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,

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

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.

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.

And very, very fragmented. Not -- really, in many ways, social care is an essential public service, but because of who offers it, a combination of the private sector and the not-for-profit sector predominantly, it doesn't feel like it, and it's not organised like it. And that meant there was no infrastructure, not the systems and processes in place that would have helped to support social care and all the people working in it and also using it when the pandemic came along.

Q. And you have prefaced your statement by saying that some people reported a positive experience during the pandemic and that some of the innovations and good practice should continue.

Can you provide a couple of examples of those innovations and good practice that you say should continue?

A. There was, for some companies, a greater use of technology to try to communicate with their staff to help with rota-ing. Of course, that's a trend that is continuing with the advent of AI, but I think it accelerated it for some companies that were progressive and also probably weren't as fragile and cottage industry-like as some others. So that was helpful.

There's no doubt that many care workers worked incredibly hard, put themselves at risk, were prepared

to do things we shouldn't really have asked them to do, without sufficient protection for themselves and their families.

And I have personal experience of that too. It's not in my statement, but throughout the pandemic I was also caring for my mum at home, who was dying, with a package of care. So, as well as doing my job for Age UK and seeing these issues from all our information sources, I was experiencing them day by day in real life as well.

Q. And you have also identified in your statement that Age UK witnessed systemic failings during the pandemic which led to the perception, particularly during the early stages, that older people were an afterthought and sometimes their lives were considered less because they were older. Why do you think that perception developed?

A. Because of the facts as they became apparent. I think, quite early on, we could see the pandemic hitting other countries first, particularly Italy, for example, and America, where there were already stories in the media about the care sectors in those countries being impacted by the pandemic in a very adverse way, and we weren't quick enough in our country to pick up on those, and really, the amount of knowledge and information held by government about social care generally, and about the

needs of older people within it, was very limited, as they themselves admitted at the start. And there was a lot of catching up having to be done very quickly.

And there weren't the structures in place, there weren't the people in place on committees, for example, at a time of crisis, to help the government make informed decisions about older people in the context of social care.

Q. And at the very start of March, on 10 March 2020, Age UK issued a statement which said that the government has to step up to advise on how the sector can plan a more coordinated and resilient response. So is that, essentially, in response to what you were saying there?

A. Absolutely. And a lot of the focus, inevitably, and understandably, was on the NHS, and that was quite right. But even early on it felt as though social care had been forgotten.

Q. And you made a further statement on 10 April, so a month later, and you've said in your statement that you made that because the sense of unease had turned to real alarm. So would it be fair to imply from that that the action that you had asked to be taken a month earlier that not in fact materialised?

A. Correct.

Q. And at that point in time, so the middle of April, what

were Age UK's key concerns?

A. That we were hearing about many deaths of people in care homes. It seemed that in particular, that the virus, once it got into a care home, was causing havoc. And yet there was no coordinated response from government. We weren't being able -- we were trying to persuade them to do things, but I think because it was a time of crisis, they sort of circled the wagons, by which I mean they were less open to comments from outside, and it made it very difficult for organisations like mine to be able to give what we would hope to be good advice. But you could see it playing out, and from what we were hearing from older people and their families, and from professionals too.

Q. A few days after that statement, so 16 April 2020, a government strategy for the adult social care sector was issued. You've perhaps answered it in that previous answer, but had your organisation been consulted on that before publication?

A. I don't think we were. I'm trying to remember. Subsequently, later on, as the pandemic continued, we were much more heavily involved but early on, no. Much less so.

Q. I think you've given some examples in your statement of the ways in which communication certainly improved

during the second wave, and you provide the examples of the Capacity Tracker in England --

A. Yes.

Q. -- and that Age UK were also part of the UK Government Social Care Sector Covid-19 Support Task Force. Both of those occurred in 2020, later in 2020, sorry. So are those examples of how that two-way relationship improved?

A. Yes, but it was also to do with people. So when Sir David Pearson was appointed to come into government and support them on social care, that made a huge difference because he knew everybody, and we could talk to him. He understood what it was like in local areas. He had been a Director of Adult Social Services himself. He had a much better, granular understanding of the needs of social care and he had the relationships with people like us, and many others, to be able to draw us in and gain our help, which I think was really helpful.

Q. Would it have been useful if somebody like Mr Pearson had been available sooner, or in post sooner?

A. Absolutely it would.

Q. And do you think that that role that he held, and the representative groups that were set up, as well, with stakeholders would be helpful in a future pandemic?

A. Yes, probably, depending on what the existing structures

are within government. It was unfortunate that the leader of social care in the department stepped down very soon into the pandemic and there was then a gap, I think, before someone else was appointed. That's not a criticism of that person at all, but if there had been somebody in post who had the knowledge and understanding, right from the start, who had stayed, perhaps someone like Sir David wouldn't have been so needed although he was always going to have made a big difference.

Q. And do you think there's also benefit in those groups meeting and that joint endeavour taking place in non-pandemic times, as well?

A. Definitely. Absolutely. And over time, as the pandemic continued, there was a group that continued to meet very often, sometimes on more specific issues, such as visiting in care homes, for example, and that also interacted with the Minister of State at the time, Helen Whately.

Q. Yes.

A. And all those conversations, I think, were very useful. They helped us at Age UK be able to be clearer with older people and their families about what the policy was, which they very much wanted to know, and which was changing quite quickly, but I think we were also able to

bring in intelligence from the world back into the department. So it was a win-win.

Q. Finally this, on the early pandemic period. You have said at paragraph 63 of your statement that promises of a protective ring around care homes did not materialise in terms of policy or practice in early stages.

A. Mm.

Q. What, in your view, was missing?

A. Partly the fact that the nature of social care as it operates in many care homes with staff coming in and out, coming from home, not living on site -- some do but most don't -- that meant that there was an immediate risk in the care home, made worse if care workers became unwell and were then unable, financially, to stop work because of the need to put food on their own tables at home. So the lack of sick pay for care workers was, I'm sure, a big gap that unfortunately contributed to what happened.

But there were other problems as well, just a general lack of money, really, to go round. The lack of access to PPE, to infection control, and sometimes some naive assumptions, I think, by government about how well equipped a care home in particular might be to care for people with medical needs as well as care needs.

Q. We're going to come on to some of those issues no doubt

in your evidence but before we do so, the statements that the Age network have provided provide many examples of the ways in which they stepped in to provide support to older people.

I'd like to ask you about just a couple of those, if I may. A common theme that arose was the use of telephone helplines, some of which received government funding --

A. Yeah.

Q. -- to increase their capacity. Although the service they offered differed slightly between each nation, they all provided a form of practical support and compassion for older people that wasn't just online, but in a different format as well. Was there high demand for those services during the pandemic?

A. There was huge demand. It absolutely spiked. Particularly after any particular government announcements or something said in a press conference that may not have been entirely clear, or when new guidance came out, which it did very frequently. Then we often saw, I think, right across the UK, large numbers of older people, and also their families, calling for clarification, for reassurance, just in despair sometimes, depending on their own situations.

Q. And did the people that were managing those services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Yeah.

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

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

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

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

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

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

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

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

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

Q. Did you raise those concerns?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

like pressure sores, skin integrity problems, that do require a district nurse in particular, or maybe a physio or somebody like that, to come in and help. And that sort of service pretty much dried up for large parts of the pandemic, particularly nearer the start.

So, in the absence of those things, of course, those conditions, which can prove to be very serious for people, often got worse.

Q. And what was the impact on the staff working in those care homes?

A. We heard awful stories about staff who felt overwhelmed by having to essentially try to plug the gap that health professionals not visiting was unintentionally leaving. People who didn't have the skills or qualifications to have to take a lot of responsibility for very unwell older people, sometimes older people who were dying, not just one, as is not unusual in a care home, but many people all at once. And I think that must have been an absolutely shattering experience for some. And it caused some, we know, to leave the care sector afterwards. Great professionals, but who just really needed to get away.

Q. I would like to ask you, if I may, about a letter that was sent by a GP practice to a care home resident in Scotland, in which the recipient was informed that the

practice would be ceasing visits.

So if we may have on screen, please, INQ000591762. And starting with the second paragraph.

Now, the quality isn't particularly good on this version, but I will read out the part that I would like to draw your attention to. So the second paragraph, it states:

"... we need to minimise patient contact to all unless absolutely essential."

And then in the fifth paragraph, in regard to patients that get Covid-19, it states:

"We would plan to continue to nurse our patients ... and not to transfer them to hospital. Sadly if they are so unwell as to require breathing support from a ventilator it is unlikely that given their frailty they would survive."

Firstly, is this the type of letter or the approach, one, that Age UK heard people experienced during the pandemic in Scotland or elsewhere in the UK?

A. We heard these kinds of things right across the UK. What is unusual about this is that the practice actually wrote it down and took the trouble to communicate with patients and care homes formally about it. More often, I think, these things happen informally, or they were conversations. They weren't actually documented. And

to an extent, I think this practice deserves some credit for it being upfront with people about what it was intending to do, even though we wouldn't necessarily agree with it.

Certainly the issue of whether an older person in a care home would be taken to hospital if they became unwell was something we heard quite a lot about right across the UK, and I think I put in our written evidence about talking to a very senior clinician who had had to intervene personally with the hospital to enable an older person with a very routine respiratory problem to be admitted. It was absolutely something the hospital could help with, but had he not intervened, there would have been no possibility of that person attending.

Q. Yes, I think you've described concerns about non-conveyancing practices during the pandemic.

A. Yes.

Q. So, again, were they quite widespread, from the evidence that you've received?

A. Very much so, yeah.

Q. And did you try to bring such issues to the attention of national decision makers or even local governments or practices?

A. Yes, we very much did try to raise this as a real concern, as a concern about the way older people were

being viewed and treated, and the lack of respect for their human rights and their ability to access healthcare, alongside everybody else of all ages. Regardless of whether you're in a care home or living at home or in hospital, we all have the same right, and that right was not being observed.

And we shared those concerns across our Age UK family and with the commissioners in Northern Ireland and Wales, and we published a statement actually saying that. And there was some response to it, but I think, from what we heard, there was patchy implementation thereafter on this issue, as indeed many others throughout the pandemic.

Q. I'd like to ask you now just briefly about end-of-life care and medications.

What concerns did Age UK have about the changes to medications and prescriptions generally, in care homes, and in the community during the pandemic?

A. Well, especially at the beginning and the early stage of the pandemic, it was a degree of disorganisation, a lack of process and system which meant that it became very difficult to get hold of end-of-life medications to ease people's suffering, as would routinely happen. And the rules were in place, of course, to protect the public, but they turned out to be very unhelpful during

a pandemic when much more urgency was required, and it took the government time to change those. And sadly, during the months that happened, that led to people dying in care homes not in a dignified way, not in a pain-free way, and it put the professionals working there, sometimes nurses, very often not medically qualified people at all, in a horrible, horrible position when they had a lot of people there who needed those drugs, they weren't able to share them from one person to another, either, for fear of breaking the rules.

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

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

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

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

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

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

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

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

society not just as something to be used in extremis.

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

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

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

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

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

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

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

painful for their relatives.

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

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

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

the understanding of the context.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

LADY HALLETT: Thank you.

MS HANDS: Thank you, my Lady.

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

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

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

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

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

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

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

MS HANDS: Thank you, Ms Abrahams.

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

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

Questions from MS MORRIS KC

MS MORRIS: Thank you.

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

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

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

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

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

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

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

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

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

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

Q. Thank you.

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

You said that:

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

You said:

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

And you're referencing there the discharge of

untested patients into care homes:

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

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

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

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

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

A. I do.

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

A. Not as I recall.

Q. Are you aware of government considering the obvious and

inherent risks of that policy?
A. That wasn't obvious to anyone outside government, I believe, at that time.
Q. Right. In your view, were care homes equipped to deal with those new admissions who had not been tested? For example, did they have sufficient facilities to isolate or quarantine returning residents? Did they have sufficient bed, staff or resources, PPE, and was there necessary training in place to make that safe?
A. I think it would be fair to say that some care homes were better placed to do that than others. If they were new buildings with separate rooms, with lots of space, that would have given them an advantage. But even for them it would have been very, very difficult without enough access to enough PPE, without having the trained staff always in place.
So for almost every care home it was a very bad idea.
MS MORRIS: Thank you, Ms Abrahams. Those are my questions.
Thank you, my Lady.
LADY HALLETT: Thank you, Ms Morris. And I think its Mr Foley, who is probably across the hearing room.

Questions from MR FOLEY

MR FOLEY: I am, my Lady. Thank you.
Good morning, Ms Abrahams, I ask questions on behalf

of the Covid-19 Bereaved Families for Justice Cymru. I'm conscious of your earlier comments about not being able to answer directly in regards to some issues in Wales, but I just have one topic to raise with you regarding measures after the pandemic that -- if I could see if you can help us with.
May I ask, please, to your knowledge, again, since the pandemic, has Age Cymru had any interaction with the Welsh Government, Public Health Wales or any other government or public health organisation -- in Wales, of course -- to address the lessons learned from the pandemic with regard to older people in care homes?
A. I'm sorry, I can't answer that on behalf of my colleagues at Age Cymru. I don't want to get it wrong.
MR FOLEY: Okay. In that case, I'll leave it and I thank you.
Thank you, my Lady.
LADY HALLETT: Thank you very much, Mr Foley.
Ms Abrahams, that completes the questions we have for you. I think you're, in my book, one of the most perfect witnesses you can have. You're not only extremely informative and very, very helpful, but you are also a stenographer's dream. Thank you very much for your clarity and the content of what you provided to the Inquiry, and much of it was really, really important

to us. So thank you very much.
THE WITNESS: Thank you.
LADY HALLETT: I was going to suggest we break before the next witness, but we are ahead of time. Shall we go to the next witness? Sorry, having told the team that --
MS HANDS: I will just check, my Lady.
Yes, we can move straight to the next witness.
LADY HALLETT: Sorry for the confusion. Thank you.
Ms Jung.
MS JUNG: Good morning, my Lady.
LADY HALLETT: Sorry, it is probably my fault there's a delay in bringing the next witness in. I suggested we would have had a break before the next witness.
MS JUNG: My Lady, the next witness is Ms Emily Holzhausen.

MS EMILY HOLZHAUSEN (sworn)

LADY HALLETT: Good morning, Ms Holzhausen.
I'm sorry if there was a confusion about whether you were going to give evidence after the break or not. My fault entirely.
THE WITNESS: Not at all. That's absolutely fine. Thank you.

Questions from COUNSEL TO THE INQUIRY

MS JUNG: Good morning. Could I ask you to confirm your full name, please.
A. Yes, my name is Ms Emily Holzhausen.

Q. Thank you. And could I ask you just to keep your voice up a little bit, please. Thank you.
Is it right that you have come to give evidence as the Director of Policy and Public Affairs at Carers UK?
A. I have.
Q. And that is a UK-wide charitable organisation that represents nearly 50,000 unpaid carers across the UK.
Carers UK has an affiliate network of local carer organisations which covers many millions of unpaid carers across the UK; is that right?
A. That's correct, and we have -- the 50,000 refers to our individual membership, so we really are here to represent all of the millions of carers in the UK today.
Q. Thank you. And is it right that you have offices in each of the devolved nations?
A. That's correct, and they work very directly with the administrations and elected parliaments and assemblies in those nations, as well.
Q. Thank you. So although the work of Carers UK is UK wide, in terms of the evidence that you can provide and the assistance that you can provide, is it right that aside from the matters relating to devolved nations in your statement and documents, you otherwise aren't able to assist with specific issues that arose in the devolved nations?

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

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

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

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

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

Q. Thank you. Sorry, did you --

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

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

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

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

Q. Thank you very much.

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

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

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

A. In England.

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

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

So we polled the general public with a slightly

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

Q. Thank you.

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

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

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

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

A. Yes.

Q. Thank you very much.

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

Q. Thank you.

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

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

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

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

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

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

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

A. No, there's nothing.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. Thank you.

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

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

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

(11.18 am)

(A short break)

(11.35 am)

MS JUNG: Thank you, my Lady.

LADY HALLETT: Ms Jung.

MS JUNG: Thank you.

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

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

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

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

Would you agree with that description?

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

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

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

Q. Thank you.

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

directly.

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

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

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

Q. Thank you.

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

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

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 in 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

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

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

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

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

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

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

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

exhausted from caring; is that right?

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

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

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

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

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

another matter.

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

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

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

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

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

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

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

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

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

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

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

exhibited you suggest that the local authorities could hold a stockpile of PPE. Is that something you would recommend in the case of a future pandemic?

A. Yes, I think so. Unless somebody comes up with a better solution, we need to have resources that can be distributed quickly.

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

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

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

Q. Sorry, about?

A. The definition of essential care.

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

later.

A. Thank you.

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

A. Mm.

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

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

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

what the real practical challenges were for unpaid carers?

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

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

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

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

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

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

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

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

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

please, pre-pandemic, what systems were in place to collect data on unpaid carers at a local level?

A. So the data sources are all really disparate. At a local level we have GP identification of carers where they have specific codes, and at the time I think there were over 100 different codes used. They've been condensed now into three or four, but --

Q. What do you mean by codes?

A. They're on the GP patient system. So GPs could identify carers, and it's usually used for flu vaccination and some public health measures, but that's not systematic. And then local authorities, of course, keep records of carers where care assessments, joint assessments or carers' assessments have been undertaken, and sometimes they have other records. We have local carers' organisations that keep records, whoever provides the local carers' service. Within council tax, for example -- you can get a council tax discount if you're a carer. That's another record.

And then nationally, of course we have the Department for Work and Pensions and claimants of Carer's Allowance, which is the main carers benefit. But locally they can't access that personalised data.

So we've got a range of different data sources, but none of them are linked.

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

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

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

Q. Thank you.

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

Q. Thank you.

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

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

A. That's right, yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. Thank you.

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

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

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

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

carers early on?

A. Yes.

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

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

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

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

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

Q. Thank you.

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

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

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

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

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

Now, people who were on Universal Credit, they got

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

Q. But in terms --

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

Q. Yes --

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

MS JUNG: Thank you very much.

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

LADY HALLETT: Oh, right.

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

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

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

Questions from MS JONES

MS JONES: Thank you, my Lady.

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

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

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

A. Quite briefly, yes. And that's what they want to be. They not only know the person and their characteristics but they very often know the different -- their different needs.

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

insight into their lives and wellbeing.

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

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

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

was not the same as carers.

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

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

A. They did, yes.

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

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

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

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

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

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

impossible to get that, really.

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

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

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

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

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

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

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

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

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

Q. Thank you.

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

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

So those things. You know, it's not just words, it's actions too. And the Caring Behind Closed Doors is a very good description of how they felt, is invisible, and we can't have that again in another pandemic.

MS JONES: Thank you very much. Those are all my questions.

LADY HALLETT: Thank you very much, Ms Jones.

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

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

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

THE WITNESS: Thank you.

LADY HALLETT: Thank you.

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

Thank you very much, Ms Jung.

MS JUNG: Thank you.

(12.20 pm)

(The Short Adjournment)

(1.35 pm)

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

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

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

MS MICHELLE DYSON (sworn)

Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 6

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

THE WITNESS: Thank you.

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

A. Michelle Sarah Dyson.

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

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

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

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

A. Yes.

Q. And you were permanently appointed in May 2021?

A. Yes.

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

A. No.

Q. -- did you join from somewhere else?

A. I was in the Department for Education.

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

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

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

Q. Of course.

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

Q. Yes.

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

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

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

through but thank you for your comments.

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

A. I mean, shall I comment about April?

Q. Yes.

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

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

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

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

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

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

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

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

are today in 2005?

A. I think it's 310.

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

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

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

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

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

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

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

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

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

with Carers UK to try and get to that list.
Q. And so is there now a list of unpaid carers? I'm not suggesting it's going to be perfect by any stretch of the imagination, but if we wanted to in July 2025 look at how many the department thought were unpaid carers, would we be able to find that number easily?
A. I mean, not to my knowledge. We rest on the ONS data that you mentioned, the 2021 data.
Q. Right. I'd like to start with a few questions, please, about pre-pandemic preparedness. And there are a number of groups set up to address this, but can I have your assistance, please, about what is called the Cross-government Pandemic Flu Response from April 2017.

And could I have on screen, please, INQ000022748.

Ms Dyson, I'm conscious that obviously you weren't in the department in 2017, but I think you have had a look at this document in preparation for giving evidence, and we can see the second box there deals with the outline work plan, and then an objective was to achieve an appropriate capability to provide adult social care in England during a severe pandemic.

And as we go across the row, there is reference at point 2 in the middle column to reviewing "existing plans for providing community-based healthcare for patients who would ordinarily receive inpatient care."

Can you help with who those plans were held by or should have been held by?
A. So I believe this point should have been directed and maybe was directed towards NHS England because this is about community-based healthcare as opposed to adult social care.
Q. So this would be not necessarily -- we can see DH and DCLG, presumably DH was the Department of Health, as then called?
A. Yes.
Q. And the former, I think it's -- it was -- Ministry of Local Government now. So this could be, essentially, at a number -- aimed at a number of different departments or organisations to help bring together a cohesive plan for adult social care.

Can we go over to the third column, because there's what are set out to be said the deliverables, and there needed to be an adequate means to measure and monitor adult social care capacity, which is clearly something that was partly the response of -- the responsibility of the Department of Health; a capability requirement; a range of policy and practical options; an overarching plan; and then again, potentially, policy and practical options for the patients who would ordinarily be treated as inpatients in the community.

Can you just help me, what plans arose as a result of this outlying work plan?
A. So I think it's, just by way of context, important to remember that adult social care is a locally-run system. So when you're talking about planning you're thinking about yes, what the department is doing, but more so, at least at this point in time, what is happening locally. And it was always assumed that a pandemic would be run by the local resilience fora with the department supporting but the response would very much sit at local level.

As I see these actions, they're very much focused on: is there going to be enough capacity in adult social care in the event of a pandemic? So will there be enough care home beds? Will there be enough homecare capacity: And will there be enough staff to support them?

The things that happen that I'm aware of as a result of these actions is, first of all, there's some really quite detailed policy work that is done within the department. I've seen the paper that was written in 2018, which looks at things like workforce shortages, it looks at things like hospital discharge, it looks at how you would prioritise local government services in the event of a worst-case scenario.

The other thing that's going on in the department at this time, maybe not so related to this, although indirectly it is, was the work on what became known as the Coronavirus Act, because it's related to this because of the care easements part of that.

So then -- that's what happened within the department. Separately from that, the department commissioned ADASS, that's the Association of Directors of Adult Social Services, to do some work on all of this. And again, I've seen what they did. They did a big survey of local government, they produced a suite of products that looked at how you would do statistics at a local level in the event of a pandemic, how you would do communications at a local level in the event of a pandemic, how you would try and recruit volunteers, and then they produced some guidance.
Q. Can I ask you about the work being done with the local authorities, though, given that in that answer you've just said a lot of the planning lies essentially with them, and I think you've said in your statement that adult social care was fully incorporated into pandemic planning, but you did say that there were some challenges that were identified, and could you just help us, what were the main challenges as the department saw them with the pandemic planning?

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

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

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

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

Q. Yes.

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

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

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

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

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

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

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

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

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

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

This is some minutes from the national steering

group that was in existence at that time.

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

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

Was that shorthand for "clinically vulnerable"?

A. I think for coronavirus.

Q. Thank you.

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

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

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

A. I would have thought so, yes.

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

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

And someone comments that LGA and ADASS had --

neither of them have the assurance skills.

"[Local authorities] are accountable to members/population and the assurance role sits with members. They can help, perhaps work on a checklist with [questions] to ask when checking the plans are fit for purpose so [local resilience forum] can be confident."

And that was agreed by another member of the committee.

"Are there plans for all [local] ... have they ... been refreshed?

"Could we share best practice if we know of a good quality plan?"

And I think you're aware, Ms Dyson, that, in due course, Minister Helen Whately asked for a number of local authority plans and received two, which in her view were inadequate.

Can you help with what was done between February 2020, when there were clearly attempts to look at the plans and see if they were robust enough, and then what happened to the -- reviewing the local authority plans thereafter.

A. So the plan that there was, was to use MHCLG, that is the local government department, to help with assurance of plans. I think that may have -- I think that was

discussed at the Helen Whately meeting in early March.

In the event, that got overtaken by events. You know, we were quite swiftly -- you know, plans were left behind and we were very much into a full-blown pandemic.

Q. So you're quite right, there was a meeting on 5 March where the minister set out her concerns about the two plans she'd seen, and indeed reference to trying to find a good one that we could then perhaps copy and replicate across the local authorities.

When you say "events overtook us", does that mean that essentially work wasn't done on checking whether local authority plans were robust enough?

A. So I wasn't there at the time, so I've been asking questions, and the answer that I have had on this is that the intention was to use MHCLG for this but my sense is it didn't actually happen because, you know, that would have been quite a big deal, I guess, to set up a whole infrastructure to do this. And then the pandemic, you know, was developing very, very fast at this point in time.

Q. That explains the position back then. What about now? What, if any, efforts have been done from the department's perspective to ensure that local authority plans are robust enough, adequate enough? Pick whichever word you choose.

A. I think that will be picked up in our pandemic preparedness strategy that the department is going to publish.

Q. And do you know when that is going to be published, or roughly?

A. I'm not sure exactly but I know we're planning to publish that, and then alongside it there will be five plans for each of the five different routes of transmission, starting with a respiratory plan.

Q. We may come back to that in a moment.

Now, sitting under the local authority plans, though, is it right that providers themselves were supposed to have plans?

A. Yes. I mean, I wouldn't necessarily describe them as sitting under the local authority plan, lots of providers don't actually have a relationship with the local authority if they just take privately funded individuals. So they have to have plans. That's part of the sort of CQC requirement.

Q. Can I ask you then, please, about -- perhaps it's my phraseology, but not the local authority plans, but plans at provider level.

Can we have up on screen, please, INQ000595342_0002.

This is from a coronavirus steering group meeting, the following week, on 19 February. So on the 12th,

they've looked at the local authority plans and whether there's assurance or robustness. Here in the middle, looking at contingency plans, we can see we're talking about 19 providers have confirmed their pan flu preparedness plan was up-to-date. Of those, 16 had plans that covered how the organisation could manage if 20% of the staff were absent, and three providers had plans to cover staff absences, but this did not extend as far as 20%.

Now, can I just ask, in ordinary times, do provider-level plans, are they something that is not ordinarily looked at by the Department of Health?

A. No.

Q. And you mentioned there the CQC. We can see there two of those three providers express an interest in further guidance from the CQC on how to prepare for the event that only 80% of the staff were present, and it looks like -- was -- is there -- was there going to be a CQC review, or you were going to ask the CQC to -- sorry, had they done one or were you going to ask them to do one?

A. I don't know the answer to that. I mean, I would just say this looks like a sort of small dip sample, you know, you've got 18,000 registered providers, this looks like a small dip sample, and I can't see how we could

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

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

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

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

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

Q. Right.

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

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

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

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

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

is very much also about these issues.

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

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

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

data returns to the Capacity Tracker mandatory?

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

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

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

Q. On a quarterly, did you say?

A. Quarterly, I think.

Q. Thank you. Thank you. I misheard you.

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

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

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.

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

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

idea that they are isolated and safe, doesn't one need to know that there isn't an infection in that home and we're not bringing in an infection into that home?

A. I mean, I would have thought that we could get that data, because we were able to see by every care home what was -- you know, we could see what was going on in terms of the infection rates in every care home across England, and that would apply equally to care homes that were designated settings.

Q. Do you know whether there is any work being done to ensure that designated settings remain available if needed? Because it took, clearly, a number of months to set up the designated settings policy. But in the event of a future pandemic, is there a plan in place to be able to quickly roll out a designated settings policy?

A. So I'm sure we could do it again. The things that you needed to make it work were we needed the funding. That came from the discharge funding that NHS England had. You needed each local authority to identify a place. You needed to get the infection prevention and control right in that place. You needed CQC then to assure it and sign it off. So I'm sure we could do all of that again.

Q. I'd like to ask you some questions, please, about restricting movement of staff between care homes. And

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

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

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

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

And then there are various other steps set out there.

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

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

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

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

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

So even if we could have eradicated staff movement,

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

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

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

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

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

Q. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

And it might just be -- there might be different

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

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

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

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

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

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

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

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

homes on a per-bed basis?

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

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

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

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

home care was relatively underfunded relative to the need.

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

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

Q. Right.

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

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

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

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

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

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

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

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

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

of face masks to the care homes that happened in mid-March of 2020, do you know?
A. Yeah, this was what happened on 13 March, when every CQC-registered provider got at least 300 face masks.
Q. Right. That is what we're talking about here?
A. Yeah.
Q. All right. And can I ask you about that, please. Clearly, one doesn't want to sniff at it, but NACAS in particular, or a member of NACAS, has commented that 300 masks don't go very far if you've got 50 staff members.

Do you know why 300 was alighted upon? Was it simply that was all the stock there was to supply at the time?
A. I imagine that was the answer. I mean, it's worth saying that the emergency response -- (b) on the list here -- that was stood up on 16 March, so these other steps happened really quite quickly after that.
Q. All right. We'll look at some of those.

That one-off supply of the masks though, as it sets out there, was only to care homes. Do you know whether there was any thought given as to whether there ought to be a one-off supply to people working in domiciliary care?
A. I don't know.

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

I mean, it's worth saying is that in the first full week of operation of this hotline, over half a million

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

I mean, should say I arrived in the department in September 2020. PPE was not an issue that was sort of

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

correct that there was no policy from either government or, indeed, the NHS that such supplies should be diverted?

A. Yes, that's absolutely correct.

Q. Can I have a look on screen, please, at INQ000608140, page 4. This is an email from the National Care Forum, and it's ... just give me one moment. 9 March 2020. And the -- Nadra Ahmed of the National Care Association, forgive me, has emailed the Department of Health. Can we have -- thank you -- page -- perhaps my paging has gone slightly awry, but there is a reference in the email to the Department of Health where there is -- the National Care Association are aware that "suppliers are only supplying handfoam and handgel to the NHS, a government directive, apparently", says the email, although clearly that's not correct.

[As read] "If that's true it is outrageous and they're bringing it to the attention of the department."

You've dealt with the fact that there was no directive, certainly as far as the Department of Health is concerned. But can you give us an idea of the scale of concerns that were brought to the department's attention about supplies going to the NHS over preference to adult social care?

A. There was a lot of anecdotal evidence of this at the

time.

Q. And do you know what the department did to try and correct the misapprehension that there'd been a directive in this regard?

A. Like I said, we were very clear that it was absolutely not the policy. I noted that in the 2 April admissions guidance there's a statement in there to that effect. I suspect there may have been other statements that I haven't seen, but, because it very much was the case that we wanted to put matters right on this.

Q. Has the department done any or did the department try and understand where the misapprehension had come from, or was it something that suppliers were doing, taking the decision themselves? Do you know where this had sprung from?

A. I mean, I have heard speculation that it might have been wholesalers who reached that but I really don't know.

Q. Right. And in relation to PPE and unpaid carers, we know that the initial advice to unpaid carers in April 2020 was that face masks were not recommended unless advised by a healthcare professional, and I think you said in your statement at paragraph 142 that the Deputy Chief Medical Officer and, indeed, Public Health England's advice was that unpaid carers should not use PPE while providing care. They were concerned that

unpaid carers would not use the PPE properly and without direct training and supervision it could create additional risk or a false sense of protection.

Do you know why there wasn't training rolled out to unpaid carers at that stage as there was later on in the year by various online resources?

A. It wasn't felt to be necessary at that point in time, and then when we looked at it again in July, by that point, the rates of Covid were very low and so it really wasn't felt to be necessary then. So SAGE was commissioned to look at the issue for the purposes of the winter and then it was taken forwards in the autumn.

Q. I think the -- either the DCMO and/or Public Health England were also worried about supply issues. From the department's perspective, was the supply issue the dominant reason for this advice, or was it concerned about false reassurance and improper -- inappropriate or lack of training in PPE usage?

A. I mean, it never came to a head in May. It came to a head in July, by which time the conclusion was we don't need to do this at a time when rates of Covid are so low.

Q. Thank you.

In September of 2020 there was a pilot, I think following advice from the SAGE Social Care Working

Group, to roll out free PPE for unpaid carers, and I think in January 2021 it was then rolled out nationally. Just to help you.

Can we have a look, please, at the results from the pilot at INQ000110355.

So this is the pilot that started in the autumn of 2020, and the outcomes of the pilot show that:

"... demand [had] been low, with under 50 carers accessing PPE in each pilot location. [Local authorities] have not required a substantial amount of additional PPE to enable them to provide this group ..."

Then if we just go down, you can see some of the figures there:

"The highest figure we are aware of for distribution to extra-resident unpaid carers [ie those that don't live with the person they are caring for] is 256 in Birmingham in the month of July. [It] did ... rise sharply to [1,300-odd] carers in November when they extended [it] ..."

On any view, these are small numbers of PPE being rolled out to 700,000-odd -- no, sorry, more, 5 million-odd unpaid carers potentially.

Do you know whether there was -- the low demand was because there was difficulty in identifying unpaid carers and therefore letting them know that there was

free PPE?
A. So I don't know why there was a low level of demand. We did this through local authorities, who would -- I mean, even if they couldn't reach all unpaid carers in their area, they would have had reach to, you know, a higher level -- higher numbers than this level of demand would suggest. So I don't know why the level of demand was low.
I note, though, that it was low in other nations as well, in Scotland, et cetera, but we never really got to the bottom of why it was so low.
Q. Do you think it might come back to the problems with defining who they are, therefore identifying them, and therefore notifying them and then getting PPE out to them if the unpaid carer needs it?
A. I think it could do but I -- I'm -- I think that local authorities would know more than, say, 50 carers in -- any given local authority would know more than 50 carers in their area, so I think it's more than that that's going on here.
Q. Was there an issue with the amount of publicity that the rollout of free PPE to unpaid carers garnered?
A. I mean, possibly. I think we did some work on that, but possibly. As I say, it's interesting that the same issues arose in other nations who actually did this

earlier. So I can't -- (overspeaking) --
Q. That was my final question on this topic. Do you know why it was that England didn't roll this out earlier than some of the devolved nations did?
A. Well, as I say, it was looked at in the summer. It was concluded that it wasn't necessary because rates were so low. Then it came back in the autumn. We did a pilot. It was important to pilot this to see what the level of demand was actually going to be, whether we would in fact have the stock that we would -- that was needed, and then it was rolled out in January 2021.
I think if you -- you can see as you look through the papers how this sort of unfolded.
Q. And what plans, if any, exist for rollout of PPE to unpaid carers in the event of a future pandemic where they need PPE? Is there any kind of plan that's ready or being formulated?
A. I mean, we're looking at PPE as a whole in terms of pandemic preparedness. I don't know explicitly on unpaid carers.
Q. Right.
My Lady, may I just deal with a couple of topics, perhaps, before our mid-afternoon break?
One of the matters that you have already referred us to, Ms Dyson, was the problems with capacity within the

workforce. And I think you mentioned there was a Workforce Capacity Fund that was set up -- it's not the only thing that the department did, but I'm not going to ask you about all of the steps the department took.
Could you go, though, please, to your paragraph 391 in your statement because you say there that the department had four objectives to address workforce challenges: ensuring the sector had enough workers, supporting the workforce, protecting the workforce, and then, indeed, protecting the recipients that the workforce looked after.
I'd just like to look at a few of those with you.
A. Could I just interject for a minute?
Q. Certainly.
A. So I, as I said here, for the purposes of this statement, this was me creating those four categories for the purposes of the statement to try and sort of --
Q. To bring them together.
A. To make it logical because there was so much activity on workforce I felt it needed to be broken down.
I wouldn't want the Inquiry to get the impression that this was the -- these categories were how we approached things.
Q. No, thank you --

A. -- (overspeaking) --
Q. It was your attempt to draw the strands together in an intelligible way for us.
A. Exactly.
Q. Understood. Thank you very much.
And bearing that in mind, clearly attempts to increase workforce capacity included a rapid induction training scheme and fast track recruitment. I'm not going to ask you about those. But the Workforce Capacity Fund was announced on 16 January 2021. And it was £120 million ring-fenced, designed to increase the use of the existing workforce, increase the size. And there was a review, as I understand it, of that fund and in total I think you say that 39,000-odd staff were recruited.
Can we have up on screen, please, INQ000279947_0014. And the section there, the "What do stakeholders think?" In the review:
"Stakeholders welcomed [the fund] being provided to mitigate the workforce capacity issues, [but said] it came late; the guidance and grant conditions being announced on 29 January ... and the first tranche of funding not being paid until February 2021. Stakeholders believe that if funding had been provided as part of the winter plan in September, it would have

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

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

Can you help with that at all, Ms Dyson?

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

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

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

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

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

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

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

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

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

Presumably that's:

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

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

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

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

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

speaking about in this statement.

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

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

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

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

paid for care.
MS CAREY: We, perhaps after the break, will turn to trying to support the workforce and deal with burnout and exhaustion.
Would that be a convenient moment, my Lady?
LADY HALLETT: Certainly.
Ms Dyson, as you've probably been told, we take breaks for the benefit of everyone but particularly the stenographer. So I shall return at 3.05. Thank you.
(2.49 pm)
(A short break)
(3.05 pm)
LADY HALLETT: Ms Carey.
MS CAREY: Thank you, my Lady.
Ms Dyson, can I ask you, please, about your paragraph 477 in your part C statement, and it's on the topic of Covid-19 positive working.
I think you set out there that in January 2021 the Regional Assurance team became aware of some staff not self-isolating after testing positive. Is that correct?
A. Yes.
Q. And it was happening in areas where there were acute staff shortages and limited alternatives to safely staff care homes, and the decision was made to work when positive rather than not, to try to mitigate those staff

shortages; is that it, in a nutshell?
A. Yes. I mean, it was only in a very few number of cases, so it wasn't widespread, but it was -- certainly seemed to be becoming more of a systemic issue than -- when we first found out about it, we thought there was a one rogue case, but it was clear there were a number of them.
Q. Yes, in due course, you wrote an email, I think, that was going to go to the minister, that you asked Chris Wormald to approve or cast his eye over, and in that you said there were six cases that were brought to the department's attention where a Covid-positive staff member had nonetheless gone on to work.
Do you know whether the scale was wider than that? Was it just limited to those six cases? Can you help at all with how widespread this problem was?
A. I believe that CQC found some more cases. The number 25 comes to mind but it may not be exactly that, but in that sort of order.
Q. And I think in January, on the 27th, there was a joint statement issued by the CQC, the Association of Directors of Public Health and Public Health England, to say that that should not happen, but you go on in your statement to say that the department was considering how best to address this issue, and advice was provided to

the minister to consider the option of police involvement.
Can you help, Ms Dyson, with what, if anything, happened in relation to police involvement in this area?
A. Our main response here was through CQC, and I remember speaking extensively to Kate Terroni, who was then the chief inspector of adult social care, and she was going to convene all her CQC inspectors to make sure we could get the message out as clearly as possible.
Ministers were also interested -- I mean, down the line, the main thing was to get the message out as quickly as possible in January and also do what we could to assuage the issues on staff shortages.
Ministers were interested also in exploring the police involvement. We looked into that. I think what happened was CQC said it was not for them to refer things to the police, that was not within their statutory powers, but what they did do was they said they would involve local authority safeguarding teams if they thought that that was necessary.
Q. I think also the police in due course said that they would not have the resources to be able to investigate this number of staff taking this action.
But can I come back to sort of the fundamental tension here between what was the department's position

between providing potentially unsafe care by a Covid-positive member of staff or not providing care at all? Did the department have any position on which of the lesser of the two evils should be adopted?
A. The department's clear position was that Covid-positive staff should not be coming to work, and we were doing everything we could to help with the staff shortages. And indeed, I think the message that that went out was, you know, if you've got staff shortages you need to be flagging that locally and relying on mutual aid. I mean, we were putting in the Workforce Capacity Fund, as we've already discussed; we did a big recruitment drive at the same time but, ultimately, providers should not be having people come to work who were Covid-positive. They needed to find alternative ways of ensuring safe staffing.
Q. January 2021, when these six examples were brought to the department's attention, it was a time when there was rising rates of Covid infection, was any thought given to how to prevent this reoccurring in winter of '21 into 2022 when, again, there were other winter pressures as normally exist?
A. It was just our very clear messaging: if you are Covid-positive, you must not come into a care home, which is such a -- where the risk of Covid spreading is

so high. This is against the law, you mustn't do it.
Q. Just before we broke, you explained how you had categorised into four, sort of, neat areas objectives that the department had to try to deal with workforce challenges, and one of those was supporting the adult social care workforce. I think you say in your statement that the Adult Social Care Taskforce recommended a review of wellbeing services in one of the reports that they had done, I think, in the summer of 2020. Do you know whether there was such a review conducted?
A. So what happened with the taskforce report was it sort of morphed into the winter plan and the two things were published alongside each other. And the winter plan talks a lot about all the sort of resources that they are --
Q. I'm going to show it on screen in a moment.
A. Okay.
Q. So, with that in mind, shall we call up, please, INQ000058216_0037 and 0038, and I've just pulled out the support part of the winter plan, and we can see there "National support" and, indeed, "Actions for local authorities", but I suppose, really, the question is, this is a plan that came out in, I think, September 2020 in preparation for the winter of 2020 to 2021. Was

there any support put in place for the workforce prior to the publication of the winter plan?
A. So I think quite a lot of these things had already been put in place and I think some of them are referred to, but I couldn't tell you off the top of my head which they are, in the April plan published on 15 April. And then the one in May, the Care Home Support Package published in -- (overspeaking) --
Q. Perhaps I can help you, Ms Dyson, because certainly if we look at some of the bullet points, there is an offer to the workforce is brought together in the Care Workforce App, that is something that was launched in May of 2020, according to your statement, and there was certainly some guidance issued on health and wellbeing in May, as well.

So -- but do you know, for example, what specific work the department did to try to support the wellbeing and workforce, aside from the winter plan?
A. I think this was principally it. I mean, if you -- the next page of this talks about the responsibilities of providers, and clearly the adult social care workforce is employed by, you know, sort of 18,000 providers. So it's very different from a public sector sort of national workforce like the NHS. And first and foremost, it's for providers to look after the wellbeing

of their staff.
Q. You alight on, there, perhaps a distinction between the NHS workforce and the adult social care workforce, but clearly the -- NHS England, for example, launched a dedicated mental health hotline for NHS staff. Is that something that the department could have chosen to do for the adult social care workforce, notwithstanding that it's for providers to help, but give the overarching banner of support to adult social care?
A. I suppose it could have chosen to do that. There was always an issue about how you reach all the adult social care workforce. There is no register of the workforce. So there are all sorts of things you can provide, but will they be taken up by -- as you said at the outset, there's 1.2 million people who are employed by 18,000 providers.
Q. We are aware that Northern Ireland, Scotland and Wales have a mandatory registration for both, I think, residential and domiciliary care workers. Not the position in England, as we understand it.

Do you think a register of the care workers would assist in the event of a future pandemic? And if so, in what ways?
A. It would definitely assist in the event of a future pandemic, because there were times when we thought

about: how can we get to the workforce? And we had no route to get to the workforce other than through providers, which is obviously an indirect route to the workforce.
Q. Given the size of the workforce in England, which is, on any view, much larger than in the devolved nations, how feasible is it for there to be a mandatory registration requirement?
A. I mean, it's feasible but there are plenty of people who think it's not a good idea. So there are mixed views on this, but it is feasible.
Q. On behalf of the department, do you have any views as to who should keep such a register and maintain a register?
A. I mean, if we were to have such a register -- and this goes to the question of -- I mean, you could have, sort of, Skills for Care. They have the adult social care workforce data. But I suppose if you were moving into a world of workforce professionalisation along these lines, I mean, maybe it's not the right thing to do to have it sort of held at such arm's length from the department. Skills for Care is an independent charity, and you could set it up within the department. All these things would be feasible.

But as I say, there are very mixed views on whether this is a good idea.

Q. And what about the views --
LADY HALLETT: I'm sorry, Ms Carey, can I just interrupt?
MS CAREY: Yes.
LADY HALLETT: What are the opposing views to a register, Ms Dyson? I don't know if Ms Carey is going to cover it. I may have stopped her in her tracks.
MS CAREY: Not at all.
A. I honestly -- I can't remember the detail of this. I remember Matt Hancock was very keen to do this, and also I think we consulted on it in late 2021 as part of some reform work. But I think there are some stakeholders who think this is not a good idea, they think it might put people off. But I think you -- yeah, I'm afraid I can't remember the detail of why they're against it.
LADY HALLETT: Thank you.
MS CAREY: One aspect of the pandemic was undoubtedly emerging evidence that showed that there was a disproportionate impact of Covid on black and minority ethnic members of staff, and can I ask you a little bit about that, please, because I think at your paragraph 449 you make reference to, there, the risk reduction framework. I'll just let you turn it up, Ms Dyson, as I do as well.
But the department developed what was called the

adult social care risk reduction framework, to be used in all social care settings or social care interventions. It was to provide guidance for employers on how they should support workers who were more vulnerable to infection or adverse outcomes, including the risks by ethnicity. And that framework came out on 19 June 2020.
Can we have a look, please, at INQ000109673.
And this is an extract from a report done by the adult social care support taskforce, BAME Communities Advisory Group. It was an advisory group that worked between 31 July and 14 August 2020, so just a two-week period, and they received 142 responses from the social care workforce.
And we can see there that confidence in support, the quantitative section of the group's work showed risk assessments were often a successful measure for BAME staff to feel more secure, higher level of confidence coming around -- sorry, around support coming from employers than the government or official guidance, and the majority of respondents had been risk assessed regarding ethnicity.
And you can see there, perhaps if we just zoom out again, "Have you had a risk assessment based around your ethnicity?" Actually, 90 of the 142 respondents had.

And 52 hadn't.
But if we just look to the bottom of that page, clearly over that two-week period, the respondees were asked for their awareness and take-up of that social care risk reduction framework, and it was much lower. And if we go over the page, please, when asked the question "Are you aware of the framework?", 88 people said no. So almost two-thirds of the respondents.
"Have you used it?" Even worse figures: 109 of the respondents had not.
Do you know whether the department was aware of, albeit a small study but, nonetheless, an important study that showed, perhaps, the risk reduction framework wasn't being utilised, no doubt, as much as the department would like.
A. I think the important -- so this is part of David Pearson's overall taskforce. I think the important thing here was: were people having the conversations? I think it mattered less whether they were having the conversations because they knew about the risk reduction framework than were they having the conversations in the first place, because the risk reduction framework was all about supporting those conversations. It was saying you should have a conversation, this is how you do it, it's a very sensitive issue, these are the sorts of

things you should talk about, and then this is how you can mitigate.
If those conversations were happening without reference to the risk reduction framework then I don't think that that's a problem. And in fact, if we put out a risk reduction framework on 19 June, bearing in mind how difficult it is to get things across such a large sector, I'm actually quite surprised that -- is it -- 38% of people were aware of the Adult Social Care Risk Reduction Framework.
Q. I follow your argument, which is as long as the risk assessment is been doing (sic), whether it's the risk assessment framework that provokes it, it doesn't matter, it's important that the risk assessment is undertaken.
A. Yes.
Q. But nonetheless, this was an area where the department were concerned about the disproportionate impact and arguably the framework that they put out isn't certainly getting the airtime or the publicity that perhaps the department wanted and you could have had more risk assessments, potentially, if the framework had been better publicised. There is that argument. Do you see that, Ms Dyson?
A. Potentially. I mean, we would have used -- I don't know

if we did in this case but we would have used Skills for Care as a way of reaching the workforce.

Q. And is the risk reduction framework still in place now or is that a pandemic-specific --

A. Not that I'm aware of. Could I just mention one other thing that was happening at the same time as this on the question of, sort of, risk around ethnicity, which is the decision that was taken on 26 June to prioritise the adult social care workforce -- sorry, the care home workforce for regular asymptomatic testing, to prioritise them ahead of the NHS by several months. And that was taken partly because of the risks in care homes to residents, but also because of the risks to the workforce. And the evidence that went into that meeting when those decisions were taken explicitly talked about the fact that 21% of the adult social care workforce was from an ethnic minority background, rising to 60% in London, and other risk factors such as living in housing of multiple occupation, being on zero-hours contracts, et cetera.

So we were doing other things alongside, at the same time, in June 2020.

Q. No, and thank you for adding that context, but if the department is going to go to the trouble to put out a risk reduction framework but then it doesn't seem to

have landed with the workforces, it's not necessarily the best advert for trying to support the workforce, particularly those who are disproportionately affected, to understand that they are being thought of, looked after, and work is being specifically done for them?

Do you think perhaps there is a communications issue surrounding things like the risk reduction framework? It wasn't publicised enough?

A. I mean, possibly but, as we discussed before, it's really hard to reach the whole of the workforce because we don't have a list of who they all are. And I do think the fact that this is, I think you said, August, so it's potentially sort of six, eight weeks on, you know, things always take a while to get through. So it would have been interesting to see, you know, if you'd done a similar survey a few months later, you know, would the numbers have improved.

Q. That's what I was going to ask you. In addition to the prioritisation of asymptomatic testing and things like the framework, are you able to point to any other measures that the department took to try to address the disproportionate impact of Covid-19 on the adult social care workforce?

A. I mean, the vaccine, clearly, which was prioritised for the adult social -- people working in care homes. You

know, they were in priority number 1, alongside residents, because of the risks, both to residents and to them, within the care home environment.

Q. I think, Ms Dyson, though, you're aware that, certainly particularly within some black and minority ethnic communities, there is lower take-up of the vaccine for a number of different reasons.

Aside from the vaccine, I just wonder whether there was perhaps not enough attention given to trying to promote the department's concerns to protect black and minority ethnic workforce members?

A. I mean, I'm not aware of other things that we did. You know, there was a lot of work done, but I mean, particularly, if I can come up back to the vaccine, NHS England did a huge amount of work with ethnic minority communities to encourage them to take up the vaccine, which was for their protection.

Q. And whilst we're on this topic, can I ask you, please, to look at INQ000543049.

This is an extract from a statement by Skills for Care. I'll just wait for it to come on screen. And if it doesn't, I can read it out to you, Ms Dyson, but the Social Care Workforce Race Equality Standard collects data from local authorities on nine race equality indicators, and I think you're aware that Skills for

Care have recommended that the Department of Health, along with the Minister of Housing, Communities and Local Government, and DfE, should mandate and fund implementation of that Workforce Race Equality Standard into all its work?

Can you help with any Department of Health comment on the Skills for Care recommendation?

A. So the department funded a pilot of 18 -- so this is for local authorities. The department funded the first 18 local authorities getting this standard. The department also funded the data tool to support the rollout of the race equality standard.

Since then, as I understand it, Skills for Care have been rolling it out themselves, without funding from central government. I believe they've got to around 73 local authorities, so they seem to be doing a good job in getting this out to local government, building on the pilot of the first 18 that was funded by the Department of Health and Social Care.

Q. And can you help us, in what way would the Department of Health have been assisted if perhaps this had been rolled out sooner or more local authorities were complying with it in the pandemic? I mean, obviously data is a good thing but is there any specific thing you can point to and say: well, that would have been really

beneficial if we'd that the equality standard collected data?

A. So this is about local authorities, I think it is about local authorities' own workforces as opposed to the care workforce, so it's about social workers, et cetera.

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

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

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

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

visitors. Further work through the commissioning of new studies was needed.

Was or is any work being done by Department of Health to try to work out the extent to which visitors bring in infections into care homes?

A. I think the point here was that there wasn't the evidence that we would have ideally had. But on the other hand, it was very clear that all footfall, if you like, into a care home brought risk with it. So anyone coming into a care home, for whatever purpose, that was a risk.

So in answer to your question, I'm not aware that we're doing any extra work in this space.

Q. It's just that a number of the Bereaved Group members in particular say: well, if the evidence emerges that we're not a vector of transmission or a significant vector of transmission, it makes the argument for imposing visiting restrictions less.

I suspect you can see that point, but hence why they are keen to know whether there is an evidential basis for the restrictions in terms of the data showing that they bring in X proportion of infection.

A. I mean, I think this is a question principally for Public Health England, but we -- every time we made changes to the visiting restrictions we worked hand in

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

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

A. Not that I can think of.

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

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

A. It was the experience of the pandemic.

So at every point in the pandemic we were wrestling with the -- trying to square the circle as -- to balance things. I mean, it is to note that when Omicron came, and I don't know if the Inquiry has heard evidence on this, but at the beginning, when we first got notified

about Omicron, which was the end of November 2021, we were incredibly fearful because we knew it was much more infectious than what had gone before, and at that point we didn't know whether it was more lethal.

And so we were fearful we were going back to the -- more -- equally lethal -- we were fearful we were going back to the position of March 2020. But against that backdrop we decided to -- not to close care homes to visiting. We brought in restrictions again, but we kept the essential caregiver learning from the experience of what had gone before.

The regulation that we brought in that you mentioned was really to codify that experience and make sure that it would only be in the most exceptional circumstances that care homes would be closed to visiting.

Q. That's what I wanted to ask you about -- because there is that caveat that, clearly, if exceptional circumstances apply, then the right to have a visitor falls away. But wouldn't a pandemic essentially be the exceptional circumstance? Wouldn't we be back in the position that we were in in March, April, May of 2020?

A. I mean, the guidance that CQC has given underneath that provision makes it clear that it really is -- if it really, really can't -- you know, there is no way of doing this safely. But we can't close the door to --

you know, it is possible that you get another pandemic where, in order to keep people safe, you do have to close visiting down again. I mean, I hope -- I hope -- very much hope we don't end up in that place.

Q. I think you said in your statement the CQC have a role to play in ensuring that visitors are being -- are allowed. And I think there's a correction to make, is there not, to your paragraph 52 in your statement A, where it should be a reference to 2023 amendment regulations not to the Health and Social Care Act of 2022?

A. Yeah.

Q. All right, well, we'll deal with the formalities but thank you for that.

Can I ask you, please, about do not attempt cardiopulmonary resuscitation notices, please. It's your paragraph 615, Ms Dyson, if it helps you, onwards.

One of the things you say there, I think at paragraph 613, is you say that:

"The Department did not receive evidence of ..."

Forgive me, let me just turn the paragraph up itself:

"... evidence of inappropriate and blanket use of DNACPRs.

What do you mean when you say the department didn't

receive evidence of it? Because the department was clearly aware of concerns and I just want there to be no misunderstanding about what the department knew or had been told.

A. I mean, there were many examples, anecdotal examples, of this. And, indeed, the CQC review that was done, I think in October 2021, said that that was the case. I think that sentence maybe simply means we didn't receive, you know, sort of comprehensive sort of analysis on this, but absolutely, we were hearing about it -- (overspeaking) --

Q. I didn't want there to be any misunderstanding about the fact that this was raised as an issue with the department, and could we have a look on screen, in fact, at INQ000565710_0002.

This is an email sent to the department in -- forgive me the date has disappeared off it, but it was sent to the department and in the middle of -- thank you -- 11 April, thank you very much -- there is reference, can you see, at point 2 there, commenting on a piece of evidence. But in the middle of that paragraph you see:

"There is a perception that people receiving services in a care home and with [Covid-19] symptoms are automatically palliative. Not every GP practice is

taking this approach but many are, and the press are not helping. This is similar to the 'blanket DNAR' to which you reference elsewhere. We do not have any volume of statistics yet but some people in care homes showing symptoms do survive and I think we should be acknowledging this fact."

And they talk about:

"The [standard operating procedure] I mention below, also has a role in dispelling this or statements that those ... requiring NHS hospital treatment will continue to receive it. Anything you are able to say in this area will go some way towards services not feeling totally isolated and cut off, and minimising the fear that everybody in a care home will die".

Now, a number of issues in that section there please, but is this an example, perhaps, of some of the anecdotal evidence to which you just referred a moment ago --

A. Yes.

Q. -- with emails being sent into the department, and the like? Right.

From the department's perspective, was there ever a policy that promoted or enabled there to be a blanket DNACPR policy?

A. Absolutely not.

Q. Or any policy that elided do not attempt cardiopulmonary resuscitation with the fact that other treatment must still be continued?

A. No. I mean, the department, as soon as it heard about this, the department, through multiple routes, wrote out to the sector, and I can go through the list if it's helpful, but, you know, through the NHS, through adult social care routes, through the Chief Social Worker routes, through the Chief Nurse, everything it could do, to say this is completely wrong, do not do it.

Q. We know that in the autumn of 2020 the department commissioned the CQC to do a DNACPR report. There was an interim report and a final report with which the chair is very familiar. And in due course there was a, I think a ministerial group set up to develop universal principles for advanced care planning.

Can we just have a look at that please, INQ000587737, page 168 to 169.

It's probably easier just to put the paragraph up on screen from your statement. You say:

"One of the key outputs of the group was the joint publication of a set of Universal Principles for Advance Care Planning ... published in March 2022 ... as to 'what good looks like' ..."

And we can see there six high-level principles.

Thank you:

"The person is central to developing and agreeing their Advance Care Plan ...

"... personalised conversations ...

"The person agrees the outcomes of their Advance Care Planning conversation ..."

And so on.

And without wishing to disparage the work of the universal principles, is there any other work being done, though, to provide more ground-level guidance to ensure that there isn't blanket or inappropriate DNACPR policies being written or being imposed on people in care homes in the care sector? What is sort of at the level under this, if I can put it like that?

A. This, then, became part of the single assessment framework which the Care Quality Commission uses and that, if you like, is the basis on which they are inspected.

Q. Can you help us now with where DNACPR records are kept for the adult social care sector, because we've often heard about perhaps there being a GP record, maybe a hospital record, maybe a care home record, and not necessarily the three records aligning. Do you know now if there is one central repository for DNACPR records,

as far as the adult social care sector is concerned?

A. So I've been trying to get to the bottom of this. There is a digital care record for care providers.

I understand any DNACPRs are not kept there, because they have to be signed off by the GP. So they will be held somewhere within a GP record, but I'm not sure what, in terms of the sort of central repository, I'm not sure what that would be, but we can continue to try and find out, and let the Inquiry know when we have.

Q. Right. One of the concerns of the bereaved groups is that the CQC report that was commissioned was perhaps commissioned too late in the pandemic and there have been these concerns that had been growing from a much earlier stage in the autumn of 2020. Can you help at all about why the decision was taken in the autumn to commission the CQC report?

A. I don't know why it was in the autumn, but I think the really important point is how much action happened during -- basically during April, you know, we could not have done more, I think, to communicate out through every channel that we have across the health and care sector to say that this was inappropriate. And in fact, that was noted in the CQC review that said there was evidence of unacceptable DNACPRs being used at the start of the pandemic but there was a quick response from

multiple agencies to highlight the issue, and deal with it.

Q. Given that there was no departmental directive saying this was acceptable or permissible, did the department do work to try and understand why, given this problem was still happening even though no one told GPs to do it or care homes to do it, to try and understand what generated?

A. I think that was the CQC review. That was the mechanism to try and understand that.

Q. Okay. Can I come on to deal with the issue of data, please. And this is mainly covered in your part D statement, Ms Dyson.

You say at the outset of that statement that the Department of Health was not operationally responsible for adult social care data collections, but you did receive annual returns from NHS Digital, we know the CQC included data in their annual report. But is this the position, that going into the pandemic, there was no realtime data available to the department?

A. Yes.

Q. Right. Now, there were some changes made during the pandemic, and I'd like to ask you about some of those, please. And in particular, you say there was changes made to test and trace data, deaths of care home

residents data, and reporting via the Capacity Tracker. Perhaps my packaging up, or yours, but I'd like to look at those three areas with you, please.

Data from test and trace, you say was useful to show prevalence and outbreaks. Can you help with, and it's at your paragraphs 16 and 17 in part D, when did the test and trace data become available to the department? Because we know test and trace was launched on 28 May, and we know it was reported in sitrep data from 16 October but it doesn't mean the data wasn't available to the department before then; can you help?

A. So the -- the test and trace data -- I mean, it became most meaningful once you had regular testing. So that rolled out from July but probably didn't become -- get into its full rhythm, I would guess, until about September. We then had the dashboard that was built, the Palantir dashboard that came on stream about that point of time, so end of September, beginning of October, and that was where the test and trace data was reported and reported daily.

Q. That brings us on to the dashboard. I think you said in your statement it was rolled out from 1 October 2020. It was interactive and local authorities had access to the dashboard and, indeed, ministers used it at meetings and various other groups. Can you help me with this:

was the dashboard in any way developed in secret or without the DHSC's knowledge?
A. No. There were many emails. You can see all the different people who were involved, including analysts, from my team, across with Palantir, and NH -- I think the NHS held the contract maybe at that point with Palantir. Many people were involved in developing the dashboard.
Q. Was there ever any orders that you're aware of not to share the dashboard with either ministers or any other group that wanted to see the dashboard data?
A. No, absolutely not.
Q. Can we have a look, please, at the actual data itself.
Thank you very much. It's INQ000512951. And I wonder if we can go to page 23, which I think may be a couple of slides on. Thank you.
This is an extract from 5 January 2021, and it shows here the regions across England, and a summary of the positive cases, both a staff and residents -- is this in care homes, Ms Dyson?
A. Yes, yes.
Q. And we can see there that, as at January 2021, there is significant increases in London, the east, and the south east, compared with the previous seven days. And so it's a useful tool to show you increase in infection

rates or decrease, depending on the position.
Obviously that regional overview was helpful but help us with the dashboard. How, from there, did one go to working out perhaps which local authority had a problem or which care home in particular had a problem? How had it sort of trickled down?
A. So this is the dashboard that many, many of us looked at every day, and it was vital. It gave us this rolling seven-day data. So, as you say, you could absolutely compare -- see what was going on at national level, then at regional level. Then you could click through and you could get to all the 150 -- I think it was then 152 local authorities. And from there, you could click down into the all the care homes that were in that local authority, and then you could see what was going on in that care home and you could see that care home's Capacity Tracker data.
So, for example, in a care home where there was an outbreak, you could have a look and see: well, what are they doing on staff movement? What are they doing on paying sick pay?
Q. So you could actually go down to, sort of, care home level and know what their outbreaks were, how many staff absences there were. I think -- did it cover PPE and whether they had --

A. Yes.
Q. -- sufficient supplies?
You mentioned the Capacity Tracker, is that a different dataset or was it just a sort of -- it sat under the regional and, indeed, national overview?
A. So what the dashboard did was bring all these different datasets together, so what we're looking at here is Test and Trace data. But the brilliant thing about the dashboard was it combined Test and Trace data and Capacity Tracker in a way that was very accessible for us as policymakers in the department.
And we could then -- once we saw what was going on, by then we had a regional -- or we were building our Regional Assurance team, and they could get on the phone to the relevant local authority or care home to say -- you know, to just ask some questions about what was going on.
Q. Is the dashboard still in use?
A. No.
Q. No.
A. But Capacity Tracker is.
Q. Right. We'll come on to that.
Is there the capability nonetheless in the department to get the dashboard back up and running again in the event that we have a future pandemic?

A. I'm sure we could do that, yes.
Q. Now the tracker, I think that was already -- that was something that was adapted for use during the pandemic. It was voluntary, as I think you said earlier. But clearly, one of the things during the pandemic to try to encourage provision of data was to make access to funds, not just the Infection Control Fund, linked to whether returns were made by the Capacity Tracker?
Help us with the position with the tracker today. Would it be useful still if there were a future pandemic now? Because clearly you might want to look at bed capacity outside of pandemic times, but what does the department say is its benefit in the event that we had a pandemic later this year?
A. I mean, we still use it for all sorts of purposes: bed occupancy, we look at staff absences. So there are all sorts of purposes it's currently used for. It's very easy for us to add extra fields if we need to. I mean, there is obviously a process to be gone through, because we're conscious of imposing burdens on providers, and it's important we do -- there's proper governance around it, but it would, in principle, be easy to add in extra data collections into the Capacity Tracker.
Q. And I think it may be something you said earlier, forgive me if I'm repeating myself, but is it now

mandatory too?
A. Yes.
Q. All right. A couple of different topics, please, perhaps before we wrap up.

In your part E, which is your lessons learned part of the statement, you make reference to the Chief Medical Officer's technical report, which refers to research and any investigation to increase care home resilience.

Are you able to help with any work that is being undertaken by the department now to conduct research, or have the capability of standing up research in the event of a future pandemic?
A. So there may well be things going on in UKHSA, but the thing that I'm aware of is that the Vivaldi Study is still going, albeit it's no longer looking at Covid, but it is looking at care homes from, sort of, other perspectives. So I think that is very useful research for the future.
Q. In relation to Vivaldi, can I just ask you a few questions, please.

I think -- was there a budget set for the project as far as the department is aware?
A. So we've been trying to get to the bottom of exactly what happened with Vivaldi. We've been digging round in

lots of emails. So from the emails that I've seen to date, I've seen a lot of emails going on in May with people trying to get a budget for Vivaldi involving finance people, involving commercial people, this was a -- sort of a procurement issue. I haven't seen where that actually got to, but definitely people were doing everything that I would expect them to be doing to get a budget for Vivaldi.
Q. Was there -- or do you know whether -- was there anyone in the Department of Health at that time that didn't want the Vivaldi project to get up and running and report on its findings?
A. I mean, there's nothing I've seen in all these emails that would suggest that that's the case.
Q. Were you aware from your research whether the department refused to share data with the Vivaldi project?
A. Again, nothing I've seen in these emails.
Q. Do you know whether Minister Whately was briefed in private about Vivaldi?
A. Not that I'm aware of.
Q. The Inquiry has seen some evidence to suggest that in summer of 2020 there were meetings in the Department of Health where people were making comments like "Come the Inquiry, we'd better cover our backs", to put it ineloquently. Have you seen any paperwork that suggests

that comments like that were being made?
A. No.
Q. By the time you joined the department in September, were comments like that being made about the need to cover themselves?
A. I can't recall anyone making that sort of comment.
Q. From your researches, was there any suggestion that the department did not want to uncover perhaps the scale of infections in care homes?
A. Not at all. And it is worth adding another point about Vivaldi. Vivaldi was a really important study, but what Vivaldi uncovered, we already knew, albeit this was a more robust study. So, for example, Vivaldi talks about staff -- preventing staff movement. We already knew that. We had already taken action in May to stop staff movement. Vivaldi -- the importance of testing, we already knew about that.

So Vivaldi is important but it's not the only study that matters, and in fact most of the action that -- in fact all the action that was needed, that Vivaldi points to, was already underway, albeit Vivaldi was sort of massively -- and very robust study.
Q. Another topic, please, is that of Care Act easements. Clearly there were a number of conditions placed on local authorities when they adopted an easement or

modification to the assessments that were carried out. I think the department is aware of concern from user groups and carer groups about potentially unmet needs being prevalent or lower wellbeing, changes being made at the last minute to assessments and the like.

You have set out in your statement that by 18 May 2020 there were six local authorities all in the Midlands that were using easements and two other local authorities that had used them but had stopped using them.

On any view, potentially quite a low number of local authorities in the scheme of things, and certainly no easements have been used since June 2020.

There is a concern that perhaps they were being used but that local authorities were not notifying the Department of Health that they were being used. Did you in the department get any sense of whether that was or might have been happening?
A. I don't think that was the case. I think the issue is whether -- because what was happening was people were using Care Act flexibilities, and in fact when Omicron came and we considered whether to turn Care Act easements back on, the conclusion -- you know, what local authorities said to us was: no, we don't need it because we have the flexibility within the Care Act.

So I think the point -- there's an important study by -- a Manchester University study, I think.

Q. Yes.

A. And the concern there is: well, actually, is there too much flexibility in the Care Act? Which --

Q. Can we have a look at that --

A. Yes.

Q. -- because it might help those following.

A. Yeah.

Q. Can we have up on screen, please, perhaps, your statement ending 737, at page 159. It might just take a moment to bring it up because we're flitting between statements.

It's INQ000587737, page 159, and at the top of the page there a reference to the University of Manchester study in November 2020:

"The project investigated the impacts of Care Act easements on older carers of people living with dementia at home to make recommendations about the operation of this legislation ..."

And there's the report -- or one of the main findings:

"... that carers and the family members they were supporting 'experienced significant changes from their usual care and support, which in many cases resulted in

lower wellbeing and unmet need'."

And it goes on, I think, to set out the point you were just referring to, Ms Dyson, that:

"Although the experiences were similar across the local authority areas in this study, easements were differentially implemented, soon revoked, and not in force for any local authority beyond July 2020. There appears to have been little consequence -- whether political, legal or regulatory -- for local authorities that did not invoke easements. However, for the local authorities that did, there was considerable pressure from lawyers, NGOs, lobby groups and adverse media attention."

Was the department aware that local authorities that did invoke easements were coming under some criticism and --

A. Yes.

Q. And what was the department's view about it from that angle, in the first instance?

A. The chief social workers went out to those local authorities and conducted extensive interviews to understand how they were using the Care Act easements to make sure that it was all in accordance with the guidance, which they concluded that it was. So I mean, I sort of understand the point that says it feels a bit

unfair that some of these local authorities that use the Care Act easements in exactly the right way were coming under pressure, but other people, other local authorities who did similar things, but without going through that process, didn't come under -- I mean, so I understand the point.

Q. To go back from the other angle, though, and perhaps the significant changes being reported by carers and their family members, which resulted in lower wellbeing and unmet need, can you help with what safeguards, if any, were written into this to try and prevent such dramatic changes to people's care needs?

A. I do think some of that is will be about lockdown more generally. So, for example, I know it was really difficult, and I should say this: the University of Manchester report makes very, very difficult reading. But some of the problems that it's alluding to were caused by lockdown so, for example, day centres closing, and indeed some, I understand, some families decided that they didn't want care because they didn't want a home carer coming into their home because they were concerned about the risk of Covid.

I mean, what we did generally was there was an ethical framework which in fact the Permanent Secretary commissioned in February, which was published on

19 March, it was always very important that all decisions of this kind, whether under Care Act easements or not, were taken being cognisant of that ethical framework.

But the broader points that are being made here, which is about how do you have oversight of what's going on in local authorities in terms of the flexibilities that there are under the Care Act, we've now legislated so that CQC has -- inspects local authorities the way in which they exercise the Care Act, so they will be looking at these types of issues, you know, either within a pandemic, let's hope not, or in normal times as well.

Q. Perhaps moving in to my final point, and levers, or the lack thereof. We've looked at the financial incentives that perhaps can be levied to try and ensure data returns are being met. You've spoken there of, I think, changes to ensure that the CQC inspects to ensure that Care Act responsibilities are being applied, but from the department's perspective, is there any recommendation that the department has got as to how to ensure it has the levers it needs, aside from those discrete areas that we've spoken about already this afternoon?

A. I think this goes to the Baroness Casey review, because

there are big questions here about whether adult social care is set up in the right way.

Q. I understand that, but that review may be many months, if not years, away. If we had a pandemic more immediately than that, do you have any recommendations or suggestions for how the government could gain the levers it might need to be able to support the care sector and, indeed, impose things on the care sector?

A. I think we're in a much, much better place than we were in 2020 through the legislation we've already talked about, through data, through CQC inspections, through the visiting regulations, and then there's one we haven't talked about, which is the power the government now has but hasn't yet used to be able to give money direct to providers. So all the money that went to providers during the Covid pandemic had to go through local authorities instructing them to pass it on. We now have the power to fund providers directly.

MS CAREY: Ms Dyson, thank you very much.

My Lady, that's all the questions I ask but there are some Core Participant questions.

LADY HALLETT: There are. Thank you, Ms Carey.

Ms Dyson, just few more questions for you but I promise you you are going to finish by the time we finish this evening.

Ms Morris should be just to your right.

Questions from MS MORRIS KC

MS MORRIS: Thank you.

Good afternoon, Ms Dyson. I ask questions on behalf of the Covid Bereaved Families for Justice UK. My first topic is returning back to the issue of Covid-positive staff within care homes. Now, Ms Carey King's Counsel has touched on that with you already. I wanted to expand a little bit in terms of the detail, please, and the scale and some of the underlying issues.

We've already mentioned your note or draft note to the Minister from January in 2021 in which you highlighted six cases the department was aware about and I think following this -- that draft note, the number of reports that the Inquiry has evidence of increased by 50 in February and 94 in April. You said you thought it was about 25. I just wanted to draw your attention to that. So by 13 April 2021 there were 94 reports, within the department's knowledge.

I wanted to ask you if you could help with whether there were cases of staff continuing to work in both residential and in community settings. Was it in both or just in one?

A. I don't recall but I mean, all the cases that were brought to my attention were in care homes, but as you

say, if there were 94, then I don't know where all of those were.

Q. In your draft note back in January to the Minister you say that it appears that in some cases the action has been signed off at a local level on the grounds that there is a risk to safe staffing levels without Covid-positive staff continuing to work. So I wanted to ask you, do you agree that the prevalence of Covid-positive staff continuing to work during the pandemic was illustrative of the failure of the UK Government to grip the workforce issues and shortages that had been known before the onset of the pandemic?

A. I mean, we are talking about 94 staff out of 1.2 million, so I do think we need to think about it in the -- get some sort of perspective on that. I mean, as we have discovered, there were problems in the workforce. There were problems particularly at this time, but equally, there were times during the pandemic when things, as regards the workforce, were relatively stable. We saw an email on that, making that point just before the break.

So I think this was a particular issue.

I should just add that that draft note became an actual note about two hours later, and went to the Secretary of State and then there was a note to the

Prime Minister on it over that weekend.

Q. Thank you.

You've touched on some of the money delivered through the Infection Control Fund, but given the reports that were received by the department, do you accept that that money had proven insufficient to tackle the problem of preventing Covid-positive staff coming in to work?

A. That's why we were doing the Workforce Capacity Fund that actually had already been announced by the time of this note, so that was -- had been announced a couple of weeks earlier. This was the end of January, I think the Workforce Capacity Fund of 120 million had been announced in mid -- I think in mid-January.

Q. My next topic, the March 2020 hospital discharge policy. I wanted to ask you a little bit more about that, please.

So there was a national steering group meeting on 11 March 2020. Ros Roughton, the then Director of Adult Social Care, emailed NHSE with her concerns that DHSC was lacking the ability to tell local authorities what she referred to as "the scary narrative" on what the pressure will be like in the acute sector so that they can really understand why the NHS may need to act the way that it does.

After the hospital discharge requirements had been issued on 19 March, PHE officials noted that NHSE had "major concerns" with the guidance for infection prevention and control in care homes and would lead the sector to being "too risk averse" describing what they described as being blocks in the system.

I wanted your help, please, with, first of all, why weren't DHSC officials able to tell local authorities this scary narrative on what pressure was anticipated to be like just days from this meeting?

A. I haven't seen that email, I don't know about that, but I -- I mean, it's clearly part of the narrative around the hospital discharge. It was being made -- and remember, I think you said that that -- the Ros Roughton email, was that, did you say, 13 March?

Q. 11 March.

A. 11 March.

Q. After 11 March.

A. Yes, so things changed a lot between 11 March and 19 March, so I'm sure that by the time of the hospital discharge guidance on 19 March, I'm sure that there were conversations happening about the need for it, you know, we needed local authorities to be helping with the hospital discharge policy.

Q. Yes. As you say, is it fair to say that the DHSC and

NHSE needed care homes to be willing to accept untested patients from hospital if that policy was in fact going to be effective?

A. Yes.

Q. So if there's an unwillingness to, or lacking the ability to deliver the scary narrative, was the ASC sector deliberately kept in the dark so that when the time came, care home managers would not be too risk averse in accepting urgent hospital discharges?

A. I think we're missing the -- between 11 March and, sort of, 19 March. I just don't know -- I wasn't there at the time, I don't know what happened in that period, but clearly we were getting closer and closer. Lockdown was on 23 March. You know, things changed very rapidly in that period. I'm sure we were communicating with the sector about what was going on. I mean, there was more guidance issued on 13 March, you know, things were moving extremely rapidly, so I don't think we should read into an email on 11 March to say that there was no communication with the sector after that.

Q. You've recognised in your evidence already this afternoon that there was later the development of designated settings. On 20 April 2020, PHE suggested that consideration be given to the question of what they call "hot" care homes as a place to cohort and manage

Covid-19-positive cases that didn't require treatment in hospital.

What consideration, if any, was given to that as an option before the March 2020 hospital discharge policy was put into place?

A. Sorry, again, I haven't seen that. What was the date of that, the hot ...?

Q. So 20 April, this is when the hot, the hot --

A. Oh, I see.

Q. Hot care homes came as suggestion. But why wasn't that considered before March 2020?

A. I mean, the issue about hospital discharge is that we didn't know about -- we didn't have the testing to know who was Covid-positive, it just didn't exist at the time, and we didn't about asymptomatic transmission.

By 20 April we did know about all of those things and the guidance had changed on 15 April to say that you must isolate people when they go into care -- when they come from hospital into care homes.

So I think it was just a case of what we didn't know at the point of the discharge guidance, but we did know by 20 April.

Q. My third topic and my final topic is around PPE and guidance for unpaid carers.

So in the 13 March 2020 guidance for home care, the

authors noted that the provision of care and support within people's home is a high priority service and -- in that most care and support cannot be deferred to another day without putting risks -- individuals at risk of harm, and therefore it is vital that these services are prioritised with this guidance and support. And this particular guidance advised the use of PPE including face masks for those performing domiciliary care when in up close and personal contact with those they were caring for.

But in relation to face masks, by contrast, on 8 April, guidance to unpaid carers said: we do not recommend use of face masks as an effective means of preventing the spread of infection unless you're told by a healthcare professional.

As far as DHSC was concerned, was the care and support provided by an unpaid carer to a person in a home a high-priority service in the same way as a domiciliary carer?

A. Absolutely. You know, the value that we put on unpaid carers was just huge. They did an amazing job during the pandemic, in really, really difficult circumstances. We've already talked about the advice that Public Health England gave us about why PPE for unpaid carers at this point in time was not appropriate. Obviously things

changed later in the year.
Q. Can you see why that distinction in guidance seemed illogical to many of the bereaved families in the UK and Northern Ireland, amongst those -- amongst the -- many of those who are unpaid carers. Can you see the --
A. I think it's important to probably distinguish between the extra-resident unpaid carers and those living in the same household. So PPE was never recommended for people living in the same household except where Covid was actually in the household.
Where we moved to was in treating the extra-resident carers in the same way as domiciliary carers, but later in the year.
MS MORRIS: Thank you very much.
My Lady, my remaining questions have been covered by Ms Carey, thank you.
Thank you very much.
LADY HALLETT: Very grateful, Ms Morris.
Thank you very much, it's now Ms Jones. If you look across the hearing room, Ms Dyson, you might see her.
MS JONES: My Lady, Ms Carey actually asked the topic I was going to ask about, so I've got no further questions for Ms Dyson.
LADY HALLETT: I'm very grateful, Ms Jones, thank you.
Ms Beattie, who is probably behind her.

Questions from MS BEATTIE
MS BEATTIE: Thank you, my Lady.
Ms Dyson, I ask questions on behalf of Disabled People's Organisations and the questions concern Care Act easements which you have covered in your statements and which continued to be in force after you came into post.
The Minister for Social Care, Helen Whately, was provided with a submission on 19 May 2020 on the impact of Care Act easements, and that submission said that chief social workers had spoken to or corresponded with principal social workers from the seven local authorities then operating easements. It might have been six at that point but there had been a total of seven. And that was out of a total of 153 local authorities in England; is that right?
A. Yes.
Q. The chief social workers had not contacted or reviewed what was happening in the other 146 local authorities, but only the seven that had formally notified their use of easements. That's correct, isn't it?
A. Yes.
Q. The submission, the same submission of 19 May, had said in terms -- and for the record, this at page 3, paragraph 6 of that submission:

[As read] "There is a gap in our knowledge concerning local authorities who are not operating under easements but whose actions mean they should be."
In order to fill that knowledge gap, the department needed to know about local authorities that had not formally declared easements but who were taking action such as reducing the care provided to people with care plans, leaving them with unmet needs, didn't it?
A. As far as I know, people were using the existing flexibilities in the Care Act. So I think you can say -- or the Care Act -- you can make the contention that the Care Act is too flexible, and there have been -- you know, people have talked about concerns about unmet need for many years. But I don't think you can say that they -- or I don't have the evidence to say that they should -- they ought to have been using Care Act easements. I just don't know.
Q. Is that precisely the thing that the department needed to look into, whether the local authorities were applying flexibilities, or really were in the territory of easements?
A. Yeah, I think it's just very difficult to get -- you know, you've got a whole country, and we do have to -- local authorities have the statutory duties here. They know their populations really well. They are real

experts in adult social care. And although I had Chief Social Worker -- I had two job-sharing chief social workers, you know, the idea that they could get across the whole country and do what they were doing in those, sort of, seven local authorities across the whole country, I don't think that they could.
As I said before, I think we are now in a different place, given that we have the CQC inspection powers which could be used for exactly this type of thing, and CQC have the expert -- you know, they have employed the experts to do -- in the right numbers to do this work.
Q. The next submission to the minister, on 25 June 2020, stated that monitoring of the overall system should remain light touch, since chief social workers have good oversight of the only local authority still operating under easements.
So that light touch monitoring would again, as I think you're accepting, still not tell you anything about the local authorities that had not formally notified the easements, would it?
A. No, I mean, that's right.
But as I say, I think we're at risk of sort of almost cutting out the expertise of local authorities here, who both had the expertise and the statutory duties to comply with the Care Act here. But yes, if

your question is "Was the department sort of all knowing as to what was going on across the 153 local authorities in this space?", no, we didn't have that information.

Q. Right, so from the point of view of central government, there wasn't any effective monitoring of how the easements were operating and whether local authorities were using the easements or the flexibilities?

A. So there was effective monitoring of those who were using easements, but we didn't know what was going on for those who were not using easements.

Q. And equally, from the point of view of central government, there wasn't any effective monitoring of whether local authorities were failing to meet care users' needs during the pandemic, for example by cutting their care packages, was there?

A. I mean, I have not seen any evidence that that was the case. The evidence that I've seen of the sort of flexibilities that were being used were things like delaying financial assessments, that sort of thing. But I'm not all knowing, so it's possible. But in terms of the evidence that has come to me.

Q. I'm not sure if you were following the Inquiry this morning, but the Inquiry heard from Age UK today that local authorities had reduced care packages for people living in their own homes. Were you aware of that?

A. I mean, what I've heard from -- just anecdotally from directors of adult social services is that people asked to have their care packages reduced because they were worried about people, say, who hadn't been vaccinated going into their homes.

But look, if Age UK have got evidence of that, then, you know, I accept that.

Q. So, similarly, if there is evidence, as there is, of daily care provision of someone who is, for example, used to receiving care three times a day and that being reduced down to once a day, so that, for example, they didn't get dressed for a prolonged period of time, because of the inability to meet their eligible needs, would that be something above and beyond the examples you've given of day services closing or people of their own volition declining services?

A. Yes.

Q. And again, would that be a matter of concern and a matter of interest to the department, having brought in the easement provisions, to know whether that was happening across the country?

A. Yes.

Q. And if that was happening, but only a very small number of local authorities had formally invoked the easements in the way that the guidance and the legislation had

told them to, might that also bring into question whether the guidance itself was being properly understood, or perhaps not complied with, because these things were happening and yet there was such a small number of reports?

A. I think the question it brings into play is -- is the Care Act flexibilities. And whether -- if it really was the case that someone was having a package of care taken down from three times a day to one, you know, once a day, I mean, it would be interesting to know what other circumstances there were. Because, I mean, other things I've heard from directors of adult social services is that there were -- family members were more around. So, you know, I think you can't judge too much without really understanding all the circumstances of the case.

But I do think that this brings up a question about the flexibilities within the Care Act. You know, is the width of the discretion there -- is it too wide? And I think we need to look at that. And again, I would expect, one, that would be looked at by the CQC when they're inspecting how local authorities operate their Care Act duties; and, two, I would expect Baroness Casey to look at that as part of her review.

Q. And after you came into post in October 2020, the Think

Local, Act Personal partnership that had been engaged by the department on an ongoing basis in relation to easements had provided a review which described a very grey line between Care Act easement implementation and other local authority responses to Covid-19.

That raised precisely this problem, didn't it, of whether -- of which was happening, and whether care needs were being appropriately met?

A. Well, it comes back to the point I've just made which is the degree of flexibility within the Care Act.

Q. And a further submission to the minister in November 2020 suggested and referred to ADASS that the national guidance was unclear, open to interpretation, and that this was limiting the use of easements by local authorities. Did that trigger any change or review of the guidance while you were in post?

A. We stopped using easements, and when we consulted about turning them back on again, as I said, for the purposes of Omicron, the universal view was that they were not needed.

Q. Right, but they remained in post, though, for ten months of your --

A. Yes, but they were not being used.

Q. According to the information you had; is that right?

A. Yes.

MS BEATTIE: Thank you, my Lady.

LADY HALLETT: Thank you very much, Ms Beattie.

That completes the questions we have for you, Ms Dyson. You mentioned the burden on providers. I am acutely conscious of the burden the Inquiry places on material providers and on our witnesses. You may want to take the I'm sure glad news back to the department that the burden that the Inquiry has placed on the department for which you currently work is coming to an end. We haven't finished with the department yet but it is coming to an end. But also, I'm sure it was a great burden on you to have to catch up on what had happened in such fast-moving times when you weren't in post. So thank you very much indeed for all that you did to get yourself up to speed, and for helping the Inquiry to the extent that you have.

THE WITNESS: Thank you.

LADY HALLETT: Thank you.

Very well, I shall return at 10.00 tomorrow.

MS CAREY: Thank you, my Lady.

(4.20 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X