	158/4 159/8 159/12	191/23 192/4 192/5
58/9 58/23 62/6 62/19	118/8 118/20 119/4	14/21 16/6 27/6 28/16	159/13 160/1 163/2	wholesalers [1]
64/19 70/23 71/6 73/1	119/12 121/22 122/3	31/14 36/9 39/9 39/21	163/17 164/13 165/16	130/17
74/1 74/5 76/2 78/22	125/3 125/5 127/11	40/13 47/10 48/16	165/18 169/15 170/4	whom [2] 63/3 80/20
79/11 81/6 81/8 83/19	130/2 134/8 134/14	53/8 62/4 63/8 64/2	170/5 173/5 173/7	whose [1] 191/3
83/21 83/23 85/10	136/17 139/24 140/2	64/8 69/4 69/13 70/9	177/5 177/25 178/24	why [47] 4/1 4/10
86/6 90/2 109/16	143/3 143/12 143/15	73/6 75/21 77/3 79/9	179/9 179/24 179/25	6/16 16/16 16/18
111/11 116/10 121/22	143/18 143/25 145/12	79/13 80/18 82/18	180/6 180/10 181/13	20/18 47/5 47/23 48/3
123/2 128/7 133/10	146/16 147/23 149/1	83/14 89/15 89/22	182/12 190/5 190/6	50/13 52/3 52/5 58/1
134/5 146/15 149/24	149/4 149/25 154/18	90/21 102/6 110/13	192/9 196/3 196/7	59/3 59/13 68/9 90/8
156/25 158/15 161/13	156/20 157/8 157/9	110/21 116/25 120/19	196/9 197/9	105/9 105/17 105/22
170/19 173/14 177/4	159/16 160/3 160/11	120/20 123/25 127/4	whichever [1] 102/25	112/3 112/4 115/21
180/13 191/25 196/9	160/16 161/25 162/3	129/12 130/12 130/14	while [4] 66/15	117/6 117/14 120/4
197/19	165/13 166/7 166/8	134/15 138/25 139/1	130/25 154/14 196/16	122/24 123/20 125/12
wellbeing [11] 50/24	167/7 170/10 170/15	141/22 142/12 144/25	whilst [3] 29/13	131/4 133/2 133/7
57/1 57/13 79/1 145/8	170/19 170/20 170/23	152/17 161/2 161/9	155/18 159/10	133/11 134/3 137/17
146/14 146/17 146/25	171/6 171/7 171/12	165/20 168/19 170/18	white [1] 38/2	140/2 149/14 158/19
176/4 178/1 179/9	171/16 172/12 173/25	174/5 174/23 183/1	who [131] 2/25 4/5	166/15 166/17 167/5
Welsh [1] 42/9	175/11 176/20 176/23	189/9 189/11	4/12 5/3 6/6 10/6 10/7	184/9 184/24 185/7
went [20] 17/25 19/3	178/18 179/10 179/23	where's [1] 97/24	13/11 14/25 21/11	187/10 188/24 189/2
19/6 32/12 84/9 88/20	184/21 184/22 185/5	whereas [1] 60/7	21/14 21/16 21/21	wide [3] 44/6 44/20
108/6 116/11 116/15	185/9 186/12 186/16	wherever [1] 114/17	23/9 25/8 28/12 28/16	195/19
116/21 117/7 117/10	186/24 187/3 187/6	whether [56] 13/24	29/7 29/23 33/17	widely [1] 15/23
117/20 122/18 137/22	187/20 190/19 192/4	14/18 20/17 23/5 24/4	33/21 34/6 34/11 35/1	wider [1] 142/14
144/8 153/14 178/20	193/2 193/9 194/1	32/24 38/2 43/17 54/5	36/11 36/19 37/15	widespread [6] 14/17
181/15 183/24	195/10 197/12	67/9 72/20 73/4 75/18	37/16 38/12 39/9 39/9	15/25 23/18 26/13
were [379]	what's [3] 115/14	79/23 92/8 92/9 97/8	41/5 41/22 45/6 45/11	142/3 142/16
weren't [20] 5/22	119/17 180/6	102/11 104/1 110/5	45/12 45/16 45/22	width [1] 195/19
6/22 7/4 7/5 8/6 14/12	Whately [5] 10/19	113/10 120/10 125/21	49/6 49/16 49/20	will [41] 4/20 14/11
17/1 20/5 22/25 25/9	101/15 102/1 174/18	125/22 132/23 134/9	49/20 49/20 49/22	17/20 18/5 22/5 27/14
29/22 60/6 68/4 74/18	190/8	137/4 142/14 145/10	53/9 55/22 57/25 58/3	27/19 29/6 30/6 43/6
79/14 93/15 98/17	whatever [3] 63/20	148/24 151/11 151/19	59/22 59/23 60/24	45/4 47/9 48/18 55/15
106/16 185/8 197/13	110/5 158/10	152/12 155/8 158/20	61/12 64/9 64/16	56/16 56/19 63/19
what [179] 2/24 7/13	when [98] 5/9 9/9	160/4 170/25 172/7	70/22 70/24 71/7	64/1 68/24 86/9 87/8
7/25 8/11 8/12 9/13	12/19 13/22 15/16	174/9 174/15 174/18	72/21 72/23 73/21	87/9 95/14 95/15
9/25 10/23 11/8 11/17	16/24 17/1 17/19 25/1	176/17 176/20 176/22	73/24 74/11 75/5	95/16 98/22 103/1
14/19 15/24 16/1 16/2	25/8 25/16 25/16	178/8 180/2 181/1	75/21 76/20 76/25	103/7 118/17 118/22
17/15 17/17 18/20	26/10 29/5 36/5 36/20	182/20 191/19 193/6	77/1 77/2 78/1 78/6	118/23 119/8 141/2
19/14 19/16 19/17	39/1 49/17 49/19	193/13 194/20 195/2	78/23 81/21 83/1	147/14 163/10 163/12
20/11 21/9 22/21 23/2	49/23 49/24 52/10	195/7 196/7 196/7	83/22 84/1 84/23	163/14 166/5 179/13
	52/12 52/17 53/10	which [107] 6/13	85/11 85/23 88/16	180/10 184/23

<p>W</p> <p>willing [2] 138/20 186/1</p> <p>win [2] 11/2 11/2</p> <p>wings [1] 123/6</p> <p>winter [14] 106/6 106/7 131/12 136/25 137/11 137/21 144/20 144/21 145/13 145/14 145/21 145/25 146/2 146/18</p> <p>wish [2] 50/24 51/3</p> <p>wishing [1] 165/8</p> <p>withdrawal [1] 57/4</p> <p>withdrawn [2] 49/24 61/12</p> <p>within [30] 7/1 10/1 32/5 48/24 58/21 69/17 76/22 80/6 81/2 81/9 91/5 95/20 96/6 114/20 120/25 121/4 124/11 134/25 143/17 148/22 155/3 155/5 166/6 176/25 180/12 182/7 182/18 188/2 195/18 196/10</p> <p>without [23] 4/23 6/2 18/1 18/2 18/25 40/19 41/14 41/15 50/15 61/6 61/17 88/17 116/16 117/20 131/1 152/3 156/14 165/8 169/2 179/4 183/6 188/4 195/15</p> <p>witness [14] 39/19 43/4 43/5 43/7 43/12 43/13 43/14 58/16 78/9 80/8 84/17 86/9 97/16 119/1</p> <p>witnessed [1] 6/12</p> <p>witnesses [5] 42/21 86/7 87/24 97/20 197/6</p> <p>woman [1] 61/11</p> <p>won [1] 52/8</p> <p>won't [4] 56/18 83/4 87/5 97/17</p> <p>wonder [2] 155/8 169/15</p> <p>wondered [1] 16/24</p> <p>word [2] 55/23 102/25</p> <p>words [2] 56/12 85/12</p> <p>work [72] 11/14 33/20 34/3 34/12 44/16 44/19 50/4 50/24 64/5 64/10 64/19 66/12 68/7 69/21 70/12 83/20 84/20 85/23 88/21 92/10 92/13 92/16 92/24 93/19 95/2</p>	<p>95/20 96/3 96/9 96/17 97/10 101/4 102/11 106/4 108/14 113/10 113/17 114/16 115/8 119/4 120/16 133/23 137/2 137/4 138/3 138/4 139/6 139/11 141/24 142/13 144/6 144/14 146/17 149/11 150/16 154/5 155/13 155/15 156/5 158/1 158/3 158/4 158/13 165/8 165/9 167/5 173/10 182/21 183/7 183/9 184/8 192/11 197/9</p> <p>worked [10] 5/24 20/1 82/21 92/21 106/13 114/7 123/7 128/7 150/11 158/25</p> <p>worker [5] 34/6 34/7 124/14 164/8 192/2</p> <p>workers [39] 5/24 11/13 11/16 31/14 33/12 34/21 49/7 52/19 52/20 53/5 54/5 54/5 54/24 61/6 61/12 61/16 63/19 85/9 88/20 118/13 118/14 118/16 120/8 120/12 121/6 121/10 124/12 135/9 139/8 147/19 147/21 150/4 157/5 178/20 190/11 190/12 190/18 192/3 192/14</p> <p>workforce [78] 33/23 49/4 49/15 51/25 53/16 91/16 95/22 97/5 97/7 97/17 98/11 98/13 98/16 99/12 99/16 99/19 117/22 117/22 118/1 118/9 118/19 119/3 119/7 135/1 135/2 135/8 135/10 135/10 135/12 135/21 136/7 136/9 136/12 136/20 137/20 138/9 138/23 139/5 140/7 141/3 144/11 145/4 145/6 146/1 146/11 146/12 146/18 146/21 146/24 147/3 147/3 147/7 147/12 147/12 148/1 148/2 148/4 148/5 148/17 148/18 150/14 153/2 153/9 153/10 153/14 153/16 154/2 154/10 154/23 155/11 155/23 156/4 157/5 183/11 183/17 183/19 184/9 184/13</p> <p>workforces [3] 49/18 154/1 157/4</p>	<p>working [18] 5/8 16/23 21/9 25/5 30/20 50/8 60/24 66/10 66/20 70/17 89/23 92/25 125/23 131/25 141/17 154/25 157/21 170/4</p> <p>world [3] 3/16 11/1 148/18</p> <p>worldwide [1] 124/8</p> <p>Wormald [1] 142/10</p> <p>worn [3] 124/12 124/13 124/17</p> <p>worried [4] 59/4 61/5 131/14 194/4</p> <p>worry [2] 25/15 99/7</p> <p>worse [8] 11/13 18/3 18/10 18/11 21/8 26/3 56/17 151/9</p> <p>worst [3] 26/17 35/16 95/25</p> <p>worth [8] 105/7 109/10 111/8 125/15 126/3 126/24 127/4 175/10</p> <p>would [176] 2/18 5/7 7/21 8/11 9/19 9/21 9/24 13/5 14/20 15/16 16/25 17/2 17/2 18/4 18/8 18/24 19/5 21/23 22/1 22/5 22/12 22/16 23/6 23/13 24/23 27/21 28/24 29/3 29/5 32/6 32/17 32/18 33/1 33/3 34/9 34/10 34/10 34/12 34/14 34/24 35/3 35/11 36/4 36/6 37/9 37/10 39/11 41/10 41/13 41/14 43/13 50/6 50/20 53/2 54/4 54/9 54/10 55/12 55/13 62/5 63/4 63/24 65/2 65/20 68/1 70/5 70/20 73/13 73/15 73/17 73/18 73/22 73/23 73/25 74/23 75/3 76/8 77/8 77/9 80/19 81/11 81/25 82/16 82/16 82/17 83/21 84/9 87/1 88/10 89/19 93/6 93/25 94/7 94/24 95/8 95/10 95/24 96/12 96/14 96/15 98/9 99/1 99/11 100/19 102/17 104/22 106/20 106/24 109/20 111/13 111/25 113/4 113/8 115/22 115/23 115/24 116/1 116/2 116/5 116/5 117/7 117/16 118/23 119/18 120/8 121/10 123/5 124/2 126/20 131/1 133/3 133/5 133/6</p>	<p>133/17 133/18 134/9 134/10 136/25 137/14 137/23 138/19 138/20 141/5 143/19 143/22 147/21 147/24 148/23 151/15 152/25 153/1 154/15 154/17 156/20 156/25 157/6 157/10 158/7 160/14 160/15 166/8 168/15 172/10 172/22 174/7 174/14 185/4 186/8 192/17 192/20 194/14 194/18 195/10 195/20 195/21 195/23</p> <p>wouldn't [11] 10/8 23/3 89/24 103/14 117/18 120/1 120/3 120/7 135/22 160/19 160/20</p> <p>wrap [1] 173/4</p> <p>wrestling [1] 159/21</p> <p>write [1] 14/13</p> <p>writes [1] 34/5</p> <p>writing [2] 13/14 29/20</p> <p>written [5] 3/1 23/8 95/21 165/12 179/11</p> <p>wrong [2] 42/14 164/10</p> <p>wrongly [1] 80/15</p> <p>wrote [3] 22/22 142/8 164/5</p> <hr/> <p>X</p> <hr/> <p>X proportion [1] 158/22</p> <hr/> <p>Y</p> <hr/> <p>yeah [9] 12/9 15/22 23/20 125/3 125/6 149/13 161/12 177/9 191/22</p> <p>year [14] 3/22 3/22 25/17 46/11 46/14 46/18 47/12 47/21 57/11 61/3 131/6 172/14 189/1 189/13</p> <p>years [5] 4/12 35/6 52/8 181/4 191/14</p> <p>yes [76] 1/24 2/3 2/8 2/16 9/3 9/9 9/25 10/20 14/4 16/22 17/5 23/15 23/17 23/24 43/7 43/25 48/22 55/17 55/21 57/20 57/20 60/16 60/22 62/2 64/24 65/4 66/9 71/23 72/3 75/2 76/10 77/13 78/17 80/8 80/11 87/15 87/17 88/9 89/7 94/10 95/6 98/7 100/19 103/14 107/2 117/12 126/9</p>	<p>128/11 128/14 128/20 129/4 141/21 142/2 142/8 149/3 152/16 163/19 167/21 169/21 169/21 171/1 172/1 173/2 177/3 177/7 178/17 185/19 185/25 186/4 190/17 190/22 192/25 194/17 194/22 196/23 196/25</p> <p>yet [6] 8/5 97/21 163/4 181/14 195/4 197/10</p> <p>you [725]</p> <p>you know [1] 191/23</p> <p>you'd [1] 154/15</p> <p>you'll [1] 36/17</p> <p>you're [27] 24/4 31/20 36/23 39/25 42/20 42/21 49/12 53/22 53/25 59/11 65/15 69/18 75/17 75/22 92/9 95/5 95/5 97/16 101/14 102/5 127/4 128/25 155/4 155/25 169/9 188/14 192/18</p> <p>you've [33] 7/19 8/17 8/24 15/23 23/15 23/19 29/14 34/19 52/4 57/16 58/11 59/17 64/25 70/1 80/23 85/25 96/18 96/20 97/6 104/24 114/3 114/15 116/11 125/10 129/19 138/5 141/7 144/9 180/17 184/3 186/21 191/23 194/15</p> <p>young [2] 48/24 58/3</p> <p>younger [1] 26/11</p> <p>your [129] 1/9 1/18 3/17 4/11 4/15 5/10 6/11 7/19 8/18 8/24 11/4 11/8 12/1 13/21 15/24 17/7 18/20 19/1 20/11 22/6 26/20 28/5 28/7 28/9 29/14 31/3 33/5 33/10 37/16 37/24 39/11 40/8 40/8 41/4 42/2 42/7 42/24 43/23 44/1 44/23 47/2 47/4 49/3 54/22 55/17 56/2 58/12 59/10 59/15 61/8 66/19 72/9 72/11 78/9 80/8 80/25 81/14 81/14 84/6 84/17 84/18 84/21 85/21 86/1 86/2 86/24 87/2 87/7 89/1 89/3 90/19 91/8 91/11 92/6 93/11 96/20 106/10 108/24 110/23 111/13 114/1 115/5 121/19</p>
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Y

your... [46] 121/23
124/20 126/3 126/10
127/4 127/12 130/22
135/6 135/7 136/2
138/8 138/13 141/15
141/16 142/23 145/6
146/13 149/21 150/24
152/11 157/19 158/12
159/10 161/5 161/8
161/8 161/17 164/20
167/12 168/6 168/22
173/5 173/5 174/15
175/7 176/6 177/10
182/1 182/11 182/17
183/3 185/7 186/21
190/5 193/1 196/22
yours [2] 83/8 168/2
yourself [2] 87/3
197/15

Z

zero [1] 153/19
zero-hours [1]
153/19
zoom [1] 150/23