Witness Name: Tony Weedon
Statement No.: 1
Exhibits:
Dated:

UK COVID-19 INQUIRY - MODULE 6

WITNESS STATEMENT OF TONY WEEDON

I, **TONY WEEDON**, of Care UK, Connaught House, 850 The Crescent, Colchester Business Park, Colchester, Essex, C04 9QB will say as follows: -

1. Introduction:

1.1. I am Strategic Programme Director at Care UK. I make this statement in connection with the Rule 9 request made of Care UK, dated 9 May 2024.

1.2. I joined Care UK in 1991, initially as a chef in one of our care homes in Chester. I progressed my career with Care UK and have held a number of leadership roles in hospitality, facilities management, operations and project management. This included a four-year period as Operations Director for the company before taking up my current role in 2014.

1.3. In my current role, I am responsible for programme management of Care UK's strategic plan, including the delivery of major growth and change projects.

1.4. During the pandemic, my role was to bring together our strategic response to the crisis; ensuring we had the right level of management information to make informed decisions; interfacing with key public sector partners; and overseeing our procurement of PPE, test kits and other key equipment.

1.5. As set out by Andrew Knight at paragraph 3.6 of his witness statement, I attended various online provider meetings on behalf of Care UK. The initial meetings took place with NHS Test and Trace and Deloitte as I understand

that Deloitte had been engaged to support the DHSC. Meetings then continued with the UK Health Security Agency (UKHSA).

1.6. I attended ad-hoc online meetings set up to address specific issues such as moving testing to weekends (meeting held on 4 August 2020). I also attended online meetings every two weeks (unless I could not attend for some reason) for the 'National Testing Programme Care Home Provider Fortnightly Forum'. It appears that this forum was set up in October 2020 through to 8 April 2021. It is possible that some dates are missing from the information that I have available to me.

1.7. The invitation for the first fortnightly forum meeting set out the following:

"This fortnightly care home provider forum is for the national testing programme team to provide you with an update on care home testing and discuss any issues and developments with you.

This forum is for those responsible for coronavirus testing in your group, so please nominate the appropriate representatives to attend regularly.

As always we will leave time during the forum for questions, feedback and any issue you wish to raise.

The forum will be led by Name Redacted*, our care home testing lead.* NR *will contact you before the session to see if there are any specific items that you would like to add to the agenda for discussion.*

The session will be attended by various representatives from the care home testing leadership team, who welcome your feedback and questions…".

1.8. Although the forum was set up to specifically focus on testing, my recollection is that over time, the meetings were also used to discuss other issues such as PPE and visiting.

1.9. It appears from my records that online provider call catch ups were then scheduled to take place on 11 and 25 January, 15 February, 6 September and 29 October 2022.

1.10. Catch up calls have continued to take place from 13 December onwards in respect of a "LFD Multiplex Pilot".

1.11. In addition to attending the meetings set out above, I received updates via email and I provided feedback on behalf of Care UK regarding any issues that were causing difficulties at the time. The people that I engaged with during this process took these issues away and then provided responses.

2. The impact of the Covid-19 pandemic

Excess deaths

2.1. Care UK experienced a significant increase in deaths due to the pandemic. Care home residents were particularly vulnerable to Covid due to the high number of underlying conditions they were already living with. Further, care homes residents across the UK were potentially exposed to the virus due to a large number of patients being discharged from hospitals and admitted to care homes prior to a negative Covid test being required. As an illustration, even with reduced demand for self-pay admissions, Care UK saw more than 1,400 admissions from hospitals and community settings across its care homes in the first three months of the pandemic (March to May 2020). I refer to the statements of Andrew Knight and Rachel Harvey in respect of the Government's decision to discharge residents from hospitals to care homes to free up NHS capacity.

2.2. From March 2020 to 28 June 2022, Care UK recorded the following:

- 2,388 non-Covid related deaths.
- 710 confirmed Covid deaths.
- 512 suspected Covid deaths.

Staffing and capacity

2.3. In pre-pandemic times, Care UK had a cohort of colleagues who would work under a bank agreement with the company (i.e., work a flexible number of hours depending on the needs of both the individual and the home), but who had a primary place of employment in the NHS or in another care home setting. When workers were prevented from working

across multiple sites, Care UK (and other care home providers) felt a significant impact as it further reduced their pool of available workers. The same challenges applied in respect of agency workers. These challenges led to Care UK losing a significant proportion of its flexible staffing during Covid.

2.4. Care UK also experienced high turnover amongst the company's permanent workforce. Moving annual total ("MAT") turnover increased by 7.6pp year on year in May 2022, having seen an increase in turnover month by month from the start of the pandemic. After May 2022, there was a decreasing trajectory for turnover, with each month bringing a negative movement month on month, realising a 7.1pp decrease year-on-year by April 2023.

2.5. Recruitment was made more difficult during the pandemic due to the negative image of the adult social sector being portrayed within the media. Care home settings were often portrayed as dangerous places to work due to the high prevalence of Covid-19 being reported. Interviews also had to be carried out remotely and restrictive working practices were potentially unattractive to candidates.

2.6. As Care UK has a high proportion of flexible and part time workers, we measure our workforce volume in hours. The number of hours worked by new starters (i.e. starter hours) dropped by 39.7% from March 2020 to January 2021, before gradually increasing back to 73% of the original starter hours experienced in March 2020. Taken together with the number of hours worked by those leaving the company (i.e. leaver hours) that Care UK experienced each month, there was negative net recruitment during 9 out of the 28 months being considered (March 2020 to June 2022).

2.7. As set out above, there were increased absences during the relevant period for mental health reasons. There were also increased absences due to colleagues needing to self-isolate having tested positive for Covid-19.

2.8. There were severe absence levels due to the need to self-isolate between March and May 2020, totalling 135,298 absence hours. This reduced by approximately 63% for the period June to August 2020.

2.9. There were increases in absence levels during the winter periods in December 2021 and December 2022, having increased by 27% and 100% respectively from the immediately preceding 3-month period.

2.10. At the peak of Covid related sickness absence, 12.6% of the workforce was unable to work. The most common reason being self-isolation due to symptoms or living with someone with symptoms (8.5%) and shielding/furlough (1.6%).

2.11. The above is an explanation of the general Care UK position but the experience of individual care homes across the country varied significantly, depending on both the pressures on workforce numbers and any reduction in occupancy. Reductions in occupancy arose due to a combination of excess deaths and restrictions on admissions.

2.12. Care UK calculates the "PPD" for a care home at any point in time, meaning "per person per day". This calculates the number of care hours required each day to support residents in any given suite or home. During the pandemic, significant reductions in occupancy coupled with the need for colleagues to shield or self-isolate exacerbated this variance - some care homes faced staffing shortages whereas in others, colleagues were furloughed for short periods of time as the number of residents in their home had reduced so significantly.

2.13. I refer to the reflective pieces of 5 care home managers, attached to Andrew Knight's statement as **Exhibit AK/05 – INQ000509768**. These set out the challenges that those managers faced in terms of staff shortages and the steps that were taken to provide cover. Care Home Manager A refers to sharing staff with a nearby care home. Care Home Manager B refers to the flexibility that her staff demonstrated in terms of swapping shifts. Care Home Manager C refers to having spent 6 days living at **I&S** **I&S** care home to ensure that there was cover.

2.14. Regional managers were in frequent contact with home managers to discuss staffing issues and to try to mitigate the pressures on individual homes. Care UK also set up a volunteer scheme to provide additional support. This involved arranging DBS checks and providing training to those willing to volunteer. The volunteer scheme was not ultimately relied on in any significant way as the initial peak of staffing pressures passed

and there was then a need to balance the benefit of relying on additional resources against the risks posed by further individuals entering homes.

3. Concerns regarding the collection of data regarding deaths

3.1. Care UK implemented a system for recording deaths potentially related to Covid early in the pandemic. To achieve this, Care UK's existing Serious Incident (SI) reporting process was replaced with a Smart SI process on the 23 March 2020 which automatically consolidated the data from the SI web forms.

3.2. Care UK's Pandemic Event Plan was updated on 23 March 2020 (version 3). Section 3 of this document set out the position regarding SI reporting and the appendices included a SI reporting responsibility flowchart. These documents are attached as **Exhibit TW/01 – INQ000509796**.

3.3. The use of a web-form meant that SI reporting was instantaneous and could be viewed by multiple recipients at the same time.

3.4. There was no standardised way of adult social care providers categorising deaths as being related to Covid-19 and it is anticipated that there will have been variations between care providers as to how the guidance was interpreted and how deaths were categorised. There was also no common system for collecting this data and so providers had to rely on their own operational processes.

3.5. Care UK adopted a relatively cautious approach and categorised deaths as being related to Covid-19 where a resident had either tested positive for Covid-19 prior to their death or experienced symptoms of Covid-19 prior to their death when testing was not available, even where the residents were already receiving palliative care for reasons unrelated to Covid.

3.6. Care UK was conscious that the media was looking for attention-grabbing headlines and thus were reporting the number of deaths occurring in care homes without grounding this in the reality of how many deaths generally occurred in care homes during normal times. It was therefore difficult for the public to have an appreciation of the increase in deaths. I also refer to the reflective piece of Care Home Manager D (**Exhibit AK/05 – INQ000509768**) which refers to residents being discharged from hospital

and admitted to care homes but then dying several days later. She expresses the view that these residents should not have been discharged from hospital and that this artificially increased the number of care home deaths.

4. Concerns regarding personal protective equipment (PPE)

Access to PPE

4.1. Care UK sourced and funded its own PPE early on during the pandemic as there was no initial indication that the Government would provide supplies of PPE. This involved an initial outlay by Care UK of over I&S by early April 2020 increasing to over I&S by the end of May 2020. At this time, the cost of a face mask had increased from I&S to I&S and suppliers required cash to be paid upfront. Care UK entered into contracts with a number of PPE suppliers, accepting that there was a risk that some suppliers may not deliver. Fortunately, all suppliers fulfilled the contracts and provided the items purchased.

4.2. During March 2020, Care UK distributed PPE very carefully to ensure that each home had at least a weeks' supply. Care UK redeployed its hotel services team to distribute PPE around the country, to ensure a steady supply to all of the company's homes. Hotel service managers are based regionally and usually cover 25-30 care homes. These managers would have PPE delivered to their homes and they would then drive significant distances, often overnight, to deliver supplies to Care UK's homes.

4.3. Care UK was in a relatively strong position in terms of PPE by mid-April 2020, due to the company's own efforts. Care UK introduced a PPE tracker Excel spreadsheet which was used during April and May 2020 to keep track of stock levels.

4.4. On 10 April 2020, the Department of Health and Social Care published the "Covid-19: Personal Protective Equipment Plan" (**Exhibit TW/02 – INQ000050008**). This was followed, on 15 April 2020, by "COVID-19: Our Action Plan for Adult Social Care" (**Exhibit TW/03 – INQ000233794**).

4.5. These documents set out that as an initial step, social care providers across England had received an emergency drop of 7 million PPE items so

that every CQC registered care provider received at least 300 face masks to meet immediate needs. It was also set out that the Government had authorised the release of a further 34 million items of PPE across 38 local resilience forums, including 8 million aprons, 4 million masks and 20 million pairs of gloves.

4.6. Care UK found that the PPE supplied by the Government was insufficient to meet the company's needs, due to the number of Care UK colleagues and residents and the frequency at which PPE needed to be changed to comply with DHSC and Public Health England guidance.

4.7. Care UK also received stocks of PPE from the Government that had been redated. The supplies had surpassed their initial use by date but had been through a quality assurance process and the expiry date changed to enable usage at that point. Care UK had serious concerns regarding the quality of this PPE. For example, our initial supplies were primarily tieback facemasks (i.e. they tied at the back rather than looping over the ears as was later the case) and on many occasions, the ties would detach from the mask as colleagues were fitting them. This caused serious concerns for colleagues. This issue was soon rectified by the Government and by the end of Summer 2020, we had much more confidence in the quality of equipment that we were being provided with.

4.8. As Care UK could not initially rely on sufficient levels of appropriate PPE being provided by the Government, the company primarily relied on its own purchases of PPE for the first few months of the pandemic.

4.9. In late Summer of 2020, we started ordering PPE via the Government portal. While the quality of this PPE was of a high standard, initially the volumes allocated to each care home fell short of what was required so we continued to top this up with our own supplies.

Suitability of PPE

4.10. Once it was acknowledged by the Government that PPE was required in care homes, it was advised that any clinician or care worker who was working in a hospital, primary care, or community care setting, including care homes, who were within two metres of a possible or confirmed Covid

patient, should wear an apron, gloves, a surgical mask and eye protection (See "Covid-19: Personal Protective Equipment (PPE) Plan", published on 10 April 2020, at **Exhibit TW/02 - INQ000050008**). Higher levels of protection were only advised for those carrying out aerosol generating procedures.

4.11. Care UK found that many of its colleagues were worried about whether surgical facemasks provided sufficient protection against the virus, especially as colleagues were often caring for residents who had tested positive for Covid. These concerns were exacerbated by media reports of NHS staff treating Covid positive patients whilst using higher levels of PPE, such as visors and hazmat suits. There were also instances of colleagues from NHS settings wearing Hazmat suits to attend care homes to collect bodies of deceased residents and care workers being expected to assist them whilst only wearing surgical face masks, aprons, gloves and eye protection.

4.12. By way of context, NHS healthcare practitioners, such as GPs and district nurses, had stopped attending care homes early in the pandemic. By contrast, care home colleagues were required to work beyond their usual roles to ensure that tasks ordinarily performed by district nurses were still carried out. This included providing administering medication, overseeing end of life care and verifying deaths.

4.13. Whilst some of Care UK's homes are nursing homes and so nurses were already working within the homes, residential homes only had experienced carers in place, who would not previously have had any formal medical or nursing training. During the pandemic, these carers worked with acutely unwell and end of life residents, with only disposable gloves, surgical face masks, aprons, and eye protection. For many, this increased level of responsibility in highly stressful circumstances had a very negative impact on their mental health, particularly as Covid related deaths in care homes continued to rise.

Fit testing of PPE

4.14. Care UK did not experience any significant issues regarding fit testing of PPE. Fit testing was only required for FFP3 masks and these masks were only required for aerosol generating procedures.

The use of PPE in care homes

4.15. On 13 March 2020, Public Health England issued guidance for social care settings stated that *"If neither the carer nor the individual receiving care is symptomatic, then no PPE is required above and beyond normal* good *hygiene practices"* (**Exhibit TW/04 – INQ000509799**). There was therefore initially no requirement to use PPE, unless a resident or carer was symptomatic. Given what was later known about the transmission of Covid by asymptomatic individuals, this guidance did not provide for adequate protection for colleagues or residents within care homes and in Care UK's view, PPE should have been required (and provided) for all care home workers from the outset.

4.16. Once it was recognised that PPE was required, Care UK had to source its own PPE as there was initially no indication that PPE would be provided by the Government. Once PPE was supplied by the Government, there was not enough to meet the needs of the company's colleagues and residents.

4.17. Care UK did not encounter any significant issues in terms of colleague compliance with the requirement to use PPE. Using PPE did make the working day uncomfortable for members of staff, particularly in care home settings which are kept warmer than most offices or homes to ensure the comfort of elderly residents. There was, at times, a need to remind colleagues to use PPE appropriately, for example reminding colleagues to ensure that their face mask covered their mouth and nose, but this was managed well by Care UK's home managers. Colleagues generally embraced the requirement to use PPE as a measure to protect themselves and residents. I refer to the reflective piece of Care Home Manager D (at **Exhibit AK/05 – INQ000509768**) which refers to having had to have difficult meetings with relatives who felt that Covid was a conspiracy and so refused to wear face masks.

4.18. It has been widely acknowledged that a carer wearing a face mask presents challenges when caring for a resident with dementia. It was not possible to explain to individuals with dementia why a face mask was being worn and this could be frightening for the resident and removed the ability for them to interpret, and to obtain reassurance from, facial expressions. The use of face masks had a significant impact on residents with dementia, including in respect of their mental and physical health.

The impact of limited PPE in care settings

4.19. Care UK considers that the initial lack of PPE undoubtedly impacted on safety in care settings. Whilst staff were working hard to protect residents, the reality is that without adequate testing and appropriate PPE, members of staff will have contributed to the transmission of Covid from the community into care homes and Covid will have been transmitted within care homes.

4.20. Once it was acknowledged that PPE was required in care homes, it was advised that any clinician or care worker who was working in a hospital, primary care, or community care setting, including care homes, who were within two metres of a possible or confirmed Covid-19 patient, should wear an apron, gloves, surgical mask, and eye protection. Higher levels of protection were only advised for those carrying out aerosol generating procedures (again, see **Exhibit TW/02 - INQ000050008**). Whilst Care UK is unable to comment on the impact that the guidance had in terms of transmission of the virus, Care UK's colleagues were worried about whether surgical facemasks provided sufficient protection.

4.21. Some colleagues reported difficulties with wearing face masks as this caused their glasses to steam up and affected their ability to see properly. Some colleagues with hearing issues also reported difficulties as they would ordinarily rely on lip reading and could no longer do this due to their colleagues wearing face masks.

5. Key guidance and advice provided by Care UK to colleagues, care homes, residents and loved ones

5.1. The key guidance provided by Care UK to its staff and care homes during the pandemic was set out within "The Pandemic Event Plan" and "The COVID-19 Outbreak Management Plan".

5.2. The Pandemic Event Plan set out guidance in relation to key areas such as Care UK's approach to the pandemic, serious incident reporting, heightened prevention and control measures, NHS and local authority bed usage, admissions criteria and processes and visiting guidance and restrictions. Guidance documents relating to these specific issues were appended to the Plan for ease of reference.

5.3. The "COVID-19 (Coronavirus) Outbreak Management Plan" set out the actions to be taken if one or more residents had a suspected or confirmed case of Covid-19. The plan set out the steps to be taken in respect of home manager reporting, communication, prevention and control measures, isolation and cohorting, admissions, healthcare appointments, visits from non-essential services and visitor infection prevention and control measures.

5.4. Both documents were introduced on 13 March 2020 and updated throughout 2020 and 2021 to reflect updates to guidance issued by the Government and other bodies. There were 42 versions of the "Pandemic Event Plan" during the relevant period and 10 versions of the "Covid-19 (Coronavirus) Outbreak Management Plan", although not all versions were issued to colleagues as guidance changed so rapidly that the documents were at times superseded before being issued. Versions 1, 2, and 42 of the Pandemic Event Plan are attached by way of examples (**Exhibit TW/05 – INQ000509800**). Versions 1, 2, and 10 of the "COVID-19 (Coronavirus) Outbreak Management Plan" are also attached (**Exhibit TW/06 - INQ000509801**).

5.5. Care UK provided in excess of 200 other guidance documents to colleagues and care homes during the Pandemic. This included the following documents which are attached as **Exhibit TW/07 – INQ000515877**:

Outbreak management

- How to complete an outbreak root cause analysis – 12.11.20.
- Outbreak root cause analysis flowchart – 01.02.2021.

Medication

- How to Guide – COVID-19 Medication supply – 01.05.20.
- Medicines re-use pathway flowchart – 01.05.2020.

PPE

- Putting on and taking off PPE – 26.03.2020.
- Eye protection flowchart – 22.04.2020.
- The use and maintenance of PPE – 24.04.20.

Social distancing and shielding

- Facilitating social bubbles – 26.06.20.
- Supporting a colleague returning from shielding – 27.07.20.
- Returning to work after travelling – 29.07.20.
- Maintaining social distance – 15.12.20.

Testing

- Consent for swab testing – 13.05.20.
- Whole home testing – 18.05.20.
- Colleague testing – 04.06.20.
- Testing for new starters – 17.06.20.
- Refusal of testing – 18.09.20.
- Recording testing – 18.09.20.
- Lateral flow guidance – 07.12.20.

Vaccinations

- Recording vaccinations – 08.12.20.
- Residents declining vaccination – 04.02.21.

End of life care

- Last days of life care plan – 15.04.20.

- Verification of expected death – competency assessment – 27.04.2020.

Recruitment and staffing

- Onboarding – 01.04.20.

Visiting

- Visiting suspension - Granting an exceptional relative visit – 03.04.20.
- How to facilitate safe visiting by relatives – 10.06.20.
- Granting an exceptional visit inside the care home – 08.12.20.
- How to facilitate indoor and outdoor visiting – 05.03.21.
- How to facilitate indoor and outdoor visiting (Scotland) – 05.03.21.

Office based colleagues

- Guidance for office based colleagues and support teams – 15.05.2020.

Residents with dementia

- How to guide – COVID-19 Supporting people with dementia walking with purpose and/ or expressing distress – 21.05.2020.
- Supporting handwashing for people with dementia to minimise the spread of infection – 12.08.2020.

5.6. Care UK also regularly wrote to relatives to keep them updated as to how any changes to restrictions would impact on their loved ones and how guidance was being implemented within Care UK's homes. Example letters are attached as **Exhibit TW/08 – INQ000509803**.

5.7. Care UK also produced the following guidance for relatives regarding visitor restrictions:

- "Your questions answered" on 01.04.2020 (**Exhibit TW/09 – INQ000509799**).
- "COVID-19 pandemic: Guide to visiting a relative or friend living with dementia in a Care UK home", produced on 10.06.20 and updated on 24.12.20 **(Exhibit TW/10 – INQ000509805)**.

5.8. A poster was also displayed in care homes titled "Care home visitors, Visiting restrictions are in place". The poster asked visitors to ring the doorbell and to wait for a member of staff, to put on a face mask and sanitise their hands and encouraged them to get their free flu vaccine if they were eligible **(Exhibit TW/11 – INQ000509806)**.

5.9. Care UK also displayed information for residents to help them understand the changes that were having to be made within care homes. This included displaying a poster which sets out in large text *"I am a nurse. I am here to help you. There is a nasty virus going round. I am wearing this face mask to **keep us safe**"* **(Exhibit TW/12 – INQ000509807)**.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

Dated: 29th Jan, 2025